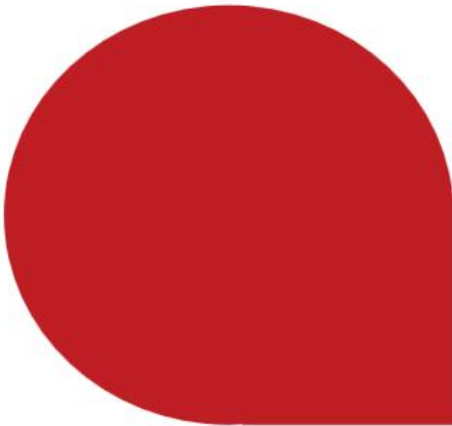




Office of Health Standards Compliance
Ensuring quality and safety in health care



Mental Health Care Unit

v1.2.1

**Regulatory Private Acute
Hospital Inspection tool**

Facility:
Date:

- **Tool Name:** Regulatory Private Acute Hospital Inspection Tool v1.2.1
- **HEs Type:** Hospitals
- **Sector:** Private
- **Specialization:** Private Acute Hospital
- **Created By:** Health Standards Development and Training

22 Mental Healthcare Unit

Domain 22.1 USER RIGHTS

Sub Domain 22.1.1 4 User information.

Standard 22.1.1.1 4(1) The health establishment must ensure that users are provided with adequate information about the health care services available at the health establishment and information about accessing those services.

Criterion 22.1.1.1.1 4(2)(a)(iii) The health establishment must provide users with information relating to visiting hours where relevant.

22.1.1.1.1.1 The visiting hours are indicated at the entrance to the unit.

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

Visiting hours must be displayed at the entrance of the unit.

Not applicable: Where the visiting hours in the unit are the same as the general visiting hours displayed at the entrance to the health establishment.

Score	Comment

Criterion 22.1.1.1.2 4(2)(a)(iv) The health establishment must provide users with information relating to the complaints, compliments and suggestions management system.

22.1.1.1.2.1 A system to provide users with information on complaints management procedure is available.

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

There must be a system in place to inform users on the procedure for lodging complaints in the unit. The system could include but is not limited to a person responsible for informing users about the complaints procedure or posters or pamphlet informing users about the complaints procedure, information displayed within the unit informing users about the complaints procedure or where to access information about complaints procedure. This can be a manual or electronic system.

Not applicable: Never

Score	Comment

Sub Domain 22.1.2 5 Access to care.

Standard 22.1.2.1 5(1) The health establishment must ensure that users are attended to in a manner which is consistent with the nature and severity of their health condition.

Criterion 22.1.2.1.1 5(2)(c) The health establishment must adhere to clinical guidelines on stabilizing users presenting in an emergency before referring them to another health establishment.

22.1.2.1.1.1 Guidelines regarding examination and stabilisation of acutely violent or unstable mental health care users are adhered to.

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

Select three health records of users presenting with a psychiatric emergency. Verify whether the aspects listed below were documented in the health record. Score 1 if the aspect is documented and 0 if not documented. Score not applicable where no users who required examination and stabilisation were seen at the time of inspection or in the previous month.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. User was assessed by a mental health care practitioner		
2. History of presenting complaint. Explanatory note: This may be history available from the user if he/she is able to provide it, from individuals accompanying the user, or records accompanying the user. Where it is not possible to obtain the history immediately, it must be obtained and documented as soon as possible.		
3. Physical examination, including vital signs. Explanatory note: This may not be possible in an acute situation, but it should be completed as soon as the user is calm enough to permit the examination.		
4. Categorisation of user according to legal classification in Mental Health Care Act assessment categories		
5. Investigations ordered and performed		
6. Treatment administered, including medicine/sedation		
7. Monitoring of user in accordance with guidelines where physical or chemical restraint is used		
8. If user was transferred, details of receiving doctor or mental health care practitioner and health establishment		
9. If user was transferred, record indicating that he/she was calm and manageable for transfer		

Unit 2 User health record 2

Aspects	Score	Comment
1. User was assessed by a mental health care practitioner		
2. History of presenting complaint. Explanatory note: This may be history available from the user if he/she is able to provide it, from individuals accompanying the user, or records accompanying the user. Where it is not possible to obtain the history immediately, it must be obtained and documented as soon as possible.		
3. Physical examination, including vital signs. Explanatory note: This may not be possible in an acute situation, but it should be completed as soon as the user is calm enough to permit the examination.		

4. Categorisation of user according to legal classification in Mental Health Care Act assessment categories		
5. Investigations ordered and performed		
6. Treatment administered, including medicine/sedation		
7. Monitoring of user in accordance with guidelines where physical or chemical restraint is used		
8. If user was transferred, details of receiving doctor or mental health care practitioner and health establishment		
9. If user was transferred, record indicating that he/she was calm and manageable for transfer		

Unit 3 User health record 3

Aspects	Score	Comment
1. User was assessed by a mental health care practitioner		
2. History of presenting complaint. Explanatory note: This may be history available from the user if he/she is able to provide it, from individuals accompanying the user, or records accompanying the user. Where it is not possible to obtain the history immediately, it must be obtained and documented as soon as possible.		
3. Physical examination, including vital signs. Explanatory note: This may not be possible in an acute situation, but it should be completed as soon as the user is calm enough to permit the examination.		
4. Categorisation of user according to legal classification in Mental Health Care Act assessment categories		
5. Investigations ordered and performed		
6. Treatment administered, including medicine/sedation		
7. Monitoring of user in accordance with guidelines where physical or chemical restraint is used		
8. If user was transferred, details of receiving doctor or mental health care practitioner and health establishment		
9. If user was transferred, record indicating that he/she was calm and manageable for transfer		

22.1.2.1.1.2 MHCA Form 22 is completed for mental health care users brought in by the South African Police Service.

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

Select the health records of users who have been brought in by the South African Police Service for admission. Verify whether the MHCA Form 22 has been completed and is available in the user's folder.

