ADAPTING THE WHO HEALTH PROMOTING HOSPITALS STRATEGY FOR SOUTH AFRICAN HOSPITALS: AN EVALUATION

Submitted to:

NELSON R MANDELA SCHOOL OF MEDICINE

UNIVERSITY OF KWAZULU-NATAL DURBAN

SOUTH AFRICA

For:

Submitted in partial fulfilment of the academic requirements of the degree:

Master in Medicine (Public Health)

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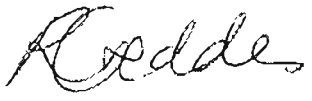
This Master of Medicine (Public Health) dissertation is my own work and all primary and secondary sources have been appropriately acknowledged. The dissertation has not been submitted to any other institution as part of an academic qualification.
This dissertation is prepared in partial fulfilment of the requirement of the Master of Medicine (Public Health) degree at the School of Family and Public Health Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban South Africa.

Signed: 

Date: 16 July 2008

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Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AL	Inkosi Albert Luthuli Central Hospital (in figures and tables)
CPD	Continuing Professional Development
DHIS	District Health Information System
DOH	Department of Health
ED	Edendale hospital
EAP	Employee Assistance Programme
FBO	Faith-based organization
GR	Greys hospital
GP	General Practitioner
HAART	Highly Active Antiretroviral Treatment
HFA	Health for All
HIV	Human Immunodeficiency Virus
HPH	Health Promoting Hospitals
IALCH	Inkosi Albert Luthuli Central Hospital
ISQua	International Society for Quality in Health Care
KZN	KwaZulu-Natal province, South Africa
LU	Lower Umfolozi hospital
ND	Northdale hospital
NG	Ngwelezana hospital
NGO	Non-governmental organization
PATH	Performance Assessment Tools for Hospitals
PMTCT	Prevention of mother-to-child Transmission
QIP	Quality Improvement Programme
SADEC	Southern African Development and Economic Community
SAT	Self-assessment Tool
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNICEF	United Nations International Children's Emergency Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YLL	Years of Life Lost

Acknowledgements

For their cooperation and support to the following:

HPH Provincial Co-ordinating Committee:
Dr PD Ramdas – Health Systems Performance Monitoring & Evaluation Unit – Project Leader
Prof MH Cassimjee – Provincial PATH Co-ordinator
Dr S Sirkar –PATH Technical Co-ordinator
Dr C Bhagwandeen – Human Resource Support Unit
Ms V Moodley – Healthy Lifestyles Unit
Mrs A Khathi – Quality Assurance & Accreditation Unit
Ms J Maher – Quality Assurance & Accreditation Unit
Mr C Shawe – Quality Assurance & Accreditation Unit

HPH Institutional Co-ordinators:
Dr VK Maistry – Edendale Hospital
Ms H Findlay – Greys Hospital
Ms V Bawany – Lower Umfolozi War Memorial Hospital
Ms R Jele – Ngwelezana Hospital
Ms Sooruth – Northdale Hospital
Ms N Mbambo – Inkosi Albert Luthuli Central Hospital

Department of Health, KwaZulu-Natal:
Professor Green-Thompson – Superintendent General KZN DOH (at time of project)
Dr SM Zungu – Deputy Director General Health Services
Quality Assurance Unit Staff
Human Resource Support Unit Staff – Head Office
Healthy Lifestyles Unit Staff
PATH Co-ordinating Unit Staff
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- Inkosi Albert Luthuli Central Hospital

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Abstract

Objective

To conduct an evaluation of the pilot implementation of the World Health Organization Health Promoting Hospitals initiative and its self-assessment tool in public hospitals in KwaZulu-Natal in 2004/2005

Study design

This evaluation utilised a cross-sectional design that incorporated both qualitative and quantitative research methods.

Main measures

Throughout the Health Promoting Hospital pilot project the opinions and responses of those with a legitimate interest in the initiative were monitored. Data collection methods utilised in this evaluation included participant observation, the World Health Organisation meta-evaluation questionnaire, records of workshops and feedback meetings and secondary analysis of all data collected by the six pilot hospitals during the implementation of the project in KwaZulu-Natal.

Results

Major constraints were found to be time, human and financial resources, lack of training and expertise and insufficient support for the project. The self-assessment tool was found to be insufficiently adapted and not all outcomes were found to be reliable and useful. Despite this, institutional staff found the Health Promoting Hospital project to be capacity building and morale boosting. Relationships between health service levels improved. All hospitals who participated recommended that other hospitals become Health Promoting Hospitals.

Conclusion

If the World Health Organisation Health Promoting Hospital initiative with its self-assessment tool is to be rolled out to the rest of KwaZulu-Natal province, then substantial

changes have to be made to the process. Amongst these are: further adaptation of the self-assessment tool, improved methods of data collection, provision of sufficient resources and increased and sustained provincial support for the project. In addition it is imperative that outcome and impact evaluations be done.

Chapter 1: Introduction

1.1 Introduction

The World Health Organization (WHO), in an attempt to realize the Jakarta declaration,[1] identified hospitals as one of the 'settings' where health promotion initiatives should be focused. As a result the concept of Health Promoting Hospitals (HPH) became established in 1990 and subsequently many hospitals in Europe became HPHs. The WHO Network of HPH recently commissioned a working group to develop standards for health promotion in hospitals. The standards attempt to define the activities that concern health promotion as an integral part of the services hospitals offer. A Self-Assessment Tool (SAT) was developed which assesses five dimensions of health promotion by providing 'standards' for each dimension.[2] These dimensions are 'management policy', 'patient assessment', 'patient information and intervention', 'promoting a healthy workplace' and 'continuity and cooperation'. The tool allows hospitals to conduct a regular self-assessment of their performance in health promotion. Over time, they then can aim to improve the quality of their health promotion practice.

The KwaZulu-Natal (KZN) Department of Health (DOH) in consultation with the European Office of WHO, Barcelona, implemented the HPH project between June and December 2004 in six public hospitals, and undertook a pilot implementation of the SAT. The purpose of the pilot implementation of standards and indicators for health promotion in hospitals was fourfold:

- To assess clarity of the self-assessment tool and complementary documentation enabling hospitals to internally assess and improve the quality of health promotion activities.
- To assess how data can be collected on indicators for health promotion.
- To assess the development of a quality improvement plan based on data on compliance of standards and performance assessed by indicators.
- To contextualize the WHO SAT for use by the KZN DOH.

The KZN DOH has submitted the collected data sets to the WHO, as part of an international collaboration. This was the first time a HPH project had been undertaken in KwaZulu-Natal and one of the first implementations in Africa.

These endeavours, whilst admirable in their attempts to solve public health problems, use substantial resources and therefore need to be evaluated. This dissertation is an evaluation of the HPH pilot project implemented in six hospitals in KwaZulu-Natal which used the generic WHO tool, the "Standards for Health Promotion in Hospitals: Self-Assessment Tool for Pilot Implementation" (Appendix I).

1.2 Background

Globally preventable conditions result in substantial morbidity and mortality. The leading causes of death in the USA in 2000 were tobacco (18% of total US deaths), poor diet and physical inactivity (15%), and alcohol consumption (3.5%). Other actual causes of death were microbial agents, toxic agents, motor vehicle crashes, incidents involving firearms, sexual behaviours, and illicit use of drugs.[3]

United Nations International Children's Emergency Fund (UNICEF) estimates that annually over 10 million children under the age of five die from readily preventable and treatable illnesses such as diarrhoeal dehydration, acute respiratory infection, measles, and malaria.[4] In half of the cases, illness is complicated by malnutrition and 42% of deaths occur in the WHO African region[i].[5]

The Burden of Disease report for South Africa, 2000 identified Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) as the top single cause of mortality followed by homicide, tuberculosis, road traffic accidents and diarrhoea. Non-communicable diseases accounted for 21% and injuries 16% of years of life lost (YLL).[6]

[i] There are 46 countries in the WHO African region, 36 of which are low-income countries, according to the World Bank.

In a large verbal autopsy[ii] study done in rural South Africa 29% of deaths were attributed to communicable, maternal, perinatal and nutritional conditions and 15% to injuries.[7]

These findings suggest that preventative efforts are inadequate both in the developing and the developed world.

Post-apartheid the new government in South Africa made substantial efforts to develop a more equitable national health care system by expanding access to care within a district-based system of primary health care with an emphasis on health promotion. The rationale has been that in the face of limited public resources, a strong primary health care system is more likely to effect equitable improvements in health status than are hospital-based services.[8] These laudable efforts have been limited by implementation problems. New clinics and the district health system are not yet properly functional because of poor management, lack of skills, inadequate training of personnel and lack of incentives for health workers to live and work in rural areas. As a result many patients bypass the clinics and seek hospitals out as their first point of contact with the health services.[9] In KZN clinics frequently underspend while hospitals overspend on their budgets. While this situation remains a concern and efforts are being made to improve it, it would seem appropriate to strengthen health promotion efforts in hospitals at the same time as improving primary health care and the district health system.

Quality in public hospitals in South Africa is severely lacking. The only external quality assessment accreditation agency which operates in South Africa, the Council for Health Service Accreditation of Southern Africa (COHSASA), has members in five provinces. Out of 169 public hospitals registered with COHSASA only 11 have achieved full accreditation. In KZN four public hospitals out of 84 currently have full accreditation.[10] Thus an opportunity potentially to improve the quality of services in hospitals by improving health promotion may seem like a good option.

[ii] Verbal autopsy – the interviewing of family members or caregivers about the circumstances of a death after the event – is an established tool in areas where routine death registration is inadequate or non-existent.

The introduction to the WHO HPH SAT states that the "project seeks to incorporate the concepts, values and standards of health promotion into the organizational structure and culture of hospitals, improving the health of patients and staff, supporting healthy environments and actively cooperating with the community. It aims to provide hospitals with an opportunity to contribute to the public health agenda." (Appendix I, page 7)

The WHO argues that health promotion is a core quality issue in hospitals and therefore should be incorporated into the daily work.[2] Health promotion includes disease prevention, health education, rehabilitation services and also health enhancement by empowering patients, relatives and employees in the improvement of their physical, mental and social well-being. Hospitals play a key role in many of these health promotion activities. Some of these are an essential part of hospital work but are often not explicit. The WHO argues that with the increasing prevalence of lifestyle-related and chronic diseases, health promotion activities should be provided in a more systematic way and the scope of provision should be expanded. It has been shown that strategies using therapeutic education, motivational counselling and enabling patients to take an active role in chronic disease management, lead to better health outcomes.[2] The WHO encourages hospitals to more intensively emphasise working conditions in order to improve the health of staff as well as the efficiency and quality of care given to patients.

1.3 Problem

Public hospitals in South Africa are faced with the challenges of limited resources and increasing workloads. The inequitable Apartheid health system has and is still currently undergoing radical reorganization to focus on the development of primary health care. This has resulted in major challenges especially related to the reallocation of resources from the tertiary and regional hospitals to the lower levels of health care. In addition, hospitals face staff shortages due to the brain drain both to the private sector or abroad, and high absenteeism. About 16% of health workers in South Africa are estimated to be HIV infected.[11] The load of primary health care services delivered at hospitals is substantial whilst the efforts to strengthen the primary care infra-structure continue. This, together with

the increased workload due to HIV/AIDS, means that hospitals are overburdened.[12] Health system interventions are necessary to improve the delivery of comprehensive health care at our clinics and hospitals. It is important, however, to be selective about which projects are rolled out to scale as valuable resources could be wasted for little real benefit.

Health promotion practice, which is notoriously difficult to measure, has few objective methods of evaluation. The potential benefits, however, of good health promotion are vast, especially in settings where resources are limited. It is therefore apparent that, in an African context, a need exists to assess the practice of health promotion with appropriate methods in suitably applicable settings to begin the process of improving the quality of health care available to patients. Proper evaluation of these efforts is essential.

1.4 Aim

The overall aim of this study was to evaluate the HPH pilot implementation project, with its SAT, in KZN in order to determine its appropriateness as a quality improvement initiative to be implemented in hospitals in other provinces and African countries.

1.5 Specific Objectives

1.5.1 Input evaluation

To describe and critique the selection of the steering teams and pilot sites for the WHO HPH project in KZN

To evaluate the adaptation of the WHO HPH tool

1.5.2 Output evaluation

To determine which activities were undertaken by the six hospitals during the HPH project and to present the results of those

1.5.3 Process evaluation

To evaluate the implementation of the WHO HPH SAT in KZN to see if project goals were met, in particular

a) to analyse the data collection methods used
b) to assess the ability of the hospitals to use their findings to create HPH action plans

c) to assess the experience and opinions of the hospital QIP teams with the HPH tool and the HPH initiative

1.5.4 To make recommendations to assist in the implementation of the HPH project in other hospitals

1.6 Definitions

Action Plans	Plans set up by hospital teams in response to project
Clinical staff	All staff in the hospitals involved in clinical work such as doctors, nurses, physiotherapists, occupational therapists, psychologists and radiographers
Exposed staff	All employed full-time health workers exposed to potential percutaneous injury including doctors, nurses, dentists, nurse assistants, phlebotomists, laboratory technicians and janitors.
Generic risk factors	Risk factors which play a role in the development of many diseases such as smoking, alcohol and nutrition
Health Care Workers	All staff employed in a hospital
Health Promoting Hospital	This is a concept for hospital development that builds upon the health promotion concept of the WHO Ottawa Charter where the reorientation of health care service is considered as one of five major action areas for overall health promotion development
Meta-evaluation	WHO evaluation questionnaire
Non-clinical staff	Staff in the hospitals not primarily working with patients such as administrative staff and support services
Percutaneous Occupational Injury	Needlestick injury to exposed staff
Self-Assessment Tool	Document with standards designed by the WHO to assess health promotion practice in a hospital
Adapted Self-Assessment Tool	WHO tool after process of adaptation for local use
Standards	Five areas of assessment of health promotion practice in the Self-Assessment Tool
Sub-standards	Individual standards to be met in the Self-Assessment Tool – these can be met fully, partially or not. There are 68 sub-standards.

1.7 Organization of the report

This dissertation has 6 chapters. Chapter 1 has introduced the subject under study and given some background information. It then stated the aim and objectives of the research.
Chapter 2, the literature review, explores the concepts and theories relevant to the subject and gives a brief historical overview of them. It explores the justifications given for health promoting hospitals. Methods currently used to measure health promotion practice and quality in hospitals internationally and in South Africa are discussed. The findings reported by other hospitals which have used HPH methods are presented. Finally, lessons are drawn from experiences with performance measurement in general.
Chapter 3 describes the methods, tools and data sources used in the HPH pilot project and to conduct this evaluation.
Chapter 4 presents the results of the HPH pilot project and the evaluation. In chapter 5 these findings are discussed in relation to the research objectives in the light of the literature reviewed. Limitations of the evaluation are presented.
Chapter 6 finally draws conclusions, makes recommendations on the further rolling out of the project and for the improvement of the project.

Chapter 2: Literature review

2.1 Introduction

2.1.1 Introduction

The Health Promoting Hospitals movement brings together many different concepts which have emerged in health and health care over the last 30 years. In this chapter the most important and lasting concepts to emerge from this period are discussed. The justification for identifying health promotion as a quality issue in hospitals is examined. Health promotion practise and the measuring of quality in health care are investigated. Experiences with HPH in Europe and lessons from performance measurement are drawn on. Finally evidence-based health care and patient participation is discussed.

2.1.2 How the literature was obtained

Medline and PubMed searches were conducted using key words: health promotion; health promoting hospitals; quality in hospitals; performance measurement in health care; evidence-based health care; patient participation and patient satisfaction. Reference lists from articles were searched for other relevant articles. Relevant books were obtained from the Discipline of Public Health in the School of Family and Public Health Medicine, University of KwaZulu-Natal (UKZN). Reading lists were obtained from the Master of Public Health, UKZN course modules in Health Management and Health Promotion.

2.2 Historical overview

2.2.1 Historical overview of concepts of health

In the 1970s the definition of health broadened and the concept of health promotion was born together with numerous models for the successful practice thereof. In 1977, the 30th World Health Assembly decided that the main health-related goal of governments and the WHO in coming decades should be directed to ensuring that the entire global population attains a level of health that would permit them to lead socially and economically

productive lives[iii]. The declaration of Alma Ata at the conference on primary care in 1978 defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease".[13]

In 1986 the first International Conference on Health Promotion produced the Ottawa Charter for Health Promotion. Process methodologies for health promotion were advocacy, enablement and mediation. The health promotion 'Action Means' as stated in the charter are building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.[14] Further international developments and conferences over the next 10 years continued to promote an approach to the wider environment. In 1997 the Jakarta declaration on health promotion encouraged a "settings" approach to health promotion.[1] This involves examining factors that impact on health in specific settings like workplaces, schools, hospitals and cities. The WHO planned programmes for these.

2.2.2 Management and efficiency in health care

Alongside the above developments, the 1980s witnessed, in Europe, the appropriateness and effectiveness of the well-established public corporation and of the large-scale standardized welfare state agency being challenged. New forms, roles, and cultures developed.[15] New public management emerged and took on various forms in, particularly, the United Kingdom, North America and Australasia. The 'efficiency drive' was introduced with its increased attention to financial control, efficiency gains, information systems, a stronger emphasis on management with target setting and monitoring of performance, financial and professional audit and increased stress on provider responsiveness to consumers. There was deregulation of the labour-market, an increase in the pace of work, a reduction in the self regulating power of the professions, tighter accountability requirements and new forms of corporate governance. There was a

[iii] Governments of the world came together to sign the declaration that promised "Health for All by 2000". However this promise was subsequently marginalized in health policy discussions and never realized. The significant feature of Health For All (HFA) 2000 was the recognition that the main determinants of health lay outside of the health sector (food, water, sanitation, housing, employment). The key to achieving the goal of HFA 2000 was Primary Health Care.

move away from the large, vertical organizations through a process of downsizing and decentralization. The 'excellence' stream of the 1980s, which represents the application to the public services of the human relations school of management theory, created a strong emphasis on the importance of organizational culture. This softened the 'efficiency drive' and highlighted the role of values, culture, rites and symbols in shaping how people actually behave at work. The late 1980s saw the emergence of the 'learning organization' movement where processes are seen as equally important as outcomes and with its emphasis on organizational development and learning. Finally, the 1990s were characterized by a major concern with service quality, with the use of quality initiatives and the rise of 'total quality management'. There was an emphasis on societal learning over and above the delivery of routine services.[15]

Despite the emergence of health promotion as a concept and the importance attached to it, managed health care rarely includes measuring health promotion efforts.

2.3 Health Promotion as a quality issue in hospitals

There are many reasons and opportunities for offering health promotion strategies in health care settings. Hospital exposures can have a long-term influence on the behaviour of patients and relatives, who are more responsive to health advice in situations where ill-health is being experienced.[16, 17] Chronic diseases are increasing in prevalence world-wide and low compliance with treatment is a major problem. Thus, therapeutic education is becoming an intervention opportunity.[18]

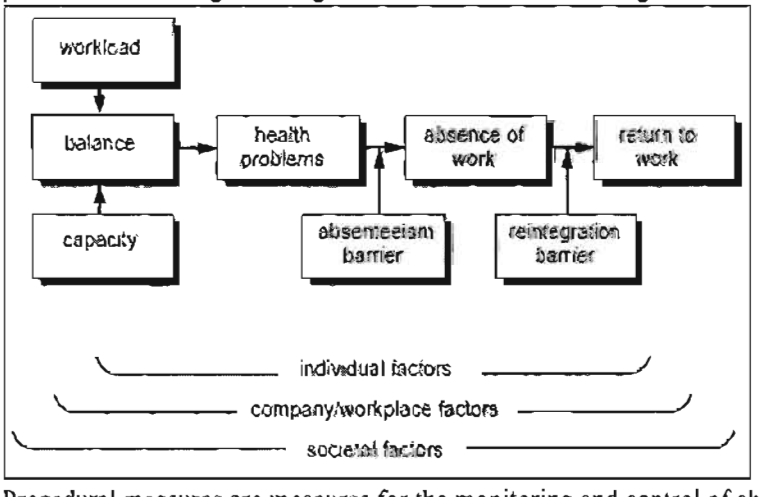
Furthermore, hospitals consume between 40% and 70% of the national health care expenditure and employ between 1% and 3% of the working population.[19] The opportunity therefore exists for the promotion of health among hospital staff.

Absenteeism places a high burden on hospital functioning in terms of the cost compensating for lost working hours, reduced productivity and an increased workload for remaining staff. Short-term absenteeism is particularly a problem since it is unpredictable and allows less time to adjust rotas and to replace absent workers. In Europe, the

absenteeism rate ranges from 3.5% (in Denmark) to 8.0% (in Portugal).[20] In Canada, average absenteeism rate is 8.1% for nurses.[21] Interventions which address absenteeism exist. The European Foundation for the Improvement of Living and Working Conditions present an underlying framework for the absenteeism and reintegration process.[20] Using this framework four types of intervention can be distinguished to address absenteeism. Firstly, procedural measures aimed at raising the 'absenteeism barrier' can be used. Secondly, preventive work-oriented measures are used to reduce the discrepancy between workload and capacity by reducing the former factor. Thirdly, person-oriented measures in which employees are supported to work and live in a safe and healthy way are employed to increase the capacity of individuals. Lastly, reintegration measures aim to lower the 'reintegration barrier' and accelerate the return to work of sick employees.[iv]

Workplaces are characterised by physical, chemical, biological and psychosocial risk factors. In South Africa, biological risks due to the high prevalence of HIV/AIDS, Hepatitis B and Tuberculosis and psychosocial risks due to staff shortages and burn-out in public hospitals mean that staff should be even further supported. A recent study (2005) conducted in 8 hospitals in KZN found 583 cases of tuberculosis in health care workers (HCW) over a period of 4.5 years. This gave an incidence of 1333/100 000 HCWs compared with 805/100 000 in the general KZN population. Treatment cure was achieved in only 22% of cases and only one hospital had a workplace policy with regard to tuberculosis in HCWs.[22]

[iv] The European Foundation for the Improvement of Living and Working Conditions framework for the process of becoming ill, being absent from work, recovering and returning from work is as follows:



Procedural measures are measures for the monitoring and control of absenteeism.

Hospitals are reluctant to acknowledge these dangers and systems to prevent illness in staff are poorly developed. This impacts on the core function of hospitals which is to provide the highest possible quality of care to patients in an efficient manner. Clear links have been demonstrated between nurses' work environments in hospitals, levels of job burnout and patients' satisfaction with their care.[23]

Hospitals produce high amounts of waste and hazardous substances which can pollute the environment. Thus, introducing a culture of health promotion may contribute to the responsible disposal thereof. Furthermore, hospitals are often research and teaching institutions and can therefore influence the local health structures and professional practice around them.

2.4 Health Promotion evaluation

2.4.1 Principles for the evaluation of health promotion initiatives

The report of the WHO European working group on health promotion evaluation defines evaluation as "the systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement or effectiveness".[24] The working group concludes that the core features of approaches appropriate for evaluating health promotion initiatives are: participation of those with a legitimate interest in the initiative (policy-makers, community members, health professionals etc); multiple methods (broad range of information gathering methods); capacity building (should enhance the capacity of individuals, organizations and governments) and appropriateness (designed to accommodate the complex nature of health promotion interventions and their long-term impact).

Lawrence Green's "Precede-Proceed"[v] model for health promotion planning and evaluation has 9 phases, with phase 7 being process evaluation, phase 8 impact evaluation and phase 9

[v] The Precede-proceed model (Green and Kreuter) – This model is valuable to health promotion planning because it provides a format for identifying factors relating to health problems, behaviours and programme implementation. Three categories of factors include: (a)predisposing factors – forces that motivate an individual or group such as knowledge, attitudes, beliefs, cultures, values and norms (b)enabling factors – include both new personal skills and available resources needed to perform a behaviour (c)reinforcing factors

outcome evaluation. His view, however, is that listing evaluation in the last phases is misleading as evaluation should be an integral and continuous part of working with the entire model from the beginning.[25]

The Oxford Textbook of Public Health describes three kinds of evaluation for health promotion activities: summative, formative and process.[26] Summative evaluation assesses programme effectiveness by noting the extent to which learning objectives have been achieved.[vi] Formative evaluation monitors progress and, where necessary, provides guidelines for remedial work and social action.[vii] Process evaluation makes available detailed documentation of the processes and procedures which have taken place during the programme to provide insight into possible reasons for its successes or failures.

2.4.2 How well is Health Promotion practised and what tools are used to measure performance in health care?

Reddy's opinion in 1995 is that in South Africa health promotion and education have been largely neglected by formal education institutions. Even where health promotion is carried out, in many cases the vital step of evaluation is not planned for or done. Therefore those implementing health promotion activities have no idea whether their work has been effective or indeed successful. Reasons for this are varied but include pressure to find hasty solutions to problems, inadequate allocation of resources to preventive health, poor training and limited knowledge of theories of health promotion.[27]
The Department of Health Draft Policy on Health Promotion of 1997 recognises the need for monitoring and evaluation and acknowledges that few systems exist for this but that systems need to be developed.[28]

The District Health Information System (DHIS) with its numerous indicators provides a system for monitoring health sector performance in general. Health promotion can affect demographic indicators like Perinatal, Infant and Maternal Mortality measures. However,

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– provide an incentive for health behaviours and outcomes to be maintained. An understanding of these three factors allows us to identify priorities and provides a basis for where to focus our efforts.

[vi] In a system approach to evaluation, summative evaluation may be sub-divided into Output, Outcome and Impact evaluation.

[vii] Formative evaluation is sometimes equated with Input in a systems approach to evaluation.

these are non-specific impact and outcome measures of health promotion. Many other factors, such as changes in the curative aspects of hospital care, can lead to changes in these rates. In the same way surveys and studies of health status such as the annual antenatal HIV seroprevalence are indirect measures of health promotion efforts in schools and health facilities. These impact and outcome evaluations are done but are non-specific to health promotion. Very few evaluations exist and where they do, they are frequently inadequate. The KZN DOH health promotion process indicators include 'number of health promotion meetings held', 'number of radio talk shows held' and 'number of health events held'.[29] From these indicators one has no way of determining the quality of the information shared at these events. Health education messages could be incorrect or harmful.

The Council for Health Service Accreditation of Southern Africa (COHSASA)[viii] has a hospital evaluation system which includes certain particular standards which incorporate health promotion efforts.[10] These are, however, few and there is no explicit reference to health promotion in the assessment process. Internationally, in most countries quality agencies have developed standards for the quality of hospital care.[30] Main agencies are in Australia (the Australian Council on Healthcare Standards), Canada (The Canadian Council on Health Services Accreditation), the United States of America (the Joint Commission on Accreditation of Health Care Organizations) and the United Kingdom (the Health Quality Services). A review of the standards developed by these agencies yielded that in general there was little reference to health promotion activities.[31]

Despite some theoretical guidance, few reliable systems exist for the monitoring and evaluation of health promotion programmes, specifically in hospitals, both in South Africa and internationally. Without these evaluation systems it is difficult to determine

[viii] The Council for Health Service Accreditation of Southern Africa (COHSASA),accredited by the International Society for Quality in Healthcare (ISQua), is an independent, non-partisan, not-for-profit NGO that has been operating in the SADEC region (but principally in South Africa) since 1995. It developed from a programme at the University of Stellenbosch begun by Professor Whittaker. The Council has worked in over 600 healthcare facilities in both the private and public sector, conferring accreditation on those facilities that comply with standards, which have been ratified by representative professional bodies. Over the past decade COHSASA has developed accreditation programmes for hospitals, sub-acute care, psychiatric facilities and programmes, primary health care clinics, home healthcare services, general practitioners and medical scheme administrators. It has also recently developed the HIV and AIDS District Evaluation Tool to systematically evaluate the quality of HIV care provided to patients.

performance and to decide how limited health resources should be allocated. It is thus necessary to identify appropriate, practical, affordable and sustainable evaluation systems for health promotion and health promoting hospitals.

2.5 Experiences of Health Promoting Hospitals

2.5.1 General difficulties

The WHO acknowledges that the concept of HPH is confusing.[32] Hospitals are complex, diverse, changing places and also constitute 'settings' for health promotion from three points of view.[33] They are workplaces, hospitals and communities. Their traditionally curative approach and limited organizational structures may make it difficult for them to reach out to communities and engage in health promotion activities. In the era of managed care there is pressure on hospital managers to focus on financial management. Thus most hospitals do not have the additional resources and motivation to promote and protect the health of their surrounding communities.[34] Hospital priorities of reducing in-patient stay periods and other functional outcomes mean that health promotion issues do not receive the requisite appropriate attention.[35]

Furthermore health workers devote most of their time to curative clinical duties and often do not provide basic health promotion programmes.[36] Involving hospital-based professionals with the HPH movement has been difficult in other parts of the world. WHO acknowledges that hospital staff generally do not regard health promotion as their function.[32] Understandably, it is difficult for clinicians who have been trained to think in terms of curative care, to change their approach and apply health promotion principles to their practice.[37] In a resource constrained country like South Africa, with its staff shortages and high workload in the public sector, this may prove even more difficult. Staff are struggling to deliver even the most basic curative care.[12]

Johnson and Baum, however, argue that although hospitals are highly curative in orientation, they control huge resources and that even a small change in their focus has the potential to bring about an increase in resources being dedicated to health promotion. In

time, this may benefit the health of the community.[38] Some argue that hospitals need to equally divide their health promoting activity into two categories: those aimed directly at reforming the institution and those targeted at reforming the health status of the surrounding community.[39]

2.5.2 Hospitals' experiences

There are few success stories from evaluations of the HPH movement in Europe and other parts of the world. Problems encountered are described rather than opportunities presented. Aujoulat *et al.* reports on the French HPH experience as having problems and being insufficient to allow for effective health promotion reform in hospitals.[40] Problems faced by the French HPH projects were lack of appropriate indicators to effectively evaluate health promotion activity, failure to facilitate the participation of the target population, lack of interdisciplinary working practices, lack of appropriately trained personnel, prioritized funding in favour of bio-technical health care regimes and failure to enable the participation and empowerment of individuals. The *Health Promoting Hospitals Network Progress Reports for 2002* which reports on experiences of 22 European member states describes similar problems.[41] These include lack of clear strategy or aims, lack of resources, lack of training facilities, lack of national and regional health service policy commitment and support, lack of health promotion priority in hospitals and difficulty in implementing overall organizational HPH structures rather than specific localized projects. These experiences were for HPH projects without the SAT which is now available from the WHO.

2.5.3 Criticisms of HPH

A major criticism of the HPH movement is the absence of sufficient evaluation of HPH activities. It is acknowledged, however, that there is a general lack of evaluation and research for all settings-based health promotion activity.[42] Where evidence does exist it frequently refers to a lack of progress and a need for further reform.[33, 38, 43] HPH initiatives generally need funding which is provided for pilot projects but seldom sustained and thus projects often fade.[36]

In recent years, in developed countries, hospitals and their leaders are increasingly expected to take responsibility for the health status of local populations.[44] This is said to be the greatest challenge for the HPH movement and perhaps its biggest failure to date.[45]

Experience so far, particularly in Europe, suggests that the HPH initiative has had a more limited impact than perhaps the WHO might have anticipated for its efforts over the last 15 years. Whitehead states that a more concerted evaluation of HPH progress is needed for an accurate measurement of its impact and progress and that if the situation remains unchanged, a fundamental review of the strategy is worth considering.[45] This makes a proper evaluation of the HPH experience in Africa, where resources are limited, even more important.

2.6 Lessons from performance measurement

Performance measurement in the health sector gained momentum with the emergence of managed care and its concomitant impact on cost controls and quality of care. Managed care calls for accountability and a social obligation and responsiveness to the community. Hence both performance measures and systems of measurement are required. Many different performance profiling strategies have been used in developed countries but most have been indicator focused.

Valuable lessons have been learnt in these countries which need to be taken into account when adopting systems for performance management in Africa. Performance indicators do not measure performance, people do. Thus adequate staff training is essential. Secondly, analysis and interpretation must accompany performance measurement in order to obtain useful, useable information. Thirdly, a tendency exists to measure what is readily measurable (easy to collect, quantify and report) regardless of its actual importance. Outcomes are often chosen that reflect a compromise between what can be measured and what is most important.[46] The ability to develop global measures of organizational quality (to identify good or bad performers) is limited. Performance is often viewed in a piecemeal fashion in healthcare. Examples are the caesarean section rate or surgical

infection rates. This may be useful in identifying specific areas in need of improvement but it fails to reflect a total picture of performance.

Various typologies of performance measures exist, particularly in the United States and the United Kingdom, and each have their various dimensions that are covered such as financial or administrative, clinical performance, health status and patient satisfaction. Often a battle arises between the desire to be comprehensive and the time and resources available to measure all dimensions. Indicators should exist for all elements of a health system namely, inputs, process, output, outcomes and impact. Often outcome and impact indicators are difficult to measure and thus neglected despite being the most important for assessing the success of a programme or service.

