



*American University of Armenia*  
*Center for Health Services Research*

*A Survey of Adherence to International*  
**Hospital Standards**  
**at Nork Marash Medical Center**

Summary Report

*American University of Armenia and*  
*Nork Marash Medical Center*  
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## **LIST OF ABBREVIATIONS**

ACC	Access to and continuity of care (function)
ANP	American University of Armenia – Nork Marash Medical Center Project
AOP	Assessment of patients (function)
AUA	American University of Armenia
CABG	Coronary arterial bypass graft
CHSR	Center for Health Services Research
CIS	Commonwealth of Independent States
COP	Care of patients (function)
DS	Discharge summary
EKG	Electrocardiogram
FMS	Facility management and safety (function)
GLD	Governance, leadership and direction (function)
ICP	Infection control program
ICU	Intensive care unit
MOH	Ministry of Health
MOI	Management of information (function)
NIS	Newly Independent States
NMMC	Nork Marash Medical Center
OR	Operating room
PCI	Prevention and control of infections (function)
PFE	Patient and family education (function)
PFR	Patient and family rights (function)
QA	Quality assurance
QI	Quality improvement
QMI	Quality management and improvement (function)
RRC	Republican Radiology Center
SEF	Structured encounter form
SES	Sanitary-Epidemiology Station
SQE	Staff qualifications and education (function)

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## **EXECUTIVE SUMMARY**

This report presents the results of an initial survey of hospital standards at Nork Marash Medical Center (NMMC). The goal of this survey was to assess the extent of compliance at NMMC with selected Joint Commission International Accreditation (JCIA) standards. The survey was conducted during the summer of 2000 by the Center for Health Services Research (CHSR) at the American University of Armenia (AUA). This survey was an activity of the AUA/NMMC Project (“ANP”). On-site observation and extensive interviews with NMMC personnel were used to collect data on functions outlined by the JCIA, the international accreditation arm of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The results identify strengths that NMMC is urged to build upon. They also identify potential areas for improvement that should be addressed in the context of improving the quality of care at NMMC.

### **Strengths**

- A close working relationship was noted between the Clinical Leadership and Management. This level of collaboration is highly commendable and crucial to the continued improvement of quality of care at NMMC.
- The Clinical Leadership has demonstrated a strong commitment to introduce Quality Improvement (QI) activities at NMMC. A number of QI projects—most notably the Infection Control Program—have been initiated. A multidisciplinary committee (the “Politburo”) investigates and addresses quality-related problems that arise in patient care.
- The Clinical Leadership has initiated data collection and monitoring activities and contributes data to regional and European registries. Such activities have been crucial in the development and evaluation of the Infection Control Program.

### **Potential areas of improvement**

- The survey team judged that NMMC met most standards “partially” or “satisfactorily”. One problem that was consistently encountered was a lack of written documentation defining criteria, policies, and procedures. This problem was noted for many functions, including Staff Qualification and Evaluation, Management of Information, Facility Management and Safety, and Assessment of Patients. The consequences of the failure of NMMC to document its policies and procedures must not be minimized—the scope and quality of care and services will vary across patients and across departments. The Management and Clinical Leadership at NMMC are urged to develop written criteria, policies, and procedures and to define standards of care to which the organization wants to hold its health professionals accountable.
  - NMMC does not have a formal QI program. “QI philosophy” is not well established at the Center. It is recommended that a QI Program be officially founded at NMMC. The responsibilities of planning, coordinating, and implementing the QI program should be allocated to a multidisciplinary team of health professionals and administrators drawn from NMMC staff who will report to Management and Clinical Leadership.
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- The success of the Infection Control Program has demonstrated the benefits of monitoring patient-level data. It is recommended that NMMC increase data collection and analysis activities in order to further study the relationship between health care delivery and patient outcomes. More specifically, the following areas might be targeted for action:
  - ❖ aggregation and critical analysis of patient-level data that are currently collected so as to identify areas for improving care;
  - ❖ collection of post-discharge data on follow-up care over time;
  - ❖ collection of data on patient health and functional status pre-operatively and at different intervals post-operatively; and,
  - ❖ enhancement of methods used to analyze data in order to account for differences in patient case-mix over time and across organizations.
- The survey team discovered that staff education efforts in almost all functional areas at NMMC—for example, for the functions Patient and Family Rights and Prevention and Control of Infections—consisted of informal, on-the-job training that was not backed by a formal analysis of training needs, a documented curriculum, nor by a structured evaluation methodology. It is recommended that NMMC improve the quality of its training programs by founding a Staff Education Department and developing the skills of professional staff to be able to identify, plan for and fulfill the educational needs of NMMC personnel.

### **Next steps**

Three current efforts that are related to or follow on the results described in this report are summarized below.

1. The CHSR team at AUA is currently studying data-related issues presented above. These studies include an investigation of the validity and reliability of patient-level data at NMMC and the feasibility of collecting data on patient follow-up care and outcomes. The result of this assessment will be presented to the Steering Committee of the ANP.
  2. Current efforts are also underway to translate the SF-36<sup>®</sup> questionnaire into Armenian so as to be able to study the relationship between care-delivery processes and patient outcomes at NMMC. The SF-36 is a self-administered survey instrument is used internationally to collect data on functional and health status of individuals.
  3. A proposal detailing recommendations for a QI program at NMMC will be presented to the ANP Steering Committee in the near future.
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## INTRODUCTION

### **Purpose of report**

The American University of Armenia (AUA) and the Nork Marash Medical Center (NMMC) are jointly implementing the AUA/NMMC Project (“ANP”). The report titled A Survey of Adherence to International Hospital Standards at Nork Marash Medical Center (“Report”) has been produced under the aegis of the ANP. The Report seeks to serve several purposes. It is the first product of the major collaborative effort between the AUA and NMMC and has thus been a point of focus that has allowed the two institutions to form a working alliance. The Report paints a broad, detailed portrait of NMMC that will allow it to serve as a reference document for a wide variety of efforts and individuals who take part in the ANP over the coming years. The Report will serve as a key source of information and a programmatic framework as NMMC and AUA collaborate to develop a comprehensive program of quality assurance at NMMC in the coming year. Finally, the Report is a model of how other health care organizations in Armenia might approach the task of assessing and improving the standard of care they provide and the manner in which they manage their organizations.

### **Basis for assessment**

The Report is framed on international standards for hospital care and management that are outlined in the first edition of the Joint Commission International Accreditation Standards for Hospitals (“Manual”; Joint Commission International Accreditation, 2000). The Joint Commission International Accreditation is a division of the international subsidiary of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO is a non-profit American organization that is recognized as the leading institution providing accreditation to healthcare organizations in the United States. The Manual has divided the various aspects of hospital care and management into 11 functions that are listed below:

#### Patient-centered functions

- ACC (Access to and continuity of care)
- AOP (Assessment of patients)
- COP (Care of patients)
- PFE (Patient and family education)
- PFR (Patient and family rights)

#### Management-centered functions

- FMS (Facility management and safety)
- GLD (Governance, leadership and direction)
- MOI (Management of information)
- PCI (Prevention and control of infections)
- QMI (Quality management and improvement)
- SQE (Staff qualifications and education)

A large number of standards are presented in the Manual for each function. An intent statement and one or more measurable elements are listed for each standard.

### **Assessment team**

The Report has been prepared through a collaborative effort between NMMC and the Center for Health Services Research (CHSR) at AUA. This effort was implemented by a core team composed of clinical and administrative personnel at NMMC, CHSR senior staff, AUA students in the Masters in Public Health program, and the Project Coordinator of the AUA/NMMC Project. AUA students

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developed the questionnaires, gathered the data and wrote an initial draft of this Report. This draft was revised and finalized by the Project Coordinator and the CHSR Technical Advisor.

**Report format**

The main body of the Report is divided into eleven chapters. Each chapter is based on a function from the Manual. Although every function is reported on, neither all standards nor—within standards—all measurable elements (MEs) have been assessed. This has been done to minimize the scope of the task; given the large number of standards, the assessment team felt it to be desirable to eliminate those that could not be objectively assessed and those that were perceived to be of lesser importance. The same criteria were used to eliminate selected MEs among standards.

A uniform format is used to report on all standards that have been assessed. For a given standard, the standard and all of the MEs that were assessed are transcribed. A textual evaluation of each of the MEs follows. Each of the MEs is then assigned an evaluation score (see description below). Finally, conclusions are presented for the standard.

Each ME is assigned one of the following evaluation scores: 1 (“standard not met”), 2 (“standard met minimally”), 3 (“standard met partially”), or 4 (“standard met satisfactorily”). The assigned evaluation scores represent the best judgment of the CHSR team. These scores have an admitted subjective component. They are intended to stimulate discussion and provide a basis for comparison among functions and standards, rather than to represent absolute, “correct” assessments.

While CHSR staff have assigned the evaluation scores and written the text of the Report, it must be stressed that this evaluation has a substantial “internal” (i.e., self-assessment by NMMC staff) component. Some of the data upon which this assessment is based were gathered through record review or observation. However, the great majority of data were gathered through interviews with NMMC personnel. The process of data collection was conducted in close collaboration between NMMC staff members and AUA students. The candor displayed by NMMC staff as they described the strengths and weaknesses of their organization convinced the assessment team that this evaluation is a fair and accurate portrayal of NMMC.

**Next steps**

What are the next steps that logically follow from this effort? How can this report be most effectively used? Since the inception of the ANP, the CHSR and NMMC have planned to implement a program to improve the quality of care and services at NMMC. The Report has great potential to serve as a resource of information for such an effort and provides a convenient structure for the program. The Report is also a natural first step towards another goal that is currently being considered by the ANP Steering Committee: that of obtaining JCAHO accreditation.

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## **BACKGROUND: NORK MARASH MEDICAL CENTER (NMMC)**

NMMC is the one of the few hospitals in the Caucasus region to offer cardiology and cardiovascular surgical services for adult and pediatric populations. Given the highly trained medical staff and the advanced technological services available at the Center, NMMC is poised to become a referral center for cardiovascular services in the region.

### **History of NMMC**

NMMC was founded in the facility formerly known as Children's Hospital #2 in 1992. Pediatric cardiovascular surgical services became available in 1994. At that time, NMMC served children 15 years of age or younger. Approximately 150-170 surgical procedures were performed per year under an annual budget of \$200,000. NMMC expanded its cardiovascular medical and surgical services to adults in 1996. NMMC was designated as a "Center" for cardiovascular services in 1997 due to the comprehensive range of specialized services rendered by the hospital. By the end of the same year, the Ministry of Health (MOH) of Armenia allowed the center to be reimbursed on a fee-for-service basis for services provided to the adult population. Pediatric services were rendered free of charge. The United Armenian Fund (UAF) provided funding support to NMMC through 1997, primarily by paying staff salaries.

Anticipating a substantial increase in revenues from adult surgical patients, NMMC constructed a new operating room and Intensive Care Unit (ICU) in 1998 and undertook other renovation projects. A regional economic crisis developed in the region during this period of expansion, resulting in a dramatic decrease in paying surgical patients. These events, coupled with a discontinuation of funding by UAF, forced NMMC management to reduce staff salaries in an effort to reduce costs. Revenue sources were limited to adult patients who could afford to pay for the services received at NMMC and the paltry reimbursement given to NMMC by the MOH for Armenian pediatric surgical patients, an amount that covers less than 10 percent of the actual cost of surgery. In the same year, NMMC instituted the Nork Project. Under this project, which had marketing as well as humanitarian aims, NMMC provides cardiovascular surgical services at the NMMC facility for 10-20 children from regional countries each year at no cost. NMMC covers all medical costs associated with the surgery.

### **NMMC staff and services**

NMMC is governed by the Yerevan municipality, the health department of the municipality, and the MOH. The Mayor of City of Yerevan has appointed the general manager of the hospital, Dr. Lida Mouradian. Dr. Mouradian is responsible for managing the organization's day-to-day operations, as well as human, financial, and other resources.

Today, NMMC is a 60-bed hospital staffed by well-trained physicians, some of whom were trained in highly renowned cardiovascular surgery centers in western Europe and the United States. These physicians have assumed crucial roles in transferring know-how and energizing other personnel in their efforts to improve quality of care at NMMC. The staff includes 30 physicians, 46 nurses, and 10 individuals in various administrative and managerial positions. In addition, there are 20 support staff members (e.g., janitors, groundskeepers). The facility is very well equipped by regional standards. The annual budget amounts to approximately \$1 million. Half of the budget is allocated to payroll, 25-30 percent to disposable equipment, and the remainder to facility maintenance. The two ICUs include 12 beds and are managed by four medical doctors and five nurses. NMMC is capable of conducting up to 1200 surgical procedures per year, although it currently performs less than half that many procedures. In the 3-year period from 1995-1998 a total of 1,520 surgical procedures were performed, including 500 coronary artery bypass graft surgeries and 256 procedures for valve replacement.

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**NMMC: Teaching hospital**

NMMC is also a teaching institution, providing post-graduate, highly specialized medical training in cardiology and cardiovascular surgery. It has attracted a number of individuals from abroad, including Syria and other countries of the former Soviet Union. Currently, there are three cardiac surgery residents who are all in the third year of a three-year program; three cardiac surgery fellows in the second year of a four-year program; three adult cardiology fellows; and three pediatric cardiology residents.

**Future directions**

Future plans include expanding areas of subspecialty in cardiology and cardiovascular surgery (i.e., electro-physiology, and inter-cardiac catheter surgery). There are also plans to add a rehabilitation center and to update its equipment. More imminently, however, the priorities of NMMC consist of planning for programmatic changes that are aimed to improve the quality of care under the auspices of the ANP.

