Republic of Rwanda

Ministry of Health

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EXECUTIVE SUMMARY REPORT FOR HOSPITAL ACCREDITATION PERFORMANCE PROGRESS SURVEYS FY 2022/2023

May 2023

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ACRONYMS

CS	Critical Standard
DG	Director General
DH	District Hospital
DHIS-2	District Health Information System-2
ED	Emergency Department
FY	Fiscal Year
HMIS	Health management information system
HR	Human Resources
ICU	Intensive Care Unit
IPC	Infection prevention and control
M&E	Monitoring and evaluation
MoH	Ministry of Health
NICU	Neonatal intensive care unit
PBF	Performance-based financing
PDSA	Plan-Do-Study-Act
RA	Risk Area
RAAQH	Rwanda Agency for Accreditation and Quality Health Care
RIHSA	Rwanda Integrated Health Systems Activity
QI	Quality improvement
WHO	World Health Organization

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ACKNOWLEDGEMENT

The Ministry of Health (MoH) would like to offer sincere thanks to the United States Agency for International Development (USAID) for their technical and financial support through the Rwanda Integrated Health Systems Activity (RIHSA).

The Ministry of Health would like to thank the Rwanda Agency for Accreditation and Quality Healthcare (RAAQH) for conducting the hospital accreditation surveys during the fiscal year 2022/2023.

We also would like to acknowledge the district authorities, Surveyors, hospitals Leaders, Facilitators and General staff who dedicated their time to participate in this exciting exercise.

1. INTRODUCTION

In 1998, the Government of Rwanda embarked on a journey to improve the quality of healthcare program to address priority healthcare issues using quality improvement approaches. It is this regard that the Ministry of Health (MOH) and its partners started the periodic accreditation assessment s in 2013 whose aim was to institutionalize a culture of quality improvement and patient safety across health facilities in Rwanda.

The third edition of Rwanda hospital accreditation standards was approved in August 2022. These standards are designed for use within the entire hospitals and cover the full range of services that are described in the Ministry of Health "Service Package for Health facilities at different levels of Service delivery".

To further strengthen the accreditation program, the USAID through Rwanda Integrated Health Activity (RIHSA) implemented by Palladium provided technical and financial support to ensure quality monitoring and measurement. The Rwanda Agency for Accreditation and Quality HealthCare (RAAQH) as subcontractor, conducted the Fiscal Year (FY) 2022/2023 accreditation progress assessment s in level 2 teaching, referral, provincial, district hospitals and Orthopedic and rehabilitation hospitals. The assessment period spanned from January to April 2023 where 51 hospitals were assessment ed. Forty-four hospitals had target of level II recognition, three hospitals level I recognition and four hospitals went through the baseline assessment.

This executive summary report details the findings of the progress and baseline assessment, outlines the challenges observed and puts forth recommendations for critical interventions to address service gaps. Comparing the accreditation progress assessment results in the last 2 consecutive years, there is a remarkable progress. In the FY2021/2022, 11 hospitals achieved level II, while in the current FY 2022/2023, 16 hospitals achieved and all 11 maintained level II.

2. METHODOLOGY

The assessments aimed at establishing the hospitals performance progress toward achieving accreditation based on hospital accreditation standards. RAAQH conducted the accreditation assessment for a total of fifty-one (n=51) hospitals with an aim to measure the level of standards compliance for hospitals. Three Orthopedics and Rehabilitation Hospitals (Gatagara Orthopedic, Rilima Orthopedic, Inkuru Nziza Orthopedic) and one district hospital (Nyabikenke DH) had baseline assessment, while forty-seven hospitals conducted progress assessments from January to April 2023. Each hospital was assessed by a team of four certified surveyors for period of four days.

The process started with a notification letter from the MoH to the hospitals. An assessment workshop orientation was organised and focused on Rwanda hospital performance assessment toolkit 3rd edition, followed by the hospitals sharing profiles that outlined their scope of services and previous year's hospital performance. Assessment teams were created considering different skills/background in each team. RAAQH and MOH conducted a one-day assessment or physical orientation workshop on January 7th, 2023, to discuss interpretation of new standards, imaged standards in the 3rd –edition toolkit and to encourage assessment to highlight challenges and clearly harmonise interpretation, scoring, and report writing. Another workshop was conducted with selected team leaders on 4th and 5th February mainly on report writing. During data collection, the assessment methodology was discussed with the hospital management team, an overview of the assessment process was discussed in details including in the assessment process and document review of both administrative and medical records. In addition, staff interviews and facility tours were conducted, allowing comprehensive and thorough observations to determine the extent to which facilities ensured environmental safety. In the FY 2022/2023, the following assessment tools were used.

1. The Rwanda Hospital Performance Assessment Toolkit -3rd edition of August 2022 which is organized in a framework of five risk areas: (1) leadership process and accountability, (2) Competent and Capable workforce, (3) Safe environment for staff and patients, (4) Clinical care of patients and (5) Improvement of Quality and Safety.

2. Physical and Functional Rehabilitation Service Accreditation Standard Performance Assessment Toolkit of December 2020 arranged in the following five risk areas; (1) Leadership and Governance, (2) Competent and Capable workforce (3) Safe environment (4) Physical and Functional Rehabilitation services and (5) Improvement of quality and safety).

Three levels of effort are the measures for reaching the expectations for each standard:

- **Level I**: Requires developing and communicating policies, procedures and plans which describe the level of quality expected in all areas within the facility.
- **Level II**: Involves implementation of policies, procedures, and plans that were developed in Level I.
- **Level III**: Requires monitoring of the effectiveness of the processes implemented in Level II. At this level, data must be used as evidence to identify opportunities for improvement, and thus action plans for improvements need to be developed.