With the emergence of the science of health economics there has been an increasing emphasis on how health care resources can be utilized most efficiently. Health economic theory is based on the fact that choices must and will be made between alternative uses of the limited resources for healthcare. Future improvements in performance measurement are heavily dependent on sustained, if not increased, levels of funding. In turn, the level of latter will be determined by the actual and perceived success of performance measurement systems in supplying healthcare professionals, accreditation agencies, purchasers and consumers with useful information on which to base decisions about healthcare. In particular, in resource constrained environments in developing countries, good performance measurement systems are required to maximize cost-effectiveness and efficiency in order to improve equity, quality and access to health services. These are three key areas of the health charter in South Africa.[47]

2.7 Evidence-based health care

Individuals making decisions about health and healthcare policy face a number of challenges. These are ageing populations, modern technology and new knowledge, rising consumer expectations and in Africa, the high burden of HIV/AIDS. The need and demand for healthcare is increasing and, as a consequence, it is necessary for decision-making to be open, explicit and evidence-based.

Internationally, especially in countries with National Health Systems, there has been increasing use of evidence-based approaches in health care. Generic and rational prescribing is now routinely centrally monitored in general practices, primary health care centres and hospitals throughout the United Kingdom. Doctors are encouraged to improve their evidence-based practice through a system of benchmarking of general practices and hospitals, and the creation of an environment conducive to transparency, accountability and good practice. Cost-drivers are identified and attempts are made to correct 'sloppy' practice. Clinical guidelines have been produced by most developed countries for all the major conditions, the most widely known in the United Kingdom being the British National Institute for Clinical Excellence (NICE)[48] and the Scottish Intercollegiate Guidelines Network (SIGN)[49] guidelines. Evidence-based, rational and cost-effective prescribing and treatment are major parts of the under- and postgraduate curricula in developed countries.

In South Africa similar attempts have been made with the publication of Standard Treatment Guidelines (STG) and the Essential Drugs List (EDL).[50] These are widely available. However, monitoring and evaluation of their use by clinical staff in the public and private sectors is lacking. Monitoring is done on an ad hoc basis and little incentive exists to comply with these. The dimension and influence of the private sector in South Africa exacerbates this situation. The profit-driven and consumerist nature of this sector means that the STGs and EDLs are often ignored in the name of business. This attitude spills over to the public sector as many doctors use the private sector to supplement their salaries. In public hospitals, guidelines are rarely displayed or available.

Evidence-based decisions are also affected by values. The clinician has to take into account the condition and values of the individual patient; the policy-maker has to consider the best current knowledge as well as the needs of the population, its values, the resources available, and the opportunity costs[ix] of any decision.[51]

[ix] In Health Economics, opportunity cost refers to the value of a resource in an alternative use.

Thus for a soundly functioning healthcare system, health promotion efforts also need to be evidence-based and it is a necessity to know whether this prevails in public facilities.

2.8 Patient rights and participation

International studies[52, 53] have shown that better clinical outcomes are achieved when patients are both satisfied and a meaningful participant in their own care.

The post-apartheid South African Constitution[54] and the National Health Act[55] afford patients substantial rights. These are restricted to some degree, however, by the clause "...within available resources" as experienced by individuals who have challenged the legislation. In KZN the adoption of the Patient Rights Charter[x] [56] and Batho Pele[xi] [57] principles have raised awareness of patient's rights and their participation although formal systems to monitor if the principles are realized are scanty. A Client Satisfaction Survey[58] is in use but not regularly done by all hospitals. When hospitals consistently

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[x] The National DOH of South Africa adopted the Patient Rights Charter in 2002. This entitles patients to: a healthy and safe environment, participation in decision-making, access to healthcare, knowledge of one's health insurance/medical aid scheme, a choice of health services, be treated by a named health care provider, confidentiality and privacy, informed consent, the right to refuse treatment, be referred for a second opinion, continuity of care and the right to complain about health services.

[xi] The Eight Principles of Batho Pele

1. Consultation
Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered
2. Service standards
Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect
3. Access
All citizens should have equal access to the services to which they are entitled
4. Courtesy
Citizens should be treated with courtesy and consideration
5. Information
Citizens should be given full, accurate information about the public services they are entitled to receive
6. Openness and transparency
Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge
7. Redress
If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response
8. Value for money
Public services should be provided economically and efficiently in order to give citizens the best possible value for money

score low on these, no system is in place to flag this and take corrective action. In recent months in KZN a new Client Satisfaction Survey has been designed which is currently being piloted. It remains to be seen whether this will be used more regularly and influence patient care. A waiting times survey has also been adopted which can provide hospital managers with information about bottlenecks in patient flow and problem areas in the hospital. The process, however, does not include any system of evaluation to determine whether any changes have had a positive impact on patient care. Monitoring of patient satisfaction and participation is a necessary tool to inform health care providers whether they are offering a quality service.

2.9 Summary

The last 30 years have witnessed major changes in the approach to health and health care. The need for holistic and preventative approaches to ill health has become clear. The benefits of a healthy work force have been shown. The increasing demand on services, greater consumer awareness and limited resources have resulted in many attempts to improve quality and cost-effectiveness and employ evidence-based methods. Measuring health service performance, however, is fraught with difficulties and it is essential to take heed of the experiences of other countries.

Health promotion practice, which is notoriously difficult to measure, has few objective methods of evaluation. The HPH initiative in Europe has left many questioning the evaluation processes and wondering whether true gains have been made. The potential benefits, however, of good health promotion are vast, especially in settings where resources are limited. It is therefore apparent that, in an African context, a need exists to assess the practice of health promotion with appropriate methods in suitably applicable settings to begin the process of improving the quality of health care available to patients. Proper evaluation of these efforts is essential.

Chapter 3: Research Methodology

3.1 Introduction

The Oxford Textbook of Public Health describes three types of evaluation: summative[xii], formative[xiii] and process[xiv].[26] Elements of all three are used in this study which utilises the systems approach to evaluation. The inputs, processes and outputs of the WHO HPH pilot project were studied. It was too early, however, to conduct outcome and impact evaluations. The WHO working group on health promotion evaluation recommends multiple methods, participation and appropriateness as core features of approaches for evaluation of health promotion initiatives.[24] In line with this, a range of information gathering procedures was used in this study. Throughout the HPH project implementation the opinions and responses of those with a legitimate interest in the initiative were monitored. The implementation of the pilot project was observed from start to finish by the principal investigator and this evaluation provides a descriptive account of the entire process as well as secondary analysis (output evaluation) of all data collected in the project.

3.2 Background

The WHO HPH pilot project was conducted as a quality improvement initiative by the Health Systems Performance Monitoring and Evaluation Unit of the KZN DOH. Provincial and institutional steering teams were formed. The former was called the Provincial Coordinating Committee (PCC) whilst the latter teams at the facilities were the members of the Quality Improvement Programme (QIP) which should have already been operational for general quality improvement initiatives in each of the hospitals. The WHO HPH SAT was then adapted for use in KZN. The adapted SAT was used in the six pilot hospitals to determine how well health promotion was being practised. In order to complete the SAT

[xii] Summative evaluation assesses programme effectiveness by noting the extent to which learning objectives have been achieved. In a system approach to evaluation, summative evaluation may be sub-divided into Output, Outcome and Impact evaluation.

[xiii] Formative evaluation monitors progress and, where necessary provides guidelines for remedial work and social action. Formative evaluation is sometimes equated with Input in a systems approach to evaluation.

[xiv] Process evaluation makes available detailed documentation of the processes and procedures which have taken place during the programme to provide insight into possible reasons for its successes or failures.

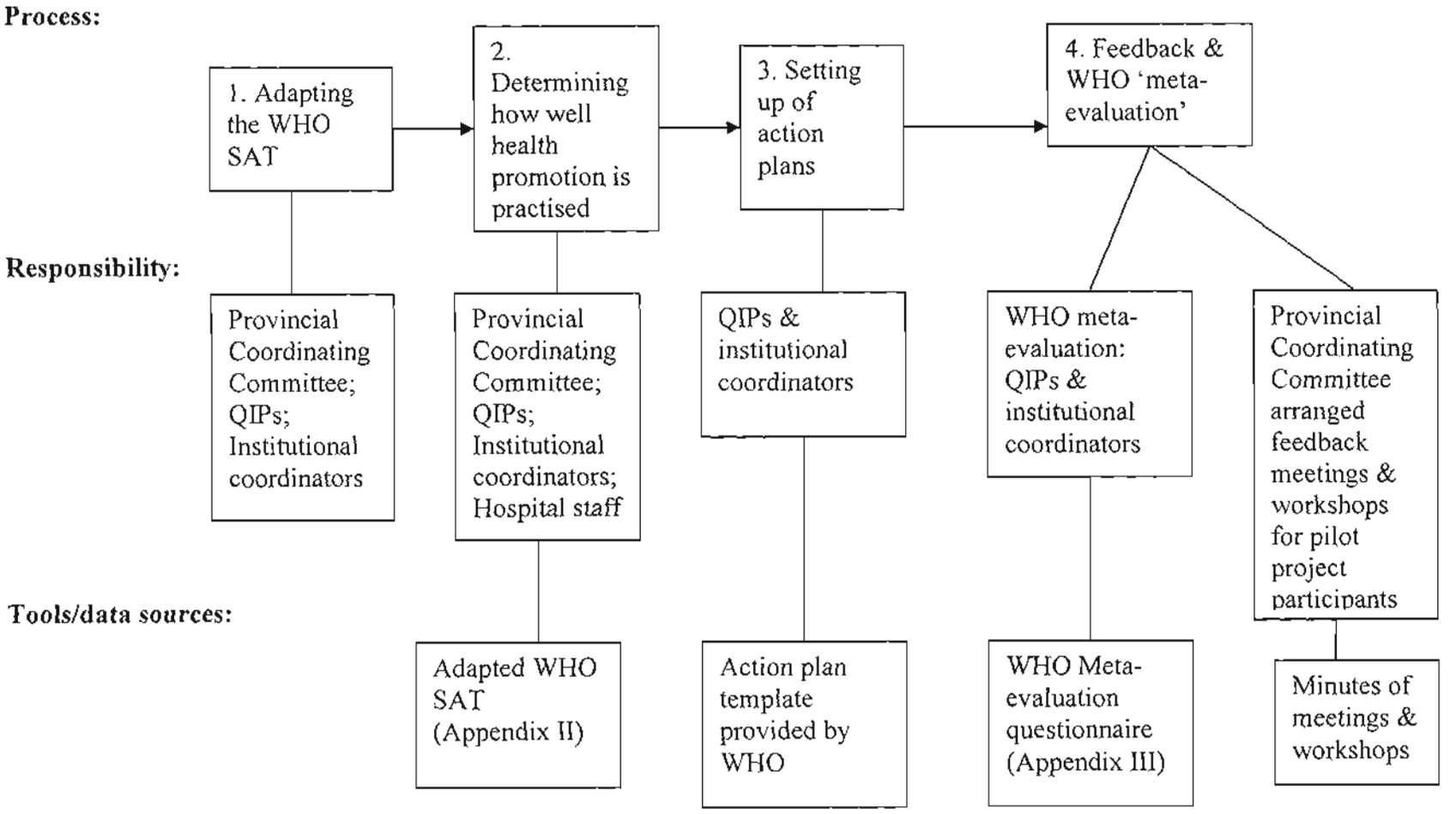

Figure 1- Schematic representation of the WHO Health Promoting Hospitals pilot project as implemented by KZN DOH in six public hospitals in KwaZulu-Natal 2004/2005

Key: WHO = World Health Organization; QIP = Quality Improvement Team; SAT = Self-Assessment Tool

hospitals had to perform various audits and surveys. Audits of the following were conducted: needlestick injuries, absenteeism, patient records and the budget spent on staff health promotion. Client satisfaction and staff surveys were done. Based on their results the individual hospitals set up action plans to improve their health promotion practice. On conclusion of the pilot, feedback meetings were held to discuss the successes and shortcomings of the project and the WHO provided an evaluation questionnaire which was completed by the QIP teams. Figure 1 is a schematic representation of the project.

3.3 Type of research

This study classifies as health systems research.

3.4 Study design

This evaluation utilised an observational descriptive cross-sectional design.

3.5 Study setting

The study was conducted in public hospitals in KZN, South Africa. All of the hospitals were large urban hospitals serving the populations of eThekwini, Umgungundlovu, Uthungulu and Zululand districts. The central hospital included in the study served all districts of KZN.

3.6 Sampling

3.6.1 Sample population

The sample population was different for the various components of the evaluation according to the systems approach which was utilized (Table 1).

Table 1 - Sample populations for the evaluation of the WHO HPH pilot project as implemented in KZN in 2004

INPUT EVALUATION	PROCESS EVALUATION	OUTPUT EVALUATION
▪ Provincial Coordinating Committee (PCC) ▪ Hospital QIP teams	▪ Feedback meetings: PCC Hospital QIP teams & other stakeholders attending the meetings ▪ WHO meta-evaluation: Hospital QIP teams	▪ WHO HPH SAT: Hospitals ▪ Client Satisfaction Survey: Clients in hospitals ▪ Staff questionnaire: Staff in hospitals ▪ Patient record audit: Medical patients and obstetric patients ▪ Needlestick audit: Exposed staff in hospitals ▪ Absenteeism audit: Nurses in hospitals ▪ Budget spent on staff health promotion: Hospitals ▪ HPH Action Plans: Hospitals

3.6.2 Sample selection and size

The ***PCC*** had eight members chosen by the head of the Health Systems Performance Monitoring & Evaluation Unit. Hospital ***QIP teams*** consisted of between 5 and 10 members in each hospital.

The PCC purposefully selected a sample of 6 out of approximately 69 public ***hospitals*** in KZN for implementation of the HPH project.

For the ***Client Satisfaction Survey***, hospitals had been asked to do convenience sampling of a minimum of 100 patients exiting the institutions, if a survey had not been conducted in the last 6 months.

For the ***staff questionnaire***, a convenience sample of 25 % of staff from each broad category of staff in each hospital was selected. In the small categories of staff all those on duty on the day of the questionnaire were selected to participate. These groups included social workers, clinical psychologists, occupational therapists, physiotherapists, dieticians, dentists, optometrists and speech therapists.

For the ***patient record audit*** the WHO expert committee had recommended a random sample of 50 patient records from each site. Admissions to the general medical departments of five of the hospitals in the previous one month were used. In the case of the maternity hospital, the obstetrics department was used.

The ***needlestick audit*** included all exposed staff in the 6 hospitals in 2003. The sample for the absenteeism audit included all full-time nurses employed by the 6 hospitals for the 3 month period of the audit.

3.7 Data sources and instruments

3.7.1 Measurement instruments

3.7.1.1 The WHO HPH SAT

The WHO gave permission for their SAT to be adapted to suit local use. The adaptation of the original WHO SAT (Appendix I) to the KZN-WHO SAT (Appendix II) will be presented in the results section. The WHO self-assessment tool assesses five dimensions of health promotion practice in hospitals. These dimensions are represented by five standards. In order to meet these, a number of sub-standards (68 in total) have to be met. In addition, indicators are chosen by the steering team in consultation with the hospital teams and calculated to represent further each dimension. The standards, complementary indicators chosen by the KZN teams and the data sources suggested by WHO were as follows:

Standard 1: Management Policy (17 sub-standards)

Indicator: % budget dedicated to staff Health Promotion activities

Data Source: Financial records in each institution

Standard 2: Patient Assessment (8 sub-standards)

Indicator: % of patients assessed for generic risk factors

Data Source: Patient record audit

Standard 3: Patient Information and Intervention (8 sub-standards)

Indicator: Score on survey of patients' experience with information and intervention procedures

Data Source: Most recent client satisfaction questionnaire and patient record audit

Standard 4: Promoting a Healthy Workplace (16 sub-standards)

Indicator: % of short-term absence

Data Source: Absenteeism record books

Indicator: % of work-related injuries

Data Source: Occupational health records

Indicator: % of staff smoking

Data Source: Staff questionnaire

Indicator: % of staff aware of their HIV-status (own KZN indicator)

Data Source: Staff questionnaire

Standard 5: Continuity and Cooperation (19 sub-standards)

Indicator: % of discharge letters handed to patients on discharge

Data Source: Patient record audit

3.7.1.2 Staff Questionnaire

The self-administered staff questionnaire (Appendix II, page 51) was designed by the Health Systems Performance Monitoring & Evaluation Unit. It constituted two sections, a section for all staff categories to complete and then an additional section for clinical staff to complete.

3.7.1.3 KZN DOH Client Satisfaction Survey

This survey was available on the intranet for all public hospitals to use. On exiting the hospital patients are asked to complete the survey which contains different sections. Hospitals were asked to access the results of the most recent survey. Only information in the 'general' section was used for the HPH pilot project.

3.7.1.4 WHO 'Meta-evaluation questionnaire'

This questionnaire (Appendix III) was designed by the WHO to evaluate the HPH project. It contains the following sections:

I. Hospital data
II. Data on multidisciplinary group
III. Data on burden of data collection
IV. Assessment of compliance
V. Importance and applicability of measurable elements
VI. Indicators
VII. Overall experience

Under section V participating hospital teams were asked to rate the WHO HPH SAT in terms of how understandable, applicable and important the standards were. A Likert scale was used to indicate an overall rating of each of the five dimensions of health promotion.

3.7.1.5 Patient record audit

Data sheets (Appendix II, page 56) were supplied to the hospitals by the PCC for the patient record audit.

3.7.2 Data collection methods

3.7.2.1 INPUT EVALUATION

Selection of the steering teams, hospital sites and adaptation of the WHO HPH self-assessment tool

Recommendations were made by the WHO on the above. The KZN activities were compared with that which the WHO suggested. Participant observation during meetings was used and minutes of meetings were obtained. The original WHO HPH SAT was compared with the adapted KZN-WHO HPH SAT.

3.7.2.2 OUTPUT EVALUATION

Secondary analysis was done of all available raw data collected at the hospitals to complete the WHO HPH SAT and to calculate indicators. This included:

Staff questionnaires

Staff members from all categories (clinical and non-clinical) were given a self-administered questionnaire (Appendix II, page 51) to complete. Clinical staff members were supplied with an additional "clinical questionnaire". The broad categories of staff were doctors, nurses, administration and management staff, and support service staff like kitchen, mortuary, groundsmen and artisans.

Patient record audits

A patient record audit was conducted using admissions to the general medical departments of five of the hospitals concerned and to the obstetrics ward of the obstetric hospital (LU) in

the previous one month. A sample of 50 patient records was to be randomly selected from each site. The data was recorded by the QIP teams onto data sheets (Appendix II, page 56). The patient record audit assessed general record-keeping including staff dating and signing their entries, assessment of certain risk factors in patients, information given to patients, clear diagnosis, documenting of treatment plans and presence of discharge summaries.

Needlestick audits

Occupational health staff of each hospital conducted an audit of all needlestick injuries which occurred in exposed staff in the previous year (2003). This was to be stratified according to profession, area of care, time of day and level of experience.

All needlestick injuries among permanent full-time exposed staff were totalled for the year 2003. This was calculated as follows:

No. of percutaneous injuries in one year
Average number of full-time equivalent exposed staff

Absenteeism audits

The QIP teams in each of the hospitals conducted a short-term (7 consecutive days or less) absenteeism audit of all nursing staff in the individual hospitals for a three month period. This was to be stratified according to qualification (professional or non-professional), gender and age group. Percentage of short-term absenteeism was calculated as follows:

No. of days/shifts of medically or non-medically justified absence for seven consecutive days or less among nurses and nursing assistants (excluding holidays and weekends)
Total equivalent full time nurses and nurse assistants x number of contractual days/shifts per time period for a full-time staff member

Client satisfaction surveys

The most recently performed KZN DOH client satisfaction survey conducted in each of the hospitals was used. Where a client satisfaction survey had not been conducted in the previous six months, one had to be performed.

Cost of staff health promotion budget

Financial managers did a costing of the finance in Rand spent on staff health promotion per staff member per annum using the previous year (2003). Institutional coordinators were emailed the following list of activities which could be included:

- Staff health screening: medical examinations for all newly employed staff; annual medical examinations for all staff in high risk areas, for example x-ray department; oral quick test for employees to determine % HIV positive staff to qualify for funding for antiretroviral therapy; determining Hepatitis B & rubella status; alcohol-dependence screening for staff;
- Staff health promoting activities: staff gym club; soccer, netball, choir; "Weighless" club; influenza vaccine and Hepatitis B immunization services; sexual advisor to advise staff; voluntary counselling and testing – pre & post test counselling/adherence counselling for staff; other counselling for staff; health education for staff e.g. lectures on care of back & lifting; smoking cessation programmes.

3.7.2.3 PROCESS EVALUATION

In order to evaluate the implementation of the SAT the following methods were used:

a) direct observation of the participants during data collection and critical analysis of raw data
b) analysis of HPH action plans of the six hospitals in response to their findings
c) assessing experiences with and opinions of the HPH pilot project by the joint completion of the WHO HPH meta-evaluation questionnaire by each hospital QIP team after the HPH pilot project
d) recording the feedback from participants during the feedback meetings

3.8 Validity and reliability of the evaluation

All phases of the pilot implementation were observed by the principal investigator.
The HPH SAT and the 'Meta-evaluation questionnaire' are tools designed by the WHO, validated by them and used extensively in European settings.

All available outcome data collected during the HPH project were secondarily processed. Facility health care workers involved in the project were given the opportunity to give feedback individually, at group meetings and through the WHO evaluation questionnaire.

3.9 Data analysis

The staff questionnaires were captured and analysed using Epi Info 6. The data sheets and WHO meta-evaluation questionnaires were analysed using Microsoft Excel.

3.10 Ethics

Ethics approval for this study was granted by the Biomedical Research Ethics Committee of the College of Health Sciences, University of KwaZulu-Natal. (Ref.: E122/05)

Chapter 4: Results

4.1 Introduction

The HPH pilot project which utilised the 'WHO Standards for Health Promotion in Hospitals Self-Assessment Tool (SAT) for Pilot Implementation' was implemented from June to December 2004 in six public hospitals in KZN. In this chapter, in the input evaluation, the appointment of the provincial coordinators and hospital teams, the selection of the hospitals and the adaptation of the WHO HPH SAT are described. In the output evaluation, the results of the pilot project are presented together with the action plans. Finally, the process evaluation is presented.

4.2 INPUT EVALUATION

4.2.1 Formation of provincial and hospital teams to assess health promotion practice and the choosing of the six pilot hospitals

In the 'General considerations' section of the WHO HPH SAT the WHO gives clear guidelines on the 'Roles and Responsibilities' of people involved in the pilot project. A regional and national coordinator is recommended.[xv] Since the project was being implemented from a provincial and not a national level there was no regional or national coordinator. Instead a Provincial Coordinating Committee was appointed to oversee the process. This committee of eight members consisted of four doctors (two trained in public health, one a professor of family medicine and one medical officer), the provincial health promotion programme manager and three members of the provincial quality assurance and accreditation unit.

[xv] ***Role of the Regional and National coordinator***

To translate the working documents prepared by WHO, to encourage and identify hospitals to participate in the implementation, to provide guidance to hospitals taking part in the implementation and to provide feedback on the results.

Furthermore the WHO recommended, at hospital level, that there be a project leader, a lead person for each of the 5 dimensions of health promotion and a multidisciplinary steering group appointed by the project leader. This consisted of a senior nurse, a senior doctor, a junior doctor, a senior manager, a human resources member and a member of staff from ancillary professions allied to medicine, general support medical services and a member from general non-clinical services.

In the pilot in KZN at hospital level, the existing Quality Improvement Programme (QIP) teams were approached and utilized. The QIP team became the multidisciplinary steering group. They also became the lead people for the 5 dimensions of health promotion. Leaders of the QIP teams became the project leaders (called institutional coordinators). The institutional coordinators at five of the hospitals were professional nurses and, at one hospital, a doctor was involved. The QIP teams were intended to be functional prior to this project. However, in some hospitals they were not yet operational. These teams ought to have been multidisciplinary in nature but at one hospital, no doctors participated in the group whilst another possessed neither human resources nor non-clinical members in the group. It was intended that each hospital have 2 doctors in the group but this applied in only 2 of the 6 hospitals. Half of QIP teams and institutional coordinators admitted to possessing either minimal or no experience of audit, surveys or research.

The six purposefully chosen hospitals[xvi] in KZN were as follows – in Pietermaritzburg: Edendale, Northdale and Grey's Hospitals; in Durban: Inkosi Albert Luthuli Central Hospital (IALCH); in Empangeni: Ngwelezana Hospital and Lower Umfolozi Hospital. IALCH is a quaternary (central referral) hospital, Greys and Ngwelezana are regional general hospitals, Lower Umfolozi is a regional maternity hospital and Edendale and Northdale are district hospitals (although more recently the latter two form part of the Greys-Edendale-Northdale regional complex). None of these hospitals are rural and all are large. The Pietermaritzburg hospitals were chosen as they were already engaged in another WHO project, PATH (Performance Assessment Tools for Hospitals), and it was assumed

[xvi] The WHO suggested five to ten hospitals to be piloted in each country. The hospitals should vary in size and location and they encouraged the participation of mainly general hospitals.

that they were familiar with the process of data collection. There were also a few overlapping processes in the two projects. Ngwelezana and Lower Umfolozi hospitals were participating in the revitalization of hospitals programme directed and supported by the National Department of Health. Thus this project, it was considered, added to the quality dimension of this programme. IALCH was chosen as it was assumed that its inclusion would assist in raising the profile of health promotion in hospitals being a 'state-of-the-art' new, modern quaternary hospital, focused on high technology care. Furthermore, being curative in orientation, it was hoped that if IALCH were able to practice adequate health promotion, then the other hospitals would experience a heightened challenge to follow suit.

4.2.2 The adaptation of the WHO HPH SAT

The generic European-designed tool, the 'WHO Standards for Health Promotion in Hospitals: Self-Assessment Tool for Pilot Implementation' (Appendix I) was adapted for use by KZN hospitals by the Provincial Coordinating Committee, institutional coordinators and QIP teams. (Appendix II)

This occurred in two phases as suggested by the WHO, the first being the preparation phase during which provincial coordinators were appointed, hospitals were selected, all relevant documentation was prepared and staff involved were briefed about the project.
The second phase witnessed two workshops being held at the DOH to review the clarity of formulation, understandability, relevance and applicability of the SAT with its measurable elements. The Provincial Coordinating Committee and institutional coordinators attended these meetings. The aim was to elicit comments on the document, make adjustments and decide on which complementary indicators would be used. The adjusted document was then finalized by the provincial team.

4.2.3 The adjusted document

The SAT was not translated into Zulu and any translation of documents to be used by the hospitals remained at the discretion and expertise of the individual hospitals. The document was accepted virtually unchanged except for the following:
a) Terminology was changed to suit local use.

b) Complementary indicators[xvii] were specified. These were chosen from the list suggested by the WHO except for one new indicator, *% of staff aware of their HIV-status.*

c) Hospitals were asked to add a 'resources needed' column to their action plans.

d) Where there were measurable elements for compliance with standards, it was decided that a score of <10% constituted a 'no', 10-60% formed a 'partly' and a >60% score was stipulated as being a 'yes'.

e) In standard 2 (patient assessment) of the original tool, it was asked whether guidelines existed to identify the health promotion needs of groups of patients[xviii] and HIV was added as one of the groups by the KZN teams. In standard 4, the existence of policies and educational materials for staff on various conditions was queried. HIV was added to the other conditions. Except for these, and the addition of the HIV-status indicator, little reference was made in the adapted self-assessment tool to patient or staff health promotion and education on the subject of HIV/AIDS.

[xvii] Below is a summary of the areas of assessment in the adapted SAT, the complementary indicators which were chosen by the KZN team and the data sources suggested by WHO.
Standard 1: Management Policy (17 sub-standards)
Indicator: % budget dedicated to staff Health Promotion activities
Data Source: Financial records in each institution
Standard 2: Patient Assessment (8 sub-standards)
Indicator: % of patients assessed for generic risk factors
Data Source: Patient record audit
Standard 3: Patient Information and Intervention (8 sub-standards)
Indicator: Score on survey of patients' experience with information and intervention procedures
Data Source: Most recent client satisfaction questionnaire
Standard 4: Promoting a Healthy Workplace (16 sub-standards)
Indicator: % of short-term absence
Data Source: Absenteeism record books
Indicator: % of work-related injuries
Data Source: Occupational health records
Indicator: % of staff smoking
Data Source: Staff Questionnaire
Indicator: % of staff aware of their HIV-status (own KZN indicator)
Data Source: Staff questionnaire
Standard 5: Continuity and Cooperation (19 sub-standards)
Indicator: % of discharge letters handed to patients on discharge
Data Source: Patient record audit

[xviii] Example of one question where HIV/AIDS has been included during the adaptation of the tool:

" 2.2.The organization ensures procedures to assess specific needs for health promotion for diagnosis-related patient-groups. Guidelines are present on how to identify needs for HP for groups of patients (e.g. HIV/AIDS, asthma patients, diabetes patients, chronic obstructive pulmonary disease, surgery, rehabilitation) [Evidence: for groups of patients specifically treated in the clinical department]."

There was no specific mention in the adapted tool of the following: guidelines to assess patient needs regarding home water supply, sanitation, or material and social needs; screening for tuberculosis in staff or patients; strategies to increase the uptake of voluntary counselling and testing (VCT) of HIV; integration of Prevention of Mother to Child Transmission (PMTCT) of HIV into standard antenatal care; guidelines to identify the need for home-based care[xix] or Directly Observed Treatment (DOT)[xx] support; use of Integrated Management of Childhood Illness (IMCI)[xxi]; Non-occupational and Occupational Post-Exposure Prophylaxis[xxii] policy and procedures and the implementation thereof.

[xix] Home-based care is a free service available to AIDS patients who need support at home.

[xx] Directly Observed Treatment (DOT) support is recommended by the WHO for patients who are on TB treatment. There are 5 principles in the DOTS strategy. The 3rd is Standardized short-course anti-TB treatment for at least all sputum smear positive patients. Patients should be observed by a treatment supporter to be taking each dose of TB medication.

[xxi] Integrated Management of Childhood Illness (IMCI) are UNICEF/WHO treatment guidelines to assist staff in paediatric wards. IMCI includes caregiver counselling which would constitute health promotion.

[xxii] Occupational Post-Exposure Prophylaxis (OPEP) means that if staff members have needlestick injuries or potentially infective blood splashes, they have access to 28 days of anti-retroviral treatment.
Non-occupational Post-Exposure Prophylaxis (NOPEP) refers to 28 days of anti-retroviral treatment given to victims of sexual assault to prevent the acquisition of HIV secondary to the incident. Both OPEP and NOPEP are initiated by a 'starter pack' with the first dose being given as soon as possible. There is a provincial policy for both these situations which hospitals should have and implement.

4.3 OUTPUT EVALUATION

Out of 6906 staff members employed in the 6 hospitals, a total sample of 2105 was chosen and 1757 staff questionnaires were completed and useable, giving a response rate of 83%. Of these, 1133 were clinical staff categories, and the rest, non-clinical (Table 2).

Table 2 - Uptake of staff survey in six hospitals in KZN for HPH pilot project 2004

	IALCH	NG	LU	ED	ND	GR	Total
All staff	386	429	240	146	221	335	1757
Clinical staff	304	234	150	145	119	181	1133
% clinical staff	79	55	63	99	54	54	64

For the patient record audit 50 records were sampled from each of the six hospitals as planned. In five hospitals random sampling was used to select patient records. In one hospital (NG) a convenience sample was used. One sampled record at NG and two at GR were excluded since the patients were unable to communicate and thus health promotion input by staff was not relevant.

Short-term absenteeism among nurses at the six hospitals was assessed for June, July and August of 2004 in five hospitals. In one hospital (IALCH) short-term absenteeism among all staff was assessed as the requisite skill or time in extracting nurse absenteeism from other categories of staff was lacking.

Needlestick injuries were calculated for the year 2003 among all exposed staff.

Finally for the client satisfaction survey, hospitals were not able to provide raw data. Their most recent results were simply forwarded and it was therefore not clear as to the numbers participating in these surveys.