As NMMC proactively modernizes its equipment and care, it is also striving to become the leading cardiovascular referral center in the region. To this end, substantial marketing efforts are underway to attract both patients and cardiology and cardiovascular surgery trainees from an expanded service area that encompasses much of the former Soviet Union.

## **FUNCTION: ACCESS TO CARE AND CONTINUITY OF CARE (ACC)**

### **Result Highlights**

- ⇒ Verbally established policies and procedures guide and standardize the admission process at NMMC for outpatients, inpatients and emergency patients.
  - ⇒ Screening is initiated for all patients at NMMC at the time of their first contact with the organization. Based on the results of the screening, the patient is matched to NMMC's resources.
  - ⇒ The patient and/or his family are provided with pertinent information during the admission process at NMMC. This information can include details regarding the proposed treatment and its consequences. Patients and family members are provided information regarding the cost of care before the patient gives consent for treatment such as surgery. Patients are provided with sufficient information so as to be able to make a decision regarding their treatment.
  - ⇒ Patients at NMMC are prioritized for assessment and treatment based on the urgency of their needs. Verbally established criteria related to the medical condition of the patient are used to identify patients that require immediate or specialized care. Staff is trained to use these criteria through lectures, written materials, and informal education from NMMC physicians.
  - ⇒ NMMC has established processes that support the continuity and coordination of care. These processes are based on the principle of the "case manager". Policy and procedure documents state that the cardiologist bears overall responsibility for the patient's care at NMMC. The cardiologist manages the patient's care when s/he is not under the care of the surgical department and is involved in making medical decisions when the patient is under the care of the surgery department. The cardiologist coordinates diagnostic and treatment services in order to ensure the continuity of care. Individuals responsible for the coordination of care in each service are verbally identified.
  - ⇒ Verbally established criteria are used to determine when a patient should be transferred to another department within NMMC. The patient medical record is the primary tool that is used at NMMC to transfer information among departments and providers.
  - ⇒ An organized, verbally established process of patient discharge and referral to outside health facilities exists at NMMC. Based on the assessment of the patient using verbally established criteria and their needs for continuing treatment, physicians determine when the patient has to be discharged / referred. A discharge summary (DS) is prepared at the time of a surgical patient's discharge from NMMC.
  - ⇒ The discharge planning process attempts to consider the need for support services and continuing medical services. Few support services outside of cardiology care at NMMC have been identified, placing patients who live outside of Yerevan at a disadvantage. There are no support services in the fields of nutrition, exercise, or psychological counseling that have been identified and are consistently used by NMMC staff.
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- ⇒ Patients are provided with instructions just before their discharge on lifestyle, diet, and when to return for follow-up care. Patients are encouraged to return to NMMC should they feel it necessary. A list of medications that have been prescribed is provided to the patient. The family members of patients are also provided with this information. Instructions on when to obtain urgent care may not consistently be communicated in a clear manner.
  - ⇒ A verbally established process guides transfers from NMMC to outside health facilities. The medical criteria that define when transfer is appropriate have been verbally established and appear to be somewhat vague.
  - ⇒ The community obtains information about NMMC and its services from medical personnel and through personal recommendations.
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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
ACC.1	Patients have access to the health organization's services based on their identified health care needs and the organization's mission and resources.	(1) Screening is initiated at the point of first contact.	4
		(2) Based on screening, the patient is matched with the organization's mission and resources.	4
		(3) Information on services, hours of operation, and the process to obtain care are provided to agencies and referral sources in the community.	2
ACC.1.1	The organization has a process for admitting patients to the organization.	(1) Policies and procedures are used to standardize the admitting process.	3
		(3) The policies and procedures address admitting emergency patients.	3
		(4) Policies and procedures address holding patient for observations.	3
ACC.1.1.1	Patients with emergency or immediate needs are given priority for assessment and treatment.	(1) The organization has established criteria to prioritize patients with immediate needs.	3
		(2) Staff is trained to use criteria.	4
		(3) Patients are prioritized based on the urgency of their needs.	4
ACC.1.1.2	Patient needs for preventive, palliative, curative and rehabilitative services are prioritized based on the patient's condition at the time of entry to the organization.	(1) The screening assessment helps staff understand the type of preventive, palliative, curative and rehabilitative services needed by the patient.	4
		(2) The setting of care to meet these needs is appropriate.	N/A
ACC.1.2	At admission, the health care organization provides the following information to patient and appropriate family members or decision-makers: information on proposed care, the expected results of that care, and any expected cost to the patient for the care.	(1) There is a process to provide patient/family with information at admission.	4
		(2) The process includes information on the proposed care.	4
		(3) The process includes information on the expected results of care.	4
		(4) The process includes information on any expected costs to the patient or family.	4
		(5) Patients receive sufficient information to make knowledgeable decisions.	4

**Evaluation Score:**

1 = Standard not met; 2 = Standard met minimally; 3 = Standard met partially; 4 = Standard met satisfactorily; N/A = Standard is not applicable to NMMC or cannot be measured from available information.

Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
ACC.1.4	Diagnostic tests for determining patient needs are completed and used as appropriate to determine whether the patient should be admitted, transferred or refused.	(1) There is a process to provide the results of diagnostic test to those responsible for determining if patient is to be admitted, transferred or refused.	4
		(2) Criteria are used to determine which screening and diagnostic required before admission.	3
		(3) Patients are not admitted, transferred or refused before the test results are available.	N/A
ACC.1.5	Entry or transfer to units providing intensive or specialized services is determined by established criteria.	(1) The organization has established entry or transfer criteria for its intensive and specialized services.	2
		(3) Staff is trained to apply the criteria.	2
		(5) Patients who no longer meet the criteria are transferred or discharged.	3
ACC.2	The organization designs and carries out processes to provide continuity of patient care services in the organization and coordination among health care professionals.	(1) The leaders of services and settings design and implement processes that support continuity and coordination of care.	4
		(2) Established criteria or policies determine the appropriateness of transfer within the organization.	3
		(4) Care is coordinated between emergency services and inpatient admission.	4
		(5) Care is coordinated between diagnostic and treatment services.	4
		(6) Care is coordinated between surgical and non-surgical services.	4
		(8) Individuals responsible for coordination are identified.	3
ACC.2.1	During all phases of care, there is a qualified individual identified as responsible for the patient's care.	(1) The individual responsible for patient's care is identified.	4
		(2) The individual is qualified to assure responsibility for patient's care.	4
		(3) The individual is identified to the organization's staff.	4

**Evaluation Score:**

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
ACC.2.2	Information about the patient’s care and response to care is shared among medical, nursing and other care providers during each shift, between shifts, and during transfer between units.	(1) There is a process to transfer patient information between the care providers on an ongoing basis or at key times in the care process.	4
ACC.2.2	Information about the patient’s care and response to care is shared among medical, nursing and other care providers during each shift, between shifts, and during transfer between units.	(2) Information exchanged includes the patient’s health status.	4
		(3) Information exchanged includes a summary of the care provided	4
		(4) Information exchanged includes the patient’s progress.	4
		(5) When a transfer occurs, the reason for transfer is communicated.	4
ACC.2.3	The patient’s record(s) is available to the care providers to facilitate the exchange of information.	(1) Policy establishes those care providers who have access to the patient’s records.	3
		(2) The patient record(s) is available to those providers.	4
		(3) The records are up to date to ensure the transfer of the latest information.	4
ACC.2.4	Information related to the patient’s care is transferred with the patient.	(1) The patient’s records or summary of patient care information is transferred with patient.	4
		(2) The summary contains the reason for admission.	4
		(3) The summary contains significant findings.	4
		(4) The summary contains any diagnosis made.	4
		(5) The summary contains any procedures performed.	4
		(6) The summary contains any medications and other treatments.	4
		(7) The summary contains the patient’s condition at transfer.	4
ACC.3	There is a process to appropriately refer or discharge patients.	(1) There is an organized process to refer and/or discharge patients.	3
		(2) The referral and/or discharge are based on the patient’s needs for continuing care.	4
		(3) Criteria are used to determine readiness for discharge.	3

**Evaluation Score:**

1 = Standard not met; 2 = Standard met minimally; 3 = Standard met partially; 4 = Standard met satisfactorily; N/A = Standard is not applicable to NMMC or cannot be measured from available information.

Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
ACC.3.1	The organization cooperates with health care practitioners and outside agencies to ensure timely and appropriate referrals.	(1) The discharge planning process considers the need for both support services and continuing medical services.	2
		(4) Referrals are made when possible for support services	3
ACC.3.2	Patients and, as appropriate, their families are given understandable follow-up instructions at referral or discharge.	(1) Follow-up instructions are provided in an understandable form and manner.	4
		(2) The instructions include any return for follow-up care.	4
		(3) The instructions include when to obtain urgent care.	2
		(4) Families are also provided the instructions as appropriate to the patient's condition.	4
ACC.3.3	Patient records contain a copy of discharge summary.	(1) A discharge summary is prepared at discharge.	4
		(2) The summary contains the reason for admission.	4
		(3) The summary contains significant findings.	4
		(4) The summary contains any diagnosis.	4
		(5) The summary contains any procedure performed.	4
		(6) The summary contains any medications and other treatments.	2
		(7) The summary contains the patient's condition at discharge.	3
		(8) The summary contains discharge medications and follow-up instructions	3
		(9) When organization or practice dictates, the patient is given a copy of discharge summary.	4
ACC.4	There is a process to appropriately transfer patients to another organization to meet their continuing care needs.	(1) There is a process to transfer patients.	3
		(2) The transfers are based on the patient's need for continuing care.	4
		(4) The process addresses who is responsible during transfer.	3
		(5) The process addresses the situation in which transfer is not possible.	3

**Evaluation Score:**

1 = Standard not met; 2 = Standard met minimally; 3 = Standard met partially; 4 = Standard met satisfactorily; N/A = Standard is not applicable to NMMC or cannot be measured from available information.

Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
ACC.4.1	The referring organization determines that the receiving organization can meet the patient’s continuing care needs.	The referring organization determines that the receiving organization can meet the needs of patients to be transferred.	4
ACC.4.1.1	The organization establishes formal or informal arrangements and affiliations with receiving organizations to ensure continuity of care for its patients.	Formal or informal arrangements are in place with receiving organizations when patients are frequently transferred to the receiving organization.	4
ACC.4.2	The receiving organization is given a written summary of the patient’s clinical condition and the interventions provided by the referring organization.	(1) Patient clinical information or a clinical summary is transferred with the patient.	4
		(2) The clinical summary includes patient status.	4
		(3) The clinical summary includes procedures and other interventions provided.	4
		(4) The clinical summary includes the patient’s continuing care needs.	4
ACC.4.3	During transfer, a qualified staff member monitors the patient’s condition	(1) All patients are monitored during transfer.	3
		(2) The qualification of the staff member is appropriate for the patient’s condition.	4
ACC.4.4	The transfer process is documented in the patient’s record	(1) The records of transferred patients note the health care organization agreeing to receive the patient.	4
		(3) The records of transferred patient note the reason(s) for transfer.	4

**Evaluation Score:**

1 = Standard not met; 2 = Standard met minimally; 3 = Standard met partially; 4 = Standard met satisfactorily; N/A = Standard is not applicable to NMMC or cannot be measured from available information.

## FUNCTION: ASSESSMENT OF PATIENTS

### **Result highlights**

- ⇒ There is a well-established process of patient assessment of NMMC. The data gathered through patient assessment are documented in structured encounter forms. As such, the organization has defined the information to be obtained for inpatient and ambulatory patients. Patient assessment is performed only by individuals who are licensed and qualified. The findings are documented in the patient's record in the appropriate format, and is readily accessible to those responsible for patient care. While nursing needs are identified for surgical patients, there appears to be no assessment of nursing needs for medical (cardiology) patients.
- ⇒ There is no pre-defined timeframe in which patient assessment should be completed and documented in the patient's record. Consequently, the timeframe in which patient assessment is completed varies greatly across patients. However, the medical and anesthesia assessment of surgical patients is documented prior to surgery, along with their pre-operative diagnosis. Priorities are established based on the needs identified through patient assessment, and patients, as well as their families participate in decision making with regard to priorities.
- ⇒ Patients are reassessed at appropriate intervals, as determined by the patient's health status and his/her response to treatment. Findings from patient reassessment are documented in all departments, either in the general clinical record or on department-specific forms specifically designed for reassessments.
- ⇒ Physicians of various specialties work collaboratively to analyze patient assessment data and to decide on an appropriate course of action. However, there seems to be no participation in this process on the behalf of the nursing staff.
- ⇒ In-house laboratory services meet the patients' needs at NMMC on a 24-hour basis:
  - ⇒ The in-house laboratory is staffed by individuals that are appropriately trained and experienced, and reports results in a timeframe to meet patient needs. Although the medical staff is satisfied with the timeliness of laboratory results, there is no established time frame in which the results should be reported.
  - ⇒ The laboratory equipment is inspected, maintained, and calibrated on a regular basis. The supplies are in adequate quantity, and maintained according to their date of expiration. However, there are no written documents to outline rules and quality control procedures with respect to equipment inspection, maintenance, calibration, or validation of test results.
  - ⇒ The laboratory has a well-established range of expected results for each test, and these ranges are available on the forms through which results are communicated to those responsible for patient care.
  - ⇒ An outside laboratory performs specialized tests. The level of compliance of this laboratory with laws and regulations is unclear.
  - ⇒ The radiology department at NMMC is equipped to perform chest X-Rays on both bedridden and ambulatory patients, 24 hours a day.
  - ⇒ The services meet all local and national standards, laws and regulations. These include ones that relate to radiation safety programs, and to equipment management and maintenance, as determined by the Inspection Committee of the Republican Radiology Center (RCC). However, problems with radiology equipment and repairs are not documented adequately.
  - ⇒ The supplies are readily available, and the staff administering radiological exams is adequately trained and experienced.