Table 1: The following criteria is currently used to determine Level I, II and III recognitions:

Level I Recognition	Level II Recognition	Level III Recognition
Overall average score of 85% Level I	Level I recognition must be achieved and maintained. Overall average score of 75% at Level II	Level I & II recognition must be achieved and maintained. Overall average score of 70% at Level III
Average score of 75% for eac risk area at Level I	Average score of 70% for each risk area at Lev	Average score of 60% for each risk area at Level III
Overall average score of crit standards of 80% at Level I*	Level I critical standards are met at 100% Overall average score of critical standards of 8 at Level II*	Overall average score of critical standar of 100% at Level III*

***Critical standards are required by national laws and regulations and, if not met, may cause death or serious harm to patients, visitors, or staff**.

3. SUMMARY OF MAIN FINDINGS AND RECOMMENDATIONS

The summary of findings and recommendations presented in this report is an aggregation of all the fifty-one public hospitals. For details of each health facility level of performance, refer to the individual hospital report. This report has documented the progress assessment findings for forty-seven hospitals countrywide and the baseline assessment report for Gatagara, Rilima, Inkuru Nziza orthopedic centers and Nyabikenke DH.

The overarching objective of the baseline assessment is to highlight key findings with regards to standards compliance, hence identifying the quality improvement gaps and recommendations that the facilities will progressively address towards meeting the Rwanda Hospital Accreditation Standards. The baseline assessment results presented will be used as a guidance for interventions required for improvement of services provided by these hospitals. These findings have been organized in four main categories, namely: the Overall Performance, Performance by Risk Area, Overall Scores for all the forty-four hospitals compared with the target, performance by standards and performance by critical standards.

3.1. Overall Performance in progress accreditation assessment for forty-four hospitals

During the current assessment in the FY 2022/2023, among the 3 hospitals that were pursuing level I recognition (Gatunda, Nyarugenge and Gatonde), one hospital achieved level I (Gatunda DH). Among the 44 hospitals pursuing level II recognition, five (n=5) hospitals achieved the target and eleven (n=11) maintained. However, twenty-six (n=26) hospitals did not achieve the targeted level rather maintained level I and two (n=2) hospitals did not achieve even level

l **(Mibilizi and Remera-Rukoma)**. Kigeme Hospital was the best performer with 94% and the three last Hospitals which scored below 50% at level II are; Kibogora L2TH (48%), Kaduha DH (44%) and Gihundwe DH (42%).