Table 3 - Summary of the WHO HPH indicators for the six hospitals in KZN 2004

Hospital	IALCH	NGW	LU	ED	ND	GR	Mean (range)
Budget : Staff HP (R) / Employee / pa (2003)	77.52	12.14	415.84	46.11	8.58	110.00	111.70 (8.58-415.84)
% Patients assessed for generic risk factors	100	4	90	54	10	69	55 (4-100)
% Positive score on client satisfaction survey	58	90	43	37	55	50	56 (37-90)
% Short term absence	1.1	0.2	1.5	1.0	3.1	4.3	1.9 (0.2-4.3)
% Staff smoking	7	8	8	4	17	11	9 (4-17)
% Staff aware of their HIV status	73	56	56	67	71	74	66 (56-74)
% Needlestick injuries	1.9	0.9	1.3	6.1	4.9	9.4	4.0 (0.9-9.4)
% Discharge letters handed to patients	100	10	0	86	40	65	50 (0-100)

AL = Inkosi Albert Luthuli Central Hospital; NGW = Ngwelezana hospital; LU = Lower Umfolozi; ED = Edendale; ND = Northdale; GR = Greys hospital; R = Rand; PA = per annum

4.3.1 Results of Standard 1 – Management policy

The mean budget per employee per year spent on staff health promotion for the year 2003 was R111,70 with the range from R8,58 to R415,84. (Table 3)

4.3.2 Results of Standard 2 – Patient assessment

Patient record audits showed that a mean of 55% (range from 4 to 100) of patients had been assessed for generic risk factors (smoking, alcohol and nutritional status). (Table 3 and 9)

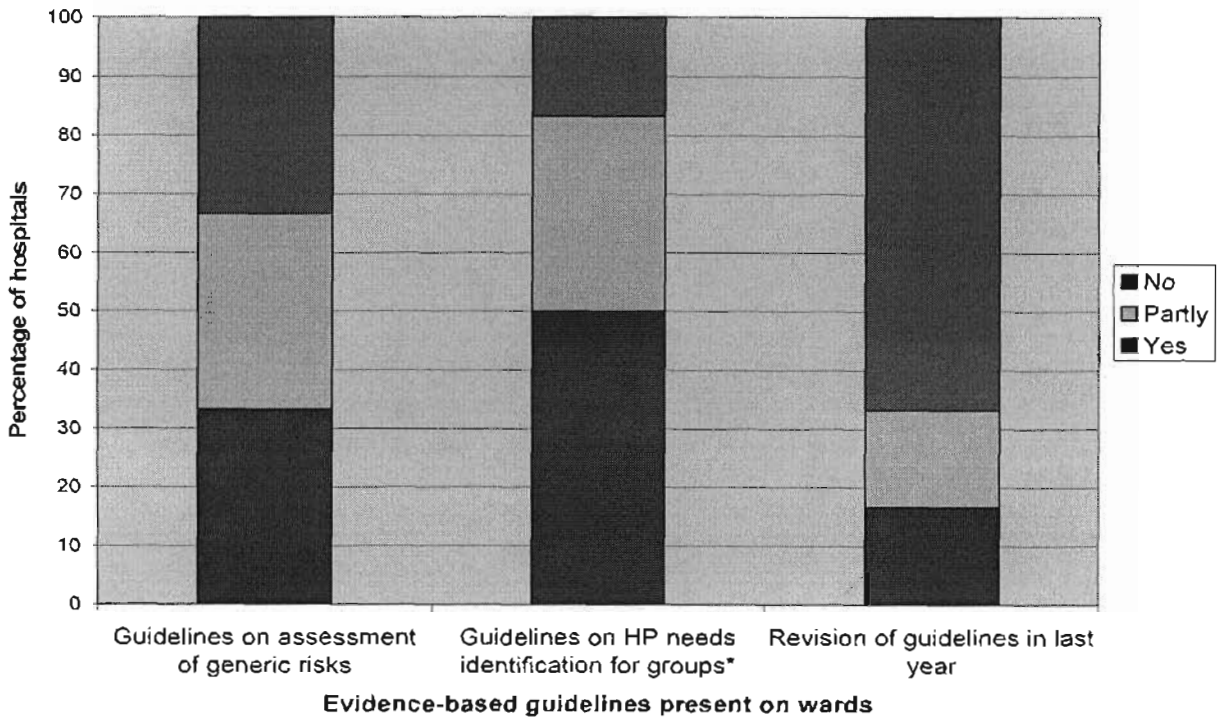

Figure 2 - Percentage of the six KZN public hospitals using evidence-based guidelines on wards June to December 2004

(*examples of groups: asthma, diabetes, COPD, post-surgery, HIV/AIDS, rehabilitation patients)

The staff questionnaire revealed that one third of the hospitals indicated that evidence-based guidelines were employed on how to identify smoking status, alcohol consumption, nutritional status and/or psycho-social-economic status. One third reported not using them at all and one third used guidelines periodically on certain wards. Half of the hospitals said they used evidence-based guidelines to identify needs for health promotion for groups of patients with specific diagnostic problems. Of those using guidelines, one out of the six hospitals had revised them in the last year. The hospitals were not asked to produce the guidelines or provide information on which of these were used. (Figure 2)

4.3.3 Results of Standard 3 – Patient information and intervention

A mean of 50% of the records reviewed in the six hospitals had documented evidence of any form of patient information being given to patients with a range from 17% to 78%.

(Table 9) Client satisfaction surveys revealed that a mean of 56% (range 37 to 90) of patients were satisfied with the information given to them on their conditions. (Table 3)

4.3.4 Results of Standard 4 – Promoting a healthy workplace

Staff development

An average of 61% of staff had received job descriptions on starting their jobs (range 41% to 76%), 51% had a performance appraisal system in place (range 36% to 81%), 78% participated in a Continuing Professional Development (CPD) programme (range 67% to 91%) and 81% (range from 74% to 88%) reported ongoing audit in their departments. (Table 4)

Table 4 - Measures of staff development at the six public hospitals in KZN in 2004

Hospital	Job descriptions n/total %	Performance appraisal system n/total %	Continuing Professional Development n/total %	Ongoing audit in department n/total %
Greys	130/181	97/178	143/176	159/180
	72	55	81	88
Northdale	86/119	42/117	77/115	96/119
	72	36	67	81
Edendale	76/145	60/141	119/142	112/144
	52	43	84	78
Lower Umfolozi	80/150	57/148	103/145	110/148
	53	39	71	74
Ngwelezana	95/234	129/229	166/224	177/232
	41	56	74	76
Albert Luthuli	231/304	246/304	273/300	270/302
	76	81	91	89
Mean	61	51	78	81

n = number of clinical staff who answered Yes (Options were Yes; No; Don't know)

Staff health

An average of 9% (range 4% to 17%) of all staff sampled were **smokers** and in all hospitals a higher percentage of males smoked than females. Likewise in all six hospitals a higher percentage of non-clinical staff smoked compared with clinical staff. (Table 5)

Table 5 - Percentage of staff smokers in the six public hospitals in KZN in 2004

Hospital	IALCH	NGW	LU	ED	ND	GR	Mean
% All staff (number/total)	7 (26/380)	8 (35/427)	8 (19/238)	4 (5/143)	17 (37/221)	11 (36/331)	9
% Male	21	19	13	11	36	25	21
% Female	4	3	7	3	7	7	5
% Clinical	5	3	6	3	10	6	6
% Non-clinical	15	14	12	5	27	17	15
Age % <40	7	7	9	5	14	8	8
% 40-55	9	9	7	2	20	15	10
% >55	3	6	14	0	30	13	11

A mean of 66% (range 56% to 74%) of **staff knew their HIV status** across the six hospitals. There was no significant difference between male and female staff concerning this except for the LU maternity hospital where a significantly ($p<0.05$) higher percentage of women said they knew their status. At both Empangeni hospitals, a higher percentage ($p<0.05$) of clinical staff said they were aware of their status compared with non-clinical staff. For the other hospitals there was no difference. At all hospitals a higher percentage of younger staff said they knew their status when compared with older staff. This difference was statistically significant ($p<0.01$) in all hospitals. (Table 6)

Table 6 - Percentage of staff who said they were aware of their HIV status in the six public hospitals in KZN in 2004

Hospital	AL	NGW	LU	ED	ND	GR	Mean
%All staff (number/total)	73 (276/379)	56 (238/424)	56 (130/232)	67 (94/141)	71 (155/220)	74 (240/324)	66
%Male	73	59	43	65	64	75	63
%Female	73	55	61	68	74	73	67
%Clinical	73	60	73	68	75	79	71
%Non-clinical	73	51	30	59	63	68	57
Age % <40	75	59	64	61	77	78	69
% 40- 55	76	53	49	75	68	69	65
% >55	60	35	46	50	48	68	51

Needlestick audit

The mean percentage of **needlestick injuries** for the year 2003 was 4% of exposed staff ranging from 0.9% to 9.4%. The incidence of needle stick injury was particularly high amongst doctors. The highest percentage injuries occurred at Greys hospital with 9.4% (80/847) of all staff being injured. If each injury occurred in a different individual (that is an injury did not occur two or more times in the same individual), then 8% of all nurses and 24% of all doctors had needlestick injuries at Greys hospital in 2003. The lowest injuries were recorded at Ngwelezana hospital with only 0.9% of exposed staff being injured. This figure may be low due to poor record keeping. IALCH had 2% injuries in all exposed staff with 11% of all doctors being injured. Lower Umfolozi recorded 1.3% injuries with 5.5% of all doctors being injured, Edendale scored 6% with 45% of all doctors being affected (again if it is assumed that injuries are not occurring in the same individual twice). At Northdale, 5% of exposed staff had injuries with 6% of all doctors being injured. (Table 7)

Table 7 - Needlestick injuries for the year 2003 at the six public hospitals in KZN among exposed staff

Hospital	IALCH	NGW	LU	ED	ND	GR	Mean
% injuries of all staff (number/ exposed staff)	1.9 (30/1595)	0.9 (9/1011)	1.3 (4/301)	6.1 (76/1243)	4.9 (22/453)	9.4 (80/847)	4.2
% injuries of all nurses	1.1	0.8	0.7	2.7	4.5	7.6	2.9
% injuries of prof nurses	1.3	1.0	1.2	2.5	5.7	-	
% injuries of non-prof. nurses	0.9	0.6	0	2.9	3.6	-	
% injuries of all doctors	10.7	5.6	5.5	44.7	5.8	24.0	16.0
% injuries of other exposed staff	8.6	7.6	25.0	-	7.5	0	
Area of care most injuries	Wards	Out-patients	Wards	Theatre & out-patients	Med & paed wards	-	
Time of day most injuries	Weekday	Weekday	None	Weekday	Weekday	-	

- No data available on this measure at these hospitals

Absenteeism audit

The mean percentage **short-term absence** for 7 or fewer consecutive days among nurses was 1.9% (range from 0.2% to 4.3%). (Table 8)

Table 8 - Percentage short-term absenteeism among nurses at the six public hospitals in KZN for June, July & August 2004

Hospital	IALCH *	NGW	LU	ED	ND	GR	Mean
%All nurses (number/ total)	1.1 (1169/ 105560)	0.2 (58/ 34580)	1.5 (197/ 13266)	1.0 (767/ 74620)	3.1 (791/ 25740)	4.3 (2058/ 48100)	1.9

*This figure is for all staff, not just nursing staff

4.3.5 Results of Standard 5 – Continuity and cooperation

An average of 50% of patients had received a discharge letter on leaving the hospital with a range from 0% to 100%. (Table 9)

Table 9 - Patient record audit results of the six public hospitals in KZN in 2004

Hospital		IALCH	NGW	LU	ED	ND	GR	Mean
Patients assessed for generic risk factors	n/total	50/50	2/49	45/50	27/50	5/50	33/48	162/297
	%	100	4	90	54	10	69	55
Discharge letters handed to patients	n/total	50/50	5/49	0/50	43/50	20/50	31/48	149/297
	%	100	10	0	86	40	65	50
Records documenting information given to patients	n/total	21/50	28/49	39/50	27/50	25/50	8/48	148/297
	%	42	57	78	54	50	17	50

n = number of patient records compliant; total = total records reviewed in that hospital

4.3.6 Overall performance of hospitals

Overall all the hospitals complied poorly with the standards for HPH. The tertiary hospital, Inkosi Albert Luthuli Central Hospital (IALCH), consistently scored the highest overall and for all the individual standards. For the overall score out of 68 measurable elements IALCH was followed by Ngwelezana, Greys, Edendale, Northdale and the lowest score being that of Lower Umfolozi War Memorial hospital. The mean score for total compliance ('Yes' response to the set standard) was 23 out of 68 with the range from 10 to 42. (Figure 3)
All hospitals scored very poorly for standard 1, management policy, with the mean out of 17 being 2 (range 1-4). Hospitals scored somewhat better for patient assessment, standard 2, with the mean of 4 out of 8 (range 2-6). For patient information and intervention,

standard 3, the mean was 4 out of 8 (range 2-6). For standard 4, promoting a healthy workplace, IALCH scored 12 and Ngwelezana 9 out of 16, the mean being 7 (range 2-12). Again IALCH scored the highest with 14 out of 19 for continuity and cooperation with Lower Umfolozi scoring 0 for this standard, the mean being 6 (range 0-14). (Table 10)

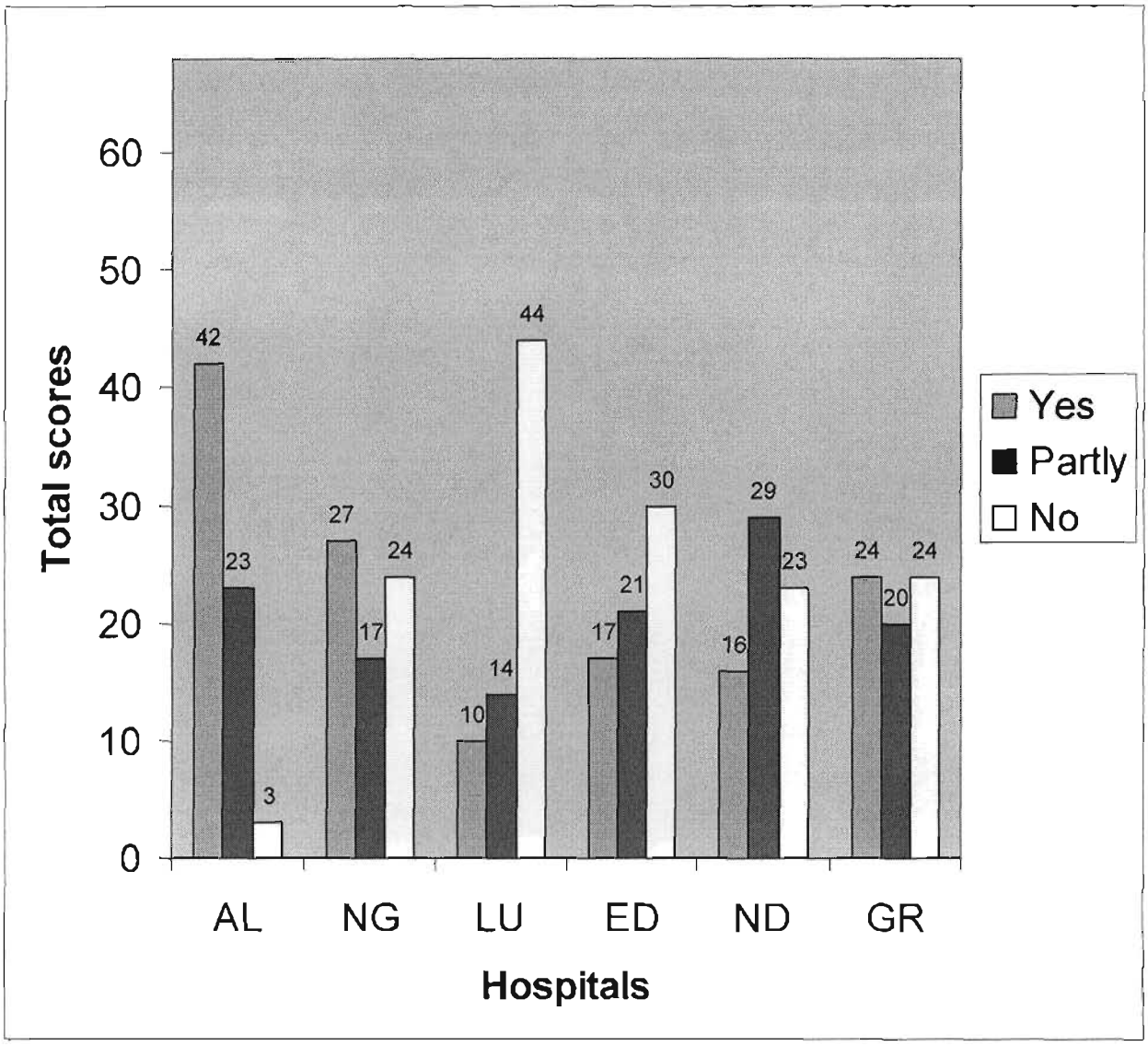

Figure 3 - Overall total score (out of 68) of health promotion standards compliance for the six KZN public hospitals as assessed between June and December 2004

Table 10 - Overall assessment of the five standards for the six KZN public hospitals as assessed between June and December 2004

Hospital	Health Promoting Hospital Standard					Total
	Standard 1 /17	Standard 2 /8	Standard 3 /8	Standard 4 /16	Standard 5 /19	/68
AL Yes	4	6	6	12	14	42
Partly	10	2	2	4	5	23
No	3	0	0	0	0	3
NG Yes	3	2	4	9	9	27
Partly	0	2	4	5	6	17
No	14	4	0	2	4	24
LU Yes	1	3	4	2	0	10
Partly	3	2	3	5	1	14
No	13	3	1	9	18	44
ED Yes	3	3	2	3	6	17
Partly	5	5	5	5	1	21
No	9	0	1	8	12	30
ND Yes	1	3	3	6	3	16
Partly	4	3	5	6	11	29
No	12	2	0	4	5	23
GR Yes	2	6	3	7	6	24
Partly	4	1	5	5	5	20
No	11	1	0	4	8	24
Mean Yes	2	4	4	7	6	23

4.3.7 Action plans

Based on the results of the assessments, QIP teams at each of the six hospitals devised plans of action to address their shortcomings. They used the template provided in the SAT for each standard. Appendix IV gives the action plans of the six hospitals.

4.4 PROCESS EVALUATION

4.4.1 Standard 1 – Management policy

For the budget calculation no standardised data collection sheets were provided. Despite the guidance given, staff at the different hospitals interpreted *staff health promotion activities* differently. Some gave a very detailed breakdown of activities with exact costing while others simply estimated their spending. As a result the range of spending was wide.

4.4.2 Standard 2 – Patient assessment

The patient record audit was conducted using admissions to the general medical departments of five of the hospitals in the previous one month. In the case of the maternity hospital, the obstetrics department was used. Admissions in one month totalled between 500 and 1000 in each of the different hospitals. The WHO expert committee had recommended a random sample of 50 patient records from each site. Half of the hospitals were able to select a sample randomly, the rest needing technical assistance. Despite training, one hospital failed in this respect. The staff at that hospital admitted to picking 50 records from a convenient pile in a haphazard manner. The audit took staff one morning in each hospital. Five groups of nurses jointly went through ten patient records together. Two of the hospitals asked for technical assistance to be provided on the day of the audit. In those hospitals the Provincial Coordinating Committee conducted a workshop prior to the audit and provided support during the audit. Data was collected onto pre-designed data collection sheets (Appendix II, page 56).

The patient record audit assessed general record-keeping, including staff dating and signing their entries, assessment of certain risk factors in patients, information given to patients, clear diagnosis, documenting of treatment plans and presence of discharge summaries. On observing this part of the process in two hospitals, it became apparent that the *assessment of risk factors*, as being present or not was left to the discretion of the nurses doing the audit. For example, some regarded simply weighing the patient and documenting the result as an assessment of nutritional status whilst others looked for a comment in the record stating the nutritional status of the patient. Nurses did not require an assessment of the

amount of alcohol or tobacco consumed, merely documentation of whether the patient used it or not being accepted as sufficient to confirm an assessment of those risk factors.

4.4.3 Standard 3 – Patient information and intervention

The most recently performed KZN DOH client satisfaction survey and the patient record audit were used. Where a client satisfaction survey had not been conducted in the previous six months, one had to be performed. Both in and out-patients in all parts of the hospital were surveyed in one day. Hospitals used convenience sampling for these surveys. A minimum of 100 patients were surveyed per hospital but exact numbers were not provided. Only one question in the client satisfaction survey[xxiii] was used: "At the time of your discharge did you feel that you had enough knowledge about your illness to take care of yourself at home?" Possible responses were Yes, No, Unsure or Not Applicable. The percentage of 'Yes' responses were calculated. In five hospitals the question appeared as part of the full patient satisfaction survey. At one hospital only the relevant question was typed onto a sheet of paper and handed out. No provincial assistance or technical advice was provided for these surveys. Client satisfaction surveys were not translated into Zulu.

For the patient record audit, no standard definition or guideline as to what qualified as *information given to patients* and an adequate *treatment plan* was supplied. In those audits that were observed, *any* information given to the patient about their condition whether or not it was correct or appropriate was accepted as sufficient evidence that information had been furnished to the patient. Likewise, any documented treatment plan, regardless of the quality thereof, was taken as sufficient.

The patient record audit only took into account what was present and documented in the patients' records. Staff protested at this as in many of the hospitals group health education was given to patients with similar problems. It was argued that patients and staff enjoyed this form of health promotion which was not routinely documented in the patient record.

[xxiii] The KZN DOH client satisfaction survey in use at the time of the HPH project implementation assessed 8 aspects of patient satisfaction with services: access, communication, courtesy, cleanliness of physical environment, respect of patient's rights, safety, general and waiting times. The question used in the HPH project came from the 'general' section of the survey.

4.4.4 Standard 4 – Promoting a healthy workplace

Staff survey

The staff questionnaire (Appendix II, page 51) assessed the professional development of staff, use of standard operating procedures and evidence-based guidelines, knowledge of safety procedures and individual healthy behaviour of staff.

The staff surveys were carried out by the QIP teams in one day without any assistance from provincial teams. At one hospital a failure to hand questionnaires out to doctors occurred. When this was noted by the PCC, it was suggested they go back on another day to capture this staff category. None of the hospitals translated the typed questionnaire into the Zulu language. One hospital (NG), however, chose to conduct the survey by handing out the English questionnaires and then verbally translating into Zulu for staff in groups. The translations were done by nurses in the QIP teams and were not checked or verified.

Needlestick injury audit

These audits were conducted satisfactorily by all of the hospitals according to the WHO methods. The audits did not, however, include whether or not post-exposure prophylaxis[xxiv] for Hepatitis B or HIV had been given or if injured staff members had been followed up. Such follow-up is necessary to identify side-effects of post-exposure prophylaxis drugs in the short-term, check if the course of medication has been completed and ascertain whether the staff member has acquired HIV or Hepatitis B from the incident.

Absenteeism audit

Ngwelezana hospital scored 0.2% for nurse absenteeism for 2003 but was questioned on the reliability of this figure. The hospital manager believed the most likely reason to be poor record-keeping. Staff members were not always handing in their sick leave forms. IALCH

[xxiv] Following a percutaneous (needlestick) injury in a health care worker (HCW), both the HCW and source patient should receive pre-test counselling and be tested for HIV and Hepatitis B. If the HCW is HIV negative then they are given post-exposure prophylaxis (PEP) to be taken for 1 month. HCWs should be routinely vaccinated against Hepatitis B but if they are not or their antibodies are found to be insufficient, they should be offered Hepatitis B immunoglobulin if the source patient is found to be Hepatitis B positive. HCWs should then be followed up after 1-2 weeks (to check for side-effects of the PEP) and at 3, 6 and 12 months to check if they have sero-converted i.e. aquired HIV, which may be as a result of the needlestick injury. It should also be recorded whether HCWs have completed the course of PEP as prescribed.

calculated absenteeism of *all staff* not just nurses as that was what was routinely collected and they were unable to extract from their system the figure for nursing staff only. There was also a reluctance to collect separately data just for the pilot project due to time constraints. Stratification was not possible at all hospitals due to their routine methods of collecting this data. Only three hospitals were able to stratify.

4.4.5 Standard 5 – Continuity and cooperation

The patient record audit was used to determine whether patients had been given discharge letters on discharge from the hospital. The way in which this was determined was by the presence or absence of the carbon copy of the letter in the patient record. This cannot, however, confirm whether firstly, the patient or a family member was actually given the letter and secondly, the letter was then passed on to the primary care provider it was intended for.

4.4.6 Action plans

Some hospitals saw this as the most important part of the project and had numerous meetings to devise action plans while other hospitals barely met once to discuss it. Action plans varied greatly with some hospitals creating detailed plans[xxv] with every single shortcoming listed while others highlighted only what they regarded as priority areas. At

[xxv] Action plans varied. Exert from detailed action plan:

ACTION	TIMEFRAME	EXPECTED RESULT	RESOURCES REQUIRED
STANDARD: 1			
Add health promotion to core values	2005/01/05	Health promotion included in core values	Paper (250 sheets); printing; lamination; staff time
Re-affirm hospital board agreement	2004/08/19	Minutes of board meeting	Staff & hospital board time
Include HP in strategic objectives	2004/10/31	CAPS document	Staff time
Develop a HP policy	2005/02/18	HP policy	Staff time; IT information; paper; printing; distribution
Develop programme for quality assessment of HP activities	2005/03/24	Quality assessment programme	Staff time; paper; printing; distribution

one hospital the action plan was said to be misplaced and so was rewritten in half an hour by one member of the QIP team. It was not clear how much input had been given by other QIP team members. Action plans also varied in terms of how practical and understandable they were[xxvi]. Some action plans identified the shortcomings but did not actually say which action would be taken to rectify the situation. The action plans were requested by and

[xxvi] Action plans varied. Exert from an incomplete action plan:

ACTION	TIMEFRAME	EXPECTED RESULT
STANDARD: 1		
Organize business development plan for allocating resources		
Operational procedures		Monitor strokes, AMI's, diabetics
Staff aware of HP policy Employment of facility information officer		Proper induction programmes to be put in place
Organization & validation of data		Efficiency & quality of data
Job descriptions incorporate HP policy Develop policy for HP activities		Efficient & timeous quality of data
Business plan & availability of necessary resources for implementation		Proper allocation of resources
STANDARD: 2		
Draw up guidelines on smoking status, number & type per day; alcohol consumption in amount/ day & brand; nutritional status - indicate like anaemia		Well-defined guidelines & population parameters defined
Guidelines on numerous specified diagnoses' DM, HPT etc		
Draw aspects of patient assessment to be recorded as a routine to be followed - subjective, objective, laboratory		Improved record audit
Diet requirements Religious Weight measurements		Increase in patient satisfaction reported in patient satisfaction questionnaire
Teach doctors/ attached & indicate in file		Improved record audit

Difficulties

The principal difficulties and challenges encountered were time constraints, lack of budget for the project, being "overloaded with improvement programmes", staff shortages resulting in a need for extra hours for some staff, lack of experience and expertise and absence of "buy in" from individual role players. Collecting data for the absenteeism audit and the budget for staff health promotion presented the teams with the greatest challenges. Only two hospitals (33%) believed this project could easily be incorporated into organizational practice at the hospital, the rest stating that this was not the case.

Other challenges were that, at the time of the pilot implementation, National and Provincial DOH did not yet have a health promotion policy and no guidelines or frameworks were supplied for the drawing up of one. One hospital felt that the provincial steering committee should have provided more support in the developing of action plans based on the individual hospital results. Another hospital had no "in house computer system" and thus data collection and processing was more time consuming.

Some hospitals complained that the National and Provincial DOH generally do not provide enough health promotion material like posters and pamphlets for hospitals to undertake their health promotion work. Another argued that the entire project should concentrate on more relevant health promotion issues such as "infectious diseases, trauma and abuse".

4.4.8 Feedback from meetings and workshops

Management policy

Hospitals emphasized that there had to be full support from hospital management for the process to be successful. Northdale hospital reported that they believed certain of their difficulties with the project sprung from not being fully supported. IALCH, who had been supplied with a high level of management support and resources for the project, were the most successful of all the hospitals in their ability to interpret and use the results for the potential benefit of staff and patients.

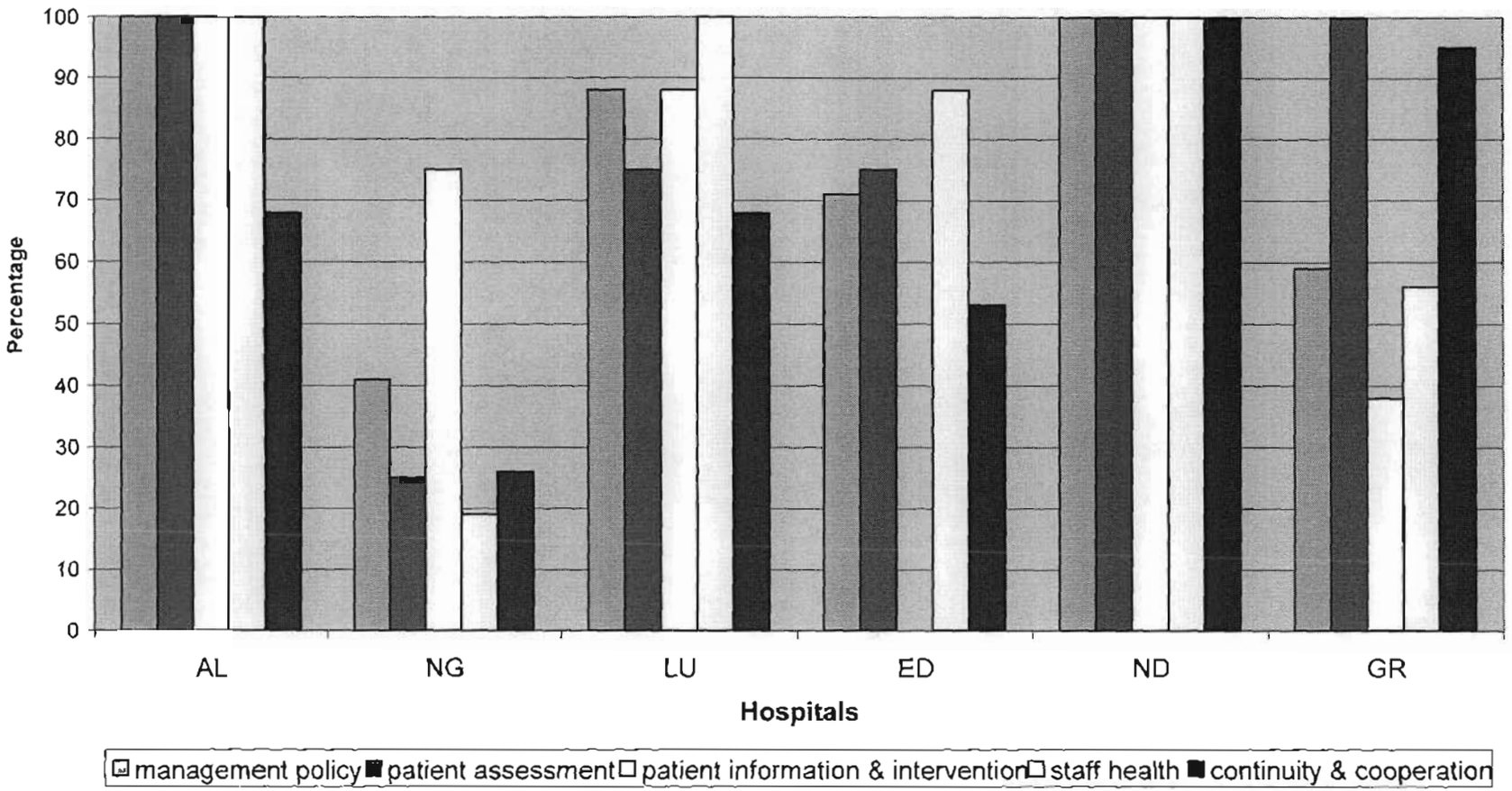

Figure 4 - Percentage standards in each category assessed by hospital QIP teams as fully understandable, applicable and important

AL=Inkosi Albert Luthuli Central; NG=Ngwelezana; LU=Lower Umfolozi; ED=Edendale; ND=Northdale; GR=Greys

Patient assessment

At IALCH the availability of the original letter of referral (from the referring institution) was found to be poor. It was only seen by the administrative staff on patient's arrival. At present, the letter is routinely scanned and thus available for all (on computer) to be reminded of why the patient was sent in the first place, thus aiming to improve patient care. IALCH also now formally reassesses patient's needs just prior to discharge.

Lower Umfolozi reviewed their antenatal clinic card. They found that the information on it was insufficient and have added extra routine questions to be asked e.g. about support at home, transport availability, smoking and alcohol use etc. A high risk antenatal clinic is now being piloted.

Patient information and intervention

In some hospitals group education was undertaken and recorded in 'health education' books, not in patients individual records. The patient record audit did not take this into account.

At IALCH electronic templates have been reviewed to expand the space for 'specific health education' so that health promotion efforts can be documented in greater detail.

Certain individual hospitals plan to make televideos with health promotion messages available in outpatient department waiting areas.

Promoting a healthy workplace

Some felt that the indicator for staff short-term absenteeism (<7 days) showed a distorted picture of absenteeism as so many staff were off for > 7 days. All absenteeism ought to have been calculated, they believed. In hospitals where the absenteeism rate was low agreement existed that most probably sick leave forms were not being handed in. Poor record keeping leading was thus resulting in false low rates.

During the pilot project some disturbing practices were discovered. A common practice mentioned was that some staff (particularly nurses) worked in both a public hospital and in the private sector at the same time. They arranged shifts for the same day but were just absent from the public hospital. QIP teams said there was a tendency among staff to 'take' all their sick leave whether or not they had genuinely been ill.

Staff stress was a major problem identified and many action plans revolved around attempts to address this. Causal factors were both work load and, often, financial debt. In some hospitals individual health worker personal finance management was addressed by offering staff in-training on the subject. One hospital has begun a stress management programme for staff, being offered by a clinical psychologist.

IALCH now has a standardized performance appraisal system in place for all staff and new recruits are to receive orientation and induction which includes their role in health promotion. Health initiatives for staff have been introduced: smoking cessation programmes; lunch time walks for staff; encouraging use of stairs as opposed to lifts; encouraging use of staff gym and relaxation facilities; increasing numbers of social events like soccer, netball and choir.

A "needleless" policy has been introduced at IALCH which involves the use of retractable needles which require no recapping (which is the process causing many needle stick injuries). 'Tightening-up' of the pre-employment medical examination of staff and routine medicals for those in high risk areas, for example radiographers, has also taken place. Plans are being considered to coordinate health awareness campaigns for staff, efforts of Employment Assistance Programme (EAP) and occupational health practitioners and, furthermore, to encourage the formation of support groups (in and out of hospital) for staff with particular problems, an example being diabetics.