Score 1 if compliant and 0 if not.

Not applicable: Where no users were brought in by the South African Police Service for admission or if the health establishment is not licensed to admit these users.

Score	Comment

Aspects	Score	Comment
1. User health record 1		
2. User health record 2		
3. User health record 3		

Domain 22.2 CLINICAL GOVERNANCE AND CLINICAL CARE

Sub Domain 22.2.1 6 User health records and management.

Standard 22.2.1.1 6(1) The health establishment must ensure that health records of health care users are protected, managed and kept confidential in line with section 14, 15 and 17 of the Act.

Criterion 22.2.1.1.1 6(2)(b) The health establishment must ensure confidentiality of health records.

22.2.1.1.1.1 Confidentiality of health records is maintained.

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

Observe how user health records are managed in the unit and determine whether unauthorised individuals would be able to access the information in the health records. This includes but not limited to the health records of users admitted to the unit, health records being used for clinical audits or other administrative purposes or health records outside the records storage area or room of the unit for any other reason. Such records should be kept in a manner that safeguards against unauthorised access to the content of the health record. User records may be placed at the foot end of the bed but must not be left open for people to be able to read them when a health care provider is not present.

Not applicable: Never

Score	Comment

Standard 22.2.1.2 6(3) The health establishment must create and maintain a system of health records of users in accordance with the requirements of section 13 of the Act.

Criterion 22.2.1.2.1 6(4)(b) The health establishment must record information relating to the examination and health care interventions of users.

22.2.1.2.1.1 A clinical assessment and management plan for the user is recorded in the user health record.

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

Select the health records of three users to verify compliance with requirements listed below. Score 1 if the aspect is compliant and 0 if not compliant. Manual or electronic records are acceptable.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Vital signs		
2. Physical examination		
3. DSM V Code		
4. Nursing care plan		
5. Nurses day-time progress notes		
6. Nurses night-time progress notes		

7. Medicines administered (signed, dated, time of administration and dose recorded)		
8. Date of each entry		
9. Time of each entry		
10. Each entry is signed by the nurse.		
11. Full names of signatory.		
12. Designation of signatory		

Unit 2 User health record 2

Aspects	Score	Comment
1. Vital signs		
2. Physical examination		
3. DSM V Code		
4. Nursing care plan		
5. Nurses day-time progress notes		
6. Nurses night-time progress notes		
7. Medicines administered (signed, dated, time of administration and dose recorded)		
8. Date of each entry		
9. Time of each entry		
10. Each entry is signed by the nurse.		
11. Full names of signatory.		
12. Designation of signatory		

Unit 3 User health record 3

Aspects	Score	Comment
1. Vital signs		
2. Physical examination		
3. DSM V Code		
4. Nursing care plan		
5. Nurses day-time progress notes		

6. Nurses night-time progress notes		
7. Medicines administered (signed, dated, time of administration and dose recorded)		
8. Date of each entry		
9. Time of each entry		
10. Each entry is signed by the nurse.		
11. Full names of signatory.		
12. Designation of signatory		

22.2.1.2.1.2 The admission process for users admitted for 72-hour observation demonstrates adherence to legislated requirements.

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

Select the health records of three mental health care users admitted as involuntary or assisted admissions. Verify whether all the required forms were completed and signed, in accordance with the Mental Health Care Act. Copies or originals of the relevant documentation (MHCA Forms) must be filed in the user's health record. Score 1 if the aspect is present in the record and 0 if not present. If not applicable, write not applicable against that aspect for the particular user. Requirements not applicable where the health establishment does not admit mental health care users for 72-hour observation. Manual or electronic records are acceptable.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. One MHCA 04 (Application for assisted or involuntary care, treatment and rehabilitation)		
2. Two MHCA 05 (Examination and finding of mental health care practitioner following an application for assisted or involuntary care, treatment and rehabilitation). Explanatory note: Two forms for each user, documenting the findings of examination by two independent mental health care practitioners must be available.		
3. One MHCA 07 (Notice by head of health establishment on his/her decision whether to provide assisted or involuntary inpatient care, treatment and rehabilitation services).		
4. Two MHCA 06 (72-hour assessment, findings of medical practitioner or mental health care practitioner and recommendations regarding further treatment). Explanatory note: Two forms for each user, documenting the 72-hour assessment findings and recommendations of two independent mental health care practitioners must be available.		
5. One MHCA 08 (Notice by head of health establishment to review board requesting approval for further involuntary care, treatment and rehabilitation on an inpatient basis). This should be marked Not applicable if there is no need for further involuntary care.		

Unit 2 User health record 2

Aspects	Score	Comment
1. One MHCA 04 (Application for assisted or involuntary care, treatment and rehabilitation)		
2. Two MHCA 05 (Examination and finding of mental health care practitioner following an application for assisted or involuntary care, treatment and rehabilitation). Explanatory note: Two forms for each user, documenting the findings of examination by two independent mental health care practitioners must be available.		
3. One MHCA 07 (Notice by head of health establishment on his/her decision whether to provide assisted or involuntary inpatient care, treatment and rehabilitation services).		
4. Two MHCA 06 (72-hour assessment, findings of medical practitioner or mental health care practitioner and recommendations regarding further treatment). Explanatory note: Two forms for each user, documenting the 72-hour assessment findings and recommendations of two independent mental health care practitioners must be available.		
5. One MHCA 08 (Notice by head of health establishment to review board requesting approval for further involuntary care, treatment and rehabilitation on an inpatient basis). This should be marked Not applicable if there is no need for further involuntary care.		