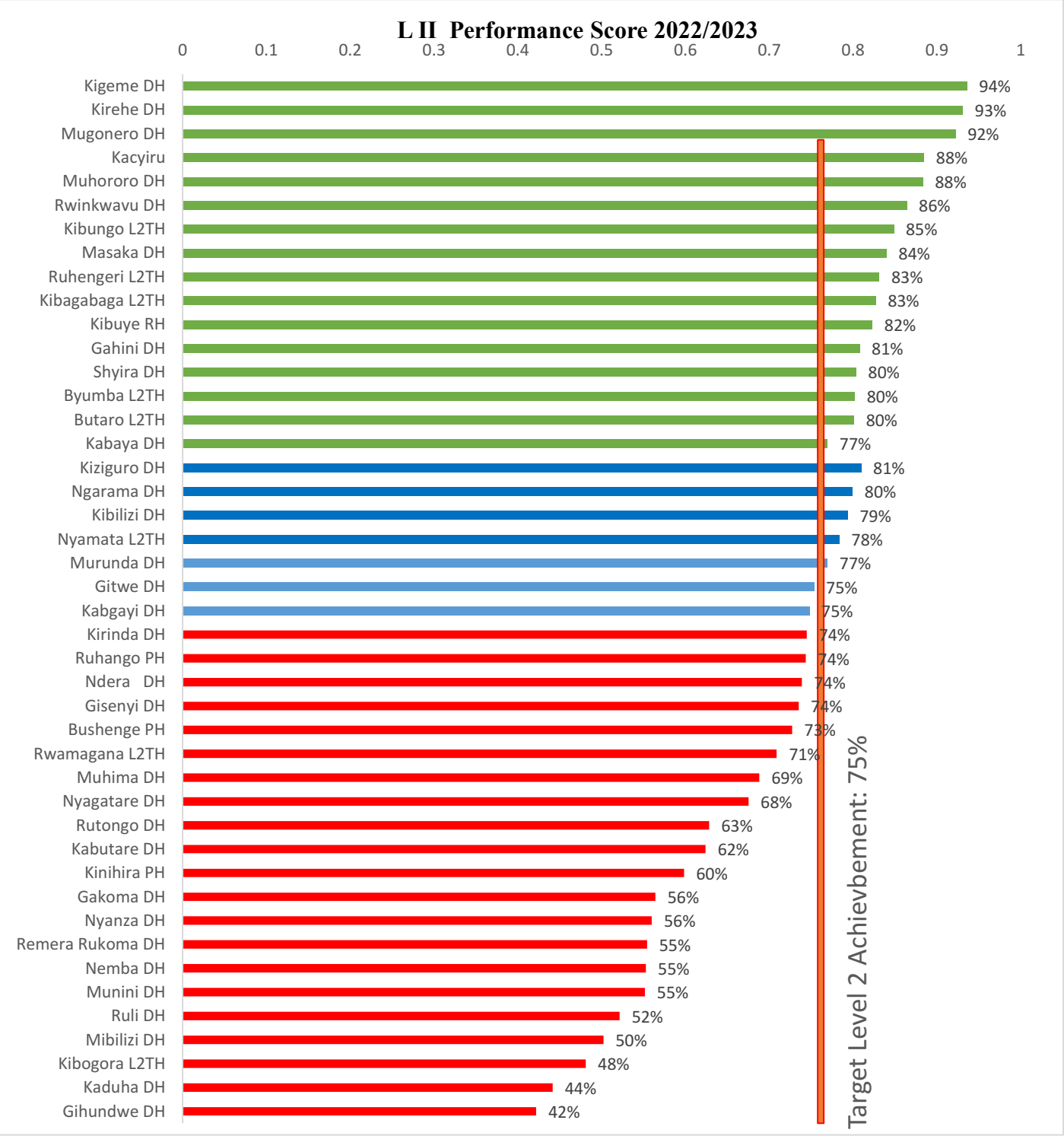

Figure 1: Overall level II performance for forty-four hospitals in FY2021/2023

Figure 1 above shows all 44-hospital performance in the FY 2022/2023 at level II which was the target. The target to achieve overall performance for level II was at 75%. The hospitals marked in green achieved or maintained level II, the hospitals highlighted in blue had overall target score of level II but did not meet the criteria of scoring 70% in each risk area at level II, and thus failed to achieve level II recognition. While those in red did not achieve level II.

3.2 Performance Analysis by Risk Area

The following section will discuss the performance by risk area as far as level II of effort is concerned.

Figure 2: Summary of the accreditation overall progress performance score for forty-four hospitals by Risk Area at level II in FY 2022/2023. The target required for each risk area at Level II recognition is an average score of 70%. Failure to achieve this target despite the overall performance affects the hospital's achievement of level II performance/ recognition.

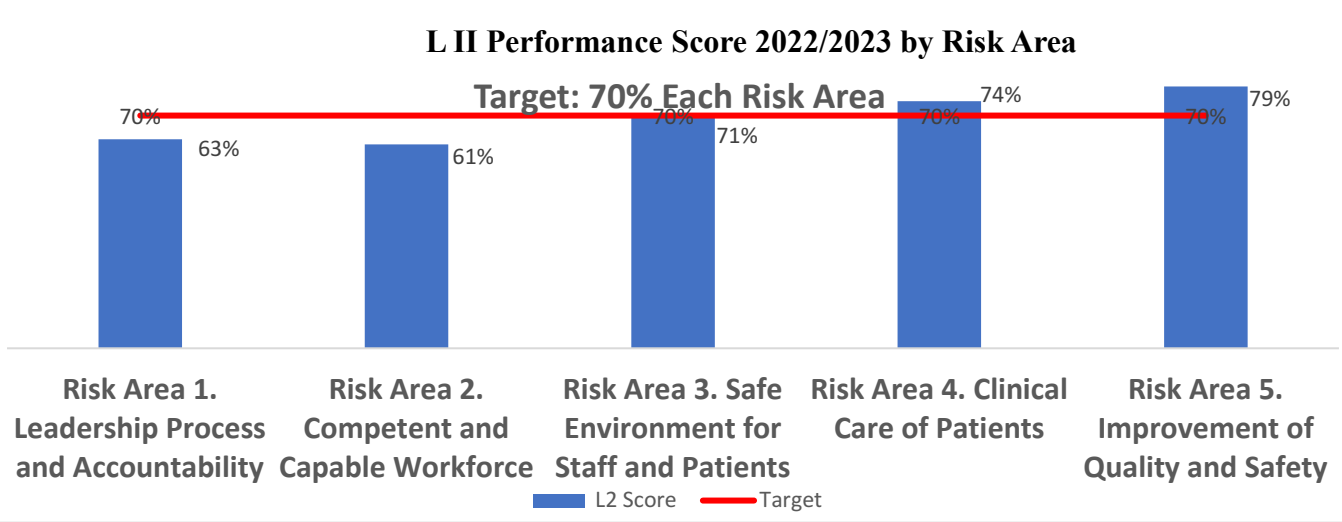

Figure 2:: overall progress performance score for forty-four hospitals by Risk Area at level II in FY 2022/2023

The risk area scored below 70% as the required overall performance per risk area at level II. From the figure above, risk area 1&2 are the main leading cause of failure to 23/44 (52%) hospitals which did not achieve the required performance target for level II. We shall present in details those 2 risk areas and summarize RA 3, 4 and 5.

3.2.1 Performance at Risk area 1(Leadership Process and Accountability)

Effective leadership is essential for promoting a culture of safety, creating accountability, and ensuring that quality improvement initiatives are implemented successfully. Below is a summary of standards with scores highlighted in red that leads to the failure of Risk Area 1 recognition.