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- ⇒ As for laboratory services, there is a lack of established timeframe in which results should be reported to individuals responsible for patient care. However, timeliness of results is not reported to be a problem, as the radiology department has a policy of reporting results as soon as possible in order to meet patients' needs.
- ⇒ Patients are referred to outside providers for tests not performed regularly at NMMC. Such providers are selected based on physician recommendation, rather than on the providers' record on quality and compliance with rules and regulations.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
AOP.1	All patients cared for by the organization have their health care needs identified through an established process.	Organization policy and procedure define the information to be obtained for inpatients and ambulatory patients.	3
AOP.1.1	The organization has determined the scope and contents of assessments, based on applicable laws and regulations.	Only those individuals permitted by licensure, applicable laws and regulations, or certification perform the assessments.	4
AOP.1.3	Assessments are completed in the time frame prescribed by the organization.	Assessments are completed within the time frames established by the organization.	1
AOP.1.4	Assessment findings are documented in the patient's record and readily available to those responsible for the patient's care.	Assessment findings are documented in the patient's record.	4
AOP.2.1	The patient's medical and nursing needs are identified from the initial assessment.	(1) The initial assessment results in the identification of the patient's medical needs.	4
		(2) The initial assessment results in the identification of the patient's nursing needs.	3
AOP.2.1.1	The initial medical assessment is documented in the patient's record within the first 24 hours after the patient's entry.	The initial medical assessment is documented in the patient's record within the 24 hours of admission.	3
AOP.2.1.2	The initial medical assessment is documented before anesthesia and surgical treatment.	(1) The medical assessment of surgical patients is documented before surgery.	4
		(2) Surgical patients have a preoperative diagnosis recorded before surgery.	4
		(3) The anesthesia assessment determines if the patient is an appropriate candidate for the planned anesthesia.	4
AOP.3	All patients are reassessed at appropriate intervals to determine their response to treatment and to plan for continued treatment or discharge.	(1) Patients are reassessed at intervals appropriate to their condition, plan of care, and individual needs or according to organizational policies and procedures.	3
		(2) Reassessments are documented in the patient's record.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
AOP.5.1	Clinical pathology services are provided by the organization to meet patient needs or are readily available through arrangements with outside sources.	(1) Adequate, regular, and convenient laboratory services are available to meet needs.	4
		(3) Outside sources are selected based on an acceptable record and compliance with laws and regulations.	2
AOP.5.2	A laboratory safety program is in place, followed, and documented.	(1) A laboratory safety program is in place and is appropriate to the risks and hazards encountered.	2
		(4) Appropriate safety devices are available.	3
AOP.5.3	Individuals with adequate training, skills, orientation, and experience administer the tests and interpret the results.	(1) Appropriately trained and experienced staff administers the test.	4
		(2) Appropriately trained and experienced staff interprets.	4
AOP.5.4	Laboratory results are available in a timely way as defined by the organization.	(1) The organization has established the expected report time for results.	3
		(2) Laboratory results are reported within a time frame to meet patient needs.	4
AOP.5.5	All laboratory equipment is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.	There is a laboratory equipment management program.	3
AOP.5.6	Essential reagents and other supplies are regularly available.	Reagents and supplies of "high quality" are readily available at the laboratory, and they are maintained according to their date of expiration.	4
AOP 5.8	Established norms and ranges are used to interpret	(1)The laboratory has established reference ranges for each test performed	4
		(2) The range is included in the clinical record at the time test results are reported.	4
		(5) Ranges are reviewed and updated as needed.	4
AOP.5.10	Quality control procedures are in place, followed, and documented.	(1) There is a quality program for the clinical laboratory.	2
		(2) The program includes the validation of test methods.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
AOP.6	Radiology services are available to meet patient needs, and all such services meet applicable local and national standards, laws, and regulations.	Radiological services meet applicable local and national standards, laws, and regulations.	4
AOP.6.1	Diagnostic imaging services are provided by the organization or are readily available through arrangements with outside sources.	(1) Adequate, regular, and convenient radiology services are available to meet needs.	4
		(2) Radiology services are available for emergencies after normal hours.	4
		(3) Outside sources are selected based on an acceptable record and compliance with laws and regulations.	2
AOP.6.2	A radiation safety program is in place, followed, and documented.	(1) A radiation safety program is in place and appropriate to the risks and hazards encountered.	4
		(5) Appropriate radiation safety devices are available.	4
AOP.6.3	Individuals with adequate training, skills, orientation, and experience administer the tests and interpret the results.	(1) Appropriately trained and experienced staff administers tests.	4
		(2) Appropriately trained and experienced staff interprets tests.	4
AOP.6.4	Radiology results are available in a timely way as defined by the organization.	(1) The organization has established the expected report time for results	2
		(2) Radiology results are reported within a time frame to meet patient needs.	4
AOP.6.5	All diagnostic equipment is regularly inspected, maintained, and calibrated, and appropriate records are maintained for these activities.	(1) There is a radiology equipment management program.	4
		(5) The program includes calibrating and maintaining equipment.	4
AOP.6.6	X-ray film and other supplies are regularly available.	(1) Essential reagents and supplies are identified.	4
		(2) Essential reagents and supplies are available.	4
AOP.6.8	Quality control procedures are in place, followed, and documented.	(2) Quality control includes daily surveillance of results.	4
		(5) Quality control includes documenting results and corrective actions.	2
AOP.7	Medical, nursing, and other individuals and services responsible for patient care	(1) Patients assessment data and information are analyzed and integrated.	4

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<b>Standard #</b>	<b>Standard</b>	<b>Measurable Element</b> (# of measurable element)	<b>Evaluation Score</b>
	collaborate to analyze and integrate patient assessments.	(2) Those responsible for the patient's care participate in the process.	3
AOP.7.1	The most urgent or important care needs are identified.	(1) Patient needs are prioritized based on assessment results.	4
		(2) The patient and his or her family participate in the decisions about the priority needs to be met.	4

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## **FUNCTION: CARE OF PATIENTS (COP)**

### **Result Highlights**

#### CARE DELIVERY FOR ALL PATIENTS

- ⇒ Clinical and managerial leaders at NMMC have collaboratively developed policies and procedures that reflect relevant laws and regulations and guide the provision of uniform care. Weekly inter-departmental conferences, integrated patient records, and the assignment of the patient's cardiologist as their "case manager" are the principal techniques used to achieve coordination of care.
- ⇒ An integrated, overall plan for each patient's care is not produced. Each of the different departments at NMMC produce separate plans for a patient's care. Only the Cardiology and Anesthesiology Departments document these plans. Plans are revised consistent with changes in the patient's condition. Provided care is always documented in the patient record. There is no uniform, established process for making orders, which can be communicated either verbally or in writing.

#### CARE OF HIGH-RISK PATIENTS AND PROVISION OF HIGH-RISK SERVICES

- ⇒ Clinical leaders at NMMC have verbally identified high-risk patients and services and developed verbal policies and procedures to guide their care. Specific policies and procedures to guide the care of vulnerable elderly patients do not exist. While written policy guides financial aspects of care provided to children, medical procedures for children are guided by orally established policies and procedures as well as by structured encounter forms (patient records).
- ⇒ A combination of documented and verbal policies and procedures guide the collection, testing, documentation, handling and administration of blood and blood products.

#### ANESTHESIA CARE

- ⇒ A documented pre-anesthesia assessment is performed for each surgical patient at NMMC before the induction of anesthesia. A partially documented plan for anesthesia care is then developed. Patients or decision-makers for the patients are only educated on selected aspects of anesthesia-related issues. The anesthesia used and the anesthesia technique are documented. Each patient's physiological status is continuously monitored and documented during the administration of anesthesia and the post-anesthesia period. The decision to discharge the patient from the operating room is made using verbally established criteria by the anesthesiologists and surgeons in a collaborative manner.

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### SURGICAL CARE

- ⇒ A plan for each surgical patient's care is developed, albeit not documented, at NMMC. The patient's preoperative diagnosis is noted in the patient's record. The surgical patient, his or her family, and/or decision makers for the patient are carefully educated on the risks and possible complications of surgery and possible complications related to blood and blood product use. A thorough description of the surgical procedure is noted in the surgical protocols, brief summaries of which are entered into patient's record. The post-operative diagnosis is not documented immediately after surgery, but rather at the time of the patient's discharge from the hospital. Post-surgical care for each patient is verbally planned based on medical, nursing and other factors.

### MEDICATION USE

- ⇒ Laws that pertain to medication and its use are followed at NMMC. An established process exists to procure necessary medications. A list of all the medications that are available at NMMC or at easily accessible outside sources is available. There is no established method to maintain, monitor and update the medication list.
- ⇒ Verbally established policies guide the prescription, ordering, administration and documentation of medications. Staff training on prescribing, ordering and administration of medications is conducted as necessary on an informal basis. Verbally established policies and procedures guide self-administration of medications by the patient.
- ⇒ The Head Nurse of NMMC has overall responsibility for pharmaceutical-related issues. A licensed pharmacist supervises the central pharmacy. Medication orders given by a physician at NMMC are not reviewed by the pharmacist, as is typical under the Armenian medical system. Medications are stored according to manufacturers' recommendations.
- ⇒ There is a uniform medication dispensing and distribution system at NMMC. Medications that have been ordered for a patient at NMMC are recorded on the Medication Order Form that is attached to the patient's record. The medication and dosage is verified against this form before administration. While the time of administration is noted, the patient is not identified using a standard protocol. Medication effects are monitored and the type and dosage of medication are adjusted as needed. Adverse effects, when they occur, are always noted in the patient's record.

### FOOD AND NUTRITION THERAPY

- ⇒ All patients have an order for food in their records that is based on the patient's nutritional status and needs. Food is provided by the patient's family or friends or by a private cafeteria at NMMC. The family is educated by NMMC regarding what kind of foods are preferable for the patient, foods that are contraindicated according to patient's care needs, and how to prepare the food that the patient needs.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
COP.1	Policies and procedures and applicable laws and regulations guide the uniform care of all patients.	(1) The organization's clinical and managerial leaders collaborate to provide uniform care process.	4
		(2) When similar care provided in more than one setting, care delivery is uniform.	4
		(3) Policies and procedures guide uniform care and reflect relevant laws and regulations.	4
COP.2	There is a process to integrate and coordinate the care provided to each patient.	(1) Care planning is integrated and coordinated among settings, departments and services.	4
COP.2.1	The care provided to each patient is planned and written in the patient record.	(1) The care for each patient is planned.	4
		(2) The care planned is noted in the patient's record.	2
		(4) The care providers for each patient are noted in the patient's record.	4
		(5) Any patient care team meetings are noted in the patient records.	1
COP.2.2	Those permitted to write patient orders write the order in the patient record in a uniform location.	(1) Orders are written when required.	3
		(2) Orders are found in a uniform location in patient records.	1
COP.2.3	Procedures performed are written into the patient's record.	(1) The results of procedures performed are entered into the patient's record.	4
COP.2.4	Each care provider has access to the patient care notes recorded by other care providers, consistent with organization policy.	(1) There is a method for one care provider to access other provider's care notes.	4
COP.2.5	The patient's plan of care is revised when indicated by a change in the patient's condition.	(1) The patient's plan of care is modified as the patient's needs change.	4
COP.3	Clinical practice guidelines, when available and adopted by the organization, are used to guide the patient's clinical care.	(1) Clinical guidelines when available and relevant to the organization's patients and sources, are used to guide patients care process.	N/A