Continuity and Cooperation

In Lower Umfolozi hospital the complementary indicator used here (*% of discharge letters handed to patients*) was said not to be applicable as it was a maternity hospital and patients

were discharged after delivery and not given any follow-up date at the clinic or hospital. The QIP team believed it was unfair that they scored 0 for this indicator since it measured something which, they believed, was not applicable to them.

Other issues raised

Technology and inexperience appeared to be a problem. Due to the distances between sites taking part in the pilot, this project relied to a large degree on email communication. Some hospitals like Northdale, Edendale and occasionally Ngwelezana regularly experienced problems with their servers and thus could not receive emails for 4-6 days at a time. Furthermore, a lack of expertise in opening certain documents retarded the process.

Time was the most common constraint mentioned by all who took part in this project. Many held that, without specific time being allocated to existing staff, an inability to sustain a project of this nature would arise. This would mean employment of extra staff to take over the tasks that the staff chosen to do the project would have undertaken. Many hospitals raised concerns about resources in order to achieve the goals of their action plans and carry out the routine monitoring of the HPH initiative. Financial support from the provincial, district or facility level was called for. Severe staff shortages were being experienced and concern existed about the sustainability of the project once the pilot was over.

Many emphasized the need for district and head office to be involved 'hand-in-hand' with the facilities in order to avoid many different fragmented initiatives coming from various quarters. Instead these initiatives should be 'integrated' into other plans. Others stressed the importance of the 'full participation' of the hospitals boards.

Primary health care clinics staff who were present at the meeting wanted to know why clinics were not involved in this project and why the DOH were concentrating on health promotion in curative centres rather than in the traditional preventative arena i.e. Primary Health Care clinics.

4.5 Summary

Both provincial and institutional staff in the hospital public sector had limited experience with implementing a quality improvement initiative such as the HPH pilot project. Despite this, the project was completed. The WHO SAT proved not to be ideal for the South African setting and, unfortunately, had not been sufficiently adapted to be regarded as highly appropriate for this context. Whilst the data collection methods proposed did attempt to be scientific, it was not always possible for the hospitals to apply them and, thus, much of the data collection did not live up to this goal. A particular problem was that methods were often non-standardised which meant that bench-marking would be meaningless. The results of the project are thus questionable. In addition, many action plans were weak, confusing and not always practical. Despite these problems, the hospital staff believed they benefited from their involvement in the HPH project and recommended that other hospitals also be involved. The WHO meta-evaluation as well as verbal feedback from staff suggested that there were substantial constraints which would prevent the successful sustaining of this project. This pilot project did not include an outcome or impact evaluation and thus the benefit for staff and patients in terms of health promotion has yet to be assessed.

Chapter 5: Discussion

5.1 Introduction

With preventative efforts in health care not being adequate and the primary health care system experiencing difficulties, HPH offers a potential interim solution while these problems are addressed, and a long-term strategy for quality improvement in hospitals. The need to measure health promotion practice in the health sector has been identified.
This work aimed to specifically assess the feasibility and appropriateness of adapting the WHO HPH self-assessment tool and using it to measure the current status of health promotion practice in public hospitals in KZN. In this chapter the application of the tool in KZN is considered and the use of a tool such as this in Africa is examined. The opportunity cost[xxvii] of the project is discussed. Thereafter, it is considered whether this project has avoided problems experienced with HPH in Europe and lessons have been learnt from performance measurement in other countries. Finally, the limitations of the evaluation are discussed.

5.2 INPUTS

5.2.1 Choosing the hospitals

In choosing the hospitals, the best-staffed and equipped public hospitals in KZN were selected for the pilot project, including two regional hospitals and one quaternary hospital. This does not represent the majority of hospitals in KZN which are often poorly staffed and likely to have more difficulty than the chosen ones. The external validity of the pilot is therefore not sufficient.

5.2.2 Choosing the institutional QIP teams

The Provincial Coordinating Committee was well chosen in terms of their training and skills. The QIP teams would have been more representative had they been more multidisciplinary. More management and human resources staff as well as staff in professions allied to medicine (physiotherapists, occupational therapists, psychologists,

[xxvii] Opportunity cost includes that which we could have spent this money on if we did not undertake this project.

social workers and radiographers) could have been included. The WHO recommended the involvement of at least two doctors at each facility and this was only achieved in two of the six hospitals. This is unfortunate since a project of this nature will only be truly implemented if the clinicians who see the bulk of the patients are involved. Doctors tend to listen to their professional peers rather than to nurses or staff in professions allied to medicine. Furthermore, if doctors are too busy to be involved in leading this project in relatively well resourced hospitals (e.g. those selected), then there is very little likelihood of finding the opportunity to take this role in the smaller poorly resourced hospitals where only one or two doctors, for the entire hospital, may be employed.

Despite the lack of staff to fulfil the WHO recommendations, the Provincial Coordinating Committee and the QIP teams displayed great enthusiasm for the project and all staff with quality improvement experience were included.

5.2.3 Training of institutional staff

QIP teams ought to have received more training in audit and surveys to produce more scientific data. The amount received was insufficient. This became apparent throughout the project. Difficulties were experienced with costing of the health promotion budget. As health promotion did not appear in the budget as an entity, financial managers were not able to supply this information and it was left to staff (QIP teams), inexperienced in budgeting, to estimate these figures.

During the patient record audit there were problems with the random selection of 50 patient records. Three hospitals needed assistance with this process and one hospital still did not randomly select.

There were also difficulties with the absenteeism and needlestick audits. Some hospitals admitted that their record-keeping in these areas was lacking. In those hospitals it may have been more useful to collect the data prospectively after awareness had been raised with those routinely responsible for collecting these data. There were problems with collecting enough detail in order to stratify. The WHO proposed stratification so as to identify the

target groups in terms of absenteeism, discouraging smoking and identifying areas in the hospitals with high needlestick incidence. Few hospitals were able to provide this detail.

5.2.4 Use of generic tools for performance assessment and quality improvement

It is important to consider the appropriateness of using quantitative European-designed generic tools for quality improvement initiatives in Africa.

Firstly, there was no initial qualitative phase or arm to this study during which the real problems facing patients and hospital staff in KZN could be clearly ascertained. Thus the organisers went into the project making assumptions about the health promotion needs of the clientele and those of the staff. Knowledge of local cultures, especially in rural areas where there is less education, is essential to determine which myths exist and need to be addressed.

Issues like the abilities (computer literacy, audit experience), education levels and morale of the staff had not been explored in advance. All organisations, including hospitals, have informal hierarchies and cultures. There was no opportunity to discover whether there were any emergent leaders whose 'buy in' was essential to make the project successful. An emergent leader's[xxviii] personal goal for the group strongly influences the group's chosen goal for the group.[59]

Secondly, if one is to use a quantitative tool, the WHO SAT has numerous problems. In striving to be comprehensive and covering all areas of health promotion practice, it fails to capture enough detail. This problem was mentioned in the literature review under 'lessons in performance measurement'. Often a battle exists between the desire to be comprehensive and the time and resources available to measure all dimensions. As a result performance is viewed in a piecemeal fashion which does not reflect the true picture of what is taking place. This is illustrated when considering the indicators suggested by the WHO. For

[xxviii] In management theory an emergent leader is one who is not formally appointed as a leader but who others in the group perceive as a leader.

standard 1 (management policy), the indicator *% budget dedicated to staff health promotion activities* was used. In the case of KZN, hospitals used different methods to determine this eliciting a wide range of non-comparable and not necessarily useful results. This indicator then had to represent all of management policy. It could be argued that this is a superficial and inaccurate measure of performance unless properly standardized. The use of just one indicator, *% of patients assessed for generic risk factors (smoking, alcohol and nutrition)*, to 'summarize' each hospital's performance in patient assessment is limiting. To summarize patient information and intervention the indicator, *score on survey of patients' experience with information and intervention procedures,* was used. Patients' experience with hospital care, however, forms only one aspect of determining quality of care provided.

Furthermore, specific problems arise with using the WHO SAT designed for Europe in a setting like KZN. During phase two a large amount of time was spent attempting to contextualize the document for the KZN setting. Many standards and indicators were inappropriate for a developing country and some health promotion issues crucial to KZN were omitted from the original tool. The indicator, *% of staff coming to work by bicycle* (under standard 4), is a case in point. South Africa is geographically a much vaster country than most Western European countries and the majority of health workers live great distances from the hospitals. Most would require travelling by taxi, bus or car. Standard 5 has an indicator asking for *% of discharge summaries sent to General Practitioners (GP).* In South Africa GPs are private and the vast majority of patients attending a public hospital would not have attended a GP regularly. Those that can afford any form of private health care would be as inclined to attend a traditional healer[60] and it could be argued that an enquiry needs to be conducted to ascertain whether traditional healers are being informed when patients are discharged.

Thirdly, the project relies largely on *documented data.* The question arises as to whether what is documented is actually performed and whether what has *not* been documented has really not been undertaken. In the case of Ngwelezana hospital for example, little patient education was discovered in their patient records. After the audit it was asserted that large patient education books or records were held on the ward in which any record of education

given in groups to patients would be stored. A culture of group education was described where patients needing similar advice would be addressed together in a group on the wards. This would not then be noted down in the individual patient records but rather in the book on that ward. The patient record audit did not take these books into account but this process could potentially be contributing substantially to health promotion practice.

Lastly, although the WHO provides a process evaluation (WHO 'meta-evaluation' questionnaire – appendix III), there is no outcome or impact evaluation. It is also not emphasized that the only way to measure improvement is to repeat the project regularly e.g. annually. In the case of KZN, the provincial team made the decision to roll out the project to other hospitals in the province without ever repeating the project. Thus there was no outcome or impact evaluation.

5.2.5 Adapting the WHO tool

Insufficient adaptation

Given the problems mentioned in 5.2 above, the WHO SAT needed substantial adaptation to be appropriate for KZN. Unfortunately the tool was not adapted enough. Although the WHO recommended translation of documents, none of the documents for the project were translated into Zulu. This may have been a particular problem where non-professional staff had been involved, for example in the completion of the staff questionnaire. Many support staff in hospitals were not fluent in English. This led to, in one hospital, a member of the QIP team verbally translating the staff survey questions to a group of employees in an informal, unchecked manner. This may have led to information bias.

In the choosing of the indicators, more specific and locally relevant indicators could have been chosen to summarize the standards. In patient assessment, whilst the generic risk factors, smoking, alcohol and nutrition, may be important to elicit in urban areas considering the emergence of chronic disease as a fourth burden of disease[6], emphasising this aspect above other problems in rural areas is questionable. An example of this is illustrated by Lower Umfolozi Maternity Hospital where results indicated that no pregnant women were routinely asked about their smoking or alcohol status. The hospital team

responded in their action plans by trying to incorporate this into their assessment procedure by adjusting their admission templates. While this would be important in Europe or the Western Cape, in KZN it is unusual for young rural women to smoke or excessively consume alcohol. In contrast eliciting, through routine questioning, symptoms suggestive of diseases like tuberculosis, HIV and STIs would be more useful and appropriate. A study conducted among 321 women in Hlabisa, a rural part of KZN, revealed that 52% of women attending a district antenatal clinic had at least one STI and 18% of attendees had more than one STI.[61] Furthermore, the prevalence of HIV in the antenatal population of KZN at the time of the pilot project was 40.7 %.[62] Whether pregnant women are offered VCT routinely, the integration of Prevention of Mother to Child Transmission (PMTCT) of HIV into routine antenatal care, STI identification, screening and management and the dissemination of general family planning and contraceptive advice would also have been more relevant exercises.

Under the staff health dimension too, there are no indicators or standards in the original tool addressing tuberculosis, HIV/AIDS, Hepatitis B or Hepatitis C. One indicator was added by the provincial team (*% staff aware of their own HIV status*). More indicators and standards could have been added. The relatively high prevalence of these communicable diseases among patients and thus the high exposure of staff makes imperative the assessment of policies and practices in hospitals, including how staff is protected and educated. As a bare minimum, the occupational health policy of hospitals on staff tuberculosis should have been assessed. Preferably the post-exposure prophylaxis policy and implementation thereof ought to have been assessed.

Choice of indicators

Considering the human resource challenges described by many during this project, it was unfortunate that the hospitals and provincial team failed to select and calculate more of the 'complementary indicators' provided for selection under standard 4 in the original WHO SAT (Appendix I). *Score on Burnout scale, Retention rate, Turnover rate and Score of survey of staff experience with working conditions*, may have revealed interesting findings which could than have been further explored and acted upon.

Some indicators were poor proxies to what was being measured. An example of this was the indicator which represented continuity and co-operation (standard 5), *% patients handed completed referral letters on discharge*, chosen to replace the WHO indicator, *% of discharge summaries sent to GPs.* This relied on identifying the standard patient (discharge) referral letter which is usually completed in triplicate in the patient's notes. One copy should remain in the notes, another is supplied to the patient and the last of these should be forwarded to the receiving organization which is usually a clinic. Possible problems are:

- The presence of the copy in the notes cannot verify that the other two copies have gone to the appropriate recipients.
- Even if patients *had* received their copies, no guarantee is available that these copies would be produced at a later appropriate stage, for example when visiting a clinic.

On discussing this with staff in one hospital, it was mentioned that patients very rarely produced these letters and that patients also attended whichever clinic was convenient at the time, thus sending a copy to a specific clinic nearest their home would not ensure continuity. One hospital (Lower Umfolozi) scored 0% for this indicator. This was because the head clinician in the department that had been audited did not regard these letters as being of any use and thus they were simply ignored. The preference was to rely on a 'patient wellness card' which patients carried with them and on which staff would write brief details of their visits to hospital or clinics.

Another indicator which could potentially be affected by information bias is from standard 4 (promoting a healthy workplace). *% Staff aware of their HIV-status* did not require any proof of status. Clearly there could be a discrepancy between what they thought they knew and what they truly knew. A more reliable figure in this respect would be staff who asserted that they were unaware of their status (34%). This is most probably true.

5.3 PROCESSES

5.3.1 Data collection methods

Non-standardized

Data collection methods were not always standardized which resulted in benchmarking being inappropriate. There are a number of examples of this. In determining the budget for staff health promotion, hospitals varied greatly in what was included. Some QIP teams ascertained that it proved difficult to cost out certain activities and therefore either estimated the cost of it or omitted it. During the patient record audit, individual hospitals utilised five groups of nurses each scrutinising ten patient records. All groups did not use the same standards for the list of characteristics they were looking for. Thus, a set of records might have failed to meet the criteria in the hands of one group of nurses but were another group to analyse them, the records may indeed have met them. For the client satisfaction questionnaire, five hospitals did a full survey[xxix] and merely used the answer to the one relevant question from the survey, for the indicator *score on survey of patients' experience with information and intervention procedure.* One hospital, however, handed out only the one question typed on a sheet of paper to clients. Patients faced with this one question may have considered it more carefully and, thus, may have answered differently than if they were faced with the full questionnaire.

Superficial

Information collected on staff development in the staff questionnaire was superficial. There were a number of Yes/No questions on whether a performance appraisal system exists, whether CPD takes place, if audits are done and whether evidence-based guidelines are used to identify risk factors in patients. There was little opportunity to elaborate on these answers. It is important to ask what kind of performance appraisal system is in place. Is it a fairly unstructured and informal peer review system or does it follow a structured format with an emphasis on accountability and individual professional development? The quality

[xxix] The 'full survey' here means the KZN DOH client satisfaction survey which is supposed to be done regularly by all public hospitals in KZN. It assesses 8 aspects of patient satisfaction with services: access, communication, courtesy, cleanliness of physical environment, respect of patient's rights, safety, general and waiting times. The question used in the HPH project came from the 'general' section of the survey.

of the CPD activities and the types of audits being done would be of interest. Furthermore, if evidence-based guidelines are being used, it would be desirable to know which ones, as many guidelines and protocols are available but there is often a difficulty in distinguishing the 'good' from the 'bad'. Many drug companies provide treatment guidelines strongly favouring the use of their products.

5.3.2 Drawing up of action plans

This project was to culminate in the drawing up of action plans which hospitals would aim to fulfil over time. It is disappointing to note that this part of the project seemed to be neglected. Hospitals had difficulty in understanding what was required of them. Some such health institutions failed to apply sufficient time and effort over their action plans. Others planned carefully but occasionally missed the point. An example of this was that there was a need for evidence-based patient assessment methods to identify risk factors, and in identifying the need for health promotion input, for high risk groups. This was identified in the majority of the hospitals in the pilot. In trying to rectify this, many of the hospitals reported in their action plans that the questions "do you smoke?" and "do you use alcohol?" would be added to their patient admission questions. They also regarded the simple documentation of the patient's weight as sufficient an assessment of nutritional status. No discussion on which methods exist to assess risk factors occurred. Thus, for example, a large volume of good quality evidence was available indicating that appropriate screening helps the detection and treatment of alcohol problems.[63] The CAGE method[xxx] is both a well-established and simple method of screening for alcohol problems. Another evidence-based method, the Alcohol Use Disorders Identification Test (AUDIT), has consistently proved its effectiveness within primary care, casualty, pre- and antenatal settings. Thus,

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[xxx] The CAGE method, designed (in 1970) for use by people such as doctors to quickly identify whether a patient may have a drink problem. Questions are designed to be put to anyone whose overall level of consumption is at a level considered risky or harmful. These are the four questions:

- **Have you ever thought you ought to CUT DOWN your drinking? YES/NO**
- **Has anyone ever ANNOYED you by criticising your drinking? YES/NO**
- **Have you ever felt GUILTY about your drinking? YES/NO**
- **Have you ever had to have an EYE-OPENER - a drink first thing in the morning? YES/NO**

In order to score one adds up the number of Yes answers. Two or more positive answers suggest that your drinking may be causing you problems.

questions were asked about evidence-based patient assessment, education and information but hospitals did not appear to have the expertise to act on their lacking, and no assistance was provided by the provincial team to rectify this.

Ngwelezana and Lower Umfolozi produced action plans which were too vague and theoretical. Shortcomings in their health promotion practice were identified but the practical actions which were needed were not clear. Greys produced a very lengthy and detailed action plan which seemed too ambitious for the resources available. Edendale's action plan was confusing. Northdale's plan was practical and achievable but not very comprehensive. Only IALCH created a really good plan which was immediately implemented with success.

5.4 OUTPUTS

5.4.1 Useful information revealed by the project

Staff smoking and HIV status

This project did yield some useful information, in particular about staff health. The prevalence of smoking was found to be high, an area which could easily be targeted with smoking cessation programmes. The number of staff not being aware of their HIV status was also high. This creates an ideal opportunity for a 'know your status' campaign with VCT being emphasized for staff.

Needlestick injuries

Needlestick injuries were very high by both international and South African standards, particularly among doctors where the mean injury rate was 16% for all the hospitals. The number of such injuries sustained by health workers internationally is still unclear, primarily due to under-reporting. However, in a meta-analysis done in 2003, a mean rate of 4% (range 1.0-6.2%) sharps injuries per 10000 was calculated from eight studies (internationally) involving more than 7000 health care workers.[64] In a study carried out in Gauteng at the end of 1998, 102 interns were questioned about needlestick incidents during their intern year and 3 years of clinical training. At least one percutaneous injury

occurred in 83% of interns, 43% from an HIV positive source, over the 4 year period.[65] This pilot found that at Edendale hospital, 45% of all doctors had had a needlestick injury in 1 year. This is of major concern since these hospitals are situated in one of the highest HIV-prevalence areas in South Africa with an antenatal HIV-seroprevalence at 40.7%.[62] Again this is an opportunity for occupational health staff to address the problem and monitor the success of their interventions. In certain countries, for example the USA and the United Kingdom, approaches to reduce this risk have included education and training on the safe handling and disposal of sharp devices, awareness campaigns and legislative action. More recently, preventative strategies have focused on needle protective devices, which may reduce the rate of sharps injuries. The General Accounting Office (GAO) review of needlestick prevention in the USA concluded that 75% of these were preventable, 29% by using safety devices, 25% by eliminating unnecessary use and 21% by using safer work practices.[66] Most hospitals planned to address the issue but few gave any detail of what they would do. One hospital, IALCH, did switch to the use of retractable needles shortly after the pilot project.

Absenteeism

Absenteeism in nurses was not found to be particularly high by international standards (Denmark 3.5% and Portugal 8.0%[20]; Canada 8.1%[21]). In this pilot the highest rate was 4%, although rates were unrealistically low for some hospitals possibly due to poor record-keeping. The management of Ngwelezana hospital regarded their nurse absenteeism rate of 0.2% as inaccurate compared with the reality being experienced.

The staff from IALCH reported at feedback meetings that although absenteeism figures seemed acceptable, this was a distorted picture. Their real problem was longer term absence (more than 7 days) which this study did not include. It may be that the high prevalence of HIV among health workers[11] is contributing to this. The ideal situation would have been to monitor all absenteeism and then stratify for short and long-term absenteeism as well as for age groups, grades and gender so that target groups could be identified. Some of the KZN pilot hospitals did mention addressing absenteeism in their action plans but no specific methods were given. There were also no solutions or suggestions offered by the

provincial teams. Despite the above problems, the absenteeism audit was useful in that it revealed poor record-keeping (which can now be addressed) and led to informal discussions. These, in turn, revealed some concerning practices, such as nurses double booking themselves for shifts (in public and private hospitals) and only being present for the private hospital shift (while being paid for both). In addition, the 'taking' of all sick leave annually, regardless of their health status, was also a feature identified. An underlying reason for this particular kind of behaviour was indicated as the levels of debt staff members were in. This constituted another area which was addressed in two hospitals (IALCH and Lower Umfolozi).

5.4.2 Capacity building

The project served to boost staff morale as it was believed that efforts were being made to improve their own health and the service they provide. An awareness of health promotion was created among staff, and management were alerted to shortcomings in their policy. Staff at the institutions had the opportunity to conduct audits and surveys, collect and analyse data, and create plans based on their results. Many were doing this for the first time. There was also a strengthening of relationships between regular staff, QIP teams, hospital management and the provincial staff during this project. It could be argued that these gains could also have been attained with any other project.

5.5 GENERAL

5.5.1 The opportunity cost of the HPH project

A further question requiring attention is whether the adoption of this hospital setting approach is effectively admitting defeat, that is, a failure to implement a successful district-based primary health care system, with clinics as both the main and first entry point to the health system undertaking most health promotion. Thus it is planned to implement health promoting hospitals as the solution to the problems of staff and skill shortages instead of concentrating our efforts on the clinics where the problems lie. The aim is to prevent and cure in one sitting. Accepting this signifies a move away from the fundamental principles of decentralisation to which adherence is claimed. By spending resources on HPH results in a failure to utilise those resources to solve the root cause of the problems needing address.

5.5.2 Similar problems as in Europe

The meta-evaluation questionnaire and staff feedback sessions revealed some similar obstacles to success in this project as in Europe. Like the 22 European countries, local staff discovered that there were *time constraints*. In KZN hospitals were so understaffed that their urgent clinical work was barely managing to be conducted. In particular a shortage of doctors and nurses prevailed. At Edendale hospital the medical manager regularly did clinical work including on-call duties. Most hospitals (67%) felt that this work was not easy to incorporate into "normal organizational work".

As previously mentioned, some hospitals *lacked expertise*. Initially some hospital teams and individuals had difficulty understanding the document since English was not their first language and many workshops were spent clarifying concepts. Many hospitals did not possess the expertise to conduct audits and some had never before administered staff questionnaires or undertaken patient surveys. Despite these constraints, all hospitals displayed a willingness and enthusiasm to improve quality of services to patients. QIP teams in the hospitals reported having acquired knowledge and new skills. Leaders also reported positive attitudes and an improvement in morale among staff as interest had been shown in their health and their views. It could be argued, however, that any pilot project would have had this response. From a staff capacity building point of view this pilot could be viewed as successful although many held the view that this may *not be sustained* without regular input from outside and that once completed, the momentum would be lost. Sustainability and lack of appropriately trained personnel were also concerns expressed by critics in Europe.[36]

Absence of 'buy in' from managerial staff was found to be a problem in some hospitals like Northdale. This, together with the lack of national and provincial policy on health promotion, was also experienced in Europe.

Some, like their European counterparts, felt that *additional budgets* should be provided to improve health promotion in hospitals and that *more guidance and input* is needed from the provincial DOH.

Successful self-assessment depends on local staff in public hospitals having the skills, resources, time and enthusiasm to accurately complete the process. As mentioned above, hospitals lacked many of these and required substantial outside input. In adopting self-assessment methods for quality improvement one needs first to ensure that these elements are in place for useful and successful outcomes.

5.5.3 Have lessons in performance measurement been learnt?

As mentioned in the literature review performance indicators do not measure performance, people do and we need therefore to emphasize the importance of training the staff involved. This was not sufficiently attained in this project and it emerged as a constraint for maintenance of the initiative.

Secondly, analysis and interpretation must accompany performance measurement in order to obtain useful, useable information. The interpretation of some of the findings by the hospitals seemed superficial and this was illustrated by their translation thereof into action plans.

Thirdly, a tendency exists to measure what is readily measurable (easy to collect, quantify and report) regardless of whether or not the element being assessed is most important. Some hospitals admitted that the reason for choosing certain indicators was the ease of collection of the data.

Finally, this process did not give hospital staff the opportunity to contribute in the design phase of the self-assessment thereby potentially missing crucial local problems. The urban and rural populations in KZN differ in many ways. True participatory research, where local staff contributes to the design of the tools, where local expertise is used and local issues are identified, would have been more appropriate.

5.6 Limitations of the evaluation

5.6.1 Selection bias

As mentioned earlier, in choosing the hospitals, the best-staffed and equipped public hospitals in KZN were selected for the pilot project. This does not represent the majority of hospitals in KZN and thus the evaluation is limited to those hospitals where the initiative was implemented.

5.6.2 Information bias

In completing the WHO Meta-evaluation questionnaire the whole QIP team in each of the six hospitals completed one questionnaire. This meant that the questionnaire represented the majority opinion of the group. If there were members in the group with stronger personalities, this may have swayed those less assertive not to hold a divergent opinion. Thus such opinions may not truly be those of the whole group and it may have been preferable to insist on anonymous individual completion of the questionnaires.

In a similar way the feedback meetings may have produced information bias. The meetings were held for the QIP teams, hospital management, head clinicians and all who participated or were interested at each hospital. The final feedback meeting included all six hospital teams as well as members from related sectors. It may have been intimidating for participants to express their views at such meetings particularly if negative opinions of the project were privately held.

As regards the accuracy of the results concerning the performance of the six pilot hospitals during this project, a number of limitations were present. The data sources consisted largely of documented data collected by inexperienced data collectors at the six institutions which was then secondarily analyzed. It has already been mentioned that the absenteeism and needlestick data were incomplete in some hospitals. For the client satisfaction survey, the raw data was not available to the principal investigator for secondary analysis. The hospitals provided the latest survey results where surveys had been done. Non-standardised

methods were often used, for example, for the patient record audit and budget calculation. All of these factors may have led to information bias.

In terms of the process evaluation, recall bias was limited as views of staff involved in the project were documented as the process took place. However, the principal investigator of the evaluation often visited hospitals together with the steering team and may have been perceived as part of the 'team from head office'. Thus, the staff at the hospitals may have been less willing to be critical of the project when asked to comment on it. It was apparent that most hospitals were grateful for any kind of involvement from the provincial DOH and therefore may have made positive comments in order not to jeopardize the interest shown in them. In the same way they were pleased to be part of an international WHO project and therefore may have tried to please by responding positively to the WHO meta-evaluation questionnaire. This again could have led to information bias.

Chapter 6 – Conclusion and recommendations

6.1 Introduction

Health and health care have undergone vast changes in the preceding 30 to 40 years. The value of preventative approaches, the corporatization of the health sector and consumer demand has resulted in the emergence of initiatives such as the HPH project. These initiatives aim to address the inadequacies of health services and in the case of HPH, health promotion practice in particular is addressed. The need exists for these initiatives to be evaluated so that their true value can be determined. The HPH movement met with mixed responses in other parts of the world. This dissertation is an evaluation of one of the first attempts to apply this project together with its recent addition, the self-assessment tool, in an African setting.

6.2 Conclusion

This evaluation has revealed that the WHO HPH self-assessment tool was not ideal for determining health promotion practice in KZN. It is a generic pre-designed tool for the developed world which would require a great deal of adaptation for it to be useful and appropriate in an African environment. Views of, and issues important to local health workers were not included in the design phase and thus results do not reflect local issues and problems.

The WHO HPH SAT was insufficiently adapted by the KZN DOH. Health promotion efforts concerning the most important diseases and conditions affecting the KZN population were either not included or only briefly referred to. This was an opportunity to explore and understand the human resources crisis in the province and this was not used.

Implementation of the HPH project was feasible but staff felt it could not easily be incorporated into routine organisational practice at the hospitals. A project of this nature placed a burden on already overstretched hospitals which were already experiencing

difficulty fulfilling their curative functions. Staff involved in the project lacked adequate training, resources and time to carry out the project successfully without assistance.

Methods used were not scientific. Due to limitations of the tool and the inexperience and lack of training of staff, results were not always valid and reliable. The data collection methods were not sufficiently standardised and thus benchmarking was inappropriate. Furthermore, hospitals were not always able to interpret the results and inadequate support was offered to compile action plans.

This project definitely served as a morale booster for the hospitals involved. All were very pleased that attempts were being made by the provincial DOH and the WHO to improve patient care and staff health in hospitals. There was capacity building in that hospital personnel were exposed to audits and surveys, and matters such as budgets and costing became realities to be confronted. In most cases relations between management and staff and between hospitals and the provincial monitoring and evaluation unit were strengthened. The project further served to highlight health promotion at hospital level.

Unfortunately the HPH project in KZN, like many in Europe, did not include an outcome or impact evaluation. There is therefore no way of knowing whether the project has been beneficial to patients or staff in the longer term. It is also not known if there has been any impact on the communities which the hospitals serve. A follow up by the staff would have been desirable after a suitable time period.

Finally, a question which remains is whether it would have been more appropriate to try to improve health promotion practice in the primary care setting rather than the hospital setting. This would be in keeping with attempts at decentralisation and success would relieve the burden on hospitals.

6.3 Recommendations

6.3.1 INPUTS

Resources

If this project is to be a success in future then it is imperative that sufficient resources are allocated. These would include adequate funds, enough time, appropriate equipment (including at least a computer at each facility) and additional staff if necessary so that hospitals are not overburdened.

QIP teams

QIP teams should be multi-disciplinary so that each member serves to 'spread the word' to others in their discipline. Different disciplines approach and deal with health promotion in different ways, so by being multi-disciplinary, these can be incorporated into the project. A concerted effort must be made to obtain 'buy in' of the managerial staff and ideally staff from management should be involved in the project.

Training

A true investment could be made by building audit and research capacity in the hospital staff through good training. Staff involved in the project need to be trained adequately in audits, computer skills, costing of activities, data collecting and analysis. The facility information officer should be actively involved. Investing in staff in this way would not only benefit the project, it would provide positive spin-offs for the hospitals in the longer term. Certainly, these teams could be used for audits and quality improvement in areas other than health promotion. It would also contribute to non-financial incentives to stay in a job and thereby reduce the problem of poor health worker retention. With this approach sustainability of the project is more likely.

Tool

The WHO/KZN SAT needs further adaptation to make it more relevant to users in KZN. In this respect, it would be advisable to include local facility staff in this adaptation. Discussion groups could be held to find out what the most common local problems are in

terms of health promotion among patients and staff. In this type of participatory research, there would be a sense of ownership of the project rather than the WHO and provincial DOH head office imposing the project on the hospitals. If groups are not forthcoming with issues then the following could be suggested:

- *in staff:* VCT uptake, quality of HIV services, tuberculosis (screening, protection/prevention, treatment, care, adherence and cure rates), occupational post-exposure prophylaxis, personal financial management and debt avoidance, staff retention and burn out;
- *in patients:* routine questioning to identify patients with tuberculosis and HIV/AIDS, uptake of HIV testing in antenatal clinics and casualty, identification of women needing HAART by the PMTCT service, gender violence, sexual abuse, quality of rape crisis centres at the facilities, identification of individuals living in severe poverty, child-headed households and problems accessing grants, identification of children with suspected HIV and referral onto appropriate services, use of IMCI for care giver counselling, communication channels between the facility and community health workers, home-based carers, welfare services and NGOs.

Depending on what the hospital teams regard as a priority, many of the above could be incorporated into the standards and indicators set by the hospitals. Indicators should be carefully chosen, not because of their ease in collection but because of their importance and appropriateness.

6.3.2 PROCESSES

Document preparation

All documents which may be used by individuals with poor English, the KZN/WHO SAT, client satisfaction survey and the staff questionnaire, should be translated into Zulu for use in KZN.

Methods

More attempts should be made to improve the reliability and validity of the results. Methods of data collection should be standardised with detailed data sheets. Selection of patient records should always be random and particular data (e.g. absenteeism and needlestick injuries) should be collected prospectively to improve quality and completeness. When conducting audits specific definitions of what is adequate should be provided, for example define *adequate* "treatment plan", "information given to patients" and "assessment of risk factors".

There should be a qualitative arm to the project where facility staff are interviewed and granted an opportunity to describe their health promotion activities for staff and patients. In this way their own health promotion practice, for example group education of patients, which is not captured by pre-designed data sheets can be included in the assessment.

Analysis and planning

Support should be provided for facilities struggling with analysis of their data. The provincial steering committee should then provide assistance with development of action plans. These plans should detail exactly what the action will be rather than just stating the problems or giving vague lists of activities. There is a need for realism, problem areas need prioritisation and budgets must, of necessity, accompany them.