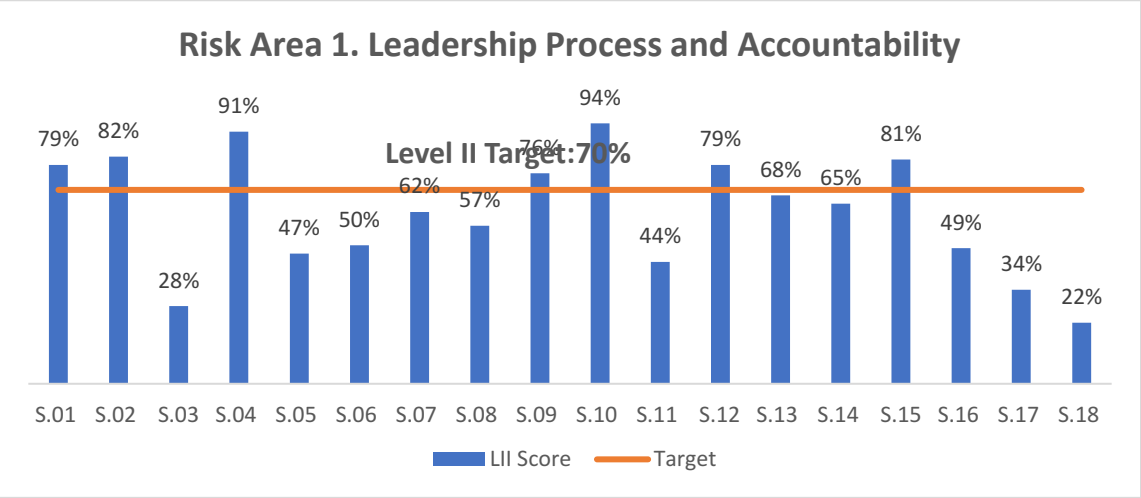

Figure 3:overall progress performance score for forty-four hospitals by Risk Area 1

Table 2:The table below summarizes standards that leads to the poor performance in risk area 1

Risk area	LII Score
Risk Area 1. Leadership Process and Accountability	**63%**
S.01 Leadership responsibilities and accountabilities identified	79%
S.02 Strategic and planning	82%
S.03 Management of policies, procedures, protocols, and clinical guidelines	28%
S.04 Management of health information	91%
S.05 Mentorship and oversight of healthcare facilities in catchment area	47%
S.06 Risk Management	50%
S.07 Financial management	62%
S.08 Efficient use of resources	57%
S.09 Leadership for quality and patient safety	76%
S.10 Quality requirements in contracts management	94%
S.11 Integration of quality, safety, and risk management	44%
S.12 Compliance with national laws and regulations	79%
S.13 Commitment to patient and family rights	68%
S.14 Patient access to services	65%
S.15 Efficient admission and registration processes	81%
S.16 Effective inventory management	49%
S.17 Effective medical record management	34%
S.18 Oversight of human subject research	22%

Findings and interpretations

In the Risk area 1; 10/18 (55%) standards marked in the red color shown in the table above have low performance in many hospitals.

- Among those standards, two are new (Std 3&6). The hospitals managers raised the issue of lack of enough time for implementation since the 3rd-edition was launched in August 2022.
- The remaining standards are linked with leaders not putting systems in place on how to integrate and monitor the quality program within the hospital.
- Lack of teamwork and dissemination of quality; In some hospitals, the process of accreditation is being owned by a small team of staff (If not only QI) without engaging other staff. The process needs to be owned by each and every one in the hospital.
- Inconsistency roadmap in mentorship and oversight of healthcare facilities; Many hospitals assessments do not have clear plans and monitoring systems to ensure that they are meeting regulatory requirements, providing high-quality care, and operating in a safe and efficient manner.

3.2.2 Performance at Risk area 2 ;(Competent and Capable Workforce)

A competent and capable workforce is essential for providing high-quality care in healthcare facilities.

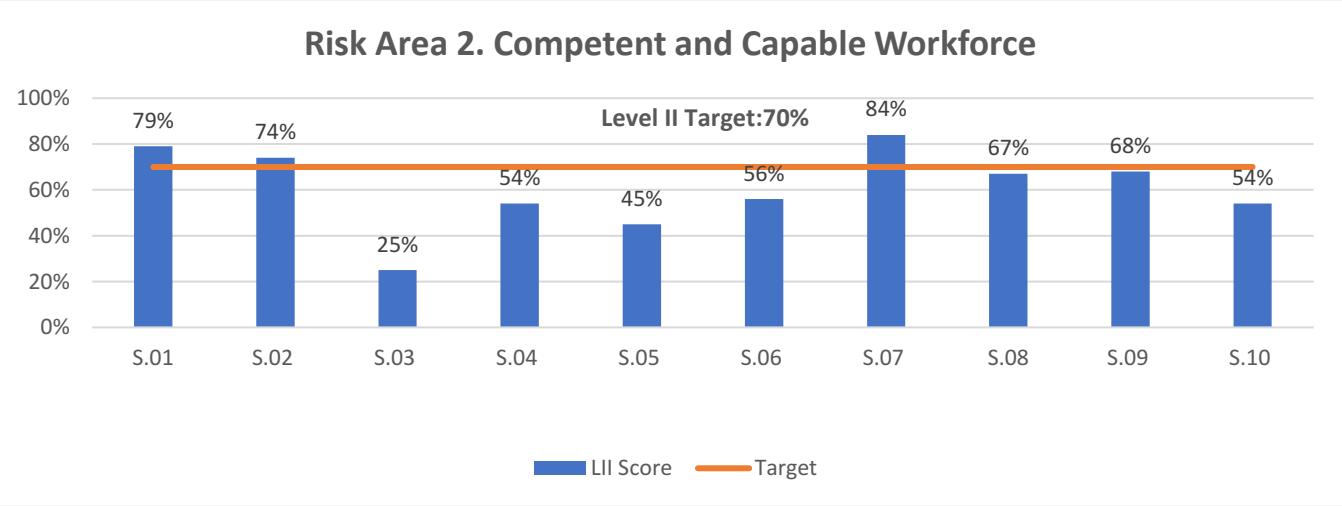

Figure 4:overall progress performance score for forty-four hospitals by Risk Area 2

Table 3:Below summarizes standards that leads to the poor performance in risk area 2.