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
COP.5	Policies and procedures guide the care of high-risk patients and the provision of high-risk patients and services.	(1) The organization's clinical and managerial leaders have identified the high-risk patients and services.	3
		(3) Staff has been trained and uses the policies and procedures to guide care.	1
COP.5.1	Policies and procedures guide the care of emergency patients.	(2) Patients receive care consistent with the policies and procedures.	3
COP.5.2	Policies and procedures guide the use of resuscitation services throughout the organization.	(1) Resuscitation is provided according to policies and procedures.	3
COP.5.3	Policies and procedures guide the handling, use, and administration of blood and blood products.	(2) Blood and blood products are administered according to policies and procedures.	4
COP.5.4	Policies and procedures guide the care of patients on life support or who are comatose.	(1) Patients on life support receive care according to the policies and procedures.	3
COP.5.8	Policies and procedures guide the care of vulnerable elderly patients and of children.	(2) Frail, dependent elderly patients receive care according to the policies and procedures.	1
		(4) Young, dependent children receive care according to the policies and procedures.	2
COP.6.	A qualified individual conducts a pre-anesthesia assessment.	(1) Pre –anesthesia assessment is performed for each patient before anesthesia induction.	4
		(2) A qualified individual performs the assessment.	4
COP.7	Each patient's anesthesia care is planned and documented.	(1) The anesthesia care of each patient is planned.	4
		(2) The plan is documented.	2
COP.7.1	The risks, potential complications, and options are discussed with the patient, his or her family or those who make decisions for the patient.	(1) The patient and decision-makers are educated on risks, potential complications and options of anesthesia.	2
		(2) The anesthesiologist or other qualified individual providers the education.	4
COP.7.2	The anesthesia used is written in the patient record.	(1) The anesthesia used and anesthetic technique are entered into the patient's anesthesia record.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
COP.7.3	Each patient's physiological status during anesthesia administration is continuously monitored and written in the patient's record.	(1) Physiological status is a continuously monitored during anesthesia administration.	4
		(2) The results of monitoring are entered into the patient's anesthesia record.	4
COP.8	The patient's post-anesthesia status is monitored and documented and a qualified individual discharges the patient from the recovery area using established criteria.	(1) The patients are monitored appropriate to their condition during the post-anesthesia recovery period.	4
		(2) Monitoring findings are entered into the patient's record.	4
		(3) Established criteria are used to make discharge decisions.	4
		(5) Recovery area arrival and discharge times are recorded.	4
COP.9	Equipment, supplies and medications recommended by anesthesia professional organizations or by alternative authoritative sources are used.	(1) Recommended equipment is used.	4
		(2) Recommended supplies are used.	4
		(3) Recommended medications are used.	4
COP.10	Each patient's surgical care is planned and documented, based on the results of the assessment.	(1) Each patient's surgical care is planned.	3
		(4) A preparative diagnosis is documented.	4
COP.10.1	The risks, benefits, potential complications, and options are discussed with the patients and his or her family or those who make decisions for patients.	(1) The patient, family and decision makers are educated on the risks, benefits, potential complications and options related to the planned surgical procedures.	4
		(2) The education includes the need for risk of, and alternatives to blood and blood product use.	4
		(3) The patient's surgeon or other qualified individual provides the education.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
COP.10.2	The surgery performed is written in the patient record.	(1) A postoperative diagnosis is documented.	2
		(2) A description of the surgical procedure, findings and any surgical specimens is documented.	4
		(3) The names of surgeon and surgical assistants are documented.	4
		(4) The surgical report is available within a time frame needed to provide post-surgical care to the patient.	4
COP.10.3	Each patient's physiological status is continuously monitored during and immediately after surgery and written in the patient's record.	(1) The patient's physiological status is continuously monitored during surgery.	4
		(3) Findings are entered into the patient's record.	4
COP.10.4	Patient care after surgery is planned and documented.	(1) Each patient's medical, nursing and other post-surgical care is planned.	4
		(2) The plan is documented in the patient's record.	1
COP.11	Medication use in the organization is efficiently organized to meet patient needs.	(1) Medication use is organized throughout the organization so that patient's medication needs are met.	4
COP.11.1	The pharmacy or pharmaceutical service and medication use in the organization comply with applicable laws and regulations.	(1) The pharmacy or pharmaceutical service and medication use comply with applicable laws and regulations.	2
COP.11.2	An appropriate selection of medications for prescribing or ordering is stocked or readily available	(1) Medications available for prescribing and ordering are appropriate to the organization's mission, patient needs and services provided.	4
		(2) There is a list of medications stocked in the organization or readily available from outside sources.	4
COP.11.2.1	There is a method for overseeing the organization's medication list and medication use.	(1) There is a method for overseeing the medication list.	2
COP.11.2.2	The organization can readily obtain medications not stocked or normally available to the organization.	(1) There is a process to obtain required medications not stocked or normally available to the organization.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
COP.11.2.3	There is a process to obtain medications when the pharmacy or pharmaceutical service is closed.	(1) There is a process to obtain medications when the pharmacy is closed.	4
COP.11.2.4	Emergency medications are available, monitored and safe when stored out of the pharmacy.	(1) Emergency medications are available in the organization within a time frame to meet emergency needs.	4
		(2) Emergency medications are protected from loss and theft	2
COP.11.3	Prescribing, ordering and administration of medications are guided by policies and procedures.	(1) Policies and procedures guide the safe prescribing, ordering and administration of medications in the organization.	3
		(2) Documentation requirements are stated.	2
		(4) Relevant staff is trained in correct prescribing, ordering and administration practice.	4
COP.11.3.2	Policies and procedures govern any patient self-administration of medications, the control of medication samples, the use of any medications brought into the organization by the patient or his her family, and dispensing of medications at discharge.	(1) Policies and procedures govern patient self-administration of medications.	3
		(3) Policies and procedures govern the documentation and management, of any medications brought into the organization for or by the patient.	3
		(4) Policies and procedures govern the dispensing of medications at the time of the patient's discharge.	3
COP.11.3.3	Policies and procedures govern the preparation, handling, storage and distribution of parenteral and enteral tube therapy.	(1) Policies and procedures guide the storage, preparation, handling and distribution of parenteral and enteral tube nutrition products.	3
COP.11.4	Medications are stored, prepared and dispensed in a safe and clean environment.	(2) Medications are stored properly.	4
		(3) Medications are prepared and disposed in clear and safe areas.	N/A
COP.11.4.1	An appropriately licensed pharmacist, technician or other trained professional supervises the storage, preparation and dispensing of medications.	(1) A qualified individual supervises all activities.	4
COP.11.4.2	Medication prescriptions or orders are verified.	(1) Each prescription or order is reviewed.	1

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
COP.11.4.3	The organization has a medication recall system.	(2) Policies and procedures address any use of medications known to be expired or outdated.	4
		(3) Policies and procedures address the destruction of medications known to be expired or outdated.	4
		(4) Policies and procedures are implemented.	4
COP.11.4.4	A system is used to dispense medications in the right dose to the right patient at the right time.	(1) There is a uniform medication dispensing and distribution system in the organization.	4
COP.11.5	Patients are identified before medications are administered.	(1) Patients are identified before medications are administered.	2
COP.11.5.1	The right dose of medication is administered at the right time.	(1) Medications are verified with the prescription or order.	4
		(2) The dosage amounts of the medication are verified with the prescription or order.	4
		(4) Medications are administered on a timely basis.	4
		(5) Medications are administered as prescribed.	4
COP.11.6	Medication effects on patients are monitored.	(1) Medication effects are monitored.	4
COP.11.6.1	Medications prescribed and administered are written in the patient's record.	(1) Medications prescribed or ordered are recorded for each patient	4
		(3) Medication information is kept in the patient's record or inserted into his or her record at discharge or transfer.	4
COP.11.6.2	Adverse medication effects are noted in the patient's record.	(1) Monitoring includes observing adverse medication effects.	4
		(3) Adverse effects are documented in the patient's record.	4
COP.12	Food, appropriate for the patient and consistent with his or her clinical care is regularly available.	(1) Food, appropriate to the patient, is regularly available.	4
COP.12.1	All patients receive an order for food or other nutrients based on their nutritional status or need, including orders for nothing by mouth, a regular diet, a special diet, or parenteral or enteral tube nutrition.	(1) All patients have an order for food in their record.	4
		(2) The order is based on the patient's nutritional status and needs.	4

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## **FUNCTION: PATIENT AND FAMILY EDUCATION (PFE)**

### **Result Highlights**

- ⇒ There is no written document that outlines policies or procedures regarding patient education at NMMC. However, a verbally established procedure does exist for providing patient education at NMMC. According to this procedure, patient education is conducted after diagnosis.
- ⇒ Health providers at NMMC informally assess patient and family educational needs. However, there is no uniform process for doing so.
- ⇒ Patients and families at NMMC are initially educated about their health condition, treatment and financial issues. They are then educated about participation in care decisions and informed consent. Following their treatment, patients and families receive any education and training that is required for follow-up care. Depending on their needs, patients and families are educated about 1) the safe and effective use of medications and potential side effects, 2) safe and effective use of medical equipment, 3) interactions between medication and food, 4) appropriate diet and nutrition, and 5) rehabilitation techniques.
- ⇒ NMMC does not engage in any community-based health promotion or prevention activities.
- ⇒ Education methods are selected considering patient and family values and preferences. Efforts are made at NMMC to educate patients and families using a variety of formats and techniques. There are no formally established techniques or procedures that are used to determine the extent of the patient's comprehension of the information that they have been given.
- ⇒ Physicians provide most patient education at NMMC (as in all of Armenia). Nursing staff only provides education of a basic, ongoing nature. While the physicians can be considered to have adequate technical knowledge to provide education, the level of their communication skills is difficult to assess. Health providers at NMMC have not been formally trained in communication techniques. Providers have reported occasional problems communicating with patients, suggesting that there may be room for improvement in their communication skills.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFE.1	Education supports patient and family participation in care decisions and care process.	(1) The organization plans education consistent with its mission, services and patient population.	3
		(2) There is an appropriate structure or mechanism for education throughout the organization.	3
PFE.1.1	Each patient's education needs are assessed and recorded in his or her records.	(1) The patient's and family education needs are assessed.	3
		(2) Assessment findings are recorded in the patient's record.	1
		(3) There is a uniform process for recording patient education information.	1
PFE.1.2	Each patient and his or her family receive education to help them give informed consent, participate in care processes, and understand any financial implications of care choices.	(1) Patients and family learn about informed consent.	4
		(2) Patients and family learn about participation in care decisions.	4
		(3) Patients and families learn about participation in the care process.	4
		(4) Patients and families learn about any financial implications of care decisions.	4
PFE.2	Education and training help meet patient's ongoing health needs.	Patients and families receive education and training to meet their ongoing health needs or achieve their health goals.	4
PFE.2.1	The organization cooperates with available community resources to provide health promotion and disease prevention education.	The organization identifies and establishes relationships with community resources that support continuing health promotion and disease prevention education.	1
PFE.3	Patient and family education include the following topics, as appropriate to the patient's care: the safe use of medications, the safe use of medical equipment, potential	(1) When appropriate, patients and families are educated about the safe and effective use of medications and potential side effects of medications.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
	interactions between medications and food, nutritional guidance and rehabilitation techniques.	(2) When appropriate, patients and families are educated about safely and effectively using medical equipment.	4
		(3) When appropriate, patients and families are educated about preventing interactions between medications and food.	4
		(4) When appropriate, patients and families are educated about appropriate diet and nutrition.	4
		(5) When appropriate, patients and families are educated about rehabilitation techniques.	4
PFE.4	Education methods consider the patient's and family's values and preferences and allow sufficient interaction among the patient, family and staff for learning to occur.	(1) Education methods are selected on the basis of patient and family values and preferences.	4
		(2) Interaction among staff, the patient, and family confirms that the information was understood.	4
PFE.4.1	The patient and family are taught in a format and language that they understand.	The patients and families are taught in a format they understand.	3
PFE.4.2	Health professionals caring for the patient collaborate to provide education.	Patient and family education is provided collaboratively when appropriate.	4
PFE.4.2.1	These professionals have the knowledge and skills required for effective education.	Those who provide education have the knowledge and communication skills to do so.	4; 2

**Evaluation Score:**

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## FUNCTION: PATIENT FAMILY AND RIGHTS (PFR)

### **Result Highlights**

- ⇒ Laws and regulations in Armenia theoretically protect some patient and family rights (PFRs). However, these laws and regulations have not been enacted. NMMC leaders work to protect and advance selected patient rights, primarily by maintaining the accessibility of their services to the Armenian public. NMMC has established written policies and procedures that guide and support patient rights as they relate to payment for service and informed patient consent to undergo treatment. Other PFR policies and procedures are verbally established. A written document specifically describing patient rights at NMMC does not exist. NMMC staff verbally informs patients and their families about their rights.
- ⇒ Vulnerable groups have been identified in NMMC documents in terms of financial issues; for example, certain categories of patients are eligible for services free of charge. Elderly individuals have not been explicitly identified as a vulnerable group, although children (up to age 8) and disabled individuals (up to age 15) are considered to be members of vulnerable groups.
- ⇒ Patient values and beliefs are identified during preliminary conversations with nurses and physicians through an informal process. NMMC medical personnel provide care to patients according to their values and beliefs to the extent that it is possible. NMMC staff members interviewed on this issue were not able to clearly articulate their role in identifying and protecting patient and family values and beliefs and patient and family rights.
- ⇒ Issues of privacy are not given high priority at NMMC. However, if a patient or his or her family request private care or services at NMMC, staff members are respectful and act according to the patient's wishes.
- ⇒ Verbally established policy dictates that only physicians and nurses have access to clinical records. Safeguards have been established by computerizing patient-related information in password-protected files, limiting access to clinical records and by instilling a respectful attitude among NMMC staff toward the patient's need for privacy.
- ⇒ A variety of verbally established policies and procedures at NMMC promote patient and family participation in care processes. Patients have the right to choose their cardiologist/surgeon and to consult a second cardiologist within NMMC. The patient's will dictates the extent to which patients and families participate in care decisions. Following the diagnosis, the patient is informed about his or her condition and possible treatments so that s/he can make an informed decision regarding how to proceed. Patients at NMMC and their families are informed about their rights to refuse or discontinue treatment during the meeting with their cardiologist. Surgery is only carried out after the patient has signed an informed consent statement. Surgical patients are allowed to decide when they will be discharged, once their medical condition will allow them to safely leave the clinic. Patients at NMMC participate in the assessment and management of their pain along with the health professionals who care for them.