Interpretation

A KZN HPH forum should be set up where hospitals registered as HPHs can meet biannually for presentation and interpretation of their results. Each facility should be given an opportunity to display graphs and charts showing their progress. In this way experiences can be shared and support and assistance to one another enjoyed. The cyclical nature of the process must thus be emphasized. Joint plans can be made to improve their individual services. These meetings can also be used to decide jointly on appropriate evidence-based guidelines to adopt for health promotion activities so that there is a provincial approach to

health promotion rather than the hospitals individually deciding on these issues in a piece meal fashion. This would be in keeping with the 'learning organisations'[xxxi] approach.

6.3.3 GENERAL

Rather than salvaging the health promoting hospital project it may be worth considering a health promoting clinic project. Alternatively, a health promoting clinic initiative could be started and run parallel with HPH. These two approaches could complement each other and aim at the provision of a seamless quality service to patients in the primary health care and curative care settings. Lessons learnt in the application of HPH in KZN would be valuable in that many problems could be avoided in the setting up of health promoting clinics.

Finally, whatever transpires in the future, an outcome and impact evaluation must be conducted to assess the true benefit of WHO's HPH initiative to patients and staff.

[xxxi] Learning Organizations are those that have in place systems, mechanisms and processes, that are used to continually enhance their capabilities and those who work with it or for it, to achieve sustainable objectives - for themselves and the communities in which they participate.
(from http://www.skyrme.com/insights/3lrnorg.htm)

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APPENIDIX I: WHO SELF-ASSESSMENT TOOL

Health Promoting Hospita

DRAFT

EUROPE

Standards for Health Promotion in Hospitals

Self-Assessment Tool for Pilot Implementation

Health Promoting Hospit

WORLD HEALTH ORGANIZATION
EUROPE

Standards for Health Promotion in Hospitals

Self-Assessment Tool for Pilot Implementation

This document has been prepared by Oliver Gröne, Svend Juul Jorgensen, Mila Garcia-Barbero and the International Working Group on Standards for Health Promotion in Hospitals. It has been developed in accordance and in cooperation with international quality organizations and the members of the International Network of Health Promoting Hospitals.

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General considerations

Introduction

The WHO Health Promoting Hospital (HPH) project seeks to incorporate the concepts, values and standards of health promotion into the organizational structure and culture of the hospital, improving the health of patients and staff, supporting healthy environments and actively cooperating with the community. It provides hospitals with an opportunity to contribute to the public health agenda.

Health promotion is a core quality issue in hospitals and therefore should be incorporated into the daily work. Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health" (Ottawa Charter for Health Promotion) [1], and is here understood to embrace health education, disease prevention and rehabilitation services. It is also understood to include health enhancement by empowering patients, relatives and employees in the improvement of their health-related physical, mental and social well-being.

Hospitals play an important role in promoting health, preventing disease and providing rehabilitation services. Some of these activities have been an essential part of hospital work although may not have been explicit. However, with the increasing prevalence of lifestyle-related and chronic diseases, a more expanded scope and systematic provision of activities is required. Therapeutic education, strategies enabling patients to take an active role in chronic disease-management or motivational counselling, can support better hospital health outcomes. Hospitals also need to put stronger emphasis on working conditions in order to improve the health of staff, and to improve efficiency and quality of care.

The main strategy to improve quality in health care is by setting standards. However, a review of the main standards in use by accreditation agencies yielded few standards related to health promotion actions [2].

The WHO Regional Office for Europe in 2003 developed standards for health promotion in hospitals which are in line with the recommendations of the ALPHA programme [3]. The standards were develop on the basis of an extensive critical literature review, several expert workshops and consultations. The final set of standards was piloted in 34 hospitals in nine European countries. The standards address the issues of management policy; patient assessment, -information and -intervention; promoting a healthy workplace and continuity and cooperation. The developmental process and final standards have recently been reported in the literature [4, 5, 6, 7].

The standards provide hospitals with a framework to evaluate their health promotion practice and to stimulate development. They provide a real opportunity for staff to question what they do, why they do it, and whether it can be done better. Performance indicators complementary to the standards were added to allow a quantitative monitoring of quality improvement over time.

To support the assessment of standards and indicators, a self-assessment tool has been developed [8]. Self-assessment is a process by which all professionals in a healthcare organization carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of an action plan, implementation and subsequent evaluation. Self-assessment has to be clearly distinguished from external evaluation.

Hospitals within the WHO Health Promoting Hospitals network and other hospitals are encouraged to use the self-assessment tool presented in this document to improve health promotion activities and to contribute to continuous quality improvement.

The Self-Assessment tool includes measurable elements and evidence to assess the compliance with standards. A complementary document, "Manual on implementing health promotion in hospitals", is being developed to facilitate implementation [9]. It will be finalized after the piloting phase of the tool has been completed.

Frequently asked questions

Q Is it compulsory for members of the WHO Health Promoting Hospitals Network to undertake self-assessment?

No - the self-assessment is voluntary. The tool is an offer to the member hospitals to facilitate the identification of areas where improvement is needed.

Q What are the incentives for hospitals to undertake this self-assessment?

Hospitals may undertake self-assessment in order to provide better patient care and improve patients quality of life. The self-assessment tool supports evaluation if health promotion services are in place and helps to identify gaps in service provision.

Q How does this fit in with other quality initiatives?

The process of setting standards is an integral part of continuous quality improvement. The health promotion standards developed in this manual aim to complement existing quality standards that do not have a concrete focus on health promotion. They have been developed in accordance with the methodology and terminology used in standards developed by accreditation bodies organized in the International Society for Quality in Health Care. Complementary indicators have been added to allow quantitative assessment of performance over time. It is highly recommended to link the self-assessment of standards for health promotion to the quality strategies already in use.

Q What will we get as an organization when we have completed the self-assessment?

You will have identified your areas of good practice and areas for improvement in the field of health promotion, and will be able to structure an action plan. This will all contribute to improved patient care.

Q Will we get a certificate?

No, certificates will not be issued. The process is a self-assessment and continuous quality improvement and development through action plans. There is not a 'pass' or 'fail'. Each hospital will be different and will have a different set of action plans designed by their own organizations depending on the results of the self-assessment, their priorities and local and national initiatives.

Q Do we need to score 'yes' in all the substandards for each standard?

You need to accurately state your position in each substandard, in order to identify areas of good practice which you may want to replicate elsewhere in the organization, and areas where there could be improvement. This is so that both can be fed into an action plan at the end of the self-assessment. This plan should then be integrated into the hospital's own quality management processes for continuous quality improvement.

Q How do we have to measure indicators?

The manual specifies for each indicator its rationale, description of numerator and denominator, data source and stratification. Indicators need to be measured repeatedly over time in order to reflect the continuous quality improvement process. In order to reduce possible biases indicators should not be altered over time.

Q How can we build an action plan based on standards and indicators?

The assessment of standards compliance is based on a number of measurable elements, which need to be assessed as being fully, partially or not fulfilled. The comments box must be filled with remarks on the evidence used, on quality potentials or further suggestions that support improvement. Data on complementary indicators at the end of each standard may be gathered, facilitating the monitoring of progress over time. The action plan should be developed based on the assessment of standards, indicators and the comments and observations that have been added during the self-assessment process. The action plan should also relate to main gaps identified during the assessment and reflect organizational priorities.

Q What happens to our action plan?

In order to ensure implementation and monitoring the action plan needs to be presented to executive management and included into the quality management processes in the hospital.

Q Will the tool be used for benchmarking with other hospitals?

No. The tool is only intended to be used for self-assessment, although at a later stage and after sound validation of the tool, benchmarking may be discussed further.

Purpose of the pilot implementation

The purpose of this pilot implementation of standards and indicators for health promotion in hospitals is threefold:

1. To assess clarity of the self-assessment tool and complementary documentation enabling hospitals to internally assess and improve the quality of health promotion activities.

2. To assess how data can be collected on indicators for health promotion.

3. To assess the development of a quality improvement plan based on data on compliance of standards and performance assessed by indicators.

It is not the purpose of the pilot implementation to assess test-hospitals. However, information about the hospitals' actual compliance with the standards will be important to identify applicability and relevance. The information will be used by WHO to improve the tool. The data will not be communicated to other parties and the analysis will be anonymous.

Phases of the pilot implementation

The pilot implementation is divided into five phases:

Phase 1: Preparation - March 2004
National coordinators appointed, hospitals selected, all documentation prepared, translated and staff involved briefed about the project.

Phase 2: Assessment of standards compliance - April and May 2004
Standards compliance being assessed using the self-assessment tool. Evaluation of the clarity of formulation, understandability, relevance and applicability of measurable elements in the self-assessment tool to be performed.

Phase 3: Data collection for indicators - June to August 2004
Data to be collected to assess performance based on selected health promotion indicators. Various methods may be applied to gather data, such as review of patient records, use of routine data, conducting surveys, etc.

Phase 4: Development of quality improvement plan - September to October 2004
Based on the assessment of compliance with standards and performance on health promotion, the project leader, together with a multidisciplinary steering group, will develop a quality improvement plan to be submitted to hospital management.

Phase 5: Reporting of results - November and December 2004
The project leader, together with a multidisciplinary steering group in the hospital, fills in the meta-evaluation form provided by WHO. This form will gather results from the assessment of compliance with standards and performance based on indicators as well as evaluate the clarity and relevance of the self-assessment tool, and the burden of data collection.

The self-assessment tool and complementary documentation will be revised afterwards. The results will make no reference to the performance of individual hospitals. They will yield important information on the relevance and applicability of measurable elements and indicators. Further, the quality improvement plan submitted to hospital management will facilitate the identification of the main scope for quality improvement related to health promotion activities within the hospital.

Roles and Responsibilities

Role of WHO

To produce the working materials for the pilot implementation, to encourage countries and hospitals to participate in the pilot implementation, to identify coordinators at regional and national levels, to coordinate the pilot implementation in the participating hospitals, to support the participation and to analyse the results sent to WHO using the meta-evaluation form.

Role of the regional and national coordinator

To translate the working documents prepared by WHO if necessary[1], to encourage and identify hospitals to participate in the pilot implementation, to provide guidance to hospitals taking part in the pilot implementation and to provide feedback on the results. Five to ten hospitals in each country, depending on the size of the country and situational factors, will participate in the project. Participating institutions may be of public or private ownership and should vary in size and location. Although the standards and indicators are not disease-specific we encourage the participation mainly of general hospitals at this stage.

Hospital Management

Essential to the success of this project is the commitment to the project of the chief executive, governing body and senior managers of the hospital, to ensure implementation of the action plan and to release the necessary resources to undertake the task.

[1] NOTE: Not all documentation will need to be translated in all countries, however, WHO strongly encourages to translate at least the complete self-assessment tool. Translated documents, particularly the self-assessment tool, should be the same in layout as the original one. WHO will provide technical assistance on the layout if necessary.

Project leader

It is also crucial that a project leader within the hospital is appointed to lead the process and train other staff in carrying out the self-assessment. Ideally, this person may already be responsible for other quality initiatives in the hospital as the project needs to be run as any other quality improvement activity.

Lead person for standards

The project leader may wish to nominate a lead person for each of the standards (lead persons may be responsible for more than one standard). They will need to take responsibility for assessing the level of compliance with the standard and substandards. They will be responsible for collecting the evidence that supports their response. They will also be responsible, in collaboration with other members of the steering group, to collect data for health promotion indicators.

Multidisciplinary steering group

The project leader needs to establish a multidisciplinary steering group that represents the staff at all levels. He will need resources for the administrative tasks (e.g. collecting the data and evidence) and for training the steering group.

Each hospital will have to identify the members of the steering group according to their organization. Nevertheless, it is suggested that the following staff should be involved in the multidisciplinary steering group:

- a senior nurse who may also be responsible for quality /clinical audit
- a senior and junior doctor
- a senior manager
- a human resources/personnel member
- a member of staff from ancillary professions allied to medicine (e.g. physiotherapy, occupational therapy), general support medical services (e.g. Radiography) and a member of staff from general non-clinical services (e.g. catering, hotel services, cleaning, etc.).

Staff at all levels in the hospital should be involved in collecting the evidence and supporting a collective response to the compliance of the standard.

The steering group will need to meet on a regular basis to discuss progress with the self-assessment, generate ideas across disciplines and promote greater ownership of the project.

It is important to stress that there is very little value in one person completing the self-assessment without the involvement of relevant staff, as the results would be subjective and prevent staff from being involved in the learning process.

Data collection

Data needs to be collected to assess standards and to construct indicators.

Standards

Regarding data collection to assess standards, the self-assessment tool contains for each standard and substandard a number of measurable elements and indicates evidence that may be used to assess the standard as being fully, partially or not fulfilled. The comments box must be filled with remarks on the evidence used, on potentials for quality improvement or further suggestions that support improvement.

The standards covering the management level, and standards covering all parts of the hospital, need to be assessed by the hospital management or quality committee if it exists.

The standards for clinical activity are to be assessed in one of the clinical units in the hospital. It is recommended, that 50 records for patients who are discharged and have been admitted to the unit within 3 months be chosen randomly for assessment (for sampling and audit procedure please refer to the corresponding section in the manual).

The audit group should be an interdisciplinary group of professionals with good knowledge about the documentation routines of the unit. The term "patients' records" covers all kinds of documentation (medical record, nursing record, therapists and dieticians notes etc.) that needs to be taken in consideration in the assessment of the hospital's compliance with the standards.

Further background information on the principles of carrying out an audit are included in the manual "Implementing health promotion in hospitals".

Indicators

Indicators need to be reported in the self-assessment tool. However, the process of data collection to construct the indicators will be carried out separately.

Indicators were developed to complement the standards for health promotion, reflecting the effect of sustained compliance with standards and hence providing a quantitative monitoring tool to improve quality of care. They are not designed to assess compliance with standards.

A number of health promotion-related indicators were selected and developed, for example: staff awareness of management's health promotion policy, patients' capacities for modifying risk factors; patients' self-management capacities; staff short-term absenteeism; staff smoking behaviour; assessment of communication with external partners; timely information transfer to providers, and preventable emergency admissions of elderly.

It is up to the hospital to decide which indicator they will choose, however, at least one indicator to complement each of the five standards needs to be collected. Indicators reflecting local priorities may also be included or developed. Such indicators should be described in the same detail (rationale, description, numerator, denominator, data source, stratification) as the indicators already included in the self-assessment tool (see manual for descriptive sheets of indicators).

Indicators need to be reported in the self-assessment tool for developing an action plan based on the assessment of both compliance with standards and the level of performance as per the indicators.

Repeated measurements of indicators over time are necessary in order to reflect changes in the indicator. It is suggested that data on indicators will be gathered every six months, however, given the restricted time for the pilot implementation only a single measurement is required for hospitals in the piloting phase.

The manual includes descriptive sheets for each indicator, specifying its rationale, description, numerator, denominator, data source and stratification of each indicator, and further information related to the data collection for indicators.

Developing an action plan

When the self-assessment is completed, the steering group will be able to identify areas of good practice and areas for development where the hospital is not meeting the standards or substandards.

An action plan can then be developed to address those issues. It is important that actions on the plan relate to local and national priorities or targets and the hospital's own available resources. The action plan should also be integrated into the existing management system of the hospital to monitor development.

This process is not an accreditation scheme, and therefore there are no 'passes or fails', and no certification on completion of the self-assessment. The core of self-assessment is better understanding of the organization and identifying potential for quality improvement.

Structure of the Standards

Five standards were developed addressing the following issues:

Standard 1: Management Policy

Standard 2: Patient Assessment

Standard 3: Patient Information and Intervention

Standard 4: Promoting a Healthy Workplace

Standard 5: Continuity and Cooperation

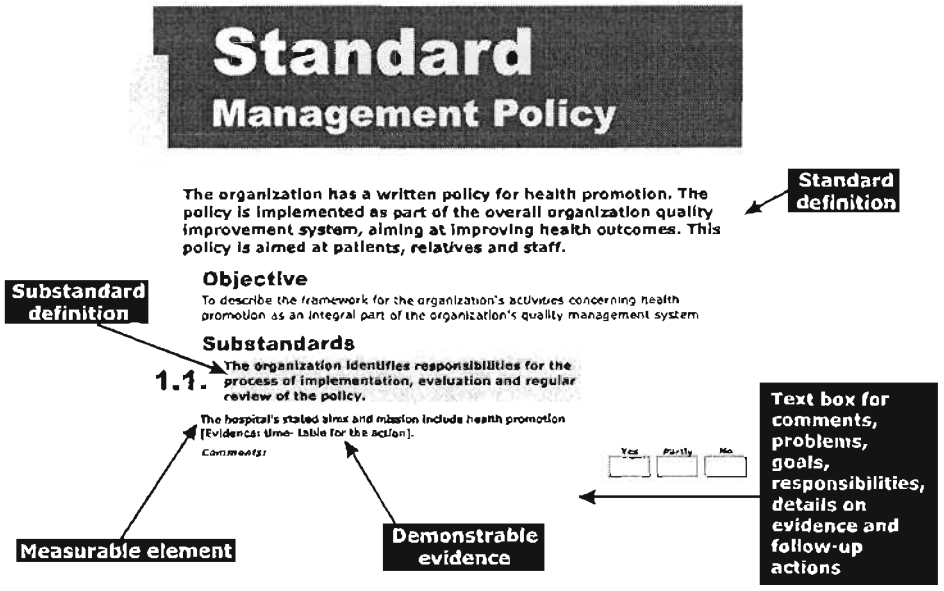
Each standard has a set of substandards, and each substandard has one or more measurable elements, which require an answer of 'yes, partly or no'. Demonstrable evidence is required to show compliance with the substandards. Examples of evidence against which substandards may be evaluated have been added in square brackets.

A box for comments is located next to the measurable elements where problems, goals, responsibilities, details on evidence and follow-up actions must be documented. This qualitative information provides important background for the development of the quality improvement plan.

Indicators have also been developed for each standard. The manual specifies for each of the indicators its rationale, description, numerator, denominator, data source and stratification. The computed indicators should be reported in the corresponding section after each of the five standards. Subsequent to each standard you will find a table where actions, responsibilities, timeframe and expected results need to be documented.

The following graph illustrates the components of the standards.

Figure 1. Key components of the standard



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[8] World Health Organization. *Self-assessment tool for health promotion standards and indicators in hospitals (Draft).* Copenhagen, WHO Regional Office for Europe, 2004 (document EU/04/5038045-S).

[9] World Health Organization. *Manual for the implementation of health promotion in hospitals (Draft).* Copenhagen, WHO Regional Office for Europe, 2004 (document EU/04/5038045-S2).

Using
the Self-Assessment Tool

Responsibilities for the self-assessment

Responsibilities for the self-assessment should be documented in this section. One person has to take the overall responsibility (project leader). Additional responsibilities may be distributed for the various standards, according to the hospital's structure and human resources available (e.g. responsibility for the assessment of standards 1 and 5 may be with a senior management member, while responsibilities for the assessment of other standards may be with a member of clinical services). Each member should sign an agreement to confirm that they will collect, or supervise the collection of data.

The action plan should be discussed and planned by the whole steering group. The project leader approves the action plan and facilitates its implementation. The action plan needs to be presented to management.

Project leader

(Takes responsibility to overlook the overall self-assessment process and for the results presented)

Name _____

Function _____

Date ___/___/___

_____

Signature

Members of the steering group

Name	Department	Title/ Function	Profession/ Discipline

Project Leader for Standard 1: Management Policy

Name _____

Function _____

Date ___/___/___

_____

Signature

Project Leader for Standard 2: Patient Assessment

Name _____

Function _____

Date ___/___/___

_____

Signature

Project Leader for Standard 3: Patient Information and Intervention

Name _____

Function _____

Date ___/___/___

_____

Signature

Project Leader for Standard 4: Promoting a Healthy Workplace

Name _____

Function _____

Date ___/___/___

_____

Signature

Project Leader for Standard 5: Continuity and Cooperation

Name _____

Function _____

Date ___/___/___

_____

Signature

Standard
Management Policy

The organization has a written policy for health promotion. The policy is implemented as part of the overall organization quality improvement system, aiming at improving health outcomes. This policy is aimed at patients, relatives and staff.

Objective

To describe the framework for the organization's activities concerning health promotion as an integral part of the organization's quality management system.

Substandards

1.1. The organization identifies responsibilities for the process of implementation, evaluation and regular review of the policy.

The hospital's stated aims and mission include health promotion [Evidence: time-table for the action or list of activities].

Comments:

Yes | Partly | No

Minutes of the governing body reaffirm agreement within the past year to participate in the WHO HPH project [Evidence: date for the decision or for payment of the annual fee].

Comments:

Yes | Partly | No

The hospital´s current quality and business plans include HP [Evidence: health promotion explicitly in the plan of action].

Comments:

Yes | Partly | No

The hospital´s HP policy has been formally adopted or revised by the executive management within the past two years [Evidence: minutes or instructions from the CEO or other responsible member of the management].

Comments:

Yes | Partly | No

The policy explicitly refers to HP for patients, staff and community [Evidence: guidelines for action for patients, specific plan for staff and community].

Comments:

Yes	Partly	No

1.2. The organization allocates resources to the processes of implementation, evaluation and regular review of the policy.

A programme for quality assessment of the health promoting activities is established [Evidence: time schedule for surveys is available].

Comments:

Yes	Partly	No

There is an identifiable budget for the evaluation of HP services and materials [Evidence: budget or staff resources].

Comments:

Yes	Partly	No

Operational procedures (e.g. clinical practice guidelines or pathways) available in clinical departments incorporate HP [Evidence: check guidelines].

Comments:

Yes	Partly	No

1.3. Staff are aware of the health promotion policy and it is included in induction programmes for new staff.

The hospital organization structure identifies personnel and functions for the coordination of HP [Evidence: staff member nominated for the coordination of HP].

Comments:

Yes	Partly	No

The policy is accessible to staff in all departments and all shifts [Evidence: newsletters, posters or brochures].

Comments:

Yes ☐ Partly ☐ No ☐

Staff in all departments are aware of the content of the policy [Evidence: annual performance evaluation or staff's participation in the HP programme].

Comments:

Yes ☐ Partly ☐ No ☐

The hospital's induction program for new staff specifies health promotion activities [Evidence: the program includes introduction to the HP plan].

Comments:

Yes ☐ Partly ☐ No ☐

1.4. The organization ensures the availability of procedures for collection and evaluation of data in order to monitor the quality of health promotion activities.

Data are routinely captured on HP interventions and available to staff for evaluation [Evidence: availability assessed in staff survey].

Comments:

Yes ☐ Partly ☐ No ☐

There is documented evidence of ongoing systematic audit including implementation of the HP policy in each department [Evidence: time schedule for the audit].

Comments:

Yes ☐ Partly ☐ No ☐

1.5. The organization ensures that staff have relevant competences to perform health promotion activities and supports the acquisition of further competences as required.

Job descriptions for all staff members specify relevant health promotion activities [Evidence: for individuals or well-defined groups. Familiarity with job description documented by survey or interview].

Yes	Partly	No

Comments:

Continuing professional development program includes health promotion [Evidence: training program on HP attended].

Yes	Partly	No

Comments:

1.6. The organization ensures the availability of the necessary infrastructure, including resources, space, equipment, etc. in order to implement health promotion activities.

Specific structures and facilities can be identified [Evidence: lifting facilities available].

Yes	Partly	No

Comments:

Complementary indicators

_____ % of staff aware of health promotion policy

_____ % of patients aware of standards of health promotion

_____ % budget dedicated to staff HP activities

Additional indicators

(local indicators you may want to consider for the action plan)

Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
1.1.				
1.2.				
1.3.				
1.4.				
1.5.				
1.6.				

2 Standard
Patient Assessment

The organization ensures that health professionals, in partnership with patients, systematically assess needs for health promotion activities.

Objective

To support patient treatment, improve prognosis and to promote the health and well-being of patients.

Substandards

2.1. The organization ensures the availability of procedures for all patients to assess their need for health promotion.

Guidelines on how to identify smoking status, alcohol consumption, nutritional status, psycho-social-economic status are present [Evidence: check availability].

Comments:

Yes	Partly	No

Guidelines/procedures have been revised within the last year [Evidence: check date, person responsible for revising guidelines].

Comments:

Yes	Partly	No

2.2. The organization ensures procedures to assess specific needs for health promotion for diagnosis-related patient-groups.

Guidelines are present on how to identify needs for HP for groups of patients (e.g. asthma patients, diabetes patients, chronic obstructive pulmonary disease, surgery, rehabilitation) [Evidence: for groups of patients specifically treated in the clinical department].

Comments:

Yes	Partly	No

2.3. The assessment of a patient's need for health promotion is done at first contact with the hospital. This is kept under review and adjusted as necessary according to changes in the patient's clinical condition or on request.

The assessment is documented in the patients record at admission [Evidence: for all patients. Identified by patient records audit].

Comments:

Yes	Partly	No

The date of assessment is written down in the patient record [Evidence: Review of patient records].

Comments:

Yes	Partly	No

There are guidelines / procedures for reassessing needs at discharge or end of a given intervention [Evidence: guidelines present].

Comments:

Yes	Partly	No

2.4. The patients' needs assessment ensures awareness of and sensitivity to social and cultural background.

The patient record documents social and cultural background as appropriate [Evidence: religion that requires special diet or other specific attention. Social conditions indicating that the patient is at risk].

Comments:

Yes	Partly	No

2.5. Information provided by other health service partners is used in the identification of patient needs.

Information from referring physician or other relevant sources is available in the patients record [Evidence: for all patients referred from physician].

Comments:

Yes	Partly	No

Complementary indicators

_____ % of patients assessed for generic risk factors

_____ % of patients assessed for disease specific risk factors according to guidelines.

_____ score on survey of patients' satisfaction with assessment procedure

Additional indicators

(local indicators you may want to consider for the action plan)

Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
2.1.				
2.2.				
2.3.				
2.4.				
2.5.				

Standard 3
Patient Information and Intervention

The organization provides patients with information on significant factors concerning their disease or health condition and health promotion interventions are established in all patient pathways.

Objective

To ensure that the patient is informed about planned activities, to empower the patient in an active partnership in planned activities and to facilitate integration of health promotion activities in all patient pathways.

Substandards

3.1. Based on the health promotion needs assessment, the patient is informed of factors impacting on their health and, in partnership with the patient, a plan for relevant activities for health promotion is agreed.

Information given to the patient is recorded in the patients record [Evidence: random review of patient records for all patients].

Comments:

Yes ☐ Partly ☐ No ☐

3.2. Patients are given clear, understandable and appropriate information about their actual condition, treatment, care and factors influencing their health.

Patient satisfaction assessment of the information given is performed and the results are integrated into the quality management system [Evidence: various assessment methods: survey, focused group interview, questionnaire. Time schedule].

Comments:

Yes ☐ Partly ☐ No ☐

3.3. The organization ensures that health promotion is systematically offered to all patients based on assessed needs.

Information and intervention is documented in the patients record [Evidence: patient records audit].

Comments:

Yes ☐ Partly ☐ No ☐

3.4. The organization ensures that information given to the patient, and health promoting activities are documented and evaluated, including whether expected and planned results have been achieved.

Activities and expected results are documented in the records [Evidence: patient records audit].

Comments:

Yes ☐ Partly ☐ No ☐

Data of review of progress is documented in the records [Evidence: patient records audit].

Comments:

Yes ☐ Partly ☐ No ☐

3.5. The organization ensures that all patients, staff and visitors have access to general information on factors influencing health.

Information is available on patient organizations [Evidence: contact-address is provided].

Comments:

Yes ☐ Partly ☐ No ☐

General health information is available [Evidence: availability of printed or online information, or special information desk].

Comments:

Yes ☐ Partly ☐ No ☐

Detailed information about high/risk diseases is available [Evidence: availability of printed or online information, or special information desk].

Comments:

Yes ☐ Partly ☐ No ☐

Complementary indicators

- % of patients educated about specific actions in self-management of their condition
- % of patients educated about risk factor modification and disease treatment options in the management of their condition
- Score on survey of patients' experience with information and intervention procedures

Additional indicators

(local indicators you may want to consider for the action plan)

Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
3.1.				
3.2.				
3.3.				
3.4.				
3.5.				

Standard 4
Promoting a Healthy Workplace

The management establishes conditions for the development of the hospital as a healthy workplace.

Objective

To support the establishment of a healthy and safe workplace, and to support health promotion activities for staff.

Substandards

4.1. The organization ensures the establishment and implementation of a comprehensive Human Resources Strategy that includes the development and training of staff in health promotion skills

A performance appraisal system and continuing professional development exists [Evidence: documented by review of staff files or interview].

Comments:

Yes ☐ Partly ☐ No ☐

New staff receive an induction training [Evidence: interviews with new staff].

Comments:

Yes ☐ Partly ☐ No ☐

Training plans are set up and fulfilled by the end of the year [Evidence: check with staff].

Comments:

Yes ☐ Partly ☐ No ☐

Working practices (procedures and guidelines) are developed by multidisciplinary teams [Evidence: check procedures, check with staff].

Comments:

Yes ☐ Partly ☐ No ☐

Staff's knowledge on health promotion is assessed through surveys [Evidence: check questionnaire used for and results of staff survey].

Comments:

Yes | Partly | No

4.2. The organization ensures the establishment and implementation of a policy for a healthy and safe workplace providing occupational health services for staff.

Working conditions comply with national/regional directives and indicators [Evidence: national and international (EU) regulations are recognized].

Comments:

Yes | Partly | No

Staff comply with health and safety requirements and all workplace risks are identified [Evidence: check data on occupational injuries].

Comments:

Yes | Partly | No

Smoking cessation programmes are offered [Evidence on availability of programmes].

Comments:

Yes | Partly | No

Information on diet and physical exercise is offered [Evidence: availability of printed or online information, or special information desk].

Comments:

Yes | Partly | No

Staff's experience with quality, choice and access to healthy food is assessed through surveys [Evidence: check questionnaire used for and results of staff survey].

Comments:

Yes | Partly | No

The canteen offers variations of healthy food [Evidence: policy for healthy food, check food offered in canteen].

Comments:

Yes ☐ Partly ☐ No ☐

4.3. The organization ensures the involvement of staff in decisions impacting on the staff's working environment.

Staff involvement in hospital policy-making, audit and review [Evidence: check with staff; check minutes of working groups for participation of staff representatives].

Comments:

Yes ☐ Partly ☐ No ☐

4.4. The organization ensures availability of procedures to develop and maintain staff awareness on health issues.

Education sessions are offered to staff [Evidence: programs and educational material].

Comments:

Yes ☐ Partly ☐ No ☐

Policies are available for staff [Evidence: check for issues smoking, alcohol, substance misuse and physical activity].

Comments:

Yes ☐ Partly ☐ No ☐

Annual staff surveys are carried out including an assessment of individual behaviour, knowledge on supportive services/policies, and use of supportive seminars [Evidence: check questionnaire used for and results of staff survey].

Comments:

Yes ☐ Partly ☐ No ☐

Staff are aware of risk management procedures [Evidence: check with staff].

Comments:

Yes ☐ Partly ☐ No ☐

Complementary indicators

_____ % of short-term absence

_____ % of work-related injuries

_____ % of staff smoking

_____ Score of survey of staff experience with working conditions

_____ Score on burnout scale

_____ % of staff participating in regular health promotion activities within the hospital

_____ % of staff coming to work by bicycle

_____ Retention rate

_____ Turnover rate

Additional indicators

(local indicators you may want to consider for the action plan)

Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
4.1.				
4.2.				
4.3.				
4.4.				

Standard 5
Continuity and Cooperation

The organization has a planned approach to collaboration with other health service levels and other institutions and sectors on an ongoing basis.

Objective

To ensure collaboration with relevant providers and to initiate partnerships to optimise the integration of health promotion activities in patient pathways.

Substandards

5.1. The organization ensures that health promotion services are coherent with current provisions and health plans.

The management board can document regulations on the health plan and reference them [Evidence: regulations and provisions identified and listed].

Comments:

Yes ☐ Partly ☐ No ☐

The management board is aware of the health plan [Evidence: interview].

Comments:

Yes ☐ Partly ☐ No ☐

The management board can demonstrate compliance with the plan (progress has been documented) [Evidence: report on compliance is available].

Comments:

Yes ☐ Partly ☐ No ☐

Criteria to assess compliance have been specified [Evidence: list of criteria available].

Comments:

Yes ☐ Partly ☐ No ☐

5.2. The organization identifies and cooperates with existing health and social care providers and related organizations and groups in the community.

There is a written rationale for the selection of partners available [Evidence: cooperating organizations and partners listed, rationale for each described].

Comments:

Yes ☐ Partly ☐ No ☐

Partners have been identified and can be documented [Evidence: documentation provided].

Comments:

Yes ☐ Partly ☐ No ☐

There is a written procedure to meet regularly [Evidence: check procedure and record date of last meeting].

Comments:

Yes ☐ Partly ☐ No ☐

Participation of all partners can be demonstrated [Evidence: minutes from the meetings].

Comments:

Yes ☐ Partly ☐ No ☐

There is a written plan for collaboration to provide seamless services to the patient [Evidence: criteria for admittance, plan for discharge].

Comments:

Yes ☐ Partly ☐ No ☐

There are procedures for the exchange of information with other health care organizations that take account of patient confidentiality [Evidence: information about patients is only exchanged after informed consent].