Unit 3 User health record 3

Aspects	Score	Comment
1. One MHCA 04 (Application for assisted or involuntary care, treatment and rehabilitation)		
2. Two MHCA 05 (Examination and finding of mental health care practitioner following an application for assisted or involuntary care, treatment and rehabilitation). Explanatory note: Two forms for each user, documenting the findings of examination by two independent mental health care practitioners must be available.		
3. One MHCA 07 (Notice by head of health establishment on his/her decision whether to provide assisted or involuntary inpatient care, treatment and rehabilitation services).		
4. Two MHCA 06 (72-hour assessment, findings of medical practitioner or mental health care practitioner and recommendations regarding further treatment). Explanatory note: Two forms for each user, documenting the 72-hour assessment findings and recommendations of two independent mental health care practitioners must be available.		
5. One MHCA 08 (Notice by head of health establishment to review board requesting approval for further involuntary care, treatment and rehabilitation on an inpatient basis). This should be marked Not applicable if there is no need for further involuntary care.		

22.2.1.2.1.3 The treatment plan for high-risk users is documented.

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

Select the health records of three users who were categorised as high-risk and verify if the treatment plan is documented. The treatment plan includes, but is not limited to, specific accommodation, specific chemical or physical restraints, specific observations and monitoring. Score 1 if it is documented and 0 if not. Manual or electronic records are acceptable.

Score	Comment	
Aspects	Score	Comment
1. User health record 1		
2. User health record 2		
3. User health record 3		

22.2.1.2.1.4 Mental health care users are managed using a multidisciplinary therapeutic approach.

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

Select the health records of three users who have already started biopsychosocial therapeutic care. Verify whether the records indicate that multidisciplinary assessments have been conducted by the categories health care provider listed below. Score 1 if the assessment by each category of health care provider is documented and 0 if not documented. Please note the user will not necessarily be assessed by all healthcare providers listed below. Manual or electronic records are acceptable.

Score	Comment	

Unit 1 User health record 1

Aspects	Score	Comment
1. Professional nurse		
2. Medical officer/psychiatrist		
3. Social worker		
4. Psychologist		
5. Occupational therapist		

Unit 2 User health record 2

Aspects	Score	Comment
1. Professional nurse		
2. Medical officer/psychiatrist		
3. Social worker		
4. Psychologist		

5. Occupational therapist		
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Unit 3 User health record 3

Aspects	Score	Comment
1. Professional nurse		
2. Medical officer/psychiatrist		
3. Social worker		
4. Psychologist		
5. Occupational therapist		

22.2.1.2.1.5 High risk mental health care users are stabilised.

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

Select the health records of three users who were categorised as high-risk. Review the documented care provided to the user to determine whether the care provided was in accordance with the treatment plan.

Score 1 if the aspect is compliant and 0 if not compliant. Manual or electronic records are acceptable. Not applicable: For aspects not applicable to individual users.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Documentation of decision for restraint/seclusion/observation		
2. Decisions for restraint documented in unit register		
3. If user was restrained, monitoring was conducted as specified in standard operating procedure		
4. User's condition and/or mental state reviewed in accordance with documented plan		
5. Documentation of treatment administered		
6. Response to treatment documented		
7. Side effects of treatment documented		

Unit 2 User health record 2

Aspects	Score	Comment
1. Documentation of decision for restraint/seclusion/observation		

2. Decisions for restraint documented in unit register		
3. If user was restrained, monitoring was conducted as specified in standard operating procedure		
4. User's condition and/or mental state reviewed in accordance with documented plan		
5. Documentation of treatment administered		
6. Response to treatment documented		
7. Side effects of treatment documented		

Unit 3 User health record 3

Aspects	Score	Comment
1. Documentation of decision for restraint/seclusion/observation		
2. Decisions for restraint documented in unit register		
3. If user was restrained, monitoring was conducted as specified in standard operating procedure		
4. User's condition and/or mental state reviewed in accordance with documented plan		
5. Documentation of treatment administered		
6. Response to treatment documented		
7. Side effects of treatment documented		

22.2.1.2.1.6 Users are monitored in the ECT room recovery area.

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

Select the health records of three users in the recovery room. Verify whether the aspects listed below are being monitored. Score 1 if the aspect is compliant is 0 if not compliant. Not applicable if the unit does not perform Electroconvulsive Therapy (ECT). Manual or electronic records are acceptable.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Blood pressure		
2. Pulse		
3. Temperature		
4. Saturation		
5. Respiration rate		

6. Level of consciousness		
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Unit 2 User health record 2

Aspects	Score	Comment
1. Blood pressure		
2. Pulse		
3. Temperature		
4. Saturation		
5. Respiration rate		
6. Level of consciousness		

Unit 3 User health record 3

Aspects	Score	Comment
1. Blood pressure		
2. Pulse		
3. Temperature		
4. Saturation		
5. Respiration rate		
6. Level of consciousness		

22.2.1.2.1.7 Formal risk assessment has been conducted to identify users at high risk of harming themselves or others.

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

Select the health records of three users admitted in the previous six months. Verify whether the risk assessments listed below have been completed. Score 1 if the aspect is compliant and 0 if not compliant. Manual or electronic records are acceptable.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Risk examination conducted for factors related to aggression		
2. Risk examination conducted for factors related to suicidal risk		
3. Risk examination conducted for factors related to substance withdrawal		