Risk area	LII Score
Risk Area 2. Competent and Capable Workforce	**61%**
S.01 Personnel files available, complete, up to date	79%
S.02 Credentials of healthcare professionals	74%
S.03 Privileges for health professionals	25%
S.04 Orientation to hospital and job	54%
S.05 Trained and competent staff	45%
S.06 Sufficient Staff to meet patient needs	56%
S.07 Oversight of students/trainees	84%
S.08 Training in resuscitative techniques	67%
S.09 Staff performance management	68%
S.10 Staff health and safety program	54%

Findings and interpretations

In the Risk Area 2 as shown above ,7/10 **(70%)** standards are the leading causes of failure in many hospitals. Below are some findings from the current assessment.

- Staff files are not regularly updated; the absence/missing of the required documents like job description, updated license can lead to hospital staff not knowing their roles and responsibilities.
- Some Human Resource managers and heads of units do not orient their staff on the quality improvement program and neither includes QI in their job description. Orienting staff on QI ensures that new employees have the information about quality from the start.
- The systems in place to evaluate quality improvement program are not efficient. It is important to evaluate the effectiveness of how staff are being engaged in the accreditation process and orientation in the specific units to ensure that it is meeting its objectives.
- No evidence regarding implementation of training plan in some hospitals, hence missing out important training like BLS, leadership skills and adoption of new protocols.

3.2.3 Performance at Risk area 3 (Safe Environment for Staff and Patients)

To ensure a safe environment for staff and patients within a healthcare facility, there is need to prevent harm and injury to both patients and staff by identifying potential hazards and implementing appropriate safety measures.

Findings and interpretation

- Gaps exist for 6/17 (20%) standards, including two new standards 1&8 that scored less than 50%. The new standards were launched in the 3rd edition (August 2022).
- S.01 Infrastructure, utilities, resources, equipment, and furniture score an average of 23%: Most of the time, the

plans set for the infrastructure did not take in account the existing, missing and needed resources which help the authorities to take appropriate decision. In other cases, the issue is the rehabilitation and maintenance of old infrastructures.

- In some hospitals, the assessment found no alternative sources of water. Most of these cases are due to poor planning.
- Infection prevention control (IPC) activities and other hospital committees are not regularly conducted due to conflicting staff priorities, the concerned staff being involved in other activities. The hospital management should ensure that accreditation committees are functional.

3.2.4 Performance at Risk area 4 (Clinical Care of Patients)

The standards in this risk area aim to ensure that patients receive safe, effective, and timely care that meets their needs and achieves the desired outcomes. This RA has low performance in 9/25 **(36%)** standards.

Findings and interpretation

- Medication is not well stored, labeled and disposed in many hospitals; this can be linked with lack of a qualified pharmacist.
- Informed consent forms are not systematically filled in in some hospitals; this hinders the participation of patients and their families in the care provided which may result to poor patient outcome.
- Health professionals in some hospitals do not provide education to the patients as required by standard, this limits patient satisfaction.

3.2.5 Performance at Risk area 5 (Improvement of Quality and Safety)

The standards ensure that the hospital is continuously evaluating and improving the quality and safety of care provided to patients. It has failed to implement 1/9 standards.

Findings and interpretation

- Reporting of Incidents, near miss and sentinel events has been a big challenge to many hospitals. The staff fear to report incidents in the hospitals. The result is that there is no mechanism to appropriately manage or prevent risks. The hospital leaders need to institutionalize the culture of incident reporting within the facility.

3.3 Performance by critical standards

Critical standards are required by national laws and regulations and, if not met, may cause death or serious harm to patients, visitors, or staff. Hospitals leadership and staff must ensure that it is a priority to address and mitigate any risks pertaining to these standards for patient and staff safety. There are twenty-one critical standards in the 3rd edition hospital accreditation standards.

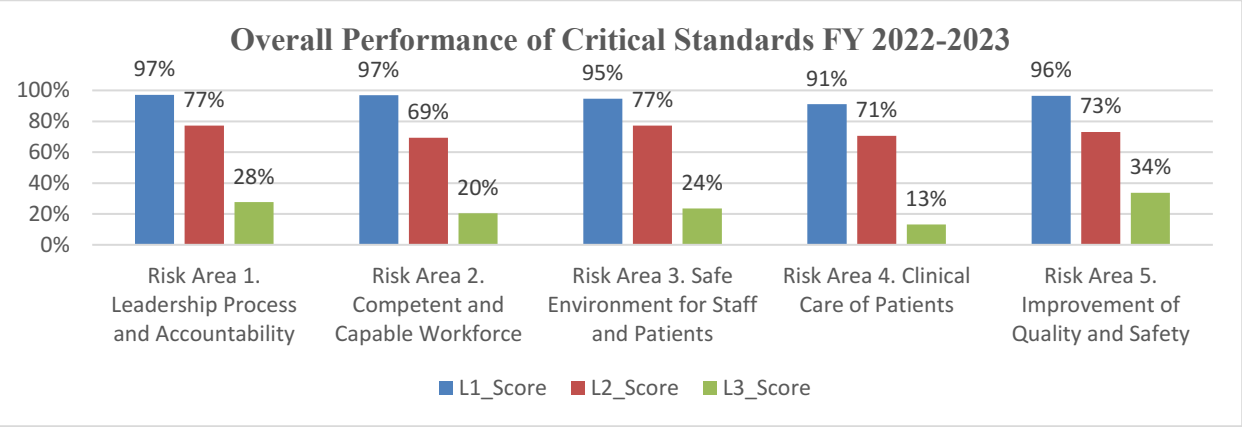

Figure 5:Overall average for all critical standards at levels II (n=44) hospitals