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#### **Evaluation Score:**

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- ⇒ NMMC has a verbally established set of policies and procedures that guide the informed consent process. The NMMC patient provides written consent before undergoing high-risk procedures such as surgery and intracardiac invasive procedures. A written list of procedures and treatments that require informed consent does not exist. A loosely defined verbal policy allows for consent to be granted by individuals other than the patient when the patient is a minor, or is unable or unwilling to make a decision by him or herself. The patient or the patient's surrogate documents consent by signing a consent statement in the patient's medical record. Special consent related to anesthesia or the use of blood or blood products is not obtained.
- ⇒ NMMC has not formally documented its position vis-à-vis the patient's rights regarding the use or withdrawal of life-sustaining procedures. The Armenian Constitution does not address the issue of the withdrawal of life-sustaining treatments and there are no laws in Armenia that apply to this topic. According to verbally established policies, the patient's family members can decide whether or not to put the patient on life-support. Once this decision is made it is irrevocable; neither physicians nor family members are allowed to withdraw the patient from such services. Decisions made by patients and their families with regards to this issue are not documented.
- ⇒ Patients and families appear to be generally aware that they have a right to voice complaints. Complaints are dealt with on the spot, as appropriate, and are reviewed during all-staff meetings of clinic staff. There are no written policies and procedures describing the process of filing a complaint, the participants in the process, and the manner in which the patient and his or her family participate in the process.
- ⇒ The education and training of NMMC staff members regarding their role in supporting the participation of the patient and his or her family in care processes is carried out informally as part of normal workday activities.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFR.1	The organization is responsible for providing process that support patients' and families' rights during care.	(2) The leaders understand patient and family rights as identified in laws and regulations.	2
		(3) The leaders work collaboratively to protect and advance patient and family rights.	3
		(5) Staff members can explain their responsibilities in protecting patient rights.	3
		(6) Policies and procedures guide and support patient and family rights in the organization.	2
PFR.1.1	The organization informs patients and families about its care and services and how to access those services.	(1) Patients are provided information on the care and services provided by the organization.	2
		(3) The information is provided to families, as appropriate.	4
		(4) Information on alternative sources of care and services is provided when the organization cannot provide the care or services.	4
PFR.1.2	Care is considerate and respectful of the patient's personal values and beliefs.	(1) There is a process to identify and respect patient values and beliefs.	3
		(2) Staff uses the process and provides care that is respectful of the patient's values and beliefs.	4
PFR.1.3	Care is respectful of the patient's need for privacy.	A patient's needs for privacy is respected for all examinations, procedures and treatments.	2
PFR.1.4	The organization takes measures to protect patient's possessions from theft and loss.	(1) The organization has determined its level of responsibility for patients' possessions.	1
		(2) Patients receive information about the organization's responsibilities for protecting personal belongings.	1
		(3) Patient's possessions are safeguarded when the organization assures responsibilities or when patient is unable to assure responsibility.	2
PFR.1.5	Patients are protected from physical assaults.	(1) The organization has a process to protect patients from physical assault.	2
		(2) Individuals without identification are investigated.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFR.1.6	Vulnerable children, disabled individuals, and elderly receive appropriate protection.	(1) The organization identifies its vulnerable patient groups.	4
		(2) Vulnerable children, disabled individuals, the elderly, and others identified by the organization are protected.	4
PFR.1.7	Patient information is confidential and protected from loss or misuse.	(2) Policies and procedures to prevent the loss of patient information are implemented.	3
		(3) Policies and procedures to prevent the misuse of patient information are implemented.	3
PFR.2	The organization supports patients' and families' rights to participate in the care process.	(1) Policies and procedures are developed to support and promote patient and family participation in care processes.	3
		(3) Staff members are trained on the policies and procedures and their role in supporting participation in care processes.	2
PFR.2.1	The organization informs patients and families how they will be told of medical conditions and treatments and how they can participate in care decisions, to the extent they wish to participate.	(1) Patients and families understand how and when they will be told of medical conditions.	4
		(2) Patients and families understand how they will be told of planned treatment.	4
		(3) Patients and families understand the process used to obtain consent.	4
		(4) Patients and families participate in care decisions to the extent they wish.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFR.2.2	The organization informs patients and families about their rights and responsibilities related to refusing or discontinuing treatment.	(1) The organization informs patients and families about their rights to refuse or discontinue treatment.	4
		(2) The organization informs patients and families about the consequences of their decisions.	4
		(4) The organization informs patients about available care and treatment alternatives.	4
PFR.2.3	The organization respects patient wishes and preferences to withhold resuscitative services and forgo or withdraw life-sustaining treatments.	(1) The organization has identified its position on withholding resuscitative services and forgoing or withdrawing life-sustaining treatments.	1
		(3) Policies and procedures guide the process for patients to make their decisions known to the organization and for modifying decisions during the course of care.	2
		(4) Policies and procedures guide the organization’s response to the patient decisions.	2
		(6) Documentation about decisions follows organization policy.	1
PFR.2.4	The organization has processes to assess and manage pain appropriately.	(1) The organization respects and supports the patient’s right to appropriate assessment and management of pain.	3
		(2) The organization identifies patients in pain during the assessment process.	4
		(3) The organization communicates with and provides education for patients and families about the pain and pain management.	4
		(4) The organization educates health professionals in assessing and managing pain.	3

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFR.4	The organization informs patients and families about how to gain access to clinical research, investigations, or clinical trials involving human subjects.	(1) Patients and families are informed about how to gain access to those research, investigations, or clinical trials relevant to their treatment needs.	4
		(2) Patients asked to participate are informed about expected benefits.	4
		(3) Patients asked to participate are informed about potential discomfort and risks.	4
		(6) Patients are assured that their refusal to participate or withdraw from participation will not compromise their access to the organization's services.	4
PFR.6	The organization informs patients and families about its process to receive and act on complaints, conflicts, and differences of opinion about patient care and the patient's right to participate in these processes.	(1) Patients are aware of their right to voice a complaint and the process to do so.	2
		(2) Complaints are reviewed according to the organization's mechanism.	2
		(4) Policies and procedures identify participants in the process.	1
		(5) Policies and procedures identify how the patient and family participate.	2
PFR.7	Staff members understand their role in identifying patient's values and beliefs and protecting patient's rights.	(1) Staff members understand their role in identifying patient and family values and beliefs and how such values and beliefs can be respected in the care process.	3
		(2) Staff members understand their role in protecting patient and family rights.	3
PFE.8	All patients are informed about their rights in a manner they can understand	(1) Each patient receives information about his or her rights in writing.	1
		(2) The organization has a process to inform patients of their rights when written communication is not effective or appropriate.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFR.9	Patient informed consent is obtained through a process defined by the organization and carried out by trained staff.	(1) The organization has a defined consent process described in policies and procedures.	3
		(3) Patients give informed consent consistent with the policies and procedures.	4
PFR.9.1	Patient and families receive adequate information about the illness, proposed treatment, and care providers so that they can make care decision.	(1) Patients are informed of their condition.	4
		(2) Patients are informed about the proposed treatment.	4
		(3) Patients are informed about the potential benefits and drawbacks to the proposed treatment.	4
		(4) Patients are informed about possible alternatives to the proposed treatment.	4
		(5) Patients are informed about the likelihood of successful treatment.	4
		(6) Patients are informed about possible problems related to recovery.	4
		(7) Patients are informed about the possible results of non-treatment.	4
PFR.9.1.1	The information is provided in a way and language understood by those making the care decision.	(9) Patients know the identity of the physician or other practitioner responsible for their care.	4
		(1) The information is provided to the patient in a clear and understandable way.	4
PFR.9.2	The organization establishes a process, within the content of existing law and culture, for when other can grant consent.	(1) The organization has a process for when others can grant informed consent.	2
PFR.9.2.1	When someone other than the patient gives the informed consent, that individual is noted in the patient's record.	(1) Individuals, other than patient, granting consent are noted in the patient's record.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PFR.9.4	Informed consent is obtained before surgery, anesthesia, use of blood and blood products, and other high-risk treatments and procedures.	(1) Consent is obtained before surgical or invasive procedures.	4
		(2) Consent is obtained before anesthesia.	1
		(3) Consent is obtained before use of blood and blood products.	1
		(4) Consent is obtained before other high-risk procedures and treatments.	4
		(5) The identity of the individual providing the information to the patient and family is noted in the patient's record.	3
PFR.9.4.1	The organization lists those categories or types of treatments and procedures that require specific informed consent.	(1) The organization has listed those procedures and treatments that require separate consent.	1
		(2) The list was developed collaboratively by those who provide the treatments and perform the procedures.	N/A
PFR.9.6	The patient's signature or other indication of all types of consent is documented in his or her record.	(1) Consent is documented in the patient's clinical record by signature or record of verbal consent.	4
PFR.10	The organization provides patient care within business, financial, ethical, and legal norms that protect patients and their rights.	(1) Organization leaders establish ethical and legal norms that protect patients and their rights.	2
PFR.10.1	The organization's mission statement is made public.	(1) The leaders make public the organization's mission statement.	1
PFR.10.2	The organization has established and implemented a framework for ethical management that includes marketing, admission, transfer, and discharge, and disclosure of ownership and any business and professional conflicts that may not be in the patients' best interests.	(3) The organization honestly portrays its services to patients.	4
		(5) The organization accurately bills for its services.	4
		(6) The organization discloses and resolves conflicts when financial incentives and payment arrangements compromise patient care.	N/A

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## FUNCTION: FACILITY MANAGEMENT AND SAFETY (FMS)

### **Result highlights**

- ⇒ Due to the deterioration of civil codes and transformations in the Armenian health system, there is little documentation regarding laws, regulations, and other requirements for facility management and safety as they apply to NMMC. NMMC does not have a documented plan to guide facility management and safety. Although verbally established plans guide the systematic inspection and maintenance of the facility, the results of these actions are not consistently documented. Twelve to fourteen percent of the NMMC budget is allocated for socioeconomic expenditures, a budget category that includes facility management and safety.
- ⇒ There is no documented program for fire management at NMMC nor is there a fire and smoke safety evacuation plan. Locations at NMMC that are potentially flammable are regularly inspected, tested and maintained, although the results of this maintenance and monitoring are generally not documented. Fire extinguishers have been placed in key positions in the facility and a safe oxygen carrying system has been installed. A fire alarm system has not been installed due to financial constraints. NMMC maintains constant contact with the local fire stations. NMMC has five safe exits that can be used for evacuations in the event of emergencies, but information about these exits and ways to reach them is not clearly elucidated for staff, patients and visitors.
- ⇒ A written policy or plan to eliminate or limit smoking within the NMMC facility does not exist. Certain areas have been designated as smoke-free while smoking is permitted in other areas.
- ⇒ A formal plan regarding how NMMC would respond to community emergency epidemics and natural or other disasters does not exist. The clinic staff's response to such an emergency has not been tested in the past 5 years. NMMC is equipped with a 30-kilowatt power generator and medical equipment that functions with alternate sources of power to guard against a power failure. Emergency medical supplies are available at NMMC and surgical and cardiology staff carries pagers to maintain communication with the hospital 24 hours a day.
- ⇒ NMMC does not have a written plan on the management of hazardous materials and waste. NMMC officials have identified hazardous or potentially harmful chemicals and materials that are used at the Center. Chemicals and wastes are disposed of appropriately at NMMC, although staff reports that waste management in the operating rooms can be improved. Reagents and supplies of radiology and laboratory services are handled, stored and used according to designated requirements.
- ⇒ NMMC does not have a written plan for the management of medical equipment. Equipment is maintained, inspected and tested by NMMC engineers according to instructions provided by the manufacturers. The inventory of medical equipment at NMMC has not been updated recently. Although the current inventory is not up to date, NMMC engineers know which equipment are currently in use and tests them at appropriate intervals.
- ⇒ NMMC has made provisions to ensure 24-hour availability of potable water and electricity. Water is supplied by the Yerevan municipality and is backed up by a 40 thousand ton facility reservoir. NMMC is supplied with 24-hour electrical power by two electrical power stations. Electrical backup is provided by the facility's own 30-kilowatt generator. The electrical system, including the power generator, is inspected daily while water quality is inspected on a monthly basis.