Comments:

Yes ☐ Partly ☐ No ☐

5.3. The organization ensures the availability and implementation of activities and procedures after patient discharge during the post-hospitalisation period.

Patients (and their families as appropriate) are given understandable follow-up instructions at referral or discharge [Evidence: patients' evaluation assessed in patient surveys].

Comments:

Yes ☐ Partly ☐ No ☐

There is a joint review procedure for discharge policy and information exchange practices between organizations [Evidence: availability of procedure].

Comments:

Yes ☐ Partly ☐ No ☐

It can be documented that the issues of appropriateness and timeliness are part of the review process [Evidence: needs to be addressed in procedure].

Comments:

Yes ☐ Partly ☐ No ☐

The receiving organization is given a written summary of the patient's condition and health needs, and interventions provided by the referring organization [Evidence: availability of copy].

Comments:

Yes ☐ Partly ☐ No ☐

This summary is included in the patient's record [Evidence: check patient's record].

Comments:

Yes ☐ Partly ☐ No ☐

Procedures for discharge and plans for post-hospitalisation period are present [Evidence: existance of protocols].

Comments:

Yes ☐ Partly ☐ No ☐

A plan for rehabilitation describing the role of the organization and the cooperating partners is documented in the patient's record [Evidence: review of records].

Comments:

Yes	Partly	No

5.4. The organization ensures that documentation and patient information is communicated to the relevant recipient/follow-up partners in patient care and rehabilitation.

It can be documented that the plan was sent: within 1 week to the GP, or where applicable within 24 hours to the community nurse [Evidence: survey of or interviews with receiving GP or nurse].

Comments:

Yes	Partly	No

Procedures for communication with relevant partners are present [Evidence: check procedures].

Comments:

Yes	Partly	No

Standard 5 Continuity and Cooperation

Complementary indicators

_____ % of discharge summaries sent to GP or referral clinic within two weeks or handed to patient on discharge

_____ Readmission rate for ambulatory care sensitive conditions within 5 days

_____ Number of guidelines developed or revised with collaboration of external users and care providers

_____ Score on patient discharge preparation survey

Additional indicators

(local indicators you may want to consider for the action plan)

Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
5.1.				
5.2.				
5.3.				
5.4.				

Overall assessment of standards compliance

Management Policy

Total:

Yes	Partly	No
17	17	17

Patient Assessment

Total:

Yes	Partly	No
8	8	8

Patient Information and Intervention

Total:

Yes	Partly	No
8	8	8

Promoting a Healthy Workplace

Total:

Yes	Partly	No
16	16	16

Continuity and Cooperation

Total:

Yes	Partly	No
19	19	19

Total:

Yes	Partly	No
68	68	68

Overall action plan

General actions

Actions related to the assessment of specific standards and indicators

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia and Montenegro
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

WHOLIS number:
Original: EU/04/5038045-S

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APPENDIX II: STANDARDS FOR HEALTH PROMOTION IN HOSPITALS: KWAZULU-NATAL DEPT OF HEALTH - WHO SELF-ASSESSMENT TOOL

DRAFT

UNIVERSITY OF
KWAZULU-NATAL

STANDARDS FOR HEALTH PROMOTION IN HOSPITALS: KWAZULU-NATAL DEPT OF HEALTH - WHO SELF-ASSESSMENT TOOL

This document is based on the original document "Standards for Health Promotion in Hospitals Self-Assessment Tool for Pilot Implementation" prepared by Oliver Gröne, Svend Juul Jorgensen, Mila Garcia-Barbero and the International Working Group on Standards for Health Promotion in Hospitals, all of the World Health Organization.

The KwaZulu-Natal - WHO Self Assessment Tool document has been developed by the KwaZulu-Natal Health Promoting Hospital Provincial Steering Committee and institutional co-ordinators of the pilot sites. The WHO document was adapted through a series of workshops conducted at 6 pilot facilities in KwaZulu-Natal province. Some terminology and concepts were adjusted for local understanding and applicability.

Health Systems Performance Monitoring & Evaluation Unit
KwaZulu-Natal Department of Health

October 2005

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I. General considerations

Introduction

The WHO Health Promoting Hospital (HPH) project seeks to incorporate the concepts, values and standards of health promotion into the organizational structure and culture of the hospital, improving the health of patients and staff, supporting healthy environments and actively cooperating with the community. It provides hospitals with an opportunity to contribute to the public health agenda.

Health promotion is a core quality issue in hospitals and therefore should be incorporated into the daily work. Health promotion is defined as "the process of enabling people to increase control over, and to improve, their health" (Ottawa Charter for Health Promotion) [1], and is here understood to embrace health education, disease prevention and rehabilitation services. It is also understood to include health enhancement by empowering patients, relatives and employees in the improvement of their health-related physical, mental and social well-being.

Hospitals play an important role in promoting health, preventing disease and providing rehabilitation services. Some of these activities have been an essential part of hospital work although may not have been explicit. However, with the increasing prevalence of lifestyle-related and chronic diseases, a more expanded scope and systematic provision of activities is required. Therapeutic education, strategies enabling patients to take an active role in chronic disease-management or motivational counselling, can support better hospital health outcomes. Hospitals also need to put stronger emphasis on working conditions in order to improve the health of staff, and to improve efficiency and quality of care.

The main strategy to improve quality in health care is by setting standards. The standards provide hospitals with a framework to evaluate their health promotion practice and to stimulate development. They provide a real opportunity for staff to question what they do, why they do it, and whether it can be done better. Performance indicators complementary to the standards were added to allow a quantitative monitoring of quality improvement over time.

To support the assessment of standards and indicators, a Self-Assessment Tool (SAT) was developed by WHO[2]. This SAT was piloted for the first time in Africa in KwaZulu-Natal between June and December 2004. Six hospitals – Greys, Northdale, Edendale, Ngwelezana, Lower Umfolozi and Inkosi Albert Luthuli Central Hospital - were chosen which represented a cross-section of hospitals by levels of care. During the pilot the SAT was adapted for conditions prevailing in public hospitals in South Africa. All six hospitals concluded that this was a useful process and recommended roll out to other hospitals in the province.

Self-assessment is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of an action plan, implementation and subsequent evaluation. Self-assessment has to be clearly distinguished from external evaluation.

Hospitals are encouraged to use the SAT to improve health promotion activities and to contribute to continuous quality improvement.

The Self-Assessment tool includes measurable elements and evidence to assess the compliance with standards.

Purpose of the Document

1. To provide hospitals with a set of internationally accepted standards and indicators for quality service delivery.

2. To enable Hospitals to assess the extent to which they comply with standards and determine aspects of their performance through the indicators.

3. To provide hospitals with an opportunity for the development and the implementation of quality improvement actions plans informed by objective evidence through the use of the self assessment tool.

Frequently asked questions

Q What are the incentives for hospitals to undertake this self-assessment?

Hospitals should undertake self-assessment in order to provide better patient care and improve patients quality of life. The self-assessment tool supports evaluation if health promotion services are in place and helps to identify gaps in service provision.

Q How does this fit in with other quality initiatives?

The process of setting standards is an integral part of continuous quality improvement. The health promotion standards developed in this manual aim to complement existing quality standards that do not have a concrete focus on health promotion. They have been developed in accordance with the methodology and terminology used in standards developed by accreditation bodies organized in the International Society for Quality in Health Care. Complementary indicators have been added to allow quantitative assessment of performance over time. It is highly recommended to link the self-assessment of standards for health promotion to the quality strategies already in use.

Q What will we get as an organization when we have completed the self -assessment?

You will have identified your areas of good practice and areas for improvement in the field of health promotion, and will be able to structure an action plan. This will all contribute to improved patient care.

Q Will we get a certificate?

No, certificates will not be issued. The process is a self-assessment and continuous quality improvement and development through action plans. There is not a 'pass' or 'fail'. Each hospital will be different and will have a different set of action plans designed by their own organizations depending on the results of the self-assessment, their priorities and local and national initiatives.

Q Do we need to score 'yes' in all the substandards for each standard?

You need to accurately state your position in each substandard, in order to identify areas of good practice which you may want to replicate elsewhere in the organization, and areas where there could be improvement. This is so that both can be fed into an action plan at the

end of the self-assessment. This plan should then be integrated into the hospital's own quality management processes for continuous quality improvement.

Q How do we have to measure indicators?

The manual specifies for each indicator its rationale, description of numerator and denominator, data source and stratification. Indicators need to be measured repeatedly over time in order to reflect the continuous quality improvement process. In order to reduce possible biases indicators should not be altered over time.

Q How can we build an action plan based on standards and indicators?

The assessment of standards compliance is based on a number of measurable elements, which need to be assessed as being fully, partially or not fulfilled. The comments box must be filled with remarks on the evidence used, on quality potentials or further suggestions that support improvement. Data on complementary indicators at the end of each standard may be gathered, facilitating the monitoring of progress over time. The action plan should be developed based on the assessment of standards, indicators and the comments and observations that have been added during the self-assessment process. The action plan should also reflect main gaps identified during the assessment and reflect organizational priorities.

Q What happens to our action plan?

You will need to include it into your own quality management processes in your own hospital so that the plans are monitored and action is taken.

Q Will the tool be used for benchmarking with other hospitals?

No. The tool is only intended to be used for self-assessment, although at a later stage and after sound validation of the tool, benchmarking may be discussed further.

II. Organizational arrangements for the implementation of the tool

Roles and Responsibilities

Role of WHO

To produce the working materials for the implementation of the standards and to encourage countries and hospitals to participate in the implementation of these standards.

Role of the Provincial Co-ordinating Committee

To translate the working documents prepared by WHO, to encourage and identify hospitals to participate in the implementation, to provide guidance to hospitals taking part in the implementation and to provide feedback on the results.

Hospital Management

Essential to the success of this project is the commitment to the project of the chief executive, governing body and senior managers of the hospital, to ensure implementation of the action plan and to release the necessary resources to undertake the task.

Project leader

It is also crucial that a project leader within the hospital is appointed to lead the process and train other staff in carrying out the self-assessment. Ideally, this person should already be responsible for other quality initiatives in the hospital as the project needs to be run as any other quality improvement activity.

Lead person for standards

The project leader may wish to nominate a lead person for each of the standards (lead persons may be responsible for more than one standard). They will need to take responsibility for assessing the level of compliance with the standard and substandards. They will be responsible for collecting the evidence that supports their response. They will also be responsible, in collaboration with other members of the steering group, to collect data for health promotion indicators.

Multidisciplinary steering group

The project leader needs to establish a multidisciplinary steering group that represents the staff at all levels. Resources will be required for the administrative tasks (e.g. collecting the data and evidence) and for training the steering group.

Each hospital will have to identify the members of the steering group according to their organization. Nevertheless, it is suggested that the following staff should be involved in the multidisciplinary steering group:

- a senior nurse who may also be responsible for quality /clinical audit
- a senior and junior doctor
- a senior manager

- a human resources/personnel member
- a member of staff from ancillary professions allied to medicine (e.g. physiotherapy, occupational therapy), general support medical services (e.g. Radiography) and a member of staff from general non-clinical services (e.g. catering, hotel services, cleaning, etc.).

III. Using the Self-Assessment Tool

The steering group should meet on a regular basis to discuss progress with the self-assessment, generate ideas across disciplines and promote greater ownership of the project. It is important to stress that there is very little value in one person completing the self-assessment without the involvement of relevant staff, as the results would be subjective and prevent staff from being involved in the learning process.

Data collection

Data needs to be collected to assess standards and to construct indicators. Staff at all levels in the hospital should be involved in collecting the evidence and supporting a collective response to the compliance of the standard.

Standards

Regarding data collection to assess standards, the self-assessment tool contains for each standard and substandard a number of measurable elements and indicates evidence that may be used to assess the standard as being fully, partially or not fulfilled. The comments box must be filled with remarks on the evidence used, on potentials for quality improvement or further suggestions that support improvement.

The standards covering the management level, and standards covering all parts of the hospital, are to be assessed by the hospital management or quality committee.
The standards for clinical activity are to be assessed in the clinical units in the hospital. It is recommended, that 50 records for patients who are discharged and have been admitted to the unit within 3 months be chosen randomly for assessment.

The audit group should be an interdisciplinary group of professionals with good knowledge about the documentation routines of the unit. The term "patients' records" covers all kinds of documentation (medical record, nursing record, therapists and dieticians notes etc.) that needs to be taken in consideration in the assessment of the hospital's compliance with the standards.

Indicators

Indicators need to be reported in the self-assessment tool. However, the process of data collection to construct the indicators will be carried out separately.

Indicators have been developed to complement the standards for health promotion, reflecting the effect of sustained compliance with standards and hence providing a quantitative monitoring tool to improve quality of care. They are not designed to assess compliance with standards.

A number of health promotion-related indicators were selected and developed: Staff awareness of management's health promotion policy, patients' capacities for modifying risk factors; patients' self-management capacities; staff short-term absenteeism; staff smoking behaviour; assessment of communication with external partners; timely information transfer to providers.

It is up to the hospital to decide which indicator they will choose, however, at least one indicator to complement each of the five standards needs to be collected.

Indicators need to be reported in the self-assessment tool for developing an action plan based on the assessment of both compliance with standards, and the level of performance as per the indicators.

Repeated measurements of indicators over time are necessary in order to reflect changes in the indicator. It is suggested that data on indicators will be gathered every six months.

Developing an action plan

When the self-assessment is completed, the steering group will be able to identify areas of good practice and areas for development where the hospital is not meeting the standards or substandards.

An action plan can then be developed to address those issues. It is important that actions on the plan relate to local and national priorities or targets and the hospital's own available resources. The action plan should also be integrated into the existing management system of the hospital to monitor development.

This process is not an accreditation scheme, and therefore there are no 'passes or fails'. The core of self-assessment is better understanding of the organization and identifying potentials for quality improvement.

Structure of the Standards

Five standards were developed addressing the following issues:

Standard 1: Management Policy
Standard 2: Patient Assessment
Standard 3: Patient Information and Intervention
Standard 4: Promoting a Healthy Workplace
Standard 5: Continuity and Cooperation

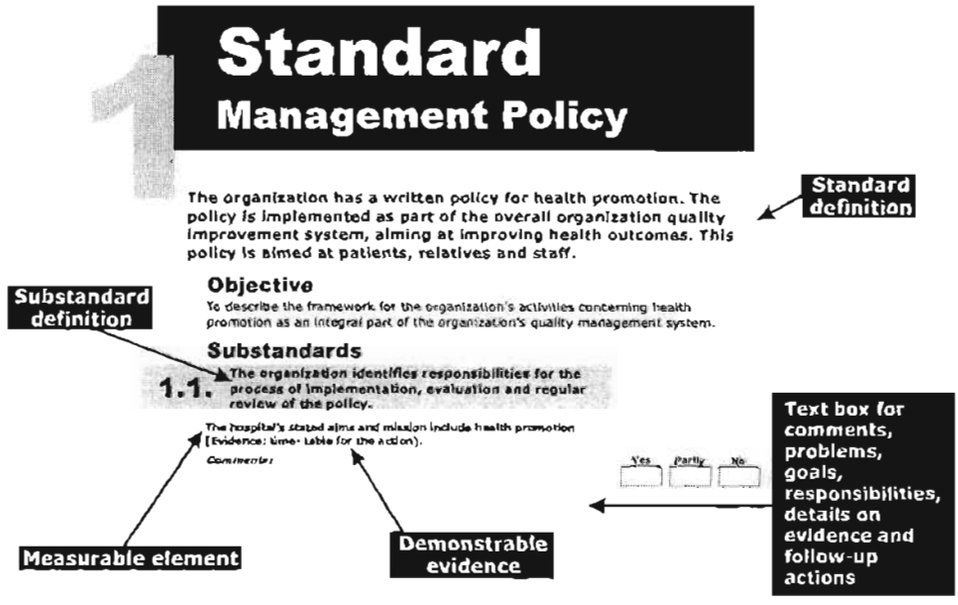
Each standard has a set of substandards, and each substandard has one or more measurable elements, which require an answer of 'yes, partly or no'. Demonstrable evidence is required to show compliance with the substandards. Examples of evidence against which substandards may be evaluated have been added in square brackets.

A box for comments is located next to the measurable elements where problems, goals, responsibilities, details on evidence and follow-up actions must be documented. This qualitative information provides important background for the development of the quality improvement plan.

Indicators have also been developed for each standard. The manual specifies for each of the indicators, its rationale, description, numerator, denominator, data source and stratification. The computed indicators should be reported in the corresponding section after each of the five standards. Subsequent to each standard you will find a table where actions, responsibilities, timeframe and expected results need to be documented.

The following graph illustrates the components of the standards.

Figure 1. Key components of the standard



References

[1] *Ottawa Charter for Health Promotion* (http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf). Ottawa, WHO, 1986 (accessed 4 March 2004).

[2] *Self-assessment tool for health promotion standards and indicators in hospitals* (Draft). Copenhagen, WHO Regional Office for Europe, 2004 (document EU/04/5038045-S).

IV. Responsibilities for the Self-Assessment

Responsibilities for the self-assessment should be documented in this section. One person has to take the overall responsibility (project leader) and ideally it should be the quality assurance co-ordinator. Additional responsibilities may be distributed for the various standards, according to the hospital's structure and human resources available (e.g. responsibility for the assessment of Standards 1 and 5 may be with a senior management member, while responsibilities for the assessment of other Standards may be with a member of clinical services). Each member should sign an agreement to confirm that they will collect, or supervise the collection of data. The action plan should be discussed and planned by the whole steering group. The project leader approves the action plan and facilitates its implementation. The action plan needs to be presented to management for their input, final approval and overall implementation.

Project leader

(takes responsibility to overlook the overall self-assessment process and for the results presented)

Name _____

Function _____

Date

_____

Signature

Members of the steering group

Name	Department	Title	Profession/ Discipline

Project Leader for standard 1: Management Policy

Name _____

Function _____

Date

_____

Signature

Project Leader for standard 2: Patient Assessment

Name _____

Function _____

Date

_____

Signature

Project Leader for standard 3: Patient Information and Intervention

Name _____

Function _____

Date

_____

Signature

Project Leader for standard 4: Promoting a Healthy Workplace

Name _____

Function _____

Date

_____

Signature

Project Leader for standard 5: Continuity and Cooperation

Name _____

Function _____

Date

_____

Signature

V. Assessment of standards

Standard 1: Management Policy

The organization has a written policy for health promotion. The policy is implemented as part of the overall organization quality improvement system, aiming at improving health outcomes. This policy is aimed at patients, relatives and staff.

Objective

To describe the framework for the organization's activities concerning health promotion as an integral part of the organization's quality management system.

Substandards

1.1.The organization identifies responsibilities for the process of implementation, evaluation and regular review of the policy.

The hospital's stated vision, mission and objectives include health promotion [Evidence: time- table for the action].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Minutes of the hospital board to reaffirm agreement to participate in the WHO HPH project [Evidence: date the board was informed].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The hospital's current quality and business plans include HP [Evidence: health promotion explicitly in the plan of action].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The hospital's HP policy has been formally adopted or revised by the executive management within the past two years [Evidence: minutes or instructions from the Hospital Manager or other responsible member of the management].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The policy explicitly refers to HP for patients, staff and community [Evidence: guidelines for action for patients, specific plan for staff and community].

Yes ☐ **Partly** ☐ **No** ☐

Comments

1.2.The organization allocates resources to the processes of implementation, evaluation and regular review of the policy.

A programme for quality assessment of the health promoting activities is established
[Evidence: time schedule for surveys is available].

Yes ☐ **Partly** ☐ **No** ☐

Comments

There is an identifiable budget for the evaluation of HP services and materials [Evidence: budget or staff resources].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Operational procedures/protocols (e.g. clinical practice guidelines or pathways) available in clinical departments incorporate HP [Evidence: check guidelines].

Yes ☐ **Partly** ☐ **No** ☐

Comments

1.3. Staff are aware of the health promotion policy and it is included in induction programmes for new staff.

The hospital organization structure identifies personnel and functions for the coordination of HP [Evidence: staff member nominated for the coordination of HP].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The policy is accessible to clinical staff in all departments and all shifts [Evidence: newsletters, posters or brochures].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Staff in all departments are aware of the content of the policy [Evidence: annual performance evaluation or staffs participation in the HP programme].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The hospital's induction programme for new staff specifies health promotion activities
[Evidence: the programme includes introduction to the HP plan].

Yes ☐ Partly ☐ No ☐

Comments

1.4. The organization ensures the availability of procedures for collection and evaluation of data in order to monitor the quality of health promotion activities.

Data are routinely captured on HP interventions and available to staff for evaluation [Evidence: availability assessed in staff survey].

Yes ☐ Partly ☐ No ☐

Comments

There is documented evidence of ongoing systematic audit including implementation of the HP policy in each department [Evidence: time schedule for the audit].

Yes ☐ Partly ☐ No ☐

Comments

1.5. The organization ensures that staff have relevant competences to perform health promotion activities and supports the acquisition of further competences as required.

Job descriptions for all staff members specify relevant health promotion activities [Evidence: for individuals or well-defined groups. Familiarity with job description documented by survey or interview].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Continuing professional development program includes health promotion [Evidence: training programme on HP attended].

Yes ☐ **Partly** ☐ **No** ☐

Comments

1.6.The organization ensures the availability of the necessary infrastructure, including resources, space, equipment, etc. in order to implement health promotion activities [evidence: tobacco cessation support or information material]

Specific structures and facilities can be identified [Evidence: lifting facilities available].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Standard 1: Management Policy – Complementary indicators

_____% of staff aware of health promotion policy

_____% of patients aware of standards of health promotion

_____% budget dedicated to staff HP activities

Additional indicators

(local indicators you may want to consider for the action plan)

Standard 1 Management Policy: Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
1.1.				
1.2.				
1.3.				
1.4.				
1.5.				
1.6.				

Standard 2: Patient Assessment

The organization ensures that health professionals, in partnership with patients, systematically assess needs for health promotion activities.

Objective

To support patient treatment, improve prognosis and to promote the health and well-being of patients.

Substandards

2.1.The organization ensures the availability of procedures for all patients to assess their need for health promotion.

Guidelines on how to identify smoking status, alcohol consumption, nutritional status, psycho-social-economic status are present [Evidence: check availability].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Guidelines/procedures have been revised within the last year [Evidence: check date, person responsible for revising guidelines].

Yes ☐ **Partly** ☐ **No** ☐

Comments

2.2.The organization ensures procedures to assess specific needs for health promotion for diagnosis-related patient-groups.

Guidelines are present on how to identify needs for HP for groups of patients (e.g. HIV/AIDS asthma patients, diabetes patients, chronic obstructive pulmonary disease, surgery, rehabilitation) [Evidence: for groups of patients specifically treated in the clinical department].

Yes ☐ **Partly** ☐ **No** ☐

Comments

2.3.The assessment of a patient's need for health promotion is done at first contact with the hospital. This is kept under review and adjusted as necessary according to changes in the patient's clinical condition or on request.

The assessment is documented in the patients record at admission [Evidence: for all patients. Identified by patient records audit].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The date of assessment is written down in the patient record [Evidence: Review of patient records].

Yes ☐ **Partly** ☐ **No** ☐

Comments

There are guidelines / procedures for reassessing needs at discharge or end of a given intervention [Evidence: guidelines present].

Yes ☐ **Partly** ☐ **No** ☐

Comments

2.4.The patients' needs-assessment ensures awareness of and sensitivity to social and cultural background.

The patient record documents social and cultural background as appropriate [Evidence: religion that requires special diet or other specific attention. Social conditions indicating that the patient is at risk].

Yes ☐ **Partly** ☐ **No** ☐

Comments

2.5. Information provided by other health service partners is used in the identification of patient needs.

Information from referring physician or other relevant sources is available in the patients record [Evidence: for all patients referred from physician].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Standard 2 Patient Assessment: Complementary indicators

_____% of patients assessed for generic risk factors *

_____% of patients assessed for disease specific risk factors according to guidelines.

_____score on survey of patients' satisfaction with assessment procedure

Additional indicators

(local indicators you may want to consider for the action plan)

*generic risk factors = alcohol, smoking & nutritional status

Standard 2 Patient Assessment: Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
2.1.				
2.2.				
2.3.				
2.4.				
2.5.				

Standard 3: Patient Information and Intervention

The organization provides patients with information on significant factors concerning their disease or health condition and health promotion interventions are established in all patient pathways.

Objective

To ensure that the patient is informed about planned activities, to empower the patient in an active partnership in planned activities and to facilitate integration of health promotion activities in all patient pathways.

Substandards

3.1. Based on the health promotion needs assessment, the patient is informed of factors impacting on their health and, in partnership with the patient, a plan for relevant activities for health promotion is agreed.

Information given to the patient is recorded in the patients record [Evidence: random review of patient records for all patients].

Yes ☐ **Partly** ☐ **No** ☐

Comments

3.2. Patients are given clear, understandable and appropriate information about their actual condition, treatment, care and factors influencing their health.

Patient satisfaction assessment of the information given is performed and the results are integrated into the quality management system [Evidence: various assessment methods: survey, focused group interview, questionnaire. Time schedule].

Yes ☐ **Partly** ☐ **No** ☐

Comments

3.3.The organization ensures that health promotion is systematically offered to all patients based on assessed needs.

Information and intervention is documented in the patients record [Evidence: patient records audit].

Yes ☐ Partly ☐ No ☐

Comments

3.4. The organization ensures that information given to the patient, and health promoting activities are documented and evaluated, including whether expected and planned results have been achieved.

Activities and expected results are documented in the records [Evidence: patient records audit]

Yes ☐ Partly ☐ No ☐

Comments

Data of review of progress is documented in the records [Evidence: Patient records audit].

Yes ☐ Partly ☐ No ☐

Comments

3.5. The organization ensures that all patients, staff and visitors have access to general information on factors influencing health.

Information is available on patient organizations [Evidence: contact-address is provided].

Yes ☐ Partly ☐ No ☐

Comments

General health information is available [Evidence: availability of printed or online information, or special information desk].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Detailed information about high/risk diseases is available [Evidence: availability of printed or online information, or special information desk].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Standard 3 Patient Information and Intervention: Indicators

Complementary indicators

_____% of patients educated about specific actions in self-management of their condition

_____% of patients educated about risk factor modification and disease treatment options in the management of their condition

_____Score on survey of patients' experience with information and intervention procedures

Additional indicators

(local indicators you may want to consider for the action plan)

Standard 3 Patient Information and Intervention: Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
3.1.				
3.2.				
3.3.				
3.4.				
3.5.				

Standard 4: Promoting a Healthy Workplace

The management establishes conditions for the development of the hospital as a healthy workplace.

Objective

To support the establishment of a healthy and safe workplace, and to support health promotion activities for staff.

Substandards

4.1.The organization ensures the establishment and implementation of a comprehensive Human Resource Strategy that includes the development and training of staff in health promotion skills

A performance appraisal system and continuing professional development exists [Evidence: documented by review of staff files or interview].

Yes ☐ **Partly** ☐ **No** ☐

Comments

New staff receive an induction training [Evidence: interviews with new staff].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Training plans are set up and fulfilled by the end of the year [Evidence: check with staff].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Working practices (procedures and guidelines) are developed by multidisciplinary teams [Evidence: check procedures, check with staff].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Staff's knowledge on health promotion is assessed through surveys [Evidence: check questionnaire used for and results of staff survey].

Yes ☐ **Partly** ☐ **No** ☐

Comments

4.2. The organization ensures the establishment and implementation of a policy for a healthy and safe workplace providing occupational health services for staff.

Working conditions comply with national/provincial directives and indicators [Evidence: The Occupational Health and Safety Act and national/provincial regulations are recognized].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Information on diet and physical exercise is offered [Evidence: availability of printed or online info, or special info desk].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Smoking cessation programmes are offered [Evidence on availability of programmes].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Staff's experience with quality, choice and access to healthy food is assessed through surveys [Evidence: check data on occupational injuries and monthly health & safety inspection reports for the past year].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Staff's experience with quality, choice and access to healthy food is assessed through surveys [Evidence: check questionnaire used for and results of staff survey].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The canteen offers variations of healthy food [Evidence: policy for healthy food, check food offered in canteen].

Yes ☐ **Partly** ☐ **No** ☐

Comments

4.3.The organization ensures the involvement of staff in decisions impacting on the staff's working environment.

Staff involvement in hospital policy-making, audit and review [Evidence: check with staff; check minutes of working groups for participation of staff representatives].

Yes ☐ **Partly** ☐ **No** ☐

Comments

4.4.The organization ensures availability of procedures to develop and maintain staff awareness on health issues.

Education sessions are offered to staff [Evidence: programmes and educational material including HIV/AIDS].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Policies are available for staff [Evidence: check for issues smoking, HIV/AIDS alcohol, substance misuse and physical activity].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Annual staff surveys are carried out including an assessment of individual behaviour, knowledge on supportive services/policies, and use of supportive seminars [Evidence: check questionnaire used for and results of staff survey].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Staff are aware of risk management procedures [Evidence: check with staff].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Standard 4 Promoting a Healthy Workplace: Complementary indicators

_____% of short-term absence

_____% of work-related injuries

_____% of staff smoking

_____Score of survey of staff experience with working conditions

_____Score on burnout scale

_____% of staff participating in regular health promotion activities within the hospital

_____% of staff aware of their HIV status

_____Retention rate

_____Turnover rate

Additional indicators

(local indicators you may want to consider for the action plan)

Standard 4 Promoting a Healthy Workplace: Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
4.1.				
4.2.				
4.3.				
4.4.				

Standard 5: Continuity and cooperation

The organization has a planned approach to collaboration with other health service levels and other institutions and sectors on an ongoing basis.

Objective

To ensure collaboration with relevant providers and to initiate partnerships to optimise the integration of health promotion activities in patient pathways.

Substandards

5.1.The organization ensures that health promotion services are coherent with current provisions and health plans.

The hospital management team can document health promotion activities coherent with the district health plan [Evidence: list of health promotion activities as laid out in the district health plan].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The hospital management team is aware of the district health plan [Evidence: interview].

Yes ☐ **Partly** ☐ **No** ☐

Comments

The hospital management team can demonstrate compliance with the district health plan (progress has been documented) [Evidence: report on compliance is available].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Criteria to assess compliance have been specified [Evidence: list of criteria available].

Yes ☐ **Partly** ☐ **No** ☐

Comments

5.2. The organization identifies and cooperates with existing health and social care providers and related organizations and groups in the community.

There is a written rationale for the selection of partners available [Evidence: cooperating organizations and partners listed, rationale for each described].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Partners have been identified and can be documented [Evidence: documentation provided].

Yes ☐ **Partly** ☐ **No** ☐

Comments

There is a written procedure to meet regularly [Evidence: check procedure and record date of last meeting].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Participation of all partners can be demonstrated [Evidence: minutes from the meetings].

Yes ☐ **Partly** ☐ **No** ☐

Comments

There is a written plan for collaboration to provide seamless services to the patient [Evidence: criteria for admittance, plan for discharge].

Yes ☐ **Partly** ☐ **No** ☐

Comments

There are procedures for the exchange of information with other health care organizations that take account of patient confidentiality [Evidence: information about patients is only exchanged after informed consent].

Yes ☐ **Partly** ☐ **No** ☐

Comments

5.3.The organization ensures the availability and implementation of activities and procedures after patient discharge during the post-hospitalisation period.

Patients (and their families as appropriate) are given understandable follow-up instructions at referral or discharge [Evidence: patients' evaluation assessed in patient surveys].

Yes ☐ **Partly** ☐ **No** ☐

Comments

There is a joint review procedure for discharge policy and information exchange practices between organizations [Evidence: availability of procedure].

Yes ☐ Partly ☐ No ☐

Comments

It can be documented that the issues of appropriateness and timeliness are part of the review process [Evidence: needs to be addressed in procedure].

Yes ☐ Partly ☐ No ☐

Comments

The receiving organization is given a written summary of the patient's condition and health needs, and interventions provided by the referring organization [Evidence: availability of copy].

Yes ☐ Partly ☐ No ☐

Comments

This summary is included in the patient's record [Evidence: check patient's record].

Yes ☐ Partly ☐ No ☐

Comments

Procedures for discharge and plans for post-hospitalisation period are present [Evidence: existence of protocols].

Yes ☐ **Partly** ☐ **No** ☐

Comments

A plan for rehabilitation describing the role of the organization and the cooperating partners is documented in the patient's record [Evidence: review of records].

Yes ☐ **Partly** ☐ **No** ☐

Comments

5.4.The organization ensures that documentation and patient information is communicated to the relevant recipient/follow-up partners in patient care and rehabilitation.

It can be documented that the patient referral letter and discharge summary was sent to the receiving hospital/institution [Evidence: survey of or interviews with receiving hospital/institution].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Procedures for communication with relevant partners are present [Evidence: check procedures].

Yes ☐ **Partly** ☐ **No** ☐

Comments

Standard 5 Continuity and cooperation: Complementary indicator

_____% of patient referral letters handed to patient on discharge

_____Readmission rate for ambulatory care sensitive conditions within 5 days

_____Number of guidelines developed or revised with collaboration of external users and care providers

_____Score on patient discharge preparation survey

Additional indicators

(local indicators you may want to consider for the action plan)

Standard 5 Continuity and cooperation: Action plan

	Action	Responsible	Timeframe	Expected result
General remarks				
5.1.				
5.2.				
5.3.				
5.4.				