4. Risk examination conducted for factors related to absconding		
5. Risk examination conducted for factors relating to being sexually inappropriate		
6. Risk examination conducted for factors related to noncompliance to treatment		
7. User has been categorised in terms of risk level (i.e. high, medium, low)		
8. User has been categorised in terms of type of risk (i.e. self-harm, violence, other)		

Unit 2 User health record 2

Aspects	Score	Comment
1. Risk examination conducted for factors related to aggression		
2. Risk examination conducted for factors related to suicidal risk		
3. Risk examination conducted for factors related to substance withdrawal		
4. Risk examination conducted for factors related to absconding		
5. Risk examination conducted for factors relating to being sexually inappropriate		
6. Risk examination conducted for factors related to noncompliance to treatment		
7. User has been categorised in terms of risk level (i.e. high, medium, low)		
8. User has been categorised in terms of type of risk (i.e. self-harm, violence, other)		

Unit 3 User health record 3

Aspects	Score	Comment
1. Risk examination conducted for factors related to aggression		
2. Risk examination conducted for factors related to suicidal risk		
3. Risk examination conducted for factors related to substance withdrawal		
4. Risk examination conducted for factors related to absconding		
5. Risk examination conducted for factors relating to being sexually inappropriate		
6. Risk examination conducted for factors related to noncompliance to treatment		
7. User has been categorised in terms of risk level (i.e. high, medium, low)		
8. User has been categorised in terms of type of risk (i.e. self-harm, violence, other)		

Standard 22.2.1.3 6(5) The health establishment must have a formal process to be followed when obtaining informed consent from the user.

Criterion 22.2.1.3.1 6 A documented procedure which describes the information to be collected and discussed during the process to obtain informed consent is implemented, in accordance with Chapter 2 of the National Health Act (Section 7).

22.2.1.3.1.1 Confirmation of informed consent is documented in the user health records.

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

Request three health records of users who gave written consent to procedures and medical treatment. Examine whether confirmation of informed consent is documented in the health records. This could be a specific form designed for this purpose by the health establishment or notes made by a healthcare provider in the health record. Score 1 if the aspect is compliant and 0 if not compliant. Manual or electronic records are acceptable.

Score	Comment	
Aspects	Score	Comment
1. User health record 1		
2. User health record 2		
3. User health record 3		

Standard 22.2.1.4 6(6) The health establishment must issue a discharge report to users in accordance with section 10 of the Act.

Criterion 22.2.1.4.1 6 Comprehensive discharge reports must be provided to users to ensure continuity of care.

22.2.1.4.1.1 The health records of discharged users include a discharge report.

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

Select the health records of three users who have been discharged in the previous week and verify whether the discharge report contains the aspects listed below. Score 1 if the aspect is present and 0 if not present. Manual or electronic records are acceptable.

Score	Comment

Unit 1 User health record 1

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or Identity number or passport number		
3. Date of admission		
4. Date of discharge		
5. Provisional diagnosis/reason for admission		
6. Name of unit to which user was admitted (this may be a name or alphanumeric details)		
7. Final diagnosis on discharge		
8. Medicine and treatment		

9. Details of referrals and/or follow-up appointments		
10. Relevant health education given		
11. Signature of health care provider completing report		
12. MHCA 03 sent to the Mental Health Review Board (where necessary)		

Unit 2 User health record 2

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or Identity number or passport number		
3. Date of admission		
4. Date of discharge		
5. Provisional diagnosis/reason for admission		
6. Name of unit to which user was admitted (this may be a name or alphanumeric details)		
7. Final diagnosis on discharge		
8. Medicine and treatment		
9. Details of referrals and/or follow-up appointments		
10. Relevant health education given		
11. Signature of health care provider completing report		
12. MHCA 03 sent to the Mental Health Review Board (where necessary)		

Unit 3 User health record 3

Aspects	Score	Comment
1. Name and surname of user		
2. Date of birth or Identity number or passport number		
3. Date of admission		
4. Date of discharge		
5. Provisional diagnosis/reason for admission		
6. Name of unit to which user was admitted (this may be a name or alphanumeric details)		
7. Final diagnosis on discharge		
8. Medicine and treatment		
9. Details of referrals and/or follow-up appointments		

10. Relevant health education given		
11. Signature of health care provider completing report		
12. MHCA 03 sent to the Mental Health Review Board (where necessary)		

Sub Domain 22.2.2 7 Clinical management.

Standard 22.2.2.1 7(1) The health establishment must establish and maintain clinical management systems, structures and procedures that give effect to national policies and guidelines.

Criterion 22.2.2.1.1 7(2)(a) The health establishment must ensure that clinical policies and guidelines for priority health conditions issued by the national department are available and communicated to health care personnel.

22.2.2.1.1.1 Clinical guidelines and policies are communicated to relevant health care personnel.

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

Documented evidence that personnel have been informed about the clinical policies and guidelines must be available. This may include, but need not be limited to, distribution lists that include personnel signatures indicating that they have read and understood the document (which must be dated and signed), proof of attendance at meetings where policies and guidelines were discussed or similar evidence for electronic distribution. Score 1 if such evidence is available and 0 if not available. Communication to relevant healthcare personnel indicating the documents are available in a portal is acceptable.

Score	Comment	
Aspects	Score	Comment
1. Policy Guidelines on 72-hour Assessment of Involuntary Mental Health Care Users, 2012 or latest		
2. Policy Guidelines on Seclusion and Restraint of Mental Health Care Users, March 2012 or latest		

Criterion 22.2.2.1.2 7 Health care personnel must be informed about standard operating procedure and guidelines.

22.2.2.1.2.1 Health care personnel have been informed about the policy or standard operating procedure or procedure or guideline of the unit and health establishment.