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### **Evaluation Score:**

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⇒ NMMC does not have a written education plan for any of the components of facility management and safety. In addition, the facility lacks a formal training and testing program for staff members regarding the maintenance of a safe and effective facility. However, NMMC leaders feel that staff members there can effectively carry out their FMS-related responsibilities based on their education, skills and experience.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
FMS.1	The organization complies with relevant laws, regulations and facility inspection requirements.	(1) The organization leaders know what laws, regulations, and other requirements apply to the organization’s facilities.	3
		(2) The leaders implement the applicable requirements or approved alternatives.	3
		(3) The leaders ensure the organization meets the condition of facility inspection reports or citations.	3
FMS.1.1	The organization plans and budgets for upgrading or replacing key systems, building, or components.	The organization plans and budgets for upgrading or replacing the systems, building, or components needed for the continued operation of a safe and effective facility.	4
FMS.3.1	The plan includes prevention, early detection, suppression, abatement and safe exit from the facility in response to fires and non-fire emergencies.	(1) The program includes the reduction of fire risks.	3
		(3) The program includes the early detection of fire and smoke.	3
		(4) The program includes the abatement of fire and containment of smoke.	4
		(5) The program includes the safe exit from the facility when fire and non-fire emergencies occur.	3
FMS.3.2	The organization regularly tests its fire and smoke safety plan, including any devices related to early detection and suppression, and documents the results.	(1) Fire detection and abatement systems are inspected, tested, and maintained at a frequency determined by the organization.	N/A
		(2) The fire and smoke safety evaluation plan is tested at least twice per year.	1
		(3) Staff is trained to participate in the fire and smoke safety plan.	1
		(5) Inspection, testing and maintenance of equipment and systems are documented.	1
FMS.3.3	The organization develops and implements a plan to limit smoking by staff and patients to designated not patient care areas of the facility.	(1) The organization has implemented a policy and plan to eliminate and limit smoking.	3
		(2) The plan applies to patients, families, visitors and staff.	3
		(3) There is a process to grant patient exceptions to the plan.	3

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
FMS.4	The organization develops a plan to respond to likely community emergencies, epidemics, and natural or other disasters.	The organization plans its response to likely community emergencies, epidemics, and natural or other disasters.	2
FMS.4.1	The organization has tested its response to emergencies, epidemics and disasters.	The plan is tested.	1
FMS.4.2	The organization has access to any medical supplies, communication equipment and other materials to support its response to emergencies, epidemics and disasters.	(1) Medical supplies are available in emergencies.	4
		(2) Communication equipment is available in emergencies.	4
FMS.5	The organization has a plan for the inventory, handling, storage and use of hazardous materials and the control and disposal of hazardous materials and waste.	(1) The organization identifies hazardous materials and waste.	3
		(2) Hazardous materials and waste are managed according to the plan.	N/A
		(3) The plan includes safe handling, storage and use.	4
		(4) The plan includes reporting and investigation of spills, exposures and other incidents.	3
		(5) The plan includes the proper disposal of hazardous waste.	3
		(8) The plan includes labeling hazardous materials and waste.	4
FMS.6	One or more qualified individuals oversee the planning and implementation of the program to provide a safe and effective physical facility.	(1) The program oversight and direction are assigned to one or more individuals.	4
		(2) The individual(s) is qualified by experience and training.	4
FMS.7	The organization plans and implements a program for inspecting, testing, and maintaining medical equipment and documenting results.	(1) Medical equipment is managed throughout the organization according to the plan.	2
		(2) There is an inventory of all medical equipment.	2
		(3) Medical equipment is regularly inspected.	4
		(4) Medical equipment is tested when new and as appropriate thereafter.	4
		(5) There is a preventive maintenance program.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
FMS.8	Potable water and electrical power are available 24 hours a day, seven days a week, through regular or alternate sources, to meet essential patients care needs.	(1) Potable water is available 24 hours a day, seven days a week.	4
		(2) Electric power is available 24 hours a day, seven days a week.	4
FMS.9	Electrical, water, waste, ventilation, medical gas and other key systems are regularly inspected, maintained, and when appropriate improved.	(1) Utility systems are regularly inspected.	4
		(3) Utility systems are regularly maintained.	4
FMS.9.1	Designated individuals or authorities monitor water quality regularly.	(1) Water quality is monitored regularly.	4
		(2) An individual(s) or agency is assigned responsibility for monitoring.	4
FMS.10	The organization educates and trains all staff members about their roles in providing a safe and effective patient care facilities.	For each component of the organization’s facility management and safety program there is a planned education to ensure that staff members can effectively carry out their responsibilities.	3
FMS.10.1	Staff members are trained and knowledgeable about their roles in the organization’s plans for their fire safety, security, hazardous materials and emergencies.	(1) Staff members can describe and/or demonstrate their role in the response to a fire.	2
		(4) Staff members can describe and/or demonstrate procedures and their role in internal and community emergencies and disasters.	2
FMS.10.2	Staff is trained to operate and maintain medical equipment and utility systems.	(1) Staff is trained to operate medical equipment.	4
		(2) Staff is trained to maintain medical equipment.	3
FMS.10.3	The organization periodically tests staff knowledge through demonstration, mock events, and other suitable methods. This testing is then documented.	(1) Staff knowledge is tested regarding their role in maintaining a safe and effective facility.	2
		(2) Staff training and testing are documented as to who was trained and tested and the results.	1

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## **FUNCTION: GOVERNANCE, LEADERSHIP, AND DIRECTION**

### **Result highlights**

- ⇒ Governance responsibilities and accountabilities are described in detail in a written document. NMMC is under the governance of the municipality and its health department, the Ministry of Health, and the Health Agency. The Mayor of the City of Yerevan has appointed the general manager of the hospital, Dr. Lida Mouradian, who is a physician. Dr. Mouradian is responsible for managing the organization's day-to-day operations, as well as all human, financial and other resources. In addition, she ensures that the organization is in compliance with applicable rules and regulations, represents the organization in Armenia and abroad, and responds to any reports from inspecting and regulatory agencies. There is close collaboration between management and the clinical leadership in formulating the mission at NMMC, and in developing policies and procedures to carry out the organization's mission.
- ⇒ Those responsible for hospital governance approve the organization's mission, the policies and plans to operate the organization, and the budget and resources required to meet the organization's mission. However, this process of approval is only a matter of formality, as those responsible for governance play no active role in formulating the organization's strategic and management plans and policies.
- ⇒ There appears to be an organizational structure and mode of operation at the hospital that is conducive to intra and inter-departmental communication and coordination/integration of services. However, there is no written documentation describing this structure (e.g., organizational chart), or identifying the individuals in their respective position(s). Similarly, there are no written protocols or criteria for staff recruitment, and continuing education of the staff.
- ⇒ The concept of quality management and improvement is novel in Armenia, and is not integrated as part of the health professionals' educational curriculum. However, the clinical leadership and staff at NMMC have come to develop and integrate such concepts through their day-to-day problem-solving activities. One great example is that of the Infection Control Program, aimed at reducing the rate of post-surgical infections.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
GLD.1	Governance responsibilities and accountabilities are described in bylaws policies and procedures, or similar documents that guide how they are to be carried out.	(1) The organization's governance structure is described in written documents.	4
		(2) Governance responsibilities and accountabilities are described in the document.	4
		(3) There is an organization chart or document.	1
		(4) Those responsible for governing and managing are identified by title or name.	3
GLD.1.1	Those responsible for governance approve the organization's mission statement.	Those responsible for governance approve the organization's mission.	1
GLD.1.2	Those responsible for governance approve the policies and plans to operate the organization.	Those responsible for governance approve the organization's strategic and management plans and operating policies.	1
GLD.1.3	Those responsible for governance approve the budget and allocate the resources required to meet the organization's mission.	(1) Those responsible for governance approve the organization's budget.	2
		(2) Those responsible for governance allocate the resources required to meet the organization's mission.	2
GLD.1.4	Those responsible for governance appoint the organization's senior manager(s) or director(s).	Those responsible for governance appoint the organization's senior manager or leader.	3
GLD.1.5	Those responsible for governance support and promote quality management and improvement efforts.	Those responsible for governance support and promote quality management and improvement.	2
GLD.1.6	Those responsible for governance collaborate with the organization's managers and leaders.	Those responsible for governance use processes that provide communication and cooperation between governance and management.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
GLD.2	A senior manager or director is responsible for operating the organization and complying with applicable laws and regulations.	(1) The senior manager or director manages the organization's day-to-day operations.	4
		(2) The senior manager or director has the education and experience to carry out his or her responsibilities.	4
		(4) The senior manager or director carries out approved policies.	4
GLD.2	A senior manager or director is responsible for operating the organization and complying with applicable laws and regulations	(5) The senior manager or director ensures compliance with applicable laws and regulations.	4
		(6) The senior manager or director responds to any reports from inspecting and regulatory agencies.	4
		(7) The senior manager or director manages human, financial and other resources.	4
GLD.3	The organization's clinical and managerial leaders are identified and are collectively responsible for defining the organization's mission and creating the plans and policies needed to fulfill the mission.	(1) The leaders of the organization are formally or informally identified.	4
		(2) The leaders are collectively responsible for defining the organization mission.	4
		(3) The leaders are responsible for creating the policies and procedures necessary to carry out the mission.	4
		(4) The leaders work collaboratively to carry out the organization's mission and policies.	4
GLD.3.1	Organization leaders plan with the community leaders and leaders of other organizations to meet the community health care needs.	The organization's leaders plan with recognized community leaders.	N/A
GLD.3.2	The clinical leaders identify and plan for the type of services required to meet the needs of the patients served by the organization.	(1) The organization plans describe the care and services to be provided.	1
		(2) The care and services to be offered are consistent with the organization's mission.	4
		(3) Clinical leaders determine the type of care and services to be provided by the organization.	4

**Evaluation Score:**

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
GLD.3.4	The medical, nursing and other leaders are educated in concept of quality management and improvement.	(1) Medical, nursing and other leaders are educated in concept of quality management and improvement.	2
		(2) Medical, nursing and other clinical leaders participate in relevant quality management and improvement processes.	4
GLD.3.5	Organization leaders ensure that there are uniform programs for the recruitment, and continuing education of the staff.	(1) There is a planned process for staff recruitment.	2
		(2) There is a planned process for staff retention.	2
		(3) There is a planned process for staff personnel development and continuing education.	2
		(4) The planning is collaborative and includes all departments and services in the organization.	2
GLD.3.6	The leaders foster communication and coordination among those individuals and departments responsible for providing clinical services.	(1) Leaders foster communication among departments, services and individual staff members.	4
		(2) Leaders foster coordination of clinical services.	3
GLD.4	Medical, nursing and other clinical leaders plan and implement an effective organizational structure to support their responsibilities and authority.	There is an effective organizational structure used by medical, nursing and other Clinical leaders to carry out their responsibilities and authority.	1
GLD.4.1	The organizational structure and processes support professional communication.	The organizational structure and processes support professional communication.	4
GLD.4.3	The organizational structure and processes support the oversight of professional clinical issues.	The organizational structure(s) and processes support oversight of professional ethical issues.	2
GLD.4.4	The organizational structure and process support the oversight of the quality of clinical services.	The organizational structure(s) and processes support oversight of the quality of clinical services.	3

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
GLD.5	One or more qualified individuals provide direction for each department or service in the organization.	(1) An individual with appropriate training, education and experience directs each department or service in the organization.	3
		(2) When more than one individual provides direction the responsibilities of each are defined in writing.	3
GLD.5.1	Directors identify in writing the services to be provided by the department.	(1) Documents describe the services provided by each department or service.	1
		(2) Each department's or service's policies and procedures guide the provision of identified services.	1
		(3) Each department's or service's policies and procedures address the staff knowledge and skills needed to assess and meet patient needs.	1
GLD.5.1.1	Services are coordinated and integrated within the department or services and with other departments and services.	(1) There is coordination and integration of services within each department and service.	4
		(2) There is coordination and integration of services with other departments and services.	4
GLD.5.2	Directors recommend space, staffing and other resources needed by the department or service.	(1) Directors recommend staff needed to provide services.	4
		(2) Directors recommend other special resources needed to provide services.	4
GLD.5.3	Directors recommend criteria for selecting the department or service's professional staff and choose individuals who meet those criteria.	The director develops and when required, submits for endorsement criteria related to education, skills knowledge and experience of professional staff.	2
GLD.5.4	Directors provide orientation and training for all staff of department or service.	The director has established an orientation for department staff.	4

**Evaluation Score:**

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## FUNCTION: MANAGEMENT OF INFORMATION