Table 4:All Hospitals (n=44) average score of critical standards at level II, FY 2022/2023

Overall Performance of Critical Standards FY 2022-2023	L II Score
Risk Area 1. Leadership Process and Accountability	77%
S.09 Leadership for quality and patient safety	76%
S.12 Compliance with national laws and regulations	79%
Risk Area 2. Competent and Capable Workforce	69%
S.02 Credentials of healthcare professionals	74%
S.07 Oversight of students/trainees	84%
S.08 Training in resuscitative techniques	67%
S.10 Staff health and safety program	54%
Risk Area 3. Safe Environment for Staff and Patients	77%
S.04 Fire safety and disaster management	70%
S.06 Stable safe water sources	70%
S.07 Stable electricity sources	89%
S.11 Effective sterilization processes	66%
S.12 Effective laundry and linen services	91%
S.14 Barrier techniques available and used	79%
S.16 Proper storage and disposal of infectious medical waste	75%
Risk Area 4. Clinical Care of Patients	71%
S.09 Protocols for managing high-risk patients/procedures	84%
S.16 Anesthesia and sedation are used appropriately	76%
S.18 Comprehensive management of emergency triage	81%
S.19 Essential emergency equipment and supplies	64%
S.20 Ambulance equipped	67%

S.21 Safe medication use	52%
Risk Area 5. Improvement of Quality and Safety	73%
S.05 Clinical outcomes are monitored	79%
S.06 Incident, near miss and sentinel event reporting system	67%
Grand Total	**73%**

As shown in table 5 and figure 3 above, in all risk areas at level II, the critical standards average overall performance (77%, 69%, 77%, 71% and 73%) remains below the required target of 80%. The hospital leadership, the QI committees and the staff should make this a priority as these standards impact reduction of mortality and morbidity. Critical standards need more attention because they lead to good patient care outcomes in the shortest possible time once enough time is invested in the entire process including reduction of maternal, child and neonatal mortality.

3.4 Year to Year Performance comparison for FY 2022/2023 and FY2021/2022

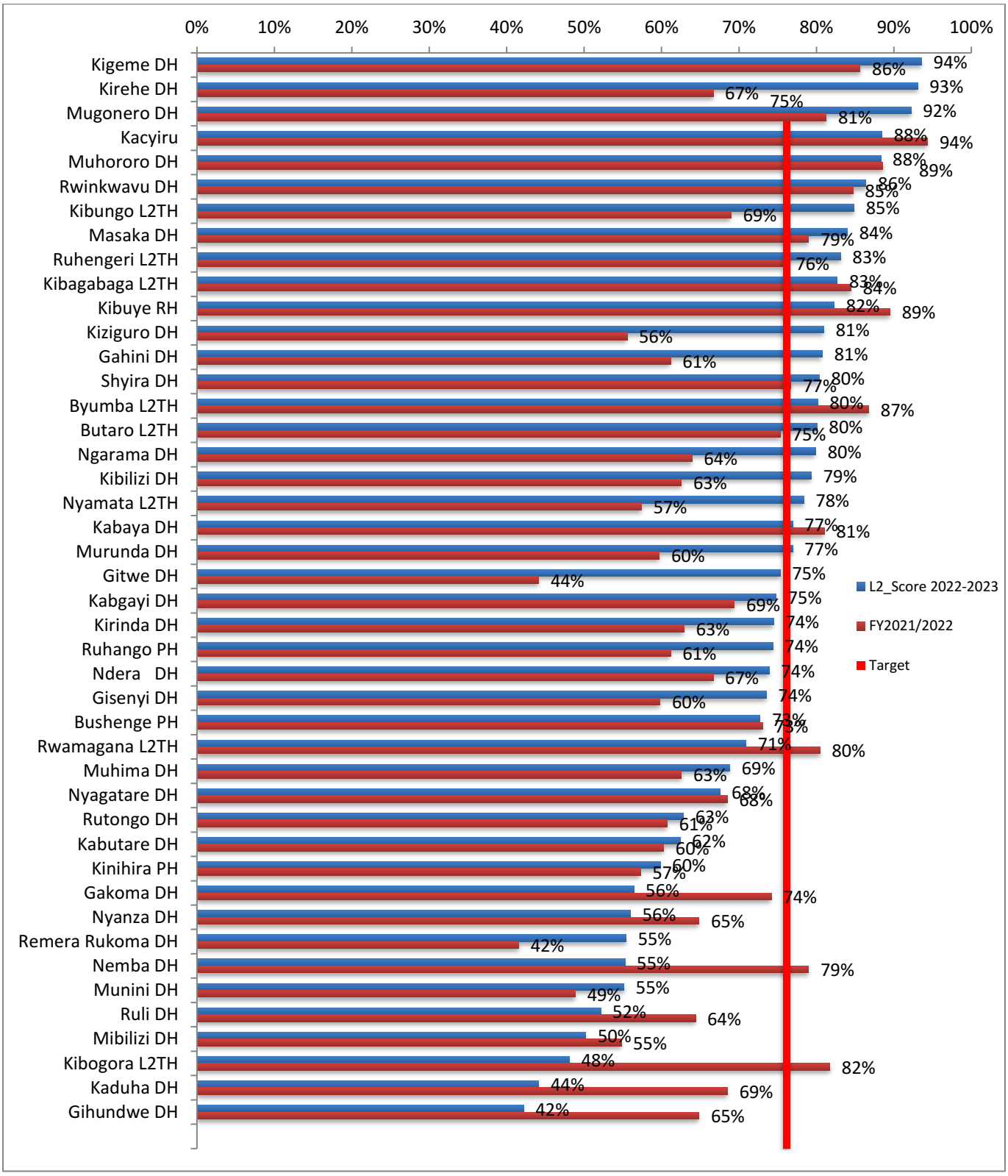

Figure 6:Overall level II performance score for forty-four hospitals during FY 2021/2022 in comparison with FY2022/2023