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

Documented evidence that personnel have been informed about the policy or standard operating procedure or procedure or guideline must be available. This could include but is not limited to distribution lists which include personnel signatures to indicate they have read and understood the document (which must be dated and signed), proof of attendance at meetings where policies, guidelines and standard operating procedures are discussed, or similar evidence for electronic distribution which could include but not limited to email distribution or documents deposited in intranet or other electronic platforms. Score 1 if such evidence is available and score 0 if it is not available.

Score	Comment	
Aspects	Score	Comment
1. Management of psychiatric emergencies		
2. Confidentiality on user health records		
3. Confirmation of informed consent		

4. Management of users detained for 72-hour observation		
5. Conducting and acting on risk assessments		
6. Conducting risk assessments for mental health care users		
7. Management of emergency resuscitations		
8. Management of users with contagious infections		
9. Management of adverse events		
10. Safe administration of medicines to users		

Standard 22.2.2.2 7(2) (b) A health establishment must establish and maintain systems, structures and programmes to manage clinical risk.

Criterion 22.2.2.2.1 7 Standardised procedures to identify and mitigate clinical risk must be implemented during the care of vulnerable users.

22.2.2.2.1.1 Risk assessments are conducted for frail or aged users to identify those at high risk of falls or developing pressure sores.

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

Select three health records of frail and/or aged users admitted to the unit at the time of inspection. Verify whether formal risk assessments, including but not limited to Waterlow or Norton scale to determine the user's risk for developing pressure sores, and the Morse fall scale to determine the user's risk of falling, were completed on admission. Score 1 if the aspect is compliant and 0 if not compliant.

Score	Comment	
Aspects	Score	Comment
1. User health record 1		
2. User health record 2		
3. User health record 3		

Criterion 22.2.2.2.2 7 Systems must be in place to facilitate user identification.

22.2.2.2.2.1 There is a system to identify mental healthcare users.

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

A system used to identify mental health care users is documented. This could be use of photographs or any other system.

Not applicable: Never

Score	Comment

22.2.2.2.2.2 All users admitted in the unit are identified in line with the documented system.

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

Select three users in the unit and verify whether they are identified in line with the documented system. Score 1 if users are identified and 0 if not identified.

Score	Comment

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

Criterion 22.2.2.2.3 7 Communication during user handover must be standardised to advance user safety.

22.2.2.2.3.1 User safety checks are applied to all users transferred from one unit to another within the health establishment.

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

Request the internal transfer form completed for three users who have been transferred from one unit to another within the health establishment at the time of inspection. Score 1 if the transfer form has been completed and 0 if not completed.

Not applicable: Where there were no users transferred.

Score	Comment

Aspects	Score	Comment
1. Health record 1		
2. Health record 2		
3. Health record 3		

Criterion 22.2.2.2.4 7 The management of emergency resuscitations must be guided and monitored to improve user outcomes.

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

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

Inspect the contents of the emergency trolley against the aspects listed below. Score 1 if the aspect listed is available, functional and not expired (if applicable) and score 0 if the aspect is not available, not functional or expired (if applicable).

Score	Comment

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

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

22.2.2.2.4.2 Medical supplies and equipment for resuscitation is available.

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

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

Score	Comment	
Aspects	Score	Comment
1. Chlorhexidine or Alcohol swabs		
2. Eye protection		
3. Facemask		
4. Gloves		
5. Spare batteries for laryngoscope		
6. Spare bulb (where applicable)		
7. Syringe (a minimum of three different sizes)		
8. Catheter tip syringe 50ml		

9. Needles (a minimum of three different sizes)		
10. Scissors		
11. Tourniquet		
12. Stethoscope		
13. Nasogastric tubes (a minimum of three different sizes).		
14. Suction catheters (a minimum of three different sizes).		
15. Suction devices (portable)		
16. Yankhauer suction		
17. Nasal cannula		
18. Blood administration set		
19. Local resuscitation protocol or Resuscitation Algorithm		

22.2.2.2.4.3 The emergency trolley and emergency equipment are checked in accordance with agreed unit practice.

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

Request a documented practice for checking the emergency trolley and verify whether it is checked as documented. This must also include checking of the defibrillator/ Automated External Defibrillator. Request documented records of checking the emergency trolley from the previous month.

Not applicable: Never

Score	Comment

Criterion 22.2.2.2.5 7 Managerial, clinical and administrative information must be used to support decision-making and planning.

22.2.2.2.5.1 The health establishment is licenced to admit assisted or involuntary mental health care users.

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

In terms of Mental health Act 2002 (Act 17 of 2002), General Regulations Chapter 9 Section 42(2) the health establishment must be licenced to admit assisted and or involuntary mental health care user. Request a copy of the license issued by the relevant authority to the health establishment.

Not applicable: Where the health establishment does not admit assisted or involuntary mental health care users.

Score	Comment

Criterion 22.2.2.2.6 7 The management of used and soiled linen must meet infection prevention and control requirements.

22.2.2.2.6.1 The mental health care unit has a designated, access-controlled area for the storage of dirty linen.

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

The area used to store dirty linen must have a door.

Not applicable: Never

Score	Comment

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Sub Domain 22.2.3 8 Infection prevention and control programmes.

Standard 22.2.3.1 8(1) The health establishment must maintain an environment, which minimises the risk of disease outbreaks, the transmission of infection to users, health care personnel and visitors.

Criterion 22.2.3.1.1 8(2)(a) The health establishment must ensure that there are hand washing facilities in every service area.

22.2.3.1.1.1 Hand washing facilities are available.

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

Assess the hand washing facilities for the items listed below. Score 1 if the item is available and 0 if not available.