### **Result highlights**

- ⇒ Although there is no written plan on management of information, NMMC has the ability to produce reports that include clinical, financial, and utilization data that are used for quality improvement, management, planning, academic evaluation activities, or to share with outside organizations. These data and information are integrated in clinical and managerial meetings and provide a basis for decision-making in governance and leadership. The area of management information is supported by programmers, analysts, and a multidisciplinary team that provides input from managerial, as well as clinical areas of the hospital.
- ⇒ A clinical record is initiated for every patient upon admission, and encounter forms that are originated from each of the departments rendering care to the patient are added to the record. The content of the latter forms has been specified by the organization. The records include sufficient information to support diagnosis, course of treatment, and its results. However, the patient records do not include justification of treatment of care. The quality of these records has not been assessed, as there is no established process to review records.
- ⇒ Patient records are accessible to health care providers every time the patient is seen for follow-up care and treatment. In addition, patient-specific data are accessible 24 hours a day.
- ⇒ Patient confidentiality is generally not well protected in Armenia. However, the staff at NMMC adheres to a strict policy of keeping all patient-specific information in securely locked cabinets and areas, and computers that can be accessed only by authorized personnel, both to make entries, and to retrieve data. Such steps are aimed at protecting records against loss, tampering, and unauthorized access. Further improvement in this area can be made by developing well-defined hospital-wide policies and by communicating them to the staff in writing. In addition, further enhancement can be made to the computer systems to protect the data against potential intruders.
- ⇒ Current medical information is available to physicians through scientific journals to support clinical education. However, there is little or no information to support patient (nursing) care or management.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
MOI.1	The organization plans and implements processes to meet patient needs of all those who provide clinical services, those who manage the organization, and those outside the organization who require data and information from the organization.	(2) The information needs of those who provide clinical services are considered in the planning process.	4
		(3) The information needs of those who manage the organization are considered in the planning process.	4
		(4) The information needs and requirements of individuals and agencies outside the organization are considered in the planning process.	4
MOI.1.1	The organization has planned to meet information needs.	An information plan is developed and implemented in the organization.	2
MOI.1.2	The plan is based on an assessment of the needs of those within and outside the organization.	(1) Strategies are implemented to meet information needs of those who provide clinical services.	4
		(2) Strategies are implemented to meet information needs of those who manage the organization.	4
MOI.1.4	The plan includes how the confidentiality, security, and integrity of data and information will be maintained.	(1) The plan includes how confidentiality of data and information will be maintained.	2
		(2) The plan includes how security of data and information will be maintained.	3
		(3) The plan includes how the integrity of data and information will be maintained.	3
MOI.1.5	The plan defines the level of security.	(1) The plan identifies the level of security for each category of data and information.	3
		(2) The plan identifies those who have need or job position that permits access to each category of data and information.	3
MOI.1.5.1	Organization policy identifies those authorized to make entries in the patient medical record and determines the record's content and format.	Those authorized to make entries in the patient clinical record are identified in organization policy.	3
MOI.1.5.2	Only authorized providers make entries in the patient clinical record.	There is a process to ensure that only authorized individuals make entries in patient clinical records.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
MOI.1.6	The organization has a policy on the retention time of records, data, and information.	(1) The organization has a policy on retaining patient clinical records and other data and information.	2
		(2) The retention process provides expected confidentiality and security.	3
		(3) Records, data, and information are destroyed appropriately.	N/A
MOI.1.7	The plan is implemented and supported by sufficient staff and other resources.	Sufficient staff support the implementation.	4
MOI.1.8	The organization uses standardized diagnosis codes, procedure codes, symbols, and definitions.	Standardized diagnosis codes are used.	4
MOI.1.9	The data and information needs of those in and outside the organization are met on a timely basis in a format that needs user expectations and with the desired frequency.	(1) Data and information dissemination meets user needs.	4
		(2) Users receive data and information on a timely basis.	4
		(3) Users receive data in a format that aids its intended use.	4
MOI.1.10	Appropriate clinical and managerial staff participates in selecting, integrating, and using information management technology.	(1) Clinical staff participates in information technology decisions.	4
		(2) Managerial staff participates in information technology decisions.	4
MOI.1.12	Records and information are protected from loss, destruction, tampering, and unauthorized access or use.	(1) Records and information are protected from loss and destruction.	3
		(2) Records and information are protected from tampering and unauthorized access or use.	3
MOI.1.13	Clinical and managerial information is integrated to support the organization's governance and leadership.	Clinical and managerial data and information are integrated as needed to support decision-making.	4
MOI.1.14	Decision-makers and other appropriate staff members are educated and trained in the principles of information management.	The education is appropriate to needs and job responsibilities.	4
MOI.2	The organization initiates and maintains a clinical record for every patient assessed or treated.	A clinical record is initiated for every patient assessed or treated by the organization.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
MOI.2.1	The clinical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results of treatment, and promote continuity of care among health care providers.	(1) Patient clinical records contain adequate information to identify the patient.	4
		(2) Patient clinical records contain adequate information to support the diagnosis.	4
		(3) Patient clinical records contain adequate information to justify the care and treatment.	2
		(4) Patient clinical records contain adequate information to document the course and results of treatment.	3
		(5) The specific content of patient clinical records has been determined by the organization.	4
MOI.2.1.1	The clinical record of every patient receiving emergency care include the time of arrival, the conclusions at termination, the patient's condition at discharge, and follow-up care instructions.	(1) The clinical records of emergency patients include arrival time.	4
		(2) The clinical records of emergency patients include conclusions at the termination of treatment.	4
		(3) The clinical records of emergency patients include the patient's condition at discharge.	4
		(4) The clinical records of emergency patients include any follow-up care instructions.	4
MOI.2.2	As part of its performance improvement activities, the organization regularly assesses patient clinical record content and the completeness of patient clinical records.	(1) Patient clinical records are reviewed regularly.	1
		(2) The review focuses on the timeliness legibility, and completeness of the clinical record.	N/A
MOI.2.3	Health care providers have access to the information in a patient's clinical record each time the patient is seen for a new or continuing care episode.	Care providers have access to the patient's clinical record each time the patient is seen for care or treatment.	4
MOI.3	Aggregate data and information support patient care, organization management and the quality management program.	(1) Aggregate data and information support patient care.	4
		(2) Aggregate data and information support organization management.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
MOI.3.2	The organization supports patient care, education, research, management with timely information from current sources.	(1) Current scientific and other information supports patient care.	1
		(2) Current scientific and other information supports clinical education.	4
		(3) Current scientific and other information supports research.	4
		(4) Current professional and other information supports management.	1
MOI.3.2.2	The organization uses external reference databases for comparative purposes.	The organization compares its performance using external reference databases.	4

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## FUNCTION: PREVENTION AND CONTROL OF INFECTIONS (PCI)

### **Result highlights**

- ⇒ There is a comprehensive infection control program (ICP) at NMMC. The ICP is based on current scientific knowledge and Armenian laws and regulations but not on accepted practice guidelines. The ICP not only meets all governmental requirements but also contains additional provisions that have been developed by NMMC personnel. Medical staff, including nurses, is involved in infection control activities at NMMC. There are no written documents that describe the ICP in detail. Management information systems at NMMC provide ample support to the ICP. Some aspects of the ICP are not implemented as planned.
- ⇒ Clinical leaders, in a collaborative process, have established the infection types, infection sites and associated devices that are focused on by the ICP in order to minimize the incidence of nosocomial infections. Nosocomial infection risks, rates and trends are tracked at NMMC through a computerized database. These data have been used to identify processes that are associated with a high risk of infection. Strategies and procedures to minimize the risk of infection have subsequently been implemented.
- ⇒ Modern techniques of equipment cleaning and sterilization are used at NMMC to reduce the risk of nosocomial infections. The disposal of infectious waste and body fluids is accomplished at NMMC based on established procedures that staff feel should be improved. Established procedures designed to reduce the incidence of nosocomial infections guide the handling and disposal of blood and blood components, the disposal of sharps and needles at NMMC, and the management of post-surgery patients. NMMC has clearly identified situations for which gloves and/or masks are required. Areas where hand washing and disinfecting procedures are required have also been identified.
- ⇒ The Sanitary-Epidemiology Station (SES) of the MOH identifies sites from which specimens are to be collected (to test for agents that might cause infection). The SES also determines the frequency of specimen collection. NMMC staff identifies and collects specimens from additional sites that they feel are likely to harbour infection.
- ⇒ A Fellow in Cardiac Surgery oversees many components of the ICP. This individual has a medical degree but feels that his training is insufficient to oversee the ICP, given the scope and complexity of the program.
- ⇒ The ICP covers many physical areas in the facility. The operating rooms, ICU and catheterization laboratory are considered to be the most important areas in this program.
- ⇒ All staff at NMMC is oriented to the policies, procedures, and practices of the infection control program. The orientation is informal and is based on transferring the knowledge needed by a given staff person so that they can carry out their assignment while minimizing the risk of infection. The thoroughness of the orientation varies among departments. Periodic staff education on issues related to the ICP is not provided at NMMC. Significant trends in infection data are conveyed to staff informally.
- ⇒ NMMC provides informal education regarding the prevention of infection to patients and their families. Some printed materials regarding infection control are available to patients.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PCI.1	The organization designs and implements a coordinated program to reduce the risks of nosocomial infectious in patients and health care workers.	(1) There is a program to reduce the risk of nosocomial infections in patients and health care workers.	3
PCI.1.1	All patient, staff, and visitor areas of the organization are included in the infection control program.	(1) All areas of the organization are included in the infection control program.	3
PCI.2	The organization establishes the focus on the nosocomial infection prevention and reduction program.	(1) The organization has established the focus of the program to prevent or reduce the incidence of nosocomial infections.	4
		(2) Respiratory tract infections are included as appropriate to the organization.	4
		(4) Intravascular invasive devices are included as appropriate to the organization.	4
		(5) Surgical wounds are included as appropriate to the organization.	4
PCI.3	The organization identifies the procedures and processes associated with the risk of infection and implements strategies to reduce infection risk.	(1) The organization has identified those processes associated with infection risk and implemented strategies to reduce infection risk in those processes.	4
		(2) Equipment cleaning and sterilization are included as appropriate to the organization.	4
		(3) Laundry and linen management are included as appropriate to the organization.	4
		(4) Disposal of infectious waste and body fluids is included as appropriate to the organization.	4
		(5) The handling and disposal of blood and blood components are included as appropriate to the organization.	4
		(6) Kitchen sanitation and food preparation and handling are included as appropriate to the organization.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
		(7) Operation of the mortuary and post-mortem area are included as appropriate to the organization.	N/A
		(8) Disposal of sharps and needles is included as appropriate to the organization.	4
		(10) The management of the hemorrhagic patients is included as appropriate to the organization.	4
PCI.4	Gloves, mask, soap, and disinfectants are available and used correctly when required.	(1) The organization identifies those situations for which gloves and/or masks are required.	4
		(3) The organization identifies those areas where hand washing and disinfecting procedures are required.	4
PCI.5	Cultures are routinely obtained from designed sites in the organization associated with significant infection risk.	(1) The organization identifies those sites from which specimens are to be collected and the frequency of the collection from each site.	4
		(2) Specimens are routinely collected.	4
PCI.6	One or more individuals oversee all infection control activities.	(1) One or more individuals oversee the infection control program.	3
		(2) The individuals are qualified for the scope and complexity of the program.	2
PCI.8	Coordination of infection control activities involves medicine, nursing, and others as appropriate to the organization.	(1) Coordination of infection control activities involves medicine.	4
		(2) Coordination of infection control activities involves nursing.	4
PCI.9	The infection control program is based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.	(1) The infection control program is based on current scientific knowledge.	4
		(2) The infection control program is based on accepted practice guidelines.	1
		(3) The infection control program is based on applicable laws and regulations.	4

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
PCI.10	Organization information management systems support the infection control program.	(1) Information management systems support the infection control program.	4
PCI.11	The infection control process is integrated with the organization's overall program for quality management and improvement.	(1) Infection control activities are integrated into the organization's quality management and improvement program.	2
PCI.11.1	The organization tracks infection risks, infection rates, and trends in nosocomial infections.	(1) Nosocomial infection risks are tracked.	4
		(2) Nosocomial infection rates are tracked.	4
		(3) Nosocomial infection trends are tracked.	4
PCI.11.3	The organization uses risk, rate, and trend information to design or modify processes to reduce nosocomial infections to the lowest possible level.	(1) Processes are redesigned based on risk, rate and trend data and information.	4
		(2) Processes are redesigned to reduce infection risk to the lowest levels possible.	4
PCI.11.4	The organization compares its infection control rates with other organizations through comparative databases.	(1) Infection control rates are compared to other organizations' rates.	2
PCI.11.5	The results of infection monitoring in the organization are regularly communicated to staff, doctors and management.	(1) Monitoring results are communicated to the medical staff.	2
		(2) Monitoring results are communicated to nursing staff.	2
		(3) Monitoring results are communicated to management.	4
PCI.11.6	The organization reports information on infections to appropriate external public health agencies.	(1) Infection control results are reported to public health agencies as required.	N/A
PCI.12	The organization provides education on infection control practices to staff, doctors, patients, and as appropriate, family and other care givers.	(1) The organization provides education about infection control program.	2
		(2) Medical, nursing and other professional staff are included in the program.	2
		(3) Patients and families are included when appropriate to the patient's needs and condition.	4

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<b>Standard #</b>	<b>Standard</b>	<b>Measurable Element</b> (# of measurable element)	<b>Evaluation Score</b>
PCI.12.1	All staff receives an orientation to the organization's infection control program.	(1) All staff is oriented to the policies, procedures, and practices of the infection control program.	3
PCI.12.2	All staff is educated in infection control when new policies are implemented and when significant trends are noted in surveillance data.	(1) Periodic staff education includes new policies and procedures.	1
		(2) Periodic staff education is in response to significant trends in infection data.	1

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## FUNCTION: QUALITY MANAGEMENT AND IMPROVEMENT (QMI)

### **Result highlights**

- ⇒ NMMC does not have a formal, explicit, documented Quality Management and Improvement (QMI) program. Formal processes do not exist for planning and implementing projects designed to improve the quality of care. There is little meaningful documentation of improvements in the quality of care at NMMC. However, various individuals and departments at NMMC do implement activities that could be categorized as “QMI activities”. A committee of individuals who govern and lead at NMMC—informally known as the “Politburo”—deals with and loosely coordinates QMI issues on a regular basis. QMI activities appear to impact policy at NMMC but are not a recognized source of information for strategic planning.
- ⇒ Monitoring activities constitute an essential aspect of QMI in any institution. Information received from NMMC staff suggests that monitoring activities could be strengthened in the areas of financial management, supply and medication procurement, patient assessment, medication use, the use of blood and blood products, anesthesia, risk management, and accident prevention. Monitoring activities appear to be strong in the areas of surgical procedures, infection surveillance, patient satisfaction, antibiotic use, patient demographics and diagnoses, and the reporting of activities as required by law and regulation.
- ⇒ NMMC leaders have identified certain activities, such as decreasing mortality rates and post-surgery complication rates and improving the financial situation of the Center, as areas of priority concern. NMMC has established which adverse events are significant and has developed a process to analyze adverse events in order to pinpoint their causes and identify solutions.
- ⇒ Examples exist where NMMC has defined and measured indicators in order to determine whether newly designed or revised processes result in an improvement in the quality of care. Indicators such as the rate of post-surgical infectious complications have been constructed and evaluated in order to both define the extent of a problem as well as to measure how well a new process operates.
- ⇒ The levels of key indicators at NMMC are compared within the organization over time in order to monitor trends. Comparisons are also made between indicator levels at NMMC and at selected cardiac centers in the West and in the CIS region. In addition, indicator levels at NMMC are compared with levels at other cardiac centers through two pediatric registries. There are no institutions in Armenia that are similar enough to NMMC so as to permit meaningful comparisons.
- ⇒ Although staff at NMMC have not been formally trained in the principles of QMI, some key principles are followed in the conduct of informal QMI activities there, such as: 1) focusing on faulty processes, not employees, as the sources of problems, 2) group approach to solving problems with the involvement in employees who are in charge of enacting changes, and 3) the development and measurement of indicators of quality to assess current and post-intervention levels of quality.
- ⇒ Financial resources for quality improvement do not constitute an established line in the NMMC budget, but essential expenditures are made when necessary in order to achieve improvement in priority areas. The NMMC does not have enough adequate financial resources to hire staff to monitor QMI activities. For this reason, existing staff members gather and analyze QMI data themselves.