Management Policy

1

Total:

Yes	Partly	No
17	17	17

Patient Assessment

2

Total:

Yes	Partly	No
8	8	8

Patient Information and Intervention

3

Total:

Yes	Partly	No
8	8	8

Promoting a Healthy Workplace

4

Total:

Yes	Partly	No
16	16	16

Continuity and Cooperation

5

Total:

Yes	Partly	No
19	19	19

Total:

Yes	Partly	No
68	68	68

General actions

Actions related to the assessment of specific standards and indicators

VI. Appendices

Appendix 1 - STAFF QUESTIONNAIRE: Health Promotion in Hospitals

CLINICAL STAFF ONLY IE DOCTORS, NURSES, OT'S, PHYSIO'S ETC

HOSPITAL.....

ABOUT THIS QUESTIONNAIRE

This questionnaire has been prepared by the **Department of Community Health, UKZN** in conjunction with the **Department of Health, KZN** for the purpose of providing information for the **World Health Organization's (WHO) Health Promotion in Hospitals Project.** This project hopes to provide your hospital with an idea of how it's policies and guidelines reflect a commitment to health promotion and how well it promotes health among patients and staff.

WHAT IS HEALTH PROMOTION?

Health Promotion is the process of enabling people (patients) to increase control over, and improve their health.

Health Promotion can include amongst others, the following activities:

Assessing patients for & counselling them on risk factors eg smoking, alcohol, condom use
Assessing patient's nutritional status, socio-economic (poverty) status etc
Educating patients on their illness/condition
Educating patients on their need for, use of and compliance with treatment
Educating patients on technical aspects eg use of asthma pumps, time needing plaster of paris
Informing patients on where to get assistance with problems eg NGO's, social security grants
Counselling patients on HIV/AIDS

PLEASE NOTE THE FOLLOWING BEFORE COMMENCING

- You are not required to put your name on this questionnaire, it is anonymous.
- There is no right or wrong, just **circle** the answer to the best of your knowledge.

STARTING YOUR JOB

1.When starting your job, did you get a **job description**?

Yes No Don't know

2. If yes, was a role in **Health Promotion** mentioned?

Yes No Don't know

3.Did you undergo an **induction programme when you started this job**?

Yes No Don't know

4. If yes, were **Health Promotion activities** highlighted?

Yes No Don't know

JOB EVALUATION AND TRAINING

5. Does a **performance appraisal system** exist in your department?
(may include peer review & nursing "inspection system")

Yes No Don't know

IF YES to 5, answer 6,7,8 & 9 (otherwise continue with 10)

6. **When** was your job performance last appraised? (date) _____

7. Do **Health Promotion skills/achievements** feature in this appraisal?

Yes No Don't know

8. Are **training plans** set up following appraisal?

Yes No

9. If Yes to 8, did you or are you fulfilling these plans?

Yes No

10. Is there a **Continuing Professional Development** programme?

Yes No Don't know (including in service training)

11. When last did you attend a **CPD** programme organized by your employer/department?
(date) _____

12. If yes to 10, did the **CPD** include **Health Promotion** aspects?

Yes No Don't know

QUALITY OF PATIENT CARE

13. Are there guidelines available and present on wards on how to identify NEEDS (not management or treatment) for **Health Promotion** for groups of patients?
(For example, asthma patients, dietry advice/footcare for diabetic patients, surgery patients, rehabilitation, ischaemic heart disease etc)

Yes No Don't know

14. Is there ongoing **Quality improvement/Audit** in your department?

Yes No Don't know

15. If Yes to 14, does this include monitoring **Health Promotion activities**?
Yes No Don't know

16. Do you have defined and documented **Working practice procedures/guidelines** in your department? (*e.g. standardized management/treatment*)

Yes No Don't know

17. If yes, are your **Working Practice procedures/guidelines** developed by **Multidisciplinary teams**?

Yes No Don't know

WORKING ENVIRONMENT

18.Are you aware of the **Patient's Rights Charter**?

Yes No

19.Are you familiar with **Batho Pele**?

Yes No

20. Are you involved with **hospital policy-making, audit and/or review** in decisions impacting on your working environment?

Yes No Not applicable

21.Are you aware of the **Risk Management procedures** (eg. *procedure following a needlestick injury)* in the hospital?

Yes No

PERSONAL

22. Do you **smoke**?

Yes No

23. Do you **know** your **HIV status**?

Yes No

24.Occupation _____ Level _____
(*e.g. doctor*) (*e.g. M.O.*)

25. Department _____
26. Age _____
27. Gender

Male Female

NON-CLINICAL STAFF

eg ADMINISTRATIVE,KITCHEN,MORTURY,CLEANING STAFF

HOSPITAL.....

ABOUT THIS QUESTIONNAIRE

This questionnaire has been prepared by the **Department of Community Health, UKZN** in conjunction with the **Department of Health, KZN** for the purpose of providing information for the **World Health Organization's (WHO) Health Promotion in Hospitals Project**. This project hopes to provide your hospital with an idea of how it's policies and guidelines reflect a commitment to health promotion and how well it promotes health among patients and **staff**.

WHAT IS HEALTH PROMOTION?

Health Promotion is the process of enabling people (patients) to increase control over, and improve their health.

Health Promotion for staff can include amongst others, the following activities:

Providing a safe workplace
Health screening
Voluntary counselling & testing for HIV
Health awareness & education
Assistance with child care
Vaccination programmes eg Hep B, Influenza

PLEASE NOTE THE FOLLOWING BEFORE COMMENCING

- You are not required to put your name on this questionnaire, it is anonymous.
- There is no right or wrong, just circle the answer to the best of your knowledge.

WORKING ENVIRONMENT

1.Are you aware of the **Patient's Rights Charter**?

Yes No

2.Are you familiar with **Batho Pele**?

Yes

No

3. Are you involved with **hospital policy-making, audit and/or review** in decisions impacting on your working environment?

Yes No Not applicable

4.Are you aware of the **Risk Management procedures** in the hospital?

Yes No

PERSONAL

5. Do you **smoke**?

Yes No

6. Do you **know** your **HIV status**?

Yes No

7.Occupation_____

8. Department _____

9. Age _____

10. Gender (circle)

Male Female

Appendix 2 – Data sheets for patient record audit

Data sheet - Health Promotion in Hospitals Patient Record Audit - Scoring of the sample records page A

Record Number:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	Total
Criteria:																		
Risk - have the following been documented? If 2 or > out of 3 then tick OVERALL,																		
1.Generic Risk																		
a)Smoking																		
b)Alcohol																		
c)Nutrition																		
1.Overall																		
2.Date of assessment																		
3.Cultural																		
4.Social																		
5.Information																		
6.Intervention																		
7.Plan																		
8.Progress notes																		
9.Discharge summary																		
10.Rehab plan																		
11.Referral letter from																		
12.Referral letter to other institution, if 2 or > / 3 then tick "OVERALL" else cross :																		
a)Patient diagnosis																		
b)Intervention																		
c)Health Needs																		
12.Overall																		
Patient Age (in years)																		
Diagnosis (write in words)																		

Data sheet - Health Promotion in Hospitals Patient Record Audit - Scoring of the sample records page B

Record Number:	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	Total
Criteria:																		
Risk - have the following been documented? If 2 or > out of 3 then tick OVERALL,																		
1.Generic Risk																		
a)Smoking																		
b)Alcohol																		
c)Nutrition																		
1.Overall																		
2.Date of assessment																		
3.Cultural																		
4.Social																		
5.Information																		
6.Intervention																		
7.Plan																		
8.Progress notes																		
9.Discharge summary																		
10.Rehab plan																		
11.Referral letter from																		
12.Referral letter to other institution, if 2 or > / 3 then tick "OVERALL" else cross :																		
a)Patient diagnosis																		
b)Intervention																		
c)Health Needs																		
12.Overall																		
Patient Age (in years)																		
Diagnosis (write in words)																		

Data sheet - Health Promotion in Hospitals Patient Record Audit - Scoring of the sample records page C

Record Number:	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	Total	Grand	%	Decisior
Criteria:																		Total		Yes/No
	Risk - have the following been documented? If 2 or > out of 3 then tick OVERALL,																			
1.Generic Risk																				
a)Smoking																				
b)Alcohol																				
c)Nutrition																				
1.Overall																				
2.Date of assessment																				
3.Cultural																				
4.Social																				
5.Information																				
6.Intervention																				
7.Plan																				
8.Progress notes																				
9.Discharge summary																				
10.Rehab plan																				
11.Referral letter from																				
12.Referral letter to other institution, if 2 or > / 3 then tick "OVERALL" else cross :																				
a)Patient diagnosis																				
b)Intervention																				
c)Health Needs																				
12.Overall																				
Patient Age (in years)																				
Diagnosis (write in words)																				

Appendix 3 - Description of the indicators

Domain	Management Policy
Indicator 1	***% of staff aware of health promotion policy***
Rationale and description	It is the main aim of the related standard that management develops a policy for health promotion that aims at staff, patients and relatives. Core components of that aim are the definition of responsibilities, development of competences and identification of infrastructures. Since the objective is not to assess directly the compliance with standards and substandards but rather their sustained implementation, it could be considered that the awareness of staff about the policy and its contents is an indirect and reflective, but highly associated performance measure. Even if staff is aware but not satisfied but the policy, the measure is conclusive in emphasizing democratic and transparent working processes.
Numerator	Number of staff aware of the policy and its content.
Denominator	All staff
Data source	Audit or survey methods. Many hospitals carry out repeated surveys on staff health and satisfaction and two items could be included to assess the awareness of staff about managements' health promotion policy.
Stratification	By departments, by professional groups

Domain	Management Policy
Indicator 2	***% of patients (and relatives) aware of standards for health promotion***
Rationale and description	Similar to above, patients need to be aware of the health promotion policy in order to benefit most from it. Patients who are informed about the policy are more likely to demand further information on their condition, on lifestyle changes and on other institutions, associations or self-help groups benefitting their sustained health. Likewise, this information should be to the avail of relatives, however, the burden of data collection may be higher since there are no systematic records of relatives visiting the hospital.
Numerator	Number of patients aware of the health promotion policy.
Denominator	All patients
Data source	Survey methods. In many countries, hospitals send satisfaction questionnaires after discharge to elicit the patients' views and experiences about the care provided. Such a survey can include an item on patients' awareness of the health promotion policy. Discharge interviews could also be used for this purpose.
Stratification	For the hospital: By department. For the patient: by age, sex and educational background.

Domain	Management Policy
Indicator 3	***% of budget dedicated to staff HP activities***
Rationale and description	Direct financial resources available for health promotion-related training, meetings and infrastructures. According to the WHO Ottawa Charter4, "Health promotion is the process of enabling people to increase control over, and to improve, their health" Areas of health promotion activities: 1) health screening, 2) promoting healthy behaviour, 3) organizational interventions, 4) safety/physical environment, 5) social and welfare. Illustrations: worksite smoking cessation programs, stress counselling service, workplace childcare centre, influenza vaccine, alcohol dependence screening, etc. An alternative is to restrict this indicator into three measures: budget related to 1) dependence(smoking, alcohol, medications), 2) nutrition and physical exercise-, and 3) stress- related programs. Inclusion criteria: For the purpose of this indicator, we only include areas 1,2 and 5. Areas 3 and 4 (in)directly deal with staff safety indicators such as % job descriptions with risk assessment of job and work-related injuries (percutaneous injuries or mucocutaneous exposure). Hospital influence: Depends on the degree of freedom to allocate funds within hospitals greatly vary between countries and public/private status and the available total budget. It also depends on National policies and legislation on health promotion within the Workplace Potential adverse effect: If hospitals are evaluated merely on the budget for health promotion activities and not on the volume and quality of health promotion activities that are set up, they might as well just define a budget without being convinced of its usefulness nor without really ever using it, but just to show off. Prevalence and potential for improvement: Little data is available on the extent of health promotion activities within hospitals. A survey in a sample of more than 1400 companies in seven European countries indicate that "activities which might be regarded as coming from the health promotion arena (e.g. eating, alcohol or smoking policies) tend to take place rarely".
Numerator	budget for activities dedicated to staff health promotion
Denominator	average number of employees on payroll during the period (alternative: average number of full time employees)
Data source	Financial data
Stratification	According to area of health promotion (see definitions above)

Domain	Patient assessment
Indicator 4	***% of patients assessed for generic risk factors***
Rationale and description	The indicator measures whether patients were assessed for generic risk factors. Generic risk factors play a role in the development of many diseases, yet, they are frequently not assessed and recorded in medical or nursing records. The purpose of the indicator is to support a systematic assessment of all patients for generic risk factors and document these in order to be available for other health professionals than those carrying out the assessment.
Numerator	Total number of patients with evidence in their records that they were assessed for risk factors, including smoking, nutrition, alcohol.
Denominator	Number of patients (in a random sample)
Data source	Clinical audit of medical or nursing records (sample)
Stratification	To be stratified by age.

Domain	Patient assessment
Indicator 5	***% of patients assessed for disease specific risk factors according to guidelines***
Rationale and description	The indicators measures whether patients were assessed for risk factors against guidelines. Many hospital admissions for chronic conditions can be related to a few risk factors, that were strongly involved in the development of the condition, e.g. smoking habits, excessive alcohol consumption, poor nutrition and lack of physical activity. Hospitals frequently provide care to ameliorate the symptoms of the chronic condition without tackling the underlying risk factors. While it is not necessarily the responsibility of the hospital to provide e.g. intensive smoking cessation programmes, it should nevertheless a) provide the patient with information on where to obtain such services and b) feed back to the primary care physician the presence of the risk factors and its relation to the condition the patient was admitted for.
Numerator	Total number of patients with evidence in their records that they were assessed for risk factors against guidelines, including smoking, nutrition and alcohol.
Denominator	Number of patients (in a random sample)
Data source	Clinical audit of medical or nursing records (sample)
Stratification	To be stratified by age

Domain	Patient assessment
Indicator 6	***score on survey of patients' satisfaction with assessment procedure***
Rationale and description	Patient satisfaction questionnaires are an accepted tool to assess the overall quality of care from the patients' perspective. Assessment is often carried out upon discharge or within a brief timeframe (e.g. two weeks) after discharge. Patient satisfaction questionnaires are a useful tool to assess the *overall* quality of care; while patients may not be able to assess technical components of the intervention they were admitted for, they are best equipped to assess those issues of care, that are very important for the patients, such as respect for privacy, continuity of care, confidentiality, the feeling that all their needs, including emotions, were taken care of. Patient satisfaction and patient experience questionnaires are a main tool to assess those aspects of care the Health Promoting Hospital projects aims to foster.
Numerator	Score on survey (e.g. patients being satisfied with care - depends on the use of the assessment tool; hospitals may choose their own cut-off point on what target they want to aim at).
Denominator	All patients
Data source	Survey
Stratification	By hospital department and by the patients' age, sex and educational background.

Domain	Patient information and intervention
Indicator 7	***% of patients educated about specific actions in self-management of their condition***
Rationale and description	A high volume of care provided is for patients with chronic conditions. However, the hospital stay is only a small component in the care chain required by chronic patients. Other main components of care are provided outside the hospital in the ambulatory sector, or managed by the patient and their relatives themselves. In fact, the empowerment of the patient to take a more active role in his/her care is a main contribution towards improving the quality of care and reducing health system expenditure. In order to involve patients more actively in the care process it is a prerequisite to provide them with more information about their condition and with possible actions related to improving their condition. Better educated patients have shown to have fewer complications and readmissions and thus contribute to both quality of life and cost-containment.
Numerator	Patients who can name actions in self-management of their condition
Denominator	All patients (sample)
Data source	Survey, interviews
Stratification	Departments, age, sex

Domain	Patient information and intervention
Indicator 8	***% of patients educated about risk factor modification and disease treatment options in the management of their conditions***
Rationale and description	Ditto indicator no 7. The difference is the focus on specific conditions
Numerator	Patients who can name actions in self-management of their condition
Denominator	Patients diagnosed with a specific condition (e.g. stroke, chronic obstructive pulmonary disease, myocardial infarction, diabetes mellitus)
Data source	Survey, interviews
Stratification	Department, age, sex, condition

Domain	Patient information and intervention
Indicator 9	***Score on survey of patients' experience with information and intervention procedures***
Rationale and description	Patient satisfaction questionnaires are a useful tool to assess the *overall* quality of care; while patients may not be able to assess technical components of the intervention they were admitted for, they are best equipped to assess those issues of care, that are very important for the patients, such as respect for privacy, continuity of care, confidentiality, the feeling that all their needs, including emotions, were taken care of. Patient satisfaction and patient experience questionnaires are a main tool to assess those aspects of care the Health Promoting Hospital projects aims to foster. This indicator assesses the experience with the process of information and interventions, e.g. did the physician provide information about the disease but in a manner incomprehensible to the patient?
Numerator	Score on survey (e.g. patients being satisfied with care - depends on the use of the assessment tool; hospitals may choose their own cut-off point on what target they want to aim at).
Denominator	All patients
Data source	Survey
Stratification	By hospital department and by the patients' age, sex and educational background.

Domain	**Promoting a healthy workplace**
Indicator 10	***% of short term absence***
Rationale and description	Absenteeism has a high burden on hospital functioning: Cost to compensate for lost of working hours, increased workload for the remaining staff, lost productivity, lower quality if highly skilled personal providing essential services cannot be replaced. Short-term absence is most disturbing because of its unpredictable nature and it allows less time to adjust schedule, take steps to replace absent worker, etc. Absenteeism has also a positive impact: Short-term absenteeism can be an effective coping strategy in the presence of stressful conditions. "Working through" illness: Incidence of employees attending work despite being ill is increasing in CIS countries, mainly because of fear of dismissal or financial motivations (loss of earnings)7 In Europe, the absenteeism rate (including temporary and permanent work incapacity) ranges from 3.5% in Denmark to 8% in Portugal8. In Canada, average absenteeism prevalence rate is equal to 8.1% for nurses. It is 80% higher than the average rate for 47 other occupation groups at 4.5%9. According to CIHI10, other health care workers are only half as likely to be absent from work as are nurses. Nurses are a high-risk group for emotional exhaustion and musculoskeletal injuries. On the other hand, incidence of employees attending work despite being ill is increasing in CIS countries, mainly because of fear of dismissal or financial motivations (loss of earnings)11. Hospital impact: In a meta-analysis of 99 studies on 12 type of absence interventions, a number of interventions proved useful in reducing absenteeism12: employee assistance programs, training and goal setting programs, policy changes to increase employees' accountability for their absence, scheduling changes such as flexible time, and games or token economies. Situational predictors of absenteeism such as organisational permissiveness, role problems, pay, and job characteristics13 are partly under hospital's sphere of influence
Numerator	Number of days of medically or non-medically justified absence for seven days or less in a row (short-term absenteeism) or 30 days or more (long-term absenteeism), excluding holidays, among nurses and nurse assistants
Denominator	Total equivalent full time nurses and nurses assistants * number of contractual days per year for a full time staff member (e.g. 250 days)
Data source	Routine information system at hospital or departmental level or data from health insurance companies.
Stratification	Collect data by age, sex and qualification (nurse or assistant)

Domain	**Promoting a healthy workplace**
Indicator 11	***% of work-related injuries***
Rationale and description	There is a great health risk for hospital staff from exposure to HIV and other bloodborne viruses (e.g. hepatitis B and C). The risk of transmission of hepatitis C virus from a needlestick injury is estimated to 1.8% -3%. Early antiviral treatment of acute hepatitis C virus infection has high cure rates. Injuries have a sustained effect on worker anxiety and distress and direct cost of medical follow-up for at-risk exposure. In a meta-analysis of the literature, the mean rate of sharps injuries per 10.000 healthcare workers to bloodborne pathogen was equal to 4%. Example for self-reported incidence rates of percutaneous injury with material contaminated with blood or biological fluids (1995 survey, Switzerland, Luthi et al 1998): Last workday Last work month Nurses 0.49 % 2.23 % Surgeons 4.28 % 11.05 % Anesthesists 2.11 % 3.14 % Domestic personnel 0.11 % 0.17 % Danish hospital employed physicians (Nelsing et al. 1997): risk per person per year (incidence rate) from 6.2-8.5 for PCE and 7.3-8.8 for MCE in highest risk specialties to 0.8-1.3 for PCE and 1.3-2.9 for MCE in lowest risk specialties. Only 35% physicians adhered to universal precautions and non-compliance with universal precautions was and non-compliance was associated with a considerably increased risk of both MCE and PCE, especially in non-surgical specialties. Note: it is difficult to compare rates because of varying definitions and methods The US General Accounting Office (GAO) estimated that 75% needlestick injuries were preventable by eliminating unnecessary use (25%), by using needles with safety features (29%), by using safer work practices (21%). Injuries are significantly associated with work environment characteristics (time pressure of work). In Laiken et al. (1997), working in hospitals characterized by professional nurse practice models and taking precautions to avoid blood contact was significantly associated with fewer injuries among nurses.
Numerator	Number of percutaneous injuries in one year (includes needlestick injuries and sharp devices injuries)
Denominator	Average number of full-time equivalent exposed staff (physician, nurses, phlebicist)
Data source	Survey among staff on self-reported injuries, further data: insurance claims, human resources specific register
Stratification	By profession, area of care (ICU, operating theatre, emergency, surgical, medical department), time on the day (or weekdays vs weekends), work experience

Domain	**Promoting a healthy workplace**
Indicator 12	***% of staff smoking***
Rationale and description	Health Promoting Hospitals have committed themselves to become a smoke-free setting and hence the proportion of staff smoking is a single indicator reflective of the overall success of implementing health promotion in hospitals. Smoking has a indisputably a negative effect on health and despite the knowledge on its effect a high number of health professionals is still smoking. Staff smoking behaviour is further related to patients' compliance with lifestyle counselling: patients who are admitted to the hospital with a condition related to their smoking habits are more responsive to lifestyle counselling in the situation of experiences ill-health. However, receiving that advice by a health professionals smoking him/herself limits the success of reducing smoking behaviour among patients.
Numerator	Number of staff smoking
Denominator	All staff
Data source	Survey
Stratification	By department, discipline, age and sex

Domain	**Promoting a healthy workplace**
Indicator 13	***Score of survey of staff experience with working conditions***
Rationale and description	A range of instruments exist to assess staff experiences with working conditions. Results of job content questionnaire (measures psychological demands, job decision latitude and social support at work) are associated with both medically certified and non-certified sickness absences among nurses in Bourbonnais and Mondor (2001)[16]. This indicator is strongly linked to indicator no 10 (satisfaction correlates negatively with absenteeism)
Numerator	Score on survey (e.g. staff being satisfied with working conditions - depends on the use of the assessment tool; hospitals may choose their own cut-off point on what target they want to aim at).
Denominator	All staff
Data source	Survey
Stratification	By hospital department and by the patients' age, sex and educational background.

Domain	**Promoting a healthy workplace**
Indicator 14	***% of staff aware of their HIV status***
Rationale and description	Studies have shown that in South Africa approximately 16.7% of health workers are HIV positive. Clearly, therefore, we should be trying to destigmatize HIV, support the "know your status" campaign and provide a supportive work environment where illness related to HIV is dealt with in a positive, non-discriminatory and professional manner. The aim of this indicator is to raise awareness amongst health workers of HIV and the importance of knowing your status so one can seek help and take action early which improves the prognosis of the disease. It is an inaccurate measure of staff actually knowing their HIV status, as individuals may think they know their status but in reality be wrong as they may not have been tested recently or may have been tested in the 'window' period (especially where they think they are negative). It is a more accurate measure of those who don't know their status, as we can assume if someone says they don't know, they probably truly don't know. This is useful for hospital managers as it gives them an idea of how much time and resource to put into HIV awareness campaigns and promotion of VCT.
Numerator	Number of staff aware of their HIV status
Denominator	Total number of staff (in sample)
Data source	Staff questionnaire
Stratification	By age, gender, department, category of staff (clinical or non-clinical)

Domain	**Promoting a healthy workplace**
Indicator 15	***turnover rate***
Rationale and description	Turnover costs for many organizations are very high and can significantly affect the financial performance of an organization. Direct costs include recruitment, selection, and training of new people. Much time and expense go into this process. Indirect costs include such things as increased workloads and overtime expenses for co-workers, as well as reduced productivity associated with low employee morale
Numerator	Full time equivalent terminations
Denominator	Number of Year-end Full-Time Equivalents
Data source	Human resource records
Stratification	By various categories of staff

Domain	**Continuity and cooperation**
Indicator 16	***% of patient referral letters handed to patient on discharge***
Rationale and description	Indicator of continuity of care. Chronic patients require continuous follow up care, however, in many contexts there is insufficient communication between the providers of health and social. Fragmented delivery of care results in delays in the detection of complications or declines in health status because of irregular or incomplete assessments or inadequate follow-up; failures in self-management of the illness or risk factors as a result or patient passivity or ignorance stemming from inadequate or inconsistent patient assessment, education, motivation, and feedback; reduced quality of care due to the omission of effective interventions or the commission of ineffective ones; undetected or inadequately managed psychosocial distress. While this indicator does not cover the whole spectrum of continuity of care the burden of data collection is not too high and it reflects an important component of continuity of care: the information flow between secondary and primary care providers. The indicators needs to be stratified by condition: the importance of discharge letters varies with the condition the patient was admitted for. If the discharge letter contains information on laboratory results that were produced in the hospital and required for the follow-up care provided by the primary care physician.
Numerator	Number of patient records with copy of patient referral letter handed to patient on discharge
Denominator	Number of patient records in sample (50)
Data source	Patient record audit
Stratification	By condition

Domain	Continuity and cooperation
Indicator 17	***readmission rate for ambulatory care sensitive conditions within 5 days***
Rationale and description	Readmissions reflect the impact of hospital care on the condition of the patient after discharge. The underlying assumption to use early readmission as a quality indicator is that something providers did or left undone during the prior stay or early post-discharge period led to the need for the patients' rehospitalization. It could be either due to sub-standard care during index hospitalization (poor resolution of the problem), either to poor discharge preparation or follow-up. This assumption is challenged by natural progression of the disease, if readmission is planned or if it is prompted by a disease not present at discharge and not related to the previous spell. From an efficiency point of view, readmission is costly. To be considered as a readmission, four conditions must be met: 1) diagnoses or procedure that was considered relevant to the initial care, 2) subsequent emergent or urgent admission (non elective), 3) the time between the discharge after the initial episode and the admission for the subsequent hospitalization lies within a specified time period defined by an expert panel, 4) the initial episode did not end with the patient signing himself out against medical advice (or died). We propose to drop condition 4 because of the burden of data collection and – to some extent– it is hospital's responsibility to encourage patients to stay as long as required. Second, a proxy for emergent or urgent readmission is to include only readmissions through the emergency department. Other potential exclusion criteria: patients already receiving continuous care at a primary care clinic, chemotherapy or radiotherapy; residing in or planned to go to nursing home; admitted only to undergo a procedure. Asthma and diabetes are two ambulatory care sensitive conditions. For ambulatory care sensitive conditions, evidence suggests that admission could have been avoided, at least in part, through better outpatient care. A central question is how much influence do hospitals have on post-discharge care and to what degree are they accountable for post-discharge care? Answers to this question may vary greatly depending on national arrangements and organization of care. By focussing on early readmissions and imposing more stringent time frame for readmission, impact of natural progression of the disease and post-discharge care is limited. For instance, for chronic disease such as asthma and diabetes, we advise to use readmission within 72 hours.
Numerator	Total number of patients admitted through the emergency department after discharge –within a fixed follow-up period– from the same hospital and with a readmission diagnosis relevant to the initial care.
Denominator	Total number of patients admitted for selected tracer condition (e.g. asthma, diabetes, pneumonia, CABG)
Data source	Routine information systems and hospital clinical records. Reimbursement claims to purchasing agency.
Stratification	Adjusted by age, sex, severity. Since it is not the aim to facilitate benchmarking between hospitals, further adjustments are not necessary at this stage.
Notes	Exclusion: Patients who died during the index hospitalization or who were discharged to another acute care hospital are excluded from the numerator.

APPENDIX III: WHO META-EVALUATION FORM

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Pilot Implementation of Standards and Indicators for Health Promotion in Hospitals

Meta-evaluation

Dear All,

Thank you for participating in the Pilot Implementation of Standards and Indicators for Health Promotion in Hospitals. The pilot implementation phase is now coming to an end and we would like to gather the data collected and experience made during this phase using this meta-evaluation form. Your data will only be used to improve the self-assessment tool and we will not publish data that identifies the performance of individual hospitals.

The aim of the meta-evaluation form is:

- to evaluate the clarity and relevance of the self-assessment tool,
- to assess the burden of data collection,
- to gather results from the assessment of compliance with standards,
- to gather information on experience with collecting and using performance based indicators,
- to assess general experiences with evaluating and improving health promotion relevant activities in your hospital.

We divided the Questionnaire into the following sections:

I. **Hospital data:** to identify the types of hospitals that participated in the pilot implementation,
II. **Data on multidisciplinary group:** to assess the composition of multidisciplinary group and level of support,
III. **Data on burden of data collection:** to assess the amount of work required to carry out the pilot implementation,
IV. **Assessment of compliance:** to assess how hospitals meet the standards at current,
V. ***Importance and applicability of measurable elements***: to assess whether the measurable elements are comprehensible, relevant and important for your daily work,
VI. **Indicators:** to assess which indicators were chosen and why,
VII. **Overall experience:** to elicit the general experience made in the process of the pilot implementation.

In general, filling in this questionnaire should **not take more than 30 minutes**.

Most of the data can be transferred from the pilot implementation form. Some of the remaining questions may be more difficult to answer, however, please try to fill in all questions as accurately as possible or provide estimates accordingly.

The last sections of the questionnaire offer the opportunity to describe your experience qualitatively and we would like to ask you to make use of this section.

Your comments are highly appreciated to improve the self-assessment tool for health promotion in hospitals.

We suggest that this questionnaire is filled in by the multidisciplinary group that carried out the self-assessment and we highly recommend putting this as an agenda item of a wrap-up meeting of the group.

As for the timeframe of **returning the questionnaire**:

We kindly ask you to return the questionnaire **plus a paper copy of the self-assessment tool** of your hospital by the date indicated in email you have received.

If you expect any problems in meeting the deadline, or have any problems in understanding the meta-evaluation form, please contact your national coordinator of the pilot implementation, or Oliver Grone or Eva Turk from the WHO European Office for Integrated Health Care Services.

Thank you very much.

Oliver Grone and Eva Turk.

I. Hospital data

1. Country: _____

2. Name of the hospital/organization (please give address, phone, fax, e-mail and WWW):

3. Contact person for HPH involvement (please give name, position, address, phone, fax and e-mail):

4. Hospital/Organization status (please add an X where applicable):

__ Public
__ Private not for profit
__ Private for profit

5. Type of hospital/Organization:

__ Community, general hospital
__ Large general hospital with teaching facilities
__ University hospital
__ Specialized hospital (concerned with specialized service(s) e.g. diabetes only)

Other (please specify):_____

6. Catchment area

__ Rural area
__ Urban area
__ Mixed area

7. Number of beds:

Number of acute-care beds in your hospital (including neonatal beds): _____

Acute care beds: beds for patients that stay in a hospital for a relatively short period (one day to several weeks) in contrast to "chronic beds" for patients staying for several months / years, like in a nursing home.

8. **Number of total patients** treated last year:

	Number/year
Inpatients	
Day cases	
Emergencies	
Outpatients visits	
TOTAL*	

9. **Number of staff (Full-time-equivalent)*:**

Physicians*	
Nurses*	
Administration*	
Auxiliary	
Other staff	
TOTAL*	

10. **Teaching (please tick where applicable):**

Teaching	**Please tick as applicable**	
	YES	**NO**
Medical students		
Postgraduate medical education		
Nursing education		
Other health professions		

11. **Research (please tick where applicable):**

Research	**Please tick as applicable**	
	YES	**NO**
Clinical research		
Basic science research		
Health outcomes research		

** One full-time equivalent (FTE) is a person working the normal total of working hours per week (40 in most countries). One FTE may also consist of two persons working part-time (50% of the time). The total number of FTE's is not the total number of persons working.*

Health system management research		
Other health research		

12. **Quality management** issues

Quality management issue	**Please tick as applicable**	
	YES	**NO**
Does your hospital have a quality assurance committee?		
Does it coordinate quality assurance / improvement activities in the whole hospital?		
Is there a professional advisory committee or equivalent body concerned with nursing quality assurance?		
Are the physicians in your hospital subjected to any form of formal peer review?		
Is your hospital certified or accredited?		
If yes, give organization (e.g. ISO, EFQM, JCI):		

13. Does your hospital have the following **commissions**?

Commission for:	**Please tick as applicable**	
	YES	**NO**
Infection control		
Drug use (e.g. antibiotic use)		
Handling complaints		
Patient safety		
Other commissions related to quality assurance or improvement?: Please add:		

14. Is your hospital using indicators to monitor quality?

Indicators:	**Please tick as applicable**	
	YES	**NO**
Clinical indicators (e.g. to measure outcome)		
Indicators for patient safety		
Process indicators (e.g. to measure guideline compliance)		

II. Data on the multidisciplinary group

15. Multidisciplinary group

Multidisciplinary group	**Please tick as applicable**	
	YES	**NO**
Did a multidisciplinary steering group conduct the pilot implementation?		
Is any of the following professions involved at the multidisciplinary steering group (multiple selection possible)?		
a senior nurse		
a senior doctor		
a junior doctor		
a senior manager		
a human resources/personnel member		
a member of staff from ancillary professions allied to medicine (e.g. physiotherapy, occupational therapy)		
a member of staff from general non-clinical services (e.g. catering, hotel services, cleaning, etc.)		