The above figure 2 results show the comparison of two successive years which are FY 2021/2022 (red color) and FY 2022/2023 (blue color) with the target (red vertical line) which is at 75%. 22/44 (50%) hospitals got an average score above the required score of 75% for achieving level II recognition which is the target for overall score in FY 2022/2023. However, not all the twenty -two hospitals that got the 75% overall average scores achieved level II because they did not all meet all the critical standards requirement/or risk area scores. Significant improvement has been attained in FY2022/2023 where 5/44 hospitals (11%) achieved level II (Kibungo L2TH, Masaka DH, Gahini DH, Butaro L2TH and Shyira DH) and 11/44 (25%) maintained level II namely, Kigeme, Kirehe DH, Mugonero DH, Kacyiru DH, Muhororo DH, Rwinkwavu DH, Kibagabaga L2T, Ruhengeri L2TH, Kibuye DH, Byumba DH, and Kabaya DH. Twenty-eight over forty-four hospitals (63.6%) maintained level I recognition.

3.5. Overall performance for hospitals with Level I target in FY 2022/2023

The hospitals (Nyarugenge, Gatonde and Gatunda) in table 5 below targeted to achieve level I in the current assessment of the FY 2022/2023. Two hospitals (Nyarugenge and Gatonde) were enrolled in the accreditation program in the previous FY 2021/2022 and Gatunda joined the program in 2021. Looking at the scores below, Gatunda DH managed to achieve level I which was the target. Nyarugenge DH failed to achieve the targeted level due risk area 3(Safe Environment for Staff and Patients) where the hospital had no water plan, decontamination and disinfection policy and procedures were missing while the Gatonde DH had an issue in Management of policies, procedures, protocols, and clinical guidelines, financial management and Leadership for quality and patient safety. The leadership of Gatonde and Nyarugenge need to put more efforts to achieve level1 while Gatunda needs to maintain level I and achieve level II in the next assessment.

Table 5:Summary of hospital assessment achievement target level I in the FY 2022/202

Level I Target			
Hospital	**Overall score at level I**	**Target**	**Achieved or not Level I**
Gatunda DH	90%	85%	Achieved
Nyarugenge DH	75%	85%	Not achieved
Gatonde DH	70%	85%	Not achieved

3.6. Baseline assessment score in the FY 2022/2023

For the baseline assessment findings three Orthopedic Hospitals (Table 6) were enrolled in the program using different set of standards and assessment toolkit (Physical and Functional Rehabilitation Service Accreditation Standards Performance Assessment Toolkit). Congratulations to Gatagara Orthopedics and Rehabilitation Hospital which scored the highest at 71%, a remarquable score for the baseline. Also baseline assessment was done at Nyabikenke district hospital as new district hospital into the program using the Rwanda hospital performance toolkit. The hospitals that

undertake a baseline are newly integrated within the accreditation program and this is in line with the vision to continuously expand the accreditation program to include more health facilities within the national accreditation program.

Table 6:Baseline assessment Scores of 4 Hospitals

Hospitals	Overall score by level LI		
	Score	LII Score	LIII Score
Orthopedic Hospitals baseline results			
HVP Gatagara Orthopedics and Rehabilitation Hospital	71%	17%	1%
Centre de Chirurgie Orthopédique Pédiatrique et de Rehabilitation, Sainte Marie de Rilima	45%	12%	0 %
Inkuru Nziza Orthopedic Hospital	1%	0%	0%
Baseline assessment of new district hospital			
Nyabikenke DH	23%	3%	0%
Grand Total	**35%**	**8%**	**0%**

4. KEY ISSUES

The 2022/2023 accreditation progress assessment was aiming at level II recognition as the third edition of the Rwanda hospital standards was being used for the first time. It has to be reminded that only seven new standards (2 in Risk#1, 2 in Risk#3 and 3 in Risk#4) were introduced in the new edition while the rest were existing standards that were merged (three in Risk#2 and two in Risk#4). Forty-four hospitals were being assessed at that level. Despite the fact that none of the hospitals has achieved level III so far, there has been though a steady improvement at level II recognition in the last three consecutive years (5, 11 and 16 hospitals respectively in FY 2020/21, 2021/2022 and 2022/2023 accreditation progress assessments achieved the required target of levelII recognition). There are only two hospitals that did not achieve any level. From the results of the current assessment, it appears clearly that Risks areas # 1 and 2 have poorly performed as opposed to others. While the implementation of new standards could have understandably posed a challenge, the great majority of non-compliant standards is composed of old standards that should not pose any particular problem.