Score	Comment

Unit 1 User care area

Aspects	Score	Comment
1. Hand washing basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Poster on correct hand washing technique		
3. Poster on the correct use of alcohol-based hand rub. Explanatory note: Posters must be placed at strategic places and above alcohol dispensers in the health establishment as stipulated in page 33 of Practical Manual for Implementation of IPC Strategic framework March 2020.		
4. Taps		
5. Running water		
6. Plain liquid soap or Chlorhexidine based soap		
7. Wall mounted soap dispenser		
8. Paper towels		
9. Paper towel dispenser		
10. Bin		
11. Alcohol based hand rub		

Unit 2 Personnel toilet

Aspects	Score	Comment
1. Hand washing basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Poster on correct hand washing technique		
3. Poster on the correct use of alcohol-based hand rub. Explanatory note: Posters must be placed at strategic places and above alcohol dispensers in the health establishment as stipulated in page 33 of Practical Manual for Implementation of IPC Strategic framework March 2020.		
4. Taps		

5. Running water		
6. Plain liquid soap or Chlorhexidine based soap		
7. Wall mounted soap dispenser		
8. Paper towels		
9. Paper towel dispenser		
10. Bin		
11. Alcohol based hand rub		

Unit 3 ECT Room (where applicable)

Aspects	Score	Comment
1. Hand washing basin. Explanatory note: The basin should not be blocked, broken, or have cracks.		
2. Poster on correct hand washing technique		
3. Poster on the correct use of alcohol-based hand rub. Explanatory note: Posters must be placed at strategic places and above alcohol dispensers in the health establishment as stipulated in page 33 of Practical Manual for Implementation of IPC Strategic framework March 2020.		
4. Taps		
5. Running water		
6. Plain liquid soap or Chlorhexidine based soap		
7. Wall mounted soap dispenser		
8. Paper towels		
9. Paper towel dispenser		
10. Bin		
11. Alcohol based hand rub		

Criterion 22.2.3.1.2 8(2)(c) The health establishment must ensure there is clean linen to meet the needs of users.

22.2.3.1.2.1 There is a designated area for storage of linen.

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

This could be but not limited to a room or a storage cupboard.

Not applicable: Never

Score	Comment

22.2.3.1.2.2 There is sufficient stock of linen in accordance with the number of users in unit.

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

The minimum and maximum number of linen items required for all users must be available in the linen storage area as determined by the unit.

Not applicable: Never

Score	Comment

Criterion 22.2.3.1.3 8(2)(d) The health establishment must ensure that health care personnel are protected from acquiring infections through the use of personal protective equipment and prophylactic immunisations.

22.2.3.1.3.1 Personal protective equipment is worn.

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

Using the checklist below, verify whether protective clothing and equipment are worn in the areas listed below. Score 1 if the items are worn and 0 if not worn. Score not applicable where at the time of the inspection personnel are not in a situation in which they are required to wear protective clothing.

Score	Comment

Unit 1 Clinical area 1

Aspects	Score	Comment
1. Latex or nitrile gloves – non-sterile		
2. Gloves – sterile		
3. Disposable gowns or aprons		
4. Protective face shields or goggles		
5. Face masks		
6. N95 or KN95 or FFP2 masks or approved equivalent.		

Unit 2 Clinical area 2

Aspects	Score	Comment
1. Latex or nitrile gloves – non-sterile		
2. Gloves – sterile		
3. Disposable gowns or aprons		
4. Protective face shields or goggles		
5. Face masks		
6. N95 or KN95 or FFP2 masks or approved equivalent.		

Unit 3 Cleaner

Aspects	Score	Comment

1. Latex or nitrile gloves – non-sterile		
2. Disposable gowns or aprons		
3. Protective face shields or goggles		
4. Face masks		
5. Domestic gloves		
6. N95 or KN95 or FFP2 masks or approved equivalent (where applicable)		

Sub Domain 22.2.4 9 Waste management.

Standard 22.2.4.1 9(1) The health establishment must ensure that waste is handled, stored, and disposed of safely in accordance with the law.

Criterion 22.2.4.1.1 9(2)(a) The health establishment must have appropriate waste containers at the point of waste generation.

22.2.4.1.1.1 The mental health care unit has appropriate containers for disposal of all types of waste.

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

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

Score	Comment

Aspects	Score	Comment
1. Infectious non-anatomical waste (red)		
2. Sharps (yellow)		
3. General waste (black, beige, white or transparent packaging can be used)		

Criterion 22.2.4.1.2 9(2)(b) The health establishment must implement procedures for the collection, handling, storage and disposal of waste.

22.2.4.1.2.1 Sharps are safely managed and discarded in the unit.

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

Select three areas and verify whether sharps, needles and the collection of sharps are correctly managed. Score 1 if the aspect is compliant and 0 if not compliant.

Score	Comment

Unit 1 Area 1

Aspects	Score	Comment
1. Sharps containers available at site of use		

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

Unit 2 Area 2

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

Unit 3 Area 3

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

22.2.4.1.2.2 There is a temporary healthcare risk waste storage area.

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

In all areas where waste is held for collection and removal to the central storage area, a designated area for temporary storage of waste must be available. Some health establishments will have a purpose-built temporary waste storage area, others will utilise a specific area within the available space. Score 1 if the aspect is compliant and 0 if not compliant, or where there is no designated area. Not applicable: For any aspects not found in the temporary waste storage area.

Score	Comment	
Aspects	Score	Comment
1. Space available to store waste containers		
2. Area is well ventilated		

3. Area is well lit		
4. Area has impervious floor surfaces (waterproof or resistant, not cracked)		

Sub Domain 22.2.5 21 Adverse events.