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### **Evaluation Score:**

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⇒ Leaders at NMMC recognize the need to improve the management information system at NMMC to support QMI and other activities.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
QMI.1	Those responsible for governing and leading the organization participate in planning and monitoring a quality management and improvement program.	Those who govern and lead participate in planning and monitoring the quality management and improvement program.	2
QMI.1.1	The organization’s clinical and managerial leaders collaborate to plan and carry out the quality management and improvement program.	(1) Clinical leaders participate to plan and carry out the quality management and improvement program.	3
		(2) Managerial leaders participate to plan and carry out the quality management and improvement program.	2
QMI.1.1	There is a written plan for the organization wide quality management and improvement program.	There is a written plan for the quality management and improvement program.	1
QMI1.1.2	The program includes all components of the organization's quality monitoring and control activities, including risk management.	The program includes all components of the organization’s quality monitoring and control activities.	2
QMI.1.3	The leaders provide technological and other support to the quality management and improvement program.	(1) The leaders understand the technology and other support requirements for tracking and comparing monitoring results.	4
		(2) The leaders provide technology and support, consistent with the organization’s resources, for tracking and comparing monitoring results. 1.	4
QMI.1.4	The quality management and improvement program is coordinated, and program information is communicated to staff.	(1) The organization’s quality management and improvement program is coordinated	2
		(2) Information on the program is communicated to staff regularly.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
QMI.2	The organization designs new and modified systems and processes according to quality improvement principles.	Quality improvement principles and tools are applied to the design of new or modified processes.	3
QMI.2.2	The organization sets expectations for how new and modified processes should operate.	Indicators are selected to measure how well the newly designed or redesigned process operates.	3
QMI.2.3	The organization collects data to see if new and modified processes meet operational expectations.	Indicator data used to evaluate the operation of the process.	4
QMI.3	The organization's leaders identify key measures (indicators) to monitor the organization's clinical and managerial structures, processes, and outcomes.	(1) The leaders identify key measures to monitor clinical areas.	3
		(2) The leaders identify key measures to monitor managerial areas.	2
QMI.3.1	Clinical monitoring includes patient assessment.	Clinical monitoring includes patient assessment.	2
QMI.3.2	Clinical monitoring includes laboratory and radiology safety and quality control programs.	Clinical monitoring includes laboratory and radiology safety and quality control programs.	3
QMI.3.3	Clinical monitoring includes surgical procedures.	Clinical monitoring includes surgical procedures.	4
QMI.3.4	Clinical monitoring includes the use of antibiotics and other medications and medication errors.	Clinical monitoring includes the use of antibiotics and other medications and medication errors.	2
QMI.3.5	Clinical monitoring includes the use of anesthesia.	Clinical monitoring includes the use of anesthesia.	2
QMI.3.6	Clinical monitoring includes the use of blood and blood products.	Clinical monitoring includes the use of blood and blood products.	2

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
QMI.3.7	Clinical monitoring includes availability, content, and use of patient records.	Clinical monitoring includes availability, content, and use of patient records	2
QMI.3.8	Clinical monitoring includes infection control, surveillance, and reporting.	Clinical monitoring includes infection control, surveillance, and reporting.	4
QMI.3.10	Managerial monitoring includes the procurement of routinely required supplies and medications essential to meet patient needs.	Managerial monitoring includes the procurement of routinely required supplies and medications essential to meet patient needs.	2
QMI.3.11	Managerial monitoring includes reporting of activities as required by law and regulation.	Managerial monitoring includes reporting of activities as required by law and regulation.	4
QMI.3.12	Managerial monitoring includes risk management.	Managerial monitoring includes risk management.	2
QMI.3.14	Managerial monitoring includes patient and family expectation and satisfaction.	Managerial monitoring includes patient and family expectation and satisfaction.	4
QMI.3.16	Managerial monitoring includes patient demographics and diagnoses.	Managerial monitoring includes patient demographics and diagnoses.	4
QMI.3.17	Managerial monitoring includes financial management.	Managerial monitoring includes financial management	2
QMI.3.18	Managerial monitoring includes the surveillance, control, and prevention of events that jeopardize the safety of patients, families, and staff.	Managerial monitoring includes the surveillance, control, and prevention of events that jeopardize the safety of patients, families, and staff.	2
QMI.3.19	Data collection supports further study of areas targeted for study and improvement.	Data collection is used to study areas targeted for improvement.	3

**Evaluation Score:**

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
QMI1.3.20	Data collection supports evaluation of the effectiveness of implemented improvements.	Data collection is used to monitor and evaluate the effectiveness of improvements	3
QMI1.4	Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the organization.	(1)Data are aggregated, analyzed, and transformed into useful information	4
		(2)Individuals with appropriate clinical or managerial experience, knowledge, and skills participate in the process.	4
QMI1.4.1	The frequency of data analysis is appropriate to the process being studied and meets organization requirements.	(1)The frequency of data analysis is appropriate to the process under study.	2
		(2)The frequency of data analysis meets organization requirements.	
QMI1.4.2	Data are intensively assessed when significant unexpected events and undesirable trends and variation occur.	(1)Intense analysis of data takes place when significant adverse levels, patterns, or trends occur.	4
		(2)The organization has established which events are significant.	3
		(3)The organization has established the process for intense analysis of these events.	3
		(4)Significant events are analyzed when they occur.	4
QMI1.4.3	The analysis process includes comparisons internally, with other organizations when available, and with scientific standards and desirable practices.	(1)Comparisons are made over time within organization.	4
		(2)Comparisons are made with similar organizations when possible.	4
		(3)Comparisons are made with standards when appropriate.	4
QMI1.4.4	Statistical tools and techniques suitable to the process or outcome under study are used.	Statistical tools and techniques are used in the analysis process when suitable.	3

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
QMI.5	Improvement in quality is achieved and sustained.	(1) The organization uses a consistent process to plan and implement improvements.	2
		(2)The organization documents the improvements achieved and sustained.	1
QMI.5.1	Improvement activities are undertaken for the priority areas identified by the organization's leaders.	The priority areas identified by the organization's leaders are included in improvement activities.	4
QMI.5.2	Assignments are made and support provided.	Those responsible for an improvement are assigned.	4
QMI.5.3	Staff is trained, appropriate policy changes are made, and necessary resources are allocated.	(1)Policy changes necessary to plan and carry out the improvement are made.	4
		(2)Necessary resources are allocated.	3
QMI.5.4	Changes to improve are planned and tested.	(1)Changes are planned.	4
		(2)Changes are tested.	4
		(3)Changes that resulted in improvements are implemented.	4
QMI.5.5	The organization collects data to show that the improvement was sustained.	Data are available to demonstrate that improvements are sustained.	4
QMI.5.6	The organization documents its continuing, systematic improvement and uses the information to develop strategic improvement plans.	Successful improvements are documented.	2
		The documentation contributes to the development of strategic improvement plan.	1

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## FUNCTION: STAFF QUALIFICATION AND EDUCATION (SQE)

### **Result highlights**

- ⇒ The level of education, knowledge, and skill is specified for all positions, mainly based on the laws and regulations in the Republic of Armenia, although these specifications are not documented in writing. For physicians, NMMC also requires the completion of in-house fellowship programs for cardiologists and cardiovascular surgeons.
- ⇒ There are no job descriptions to reflect current positions at NMMC. For physicians, recruitment in recent years has followed completion of the fellowship program. For nurses, recruitment is made through nursing schools, and from within the organization via lateral and vertical moves. Nurses are given a two-month probation period, and permanent position is offered only after their performance during the probation period is deemed satisfactory.
- ⇒ The personnel file includes a standardized form that outlines the individual's qualifications and work history upon recruitment. Credentials are verified as they are documented in the personnel file. The files are not updated regularly and do not include any performance evaluation, as there is no ongoing evaluation of the staff. Such evaluations are initiated only in the perceived presence of quality-related problems. Similarly, there is no history of in-service or continuing education on the personnel record.
- ⇒ Staff credentials are reviewed every year, but mainly to ensure that the license is current, or to determine the time of license renewal. As for other staff members, there is no formal assessment of physician performance. However, as quality improvement activities are initiated, physician performance is examined by a multidisciplinary team (the "Politburo"), and specific problems addressed.
- ⇒ The staffing plan is developed collaboratively by clinical and managerial leaders, and is based on the projected number of utilization of services in a given year. In addition, financial realities of NMMC are an important factor in enabling or impeding efforts to adequately staff the organization. As such, staffing plans are revised frequently to meet fluctuations in the finances of NMMC, which is closely related to the economy of the region. There is no written document to outline the criteria used in projections or planning, or that of changes in staffing plans.
- ⇒ New staff members are provided a two-week orientation prior to assuming full responsibility in their job, both by the administrative staff, and by staff members in individual departments. The medical staff receives ongoing in-service education that complements advanced training programs attended in the West. However, no advanced courses or training are offered to the nursing staff.

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
SQE.1	Organization leaders define the desired education, skills, knowledge, and other requirements of all staff members.	(2) The desired education, skills, and knowledge are defined for staff.	3
SQE.1.1	Each staff member's responsibilities are defined in a current job description.	(1) Those staff members not permitted to practice independently have a job description.	1
		(2) Job descriptions are current.	1
SQE.2	Organization leaders develop and implement processes for recruiting, evaluating, and appointing staff as well as other procedures identified by the organization.	(1) There is a process in place to recruit staff.	2
		(2) There is a process in place to evaluate the qualifications of new staff.	2
		(3) The process is implemented.	3
SQE.3.1	Each staff member's ability to carry out the responsibilities in his or her job description is evaluated at appointment and then regularly thereafter.	(1) New staff members are evaluated at the time they begin their work responsibilities.	2
		(2) There is at least one documented evaluation of staff each year or more frequently as defined by the organization.	1
SQE.3.2	There is documented personnel information for each staff member.	(1) Personnel information is maintained for each staff member.	4
		(2) Personnel files are standardized.	4
		(3) Personnel files are kept current.	1
		(4) Personnel files contain a record of in-service education attended by the staff member.	1
SQE.4	A staffing plan for the organization, developed collaboratively by the clinical and managerial leaders, identifies the number, types, and desired qualifications of staff.	(1) There is a written plan for staffing the organization.	1
		(2) The clinical and managerial leaders developed the plan collaboratively.	4
SQE.4.1	The staffing plan is reviewed on an ongoing basis and updated as necessary.	(1) The plan is revised and updated when necessary.	3
SQE.5	All staff members are oriented to the organization and to their specific job responsibilities at appointment to the staff.	(1) New staff members are oriented to the organization, job responsibilities, and their specific assignments.	3

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
SQE.6	Each staff member receives ongoing in-service and other education and training to maintain or advance his or her skills and knowledge.	(1) Organization staff is provided ongoing in-service education and training.	2
SQE.6.4	Staff is given the opportunity to participate in advanced education, research, and other educational experiences to acquire new skills and knowledge and to support job advancement.	(1) Staff is informed of opportunities to participate in advanced education, training, research, or other experiences.	1
		(2) The organization supports staff participation in such opportunities as appropriate to its mission and resources.	1
SQE.7	The organization has an effective process for gathering, verifying, and evaluating the credentials (license, education, training, and experience) of those medical staff permitted to provide patient care without supervision.	(1) Those permitted by law, regulation, and the organization to provide patient care without supervision are identified.	3
SQE.7.1	The organization maintains a record of the current professional license, certificate, or registration, when required by law, regulation, or by the organization, of every medical staff member.	(1) There is a record maintained for every medical staff member.	4
		(2) The record contains copies of any required license, certification, or registration.	4
SQE.7.2	The credentials of medical staff members are reevaluated at least every three years to determine their qualifications to continue to provide patient care services in the organization.	(1) There is a process to review each record every three years.	1
SQE.8	The organization has an effective process to authorize all medical staff members to admit and treat patients and provide other clinical services consistent with their qualifications.	(1) There is a process to authorize the individual to admit and care for patients.	2
		(2) A medical staff member's licensure, education, training, and experience are used to authorize the individual to provide clinical services consistent with qualifications.	???

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Standard #	Standard	Measurable Element (# of measurable element)	Evaluation Score
SQE.9	The organization has an effective process for medical staff participation in the organization's quality improvement activities, including evaluating individual performance, when indicated, and for periodically reevaluating the performance of all medical staff members.	(1) Medical staff members participate in the organization's quality improvement activities.	4
		(2) The performance of individual medical staff members is reviewed periodically, as established by the organization.	2
SQE.10.1	The organization maintains a record of the current professional license, certificate, or registration, when required by law, regulation, or the organization, of every nursing staff member.	(1) There is a record maintained on every nursing staff member.	4
SQE.11	The organization has an effective process to identify job responsibilities and make clinical work assignments based on the nursing staff member's credentials and any regulatory requirements.	(1) Licensure, education, training, and experience of a nursing staff member are used to make clinical work assignments.	4
SQE.12	The organization has an effective for nursing staff participation in the organization's quality improvement activities, including evaluating individual performance when indicated.	(1) Nursing staff participates in the organization's quality improvement activities.	4
SQE.13.1	The organization maintains a record of the current professional license, certificate, or registration, when required by law or regulation, of those other health professional staff members.	(1) The organization has a process in place to gather the credentials of other health professional staff members.	4

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