16. For the assessment of compliance with standards, how many patient records did you review? _____

17. How were patient records selected?* (please add an X where appropriate)
    - ___ Randomly
    - ___ Quota
    - ___ Convenient

18. Where did you collect the patients' records from (multiple selection possible)?
    - ___ Medical record
    - ___ Nursing record
    - ___ Therapists record
    - ___ Dieticians record

19. Departments that participated at the Self Assessment Tool **(multiple selection possible):**

Randomly - gives each of the units in the population targeted a calculable (non-zero) probability of being selected.
Quota- method of stratified sampling in which the selection is non-random and the choice of sample members is left to the interviewers.
Convenient – the method does not aim to generate a random group of respondents. This is sampling for reasons of convenience.

Departments participating	Please tick as applicable	
	YES	NO
Surgery[1]		
Orthopaedics		
Traumatology		
Gynaecology and obstetrics		
Internal medicine (general)[1]		
Cardiology		
Urology		
Neurology		
Pulmonology		
Respiratory medicine		
Rehabilitation medicine		
Paediatrics		
Psychiatrics		

III. Data burden

20. Assessment of burden of data collection

Data burden	Please fill in as applicable	
How many times did the steering group meet?		**Times**
Estimate, how many **hours** the team spent in total on the pilot implementation (incl. all members of the team and data collection)		**Hours**
Did you have any direct expenses related to the pilot implementation (e.g. copies, phone bills...)? If yes, please provide an estimate of the overall direct cost in EURO.		**EURO**

[1] *Subspecialties of surgery and internal medicine (e.g. urology, cardiology) that have their own departments / specialty group within your hospital are not included in the question about general surgery and general internal medicine.*

IV. Overall Assessment of Compliance with Standards

Data on the current level of compliance is important to evaluate the standards' relevance and applicability. We would therefore like to ask you to fill in the subsequent table based on the results from the self-assessment carried out (page 47 of the self-assessment tool).

In addition to filling in the results from the overall assessment of compliance in the table below, we would like to ask you to send us a paper-copy of the completed self-assessment tool. We will need the information on the compliance with individual substandards in the review process of the self-assessment tool.

The numbers already included refer to the numbers of measurable elements per standard. Please indicate in the table how many measurable elements for each standard were assessed as complied with (yes), partly compiled with (partly), and not complied with (no).

We will **not use this information to rank** individual hospitals.

Example:

During the pilot-implementation your self-assessment showed the following results for **standard 1**:

- 9 of 17 measurable elements were in full compliance,
- 3 of 17 measurable elements were partly in compliance,
- 5 of 17 measurable elements were not in compliance.

In this case the table needs to be filled in as follows:

	Assessment of compliance					
Standard	yes		partly		no	
1. Management Policy	9	17	3	17	5	17

	Assessment of compliance					
Standard	**yes**		**partly**		**no**	
1. Management Policy		17		17		17
2. Patient Assessment		8		8		8
3. Patient Information and Intervention		8		8		8
4. Promoting a Healthy Workplace		16		16		16
5. Continuity and Cooperation		19		19		19
OVERALL		68		68		68

V. Assessment of Comprehension, Applicability, Importance

In this section, please evaluate **only the measurable elements**, not the standards and substandards.

Measurable elements will be evaluated according to *three dimensions*:

- **Comprehension**: is the formulation of the measurable element understood?
- **Applicability**: is the measurable element applicable to the situation in your hospital?
- **Importance**: Does the measurable element relate to an important issue to sustain health promotion in the hospital structure and culture?

Measurable elements will be evaluated using a **five-point scale**, ranging from 1 to 5:

1= I agree fully
2= I partly agree
3= I neither agree nor disagree
4= I partly disagree
5= I fully disagree

EXAMPLE:

STANDARD 1 MANAGEMENT POLICY		Comprehension (1-5)	Applicability (1-5)	Importance (1-5)
Substandard 1.4: Availability of procedures for collection and evaluation of data				
Measurable element 1.4.1	Data are routinely captured	1	2	1
Measurable element 1.4.2.	There is document evidence of ongoing systematic audit	2	3	4

Explanation:

The *first measurable* element was rated by hospital X as follows:

- The multidisciplinary team *agrees* that the meaning of the measurable element is fully understood.
- The multidisciplinary team *partly agrees* that the measurable element in applicable to their setting [...].

The *second measurable* element was rated as follows:

- The multidisciplinary team *partly agrees* that the meaning of the measurable element is fully understood.
- The multidisciplinary team *neither agrees nor disagrees* that the measurable element is applicable to their setting [...].

Your rating of measurable elements (ME) will be of great importance to identify where problems exists in **understanding** what is meant, in assessing to what extend the measurable element refers to health promotion actions that are

applicable to your context and to evaluate whether the measurable elements refers to issues that are **important** to sustain health promotion practices in hospitals.

Note: the tables use a shortened phrasing of the measurable element. For your assessment of comprehension, applicability and importance **please refer to the full phrasing of the measurable element as included in the self-assessment tool** that you used during the pilot implementation.

STANDARD 1: MANAGEMENT POLICY				
	Add a number from 1 to 5 corresponding to your perceived comprehension (C), applicability (A) and importance (I) of the measurable element (ME): **1 = fully understood / applicable / important.** **2 = partly understood / applicable / important.** **3 = neither-nor understood / applicable / important.** **4 = partly Not understood / not applicable / not important.** **5 = Not understood / not applicable / not important.**			
		C (1-5)	A (1-5)	I (1-5)
Substandard 1.1.: The organization identifies responsibilities				
ME 1.1.1.	Hospitals' states aims and mission			
ME 1.1.2.	Minutes of governing body reaffirm HPH			
ME 1.1.3.	Current business and quality plan includes HPH			
ME 1.1.4.	The hospitals' quality has been adopted or revised			
ME 1.1.5.	The policy explicitly refers to health promotion (HP).			
Substandard 1.2.: The Organization allocates resources				
ME 1.2.1.	Programme for quality assessment established			
ME 1.2.2.	Identifiable budget for health promotion			
ME 1.2.3.	Operational procedures incorporate HP.			
Substandard 1.3.: Staff are aware of the health promotion policy				
ME 1.3.1.	Identification of personnel and functions			
ME 1.3.2.	Policy accessible			
ME 1.3.3.	Staff in all departments aware			
ME 1.3.4.	Hospital's induction program includes HP.			
Substandard 1.4.: Availability of procedures for collection and evaluation of data				
ME 1.4.1.	Data are routinely captured			
ME 1.4.2.	There is document evidence of ongoing systematic audit			
Substandard 1.5: The Organization ensures competences				
ME 1.5.1.	Job descriptions			
ME 1.5.2.	Continuing professional development			
Substandard 1.6.: The Organization ensures infrastructures				
ME 1.6.1.	Specific structures can be identified			

STANDARD 2: PATIENT ASSESSMENT				
	Add a number from 1 to 5 corresponding to your perceived comprehension (C), applicability (A) and importance (I) of the measurable element (ME): 1 = fully understood / applicable / important. 2 = partly understood / applicable / important. 3 = neither-nor understood / applicable / important. 4 = partly Not understood / not applicable / not important. 5 = Not understood / not applicable / not important.			
		C (1-5)	A (1-5)	I (1-5)
Substandard 2.1.: Availability of procedures to assess patients				
ME 2.1.1.	Guidelines for risk factors present			
ME 2.1.2.	Guidelines/Procedures revised			
Substandard 2.2.: Procedures for diagnosis-related patients' groups				
ME 2.2.1.	Guidelines for groups of patients present			
Substandard 2.3.: Assessment carried out				
ME 2.3.1.	Assessment documented at admission			
ME 2.3.2.	Date of assessment in patients record (PR)			
ME 2.3.3.	Guidelines/procedures for reassessing needs			
Substandard 2.4.: Sensitivity for social and cultural background				
ME 2.4.1.	Social/cultural background in PR			
Substandard 2.5: Information provided by others is used				
ME 2.5.1.	Information of relevant sources available in PR			
STANDARD 3: PATIENT INFORMATION AND INTERVENTION				
	Add a number from 1 to 5 corresponding to your perceived comprehension (C), applicability (A) and importance (I) of the measurable element (ME):			
		C (1-5)	A (1-5)	I (1-5)
Substandard 3.1.: Patient informed and plan developed				
ME 3.1.1.	Information given recorded in patients record (PR)			
Substandard 3.2.: Patients are given clear information				
ME 3.2.1.	Patient assessment on information performed and integrated into QM system			
Substandard 3.3.: Organization ensures that HP is systematically offered				
ME 3.3.1.	Information/Intervention documented in PR			
Substandard 3.4.: Organization ensures provision and documentation				
ME 3.4.1.	Activities and results documented			
ME 3.4.2.	Data of review of progress documented			
Substandard 3.5: The Organization ensures general access to health information				
ME 3.5.1.	Information on patient organizations available			
ME 3.5.2.	General health information available			
ME 3.5.3.	High/risk diseases information available			

STANDARD 4: PROMOTING A HEALTHY WORKPLACE				
	Add a number from 1 to 5 corresponding to your perceived comprehension (C), applicability (A) and importance (I) of the measurable element (ME): **1 = fully understood / applicable / important.** **2 = partly understood / applicable / important.** **3 = neither-nor understood / applicable / important.** **4 = partly Not understood / not applicable / not important.** **5 = Not understood / not applicable / not important.**			
		C (1-5)	A (1-5)	I (1-5)
Substandard 4.1.: Comprehensive Human Resource Strategy				
ME 4.1.1.	Existing appraisal/continuing development system			
ME 4.1.2.	Induction training for new staff present			
ME 4.1.3.	Yearly set up and fulfilled training plans			
ME 4.1.4.	Multidisciplinary teams evolve working practices			
ME 4.1.5.	Staff knowledge on HP assessed through surveys			
Substandard 4.2.: Policy for healthy and safe workplace				
ME 4.2.1.	National/regional directives on working conditions			
ME 4.2.2.	Working risks and safety requirements identified			
ME 4.2.3.	Smoking cessation programmes offered			
ME 4.2.4.	Information on diet, physical exercise offered			
ME 4.2.5.	Availability of healthy food won through surveys			
ME 4.2.6.	Variability of health food in canteen			
Substandard 4.3.: Staff involvement				
ME 4.3.1.	Staff involved in decisions on their work environment			
Substandard 4.4.: Developing and maintaining staff awareness on health issues				
ME 4.4.1.	Education sessions offered to staff			
ME 4.4.2.	Policies available for staff			
ME 4.4.3.	Annual staff surveys carried out			
ME 4.4.4.	Staff aware of risk management procedures			

STANDARD 5: CONTINUITY AND COOPERATION				
	Add a number from 1 to 5 corresponding to your perceived comprehension (C), applicability (A) and importance (I) of the measurable element (ME): **1 = fully understood / applicable / important.** **2 = partly understood / applicable / important.** **3 = neither-nor understood / applicable / important.** **4 = partly Not understood / not applicable / not important.** **5 = Not understood / not applicable / not important.**			
		C (1-5)	**A (1-5)**	**I (1-5)**
Substandard 5.1.: Coherence of HP with provisions and health plans				
ME 5.1.1.	Documentation of regulations on health plan			
ME 5.1.2.	Awareness of the health plan (management board)			
ME 5.1.3.	Compliance with health plan			
ME 5.1.4.	Specified criteria for assessment of compliance			
Substandard 5.2.: Cooperation with health/social care providers				
ME 5.2.1.	Written rationale for selection of partners			
ME 5.2.2.	Partner identification/documentation			
ME 5.2.3.	Regularly meetings written procedure			
ME 5.2.4.	Participation of all partners demonstrated			
ME 5.2.5.	Plan for collaboration on seamless services			
ME 5.2.6.	Patient confidentiality in information exchanged			
Substandard 5.3.: Post-hospitalization activities and procedures				
ME 5.3.1.	Follow-up instructions at discharge			
ME 5.3.2.	Joint review for discharge policy in organizations			
ME 5.3.3.	Appropriateness/timeliness part of review process			
ME 5.3.4.	A summary of patient's needs provided			
ME 5.3.5.	Summary included in patient's record			
ME 5.3.6.	Procedures for discharge and post-hospitalization			
ME 5.3.7.	Plan for rehabilitation in patient's record			
Substandard 5.4.: Ensuring of relevant recipient/follow-up partner				
ME 5.4.1.	Timeliness of sending the plan			
ME 5.4.2.	Procedures for communication with partners			

VI. Assessment of Indicators

Please indicate in the following section *for which indicators you have collected data*. Please add an X in the column corresponding to the indicator you have chosen:

X = Indicator collected

In the adjacent column please add a number reflecting *whether you consider the indicator to be important* to monitor health promotion actions, irrespective of whether you have chosen the data in your hospital or not:

1 = very important
2 = important
3 = neither important nor unimportant
4 = Not important
5 = Not at all important

EXAMPLE:

STANDARD DOMAIN	INDICATOR	
	Chosen	Important
Standard 1: Management Policy		
% of patients aware of standards for health promotion	X	1
% of budget dedicated to staff HP activities		4

Explanation:
- Data on the first indicator was collected; the indicator itself was assessed as very important.
- Data on the second indicator was not collected; the indicator itself was assessed as being not important.

Note: Even if you have not chosen a given indicator, it can still be a very important one (or vice versa).

21. Which of the stated indicators were chosen? How do you assess their importance (**for each indicator, please add an X and a number in the corresponding columns**)?

STANDARD DOMAIN	INDICATOR	
	Chosen (X)	Important (1-5)
Standard Domain 1: Management Policy		
patients aware of standards for health promotion		
budget dedicated to staff HP activities		
STANDARD DOMAIN	INDICATOR	

	Chosen (X)	Important (1-5)
Standard Domain 2: Patient assessment		
patients assessed for generic risk factors		
patients assessed for disease specific risk factors according to guidelines		
score on survey of patients' satisfaction with assessment procedure		
Standard Domain 3: Patient information and intervention		
patients educated about specific actions in self-management of their condition		
patients educated about risk factor modification and disease treatment options in the management of their conditions		
Score on survey of patients' experience with information and intervention procedures		
Standard Domain 4: Promoting a healthy workplace		
short term absence		
work-related injuries		
staff smoking		
Score of survey of staff experience with working conditions		
Score on burnout scale		
staff participating in regular health promotion activities within the hospital		
staff coming to work by bicycle		
retention rate		
turnover rate		
Standard Domain 5: Continuity and Cooperation		
discharge summaries sent to GP or referral clinic within two weeks or handed to patient on discharge		
readmission rate for ambulatory care sensitive conditions within 5 days		
number of guidelines developed or revised with collaboration of external users and care providers		
Score on patient discharge preparation survey		

22. Why did you choose those indicators (easily available data, organizational priorities etc.)?

23. Please forward to us in an Annex data on any other collected indicators.

VII. Overall experience

Please answer the following questions regarding your overall experience with the pilot implementation. Your questions will be very helpful to guide the future use of the self-assessment tool.

Please indicate your agreement for each of the following statements, putting an X in the corresponding box.

Example:

The participation in the pilot-implementation of standards and indicators for health promotion in hospitals was useful!

I strongly agree	I agree	Neither agree nor disagree	I disagree	I strongly disagree
	X			

31. The **participation** in the pilot-implementation of standards and indicators for health promotion in hospitals was useful!

I strongly agree	I agree	Neither agree nor disagree	I disagree	I strongly disagree

32. Through the participation in the pilot-implementation I have **identified new potentials** for quality improvement of health promotion activities in hospitals!

I strongly agree	I agree	Neither agree nor disagree	I disagree	I strongly disagree

33. The **work** related to gathering data for the self-assessment of health promotion activities can be **incorporated into organizational practice!**

I strongly agree	I agree	Neither agree nor disagree	I disagree	I strongly disagree

34. **I recommend** other hospitals interested in health promotion to carry out a self-assessment of health promotion activities using the WHO self-assessment tool!

I strongly agree	I agree	Neither agree nor disagree	I disagree	I strongly disagree

35. **All Health Promoting Hospitals in the WHO HPH Network should carry out a self-assessment of their health promotion activities to see how well they are doing (without the need to make the results public)!**

I strongly agree	I agree	Neither agree nor disagree	I disagree	I strongly disagree

In this final section we would like to ask you to describe briefly the main issues that arose in the process of the pilot implementation.

36. Please state the **main difficulties and challenges** with the pilot-implementation (if there is insufficient place, please add an Annex).

37. Please describe your **main success-story** with the pilot implementation of standards and indicators for health promotion (if there is insufficient place, please add an Annex).

38. Please state any **recommendations** for future improvement and use (if there is insufficient place, please add an Annex).

We would like to thank you for taking the time to fill in this questionnaire. Your results will greatly contribute to this international project on developing standards and indicators for health promotion in hospitals.

We will analyse the results and share them with you once this work has been carried out.

Yours sincerely,

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APPENIDIX IV: ACTION PLANS

Action plan of Inkosi Albert Luthuli Central Hospital following the HPH pilot

ACTION PLAN
HOSPITAL: IALCH

ACTION	TIMEFRAME	EXPECTED RESULT
STANDARD: 1		
Formulate a HP policy	Jan-05	Reviewed vision & mission of the hospital that incorporates HP. Policy available to all
Allocate resources to HP	Apr-05	Allocated budget for HP activities
Raise awareness to staff of HP policy	Jan-Dec 2005	Results of staff survey
Ensure the validity of data to monitor HP activities	Jan-Dec 2005	Audit reports
STANDARD: 2		
Formulate guidelines for reassessing needs at discharge	Jan-Dec 2005	Implementation of the policy for reassessing needs
Scan all referring letters at the reception/ admission desk	Mar-05	All referring letters to appear on patients records
STANDARD: 3		
Record all information given to patients	Jan-Dec 2005	Reports on patient record audits & surveys
STANDARD: 4		
Incorporate smoking cessation programme in an annual staff training programme & EAP	Jan-Dec 2005	Reports on % participation in programme
Involve staff in policy formulation, audit & review	Jan-Dec 2005	Results on staff surveys Minutes on policy reviews

STANDARD: 5

Obtain the district health plan & create awareness to the staff	Jan-June 2005	Copy available & communicated to all staff
Involve community structures & other stake holders in HP	Quarterly evaluation in 2005	Reports on health awareness programmes

Action plan of Lower Umfolozi War Memorial Hospital following the HPH pilot

ACTION PLAN
HOSPITAL: LOWER UMFOLOZI WAR MEMORIAL

ACTION	TIMEFRAME	EXPECTED RESULT	RESOURCES
STANDARD:1			
Review of hospital mission & vision to include HP	Feb-05	A comprehensive health service that includes HP	Stationery Human resources
To inform hospital board about HPH initiative	Apr-04	Participatory decision making on HPH initiative by community representatives	Nil
Develop a HP policy for LUWMH	Mar-05	Clearly defined roles, responsibilities & actions in order to provide HP activities	Stationery Human resources
To develop a programme to monitor quality & HP activities	Jun-05	Ongoing quality improvement initiatives & HP activities	Stationery Human resources
STANDARD:2			
Develop a tool that includes assessment of smoking & alcohol consumption of pts	Feb-05	Comprehensive assessment of patients at time of initial assessment	Stationery Human resources
Develop a tool which assesses social & cultural background of pts	Feb-05	Comprehensive assessment of patients at time of initial assessment	Stationery Human resources
STANDARD:3			
Develop a structure of giving information to patients & keeping records thereof	Feb-05	Empowerment of our clients & community in identification of risks & self-care	Stationery Human resources
Develop information brochures & keep records of distribution	Feb-05	Empowerment of our clients & community in disease prevention & healthy living	Stationery Human resources
STANDARD:4			
To get assistance	Feb-05	Identification of strengths &	Human resources

from Head Office on developing a staff appraisal tool		weaknesses of staff & setting up appropriate training plans	
Develop a tool for staff survey that includes HP	Mar-05	Introduce HP activities as requested by staff	Stationery Human resources
To develop a tool & carry out monthly inspections to ensure staff working conditions comply with Provincial / National directives	Feb-05	A healthy & safe working environment	Stationery Human resources
To include HP issues in the in service education programme	Feb-05	Create an awareness about health issues & HP	Stationery Human resources
STANDARD:5			
To acquire a copy of the district health plan	Feb-05	HP activities at institutional level will be coherent with the district health plan	Transport to district office

Action plan of Greys Hospital following the HPH pilot

ACTION PLAN
HOSPITAL: GREYS

ACTION	TIMEFRAME	EXPECTED RESULT	RESOURCES REQUIRED
STANDARD: 1			
Add health promotion to core values	2005/01/05	Health promotion included in core values	Paper (250 sheets); printing; lamination; staff time
Re-affirm hospital board agreement	2004/08/19	Minutes of board meeting	Staff & hospital board time
Include HP in strategic objectives	2004/10/31	CAPS document	Staff time
Develop a HP policy	2005/02/18	HP policy	Staff time; IT information; paper; printing, distribution
Develop programme for quality assessment of HP activities	2005/03/24	Quality assessment programme	Staff time; paper; printing; distribution
Identify budget aligned to HP activities	2005/03/24	Business plan	Staff time; paper; printing
Ensure inclusion of HP activities in clinical operational procedures & protocols	2005/06/30	HP icluded in clinical procedures, protocols & guidelines	Staff time; paper; printing; distribution
Identify HP team & their functions	2005/01/27	HP team & list of functions	Staff time
Dissiminate & implement policy according to management policy 16	2005/03/18	Signed distribution lists	Staff time; paper; printing; distribution
Ensure staff awareness of policy	2005/04/15	Completed evaluation tool (survey)	Staff time (meetings, training, orientation)
Ensure inclusion of HP policy & activities in induction programme	2005/03/01	Orientation programme & attendance records	Staff time
Develop means of data capture/assessment, analysis & evaluation	2005/03/31	HP information system	Staff time, IT, information & system

Conduct systematic HP audits	2005/04/15	Audit reports	Staff time, paper, printing
Formulate job description to include HP activities	2005/06/15	HP included in job descriptions	Staff time, paper, printing
Ensure that CPD & continuing education programmes include HP activities	2005/03/18	Inclusion of HP in all educational programmes & proof of attendance	Staff time
Ensure availability of necessary resources to implement HP activities (within available budget)	2005/03/24	Necessary resources in place	Staff time, finanace as identified by HP budget
STANDARD: 2			
2.1 Annual revision of guideline procedures	yearly	procedures/guidelines updated, annual keeping abreast of latest trends	Stationery, staff time
2.2 Policy draft available needs to be made a formal policy through policy committee	May-05	Adherence to policy	Staff time , stationery, P.C
STANDARD: 3			
3.1 Review interview guide & basic plan for nursing	Jun-05	A comprehensive interview guide & care plan including HP inter= vention	Paper, staff time
Develop a medical & supplementary services assessment & manage= ment guidelines	Jun-05	Assessment & manage= ment tool available for medical & supplementary services to facilitate information given to pt	Paper, staff time
Information given to pt verbally needs to be documented by informing staff to document pt information according to HP policy	Feb-05	Staff awareness regarding documentation of pts information	Paper, staff time
3.2 Draw up patient satisfaction question= naire Conduct interviews with	Jun-05	Obtain an indicator of % of pts receiving adequate information in order to improve their	Paper, staff time

patients		condition	
3.3/3.4 Audit of medical, nursing & supplementary records	June 2005 & ongoing	Sustained documentation	Paper, staff time
3.5			
To establish a data base for contact addresses for patient organizations	May-05	Easy access to data base with available information on patient organizations	Paper, staff time
Ensure patient information brochures available		All services have brocures available for pts	
To establish an information desk for provision of general information	Jul-05	Availability of general information	Furnished office, staff member
To establish detailed information on high risk diseases	Jan-06	Availability of information on high risk diseases	Paper, staff time
STANDARD: 4			
4.1			
A performance appraisal system & CPD must exist Develop evaluation reports	Every 3 months; end of Feb-05	Each department will comply with a 3 monthly appraisal report on staff. To uplift standards in the departments & identify shortfall in skills & knowledge	P.C, orientation to managers Additional staff for H.R.D Quality assurance manager Secretary Office & furniture
New staff must receive induction training	Once off End of January	Overall view of the situation	H.R.D contracts Staff time, stationery
Training plans must be set up & fulfilled. Draw up training schedule	Yearly 30-Jan-05	Competent staff Identify shortfalls Lifting career path Improving knowledge	Service providers H.R. Practitioners P.C; Questionnaire Stationery Staff time
Procedures & guidelines must be developed within existing national legislations	End of Feb 2005 & ongoing	Maintain standards & provide a high service delivery	Stationery Staff time P.C
Assess knowledge of HP through staff surveys	End of Jan 2005 Every 3 months	Improving employees knowledge of health as	Occupational staff P.C; office

Draw up surveys		well as their own health	Staff time, stationery
4.2			
Working conditions must comply with national & provincial directives	Ongoing	Adhering to National & Provincial legislation	Occupational officer P.C Office & staff time
Health & safety requirements must be adhered to to prevent workplace risk Do survey	End of Feb & ongoing	Safe working environment to minmize injuries	Staff time Stationery
Smoking cessation programmes must be offered & drawn up	31 Jan 2005 & ongoing	Healthy staff members Less absenteeism	Stationery Staff time Workshops
Offer information on diet & physical exercise through information booklets	Ongoing End of Jan 2005	Healthy staff members More staff will eat on duty	Staff time Workshops Stationery
Survey needs to be developed to assess quality & choice of food	Ongoing 31-Dec-05	Healthy staff members More staff to eat on duty Assess the quality of food	Staff time P.C. Stationery
The canteen should offer variation of healthy food Draw up menu & send out to all departments	End of Dec Specified mealtimes e.g. breakfast, lunch, supper	Can cater for different cultures & needs Promote a healthy employee	Stationery Staff time
4.3			
Staff meetings to be held to formulate policies & review them. Auditing of records	Ongoing Review yearly	Policies guide staff function Compliance of staff	Staff time P.C. Stationery
To develop & maintain education programmes on health issues	Monthly for the year	Improve knowledge Change ways Develop skills Update of new information	Stationery Staff time
4.4			
Develop policies for health issues e.g smoking	31 Jan 2005 & ongoing	Healthy staff Better work attendance	Stationery Staff time
Draw up questionnaire on institutional HP activities Undertake staff survey Develop questionnaire	End of Feb 2005 Every 3 months	Identify deficiency in staff awareness of HP issues	Staff time Stationery P.C; Typist

Develop a questionnaire on awareness of risk management procedures e.g. bomb, fire	31-Jan-05	Ensure maximise safety	Stationery Staff time Typist
STANDARD: 5			
5.1			
Obtain district health plan	31-Jan-05	HP activities aligned to district health plan	Telephone, fax, email
Draw up rationale for selection of partners	31-Mar-05	Staff awareness & cooperation of health & social care providers	Meetings, stationery, typing, staff time
5.2			
List of partners	31-Mar-05	List of partners	Distribution of lists Staff time, stationery
Written procedures to meet regularly	31-Jan-05	Regularly planned meetings	Meetings, stationery, staff time, typing
Minutes of meetings	30-Jun-05	Minutes of meetings Continuity of appropriate care	Meetings Staff time
Admittance & discharge plans	31-Jan-05	Continuity of appropriate care	Meetings Staff time Stationery
Uniform consent form drawn up & implemented	31-Mar-05	Uniform consent form drawn up & implemented Better health patient awareness communications	Meetings Staff time Stationery
5.3			
Draw up joint review procedure for discharge policy & information exchange	31-Mar-05	Documented procedure, improved prompt communication & continuity of care	Meetings Staff time Stationery
5.4			
Communication procedures for relevant partners	30-Jun-05	Improved communication with partners ensuring seamless patient care	Meetings Staff time Stationery

Action plan of Ngwelezana Hospital following the HPH pilot

ACTION PLAN
HOSPITAL: NGWELEZANA

ACTION	TIMEFRAME	EXPECTED RESULT
STANDARD: 1		
Quality & business plans to include HP	2005/03/30	To have quality & business plans that include HP
Develop programmes for HP activities & time schedule for surveys	2005/02/28	To have programmes for quality assessment of HP activities
Ensure incorporation of HP into operational procedures & protocols	2005/03/30	Protocols & procedures incorporate HP
Capturing of data on HP interventions	2005/03/30	All HP interventions are date captured
Documentation of HP audits	2005/03/30	Documentation records of HP audits
Identification of HP structures & facilities	2005/03/30	To have identified HP structures & facilities
STANDARD: 2		
Assessment must be documented in patients record on admission	2005/03/30	Assessment must be done effectively
Guidelines for reassess= ing needs on discharge	2005/03/30	Discharge evaluation to be done effectively
STANDARD: 3		
To ensure effective patient satisfaction survey & record keeping	2005/10/31	Good record keeping of patient satisfaction survey
Detailed information about high risk diseases to be available	2005/01/31	To ensure effective information about high risk diseases to be available
STANDARD: 4		

All new staff to receive induction programme on Health & safety	2005/03/31	All employees to be aware of health hazards in their work area
Multi-disciplinary team to be involved when developing procedures	2005/04/30	All employees to be conversant with the formulation of procedures on health & safety
Staff to be involved in policy making	2005/05/31	All staff will have been involved in policy making, audit & review

STANDARD: 5

To document HP activities so as to be coherent with the District Health Plan	2005/03/30	To have a coherent health plan of activities with those of the District Health Plan
Coordination with the community on identifica= tion of social care provision	2005/03/30	To ensure the coordination with the community
To ensure confidentiality of procedures for the exchange of information with other health care organizations	2005/03/30	To have confidentiality of procedures for exchange of information
To ensure joint procedures for discharge policy & information exchange	2005/03/30	To have joint procedures for discharge policy

Action plan of Edendale Hospital following the HPH pilot

ACTION PLAN
HOSPITAL: EDENDALE

ACTION	TIMEFRAME	EXPECTED RESULT
STANDARD: 1		
Organize business development plan for allocating resources		
Operational procedures		Monitor strokes, AMI's, diabetics
Staff aware of HP policy Employment of facility information officer		Proper induction programmes to be put in place
Organization & validation of data		Efficiency & quality of data
Job descriptions incorporate HP policy Develop policy for HP activities		Efficient & timeous quality of data
Business plan & availability of necessary resources for implementation		Proper allocation of resources
STANDARD: 2		
Draw up guidelines on smoking status, number & type per day; alcohol consumption in amount/ day & brand, nutritional status - indicate like anaemia		Well-defined guidelines & population parameters defined
Guidelines on numerous specified diagnoses: DM, HPT etc		
Draw aspects of patient assessment to be recorded as a routine to be followed - subjective,		Improved record audit

objective, laboratory		
Diet requirements Religious Weight measurements		Increase in patient satisfaction reported in patient satisfaction questionnaire
Teach doctors/ attached & indicate in file		Improved record audit
STANDARD: 3		
Plan for hospital patient record audit to be undertaken	Mar-05	Internal & external clients Clients made aware of documents in the file
To formulate information brochures that is incorp= orated in patient file Not more than 8 Qs on HP to be filed etc.		Increase patient satisfaction survey between 3-6%
Patient record audit	June-Dec 2005	To increase compliance of HP plans for patient in file
Patient record audit	Every quarter	
STANDARD: 4		
4.1		
Ensure establishment of comprehensive HR strategy	31-Mar-05	Improve efficiency
4.2		
Ensure establishment of healthy & safe work place	31-Mar-05	Reduction in occupational related injuries
4.3		
Develop standard questionnaire	31 April 2005	Input obtained
STANDARD: 5		
5.1		
Develop HP plan for the institution	28-Feb-05	Availability of institution's HP plan & implementation thereof
5.2		
Not applicable		
5.3		
Continue monitoring discharge summaries Policy &procedure will be developed for timeous review process		Improve documentation of our discharge summaries by 3% Availability of policy & procedure manual

STANDARD: 5

	5.4		
To improve communication plan with relevant partners		2005/05/30	Improved communication system between relevant partners

Action plan of Northdale Hospital following the HPH pilot

ACTION PLAN
HOSPITAL: NORTHDALE

PROBLEM	TASK TEAM	ACTIVITIES	TIMEFRAME	RESOURCES	EXPECTED OUTCOME
High Incidence of smoking		Introduce a smoking cessation programme			
Lack of information given to patient & care giver	Hospital manager Nursing manager Medical manager Unit managers Clinical tutors	1. Conduct in-service training - documents (Patients Rights Charter, Batho pele principles) 2. Draw up format for letter to caregiver/discharge summary 3. Draw up Letter to caregiver / discharge summary polices 4. Carry out in-service.	May 2005 & ongoing	PRO Clinical tutors	1. Task completed 2. Patient & care giver fully informed
High incidence of Needlestick injuries	Hospital manager Nursing manager Medical manager Unit managers OHN Infection control sister	1. Policies & procedures in place 2. In-service training on a) policies & procedures b) working within scope of practice 3. Regular inspections 4. Provision of Personal Protective Equipment e.g. gloves, eye shields etc 5. In-service on use of Post-exposure Prophylaxis 6. Compile monthly statistics for Accidental exposure to body fluids	May 2005 & ongoing	OHN Clinical staff Infection control sister Policy/procedure manuals	Decrease in Needlestick injuries