Standard 22.2.5.1 21(1) The health establishment must have a system to monitor and report all adverse events.

Criterion 22.2.5.1.1 21(2)(a) The health establishment must have a register for all adverse events.

22.2.5.1.1.1 The unit has an adverse event reporting register.

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

The register must include the following: name of affected person, date of incident, time of incident and nature of incident. This register could be manual or electronic.

Not applicable: Never

Score	Comment

Criterion 22.2.5.1.2 21(2)(b) The health establishment must have systems in place to report adverse incidents to a structure in the health establishment or responsible authority that monitors these events.

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

Assessment type: Staff interview - **Risk rating:** Essential measure

Interview three health care personnel to establish their awareness on reporting of adverse events. Score 1 if they are able to explain the aspects listed below and 0 if not.

Score	Comment

Unit 1 Health care personnel 1

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

Unit 2 Health care personnel 2

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

Unit 3 Health care personnel 3

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

Domain 22.3 CLINICAL SUPPORT SERVICES

Sub Domain 22.3.1 10 Medicines and medical supplies.

Standard 22.3.1.1 10(1) The health establishment must comply with the provisions of the Pharmacy Act, 1974 and the Medicines and Related Substances Act, 1965.

Criterion 22.3.1.1.1 10(2)(a) The health establishment must implement and maintain a stock control system for medicine and medical supplies.

22.3.1.1.1.1 Stock control system for medicine shows minimum and maximum levels and/or reorder/preferred levels.

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

Each item held as stock must have documented minimum, maximum and/or re-order/preferred levels. These levels must be recorded on bin cards or equivalent. The system maybe manual or electronic.

Not applicable: Never

Score	Comment

22.3.1.1.1.2 Stock levels of medicine on the shelves corresponds with recorded stock control system.

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

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

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

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

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

Select three medicines from the schedule 5 and 6 medicine cupboard and verify whether the quantity available corresponds with the balance recorded in the register. Score 0 if the medicines do not correlate or if any of the columns have not been completed.

Score	Comment

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

22.3.1.1.1.4 Stock control system shows minimum and maximum levels and/or re-order/preferred levels for medical supplies.

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

Each item held as stock must have documented minimum, maximum and/or re-order/preferred levels. These levels must be recorded on bin cards or equivalent. The system may be manual or electronic.

Not applicable: Never

Score	Comment

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

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

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

Score	Comment

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

Criterion 22.3.1.1.2 10(2)(b) The health establishment must ensure the availability of medicines and medical supplies for the delivery of services.

22.3.1.1.2.1 Basic medical supplies (consumables) are available.

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

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

Score	Comment

Aspects		Score	Comment
Surgical supplies			
1. Item 1			
2. Item 2			
3. Item 3			
4. Item 4			
5. Item 5			
Dressing supplies			
6. Item 1			
7. Item 2			
8. Item 3			
9. Item 4			
10. Item 5			
Other supplies			
11. Item 1			
12. Item 2			
13. Item 3			
14. Item 4			
15. Item 5			

Sub Domain 22.3.2 13 Medical equipment.

Standard 22.3.2.1 13(1) Health establishments must ensure that the medical equipment is available and functional in compliance with the law.

Criterion 22.3.2.1.1 13(2)(b) The health establishment must ensure that equipment is in accordance with the essential equipment list in all clinical service areas.

22.3.2.1.1.1 Functional essential medical equipment is available in the unit.

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

Request the list of medical equipment for the unit. Randomly sample ten different items and check whether the sampled equipment is available and functional. Document the name of the non-compliant equipment that was sampled. Score 1 if the sampled item is available and functional or 0 if not available or not functional or if the list is not available.

Score	Comment

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

22.3.2.1.1.2 The room used for Electroconvulsive Therapy (ECT) procedures is suitably equipped.

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

Assess whether the area used for Electroconvulsive Therapy (ECT) meets the requirements listed below. Score if complaint and 0 if not. Not applicable if the unit does not perform Electroconvulsive Therapy (ECT)

Score	Comment	
Aspects	Score	Comment
1. Oxygen supply (piped or portable)		
2. An emergency trolley which is easily accessible		
3. Safe storage for medication and medical supplies		
4. Access to sterilisation and disinfecting facilities		
5. Infection prevention and control supplies		
6. A mechanism for summoning assistance		

Domain 22.4 GOVERNANCE AND HUMAN RESOURCES

Sub Domain 22.4.1 19 Human resources management.

Standard 22.4.1.1 19(1) The health establishment must ensure that they have systems in place to manage health care personnel in line with relevant legislation, policies and guidelines.

Criterion 22.4.1.1.1 19(2)(a) The health establishment must, as appropriate to the type and size of the establishment, have and implement a human resource plan that meet the needs of the health establishment.

22.4.1.1.1.1 Staffing levels for the unit as determined by acuity levels are available.

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

Documented staffing levels for the unit are available. Request staffing levels from the previous three months.

Not applicable: Never

Score	Comment

Sub Domain 22.4.2 20 Occupational health and safety.

Standard 22.4.2.1 20(1) The health establishment must comply with the requirements of the Occupational Health and Safety Act, 1993.

Criterion 22.4.2.1.1 20 The health establishment must have a disaster management plan in place, which is communicated to health care personnel and tested annually.

22.4.2.1.1.1 The actions to be taken when the disaster management response is activated are visibly displayed.

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

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

Not applicable: Never

Score	Comment

Domain 22.5 FACILITIES AND INFRASTRUCTURE

Sub Domain 22.5.1 15 Engineering services.

Standard 22.5.1.1 15(1) The health establishment must ensure that engineering services are in place.

Criterion 22.5.1.1.1 15(2) The health establishment must have 24-hour electrical power, lighting, medical gas, water supply and sewerage disposal system.

22.5.1.1.1.1 Oxygen cylinder is available in the unit.

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

An oxygen cylinder fitted with a regulator to adjust the flowrate must be available.

Not applicable: Never

Score	Comment

22.5.1.1.1.2 The oxygen available in the cylinder is above the minimum level.

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

Explanatory note: Oxygen levels must not be below the minimum level indicated in the oxygen cylinder gauge.

Not applicable: Never

Score	Comment

22.5.1.1.1.3 Piped or portable suction is available in the unit.

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

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

Not applicable: Never

Score	Comment



The National Health Act, 2003 (Act No. 61 of 2003) provides for quality requirements and standards in respect of health services provided by health establishments to the public. The main objective is to promote and protect the health and safety of the users of health services and contribute to improved outcomes and improved population health.

To achieve this mandate standardised inspection tools aligned to Norms and Standards Regulations applicable to different categories of health establishments promulgated by the Minister of Health in 2018 have been developed for Private Acute Hospitals.


Acknowledgments

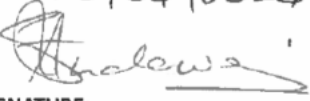
Many people have contributed to the update of the Private Acute Hospital Inspection Tools version 1.2.1. The Office of Health Standards Compliance wishes to extend the most heartfelt acknowledgment and gratitude to the following:

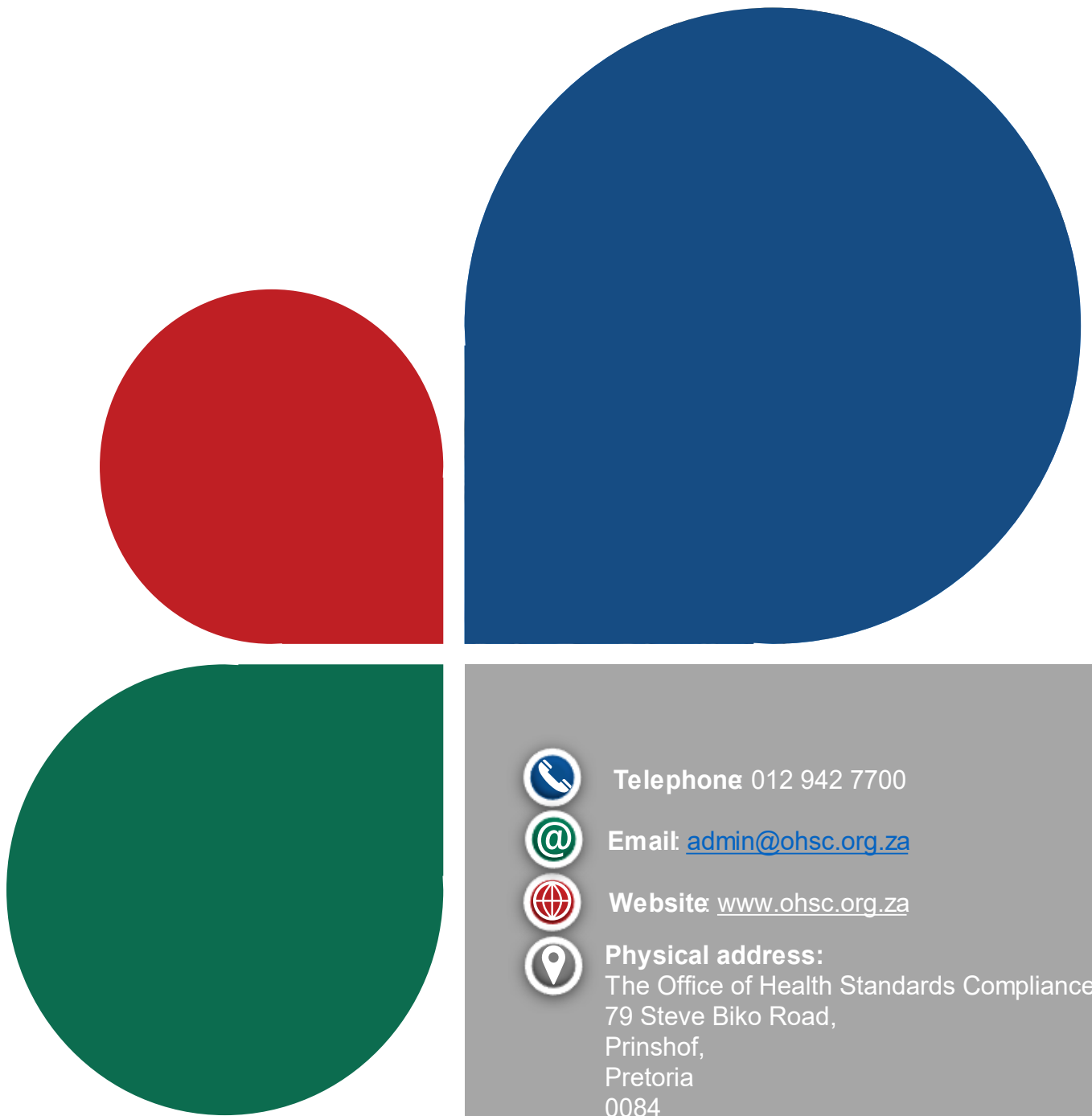
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It is hereby certified that the Regulatory Private Acute Hospital Inspection tools version 1.2.1 was updated by the Office of Health Standards Compliance.

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