A. Risk area 1; Leadership process and Accountability:

In Risk area #1, nine out of eighteen standards were not compliant; while there are two new standards (S.03 Management of policies, procedures, protocols, and clinical guidelines; S.06 Risk Management) whose implementation may pose a challenge in such limited time; the rest are old standards (S.08 Efficient use of resources; S.11 Integration of quality, safety and risk management;S.14 Patient access to services; S.16 Effective inventory management; S.17

Effective medical record management) that are about processes and should not become an issue at level II. Analysis of the above situation points therefore to the following issues:

1. The management of the quality program seems to be concentrated in the hands of a few staff without active involvement of unit managers in the implementation and monitoring.
2. Some hospital managers do not put emphasis on effective communication of standards and monitoring of quality performance across the facilities.
3. Lack of information management systems resulting in inability to track compliance on day-to-day basis at facility level. This is an issue at all levels of quality management (MoH, RAAQH, hospitals, districts, etc.)

B. Risk area 2; Competent and Capable Workforce

In Risk area #2 overall performance average, six out of ten standards performed poorly with none of them being new (S.04 Orientation to hospital and job; S.05 Trained and competent staff; S.06 Sufficient Staff to meet patient needs; S.08 Training in resuscitative techniques; S.09 Staff performance management; S.10 Staff health and safety program). The non-compliance with the bulk of the Risk area #2 standards shows clearly that, in most of our hospitals, the management does not have institutional system to monitor the implementation of standards as a routine practice on daily basis without waiting for the period just before the assessment.

C. Risk 3; Safe Environment for Staff and Patients

In Risk#3, four out of seventeen standards (S.05 Biomedical equipment safety S.11 Effective sterilization processes S.13 Reduction of health care-associated infections S.17 Monitoring, reporting, and preventing the spread of communicable diseases) performed poorly on average; there are also two new standards that posed implementation challenges at level II. There is no specific challenge to compliance with the above four standards apart from the insufficient capacity of the hospitals in most cases to monitor the implementation of standards as a routine practice on daily basis without waiting for the period just before the assessment.

D. Risk area 4: Clinical care for patients

In Risk area #4, on average performance, six old standards out of twenty-five (S.02 Informed consent; S.07 Written plan of care S.19 Essential emergency equipment and supplies S.20 Ambulance equipped S.21 Safe medication use S.22 Patients are educated to participate in their care) performed poorly; two new standards did not achieve level II requirements. As seen earlier, there is no evidence in most hospitals that the management has institutionalized the quality program into all units and there is a routine monitoring of the compliance.

E. Risk 5: Improvement of Quality and Safety

In Risk area#5, most hospitals seem to have done quite well as there is only standard S.06 (Incident, near miss and sentinel event reporting system) that seems to have performed poorly. It has been noted throughout the last three annual accreditation assessment progress that incident reporting does not make progress; here, unless a robust

management action is taken to initiate a cultural change in the institution de-linking incident report with punishment, mindset change will be problematic.

5. RECOMMENDATIONS

Below are proposed recommendations to address identified challenges at hospitals to meet national hospital accreditation standards and improve the quality of healthcare services delivery.

A. Recommendations to the Ministry of Health (MoH)

1. **Equipment and Infrastructure:** MoH and supporting partners need to jointly work together and ensure infrastructure is rehabilitated, necessary equipment and supplies are provided to different hospitals as this is critical to achieving quality.

2. **Implement ongoing monitoring and evaluation mechanisms**: The Ministry of Health should implement a mechanism, preferably an electronic information management system that will monitor implementation of accreditation assessment key findings, actions, and recommendations provided to the facilities. On-going mentorship should ensure that the hospital is making progress towards achieving accreditation. This could include regular site visits, audits, and performance assessments.

3. **Facilitation:** The MoH and development partners must prioritize support for the low performing hospitals to ensure all hospitals meet Level 3 and get accredited. Further, the four hospitals which have just joined the program need more support to address all gaps identified in respect to the standards compliance.

4. **Capacity building in accreditation standards implementation:** The Ministry of Health should build capacity of the relevant stakeholders such as partners, district administration and health facility leadership, staff, and patients, to ensure that everyone understands their roles and responsibilities with regards to standards implementation. As a priority, there should be an ongoing CPD for hospital leaders on their role in the adoption and management of quality in the hospital.

B. Recommendations to the District Authorities, Decentralized level actors (Provinces, DHU and DHMT's):

1. **Implement twinning and collaborative learning:** The DHMT and DHU should reinforce the implementation of learning and best practices sharing between hospitals within the same district and outside the district to share best practices in standards implementation. These learning sessions should be an opportunity to share best practices and sharing of approaches for accreditation standards implementation.

2. **Equipment and Infrastructure:** The focus for all districts and hospitals should be ensuring there is constant running safe water in all services, functional laundry, sterilization process, medical waste incineration and modern kitchens. Further, water should be made priority in new infrastructure buildings.

3. **Develop a corrective action plan:** Based on the assessment, the district leadership in collaboration with the hospital leaders and Quality Improvement officers need develop a corrective action plan that addresses the issues identified. The plan should be comprehensive and include specific actions and timelines for implementation.

4. **Quality Improvement (QI) Officers and Staff Shortage**: The Ministry of Health, districts and hospital leaders must speed up staff placement/replacement process of hospital staff for the vacant positions. The role of the QI officer at health facility level should be reconsidered as an executive management role. In addition, there are no qualified pharmacists in most facilities; the districts and health facilities should implement innovations such as sharing the oversight by one pharmacist including those in private sector.

Recommendation to the Hospital leadership

1. **Conduct a root cause analysis:** The hospital leaders and Quality Improvement officer should conduct a thorough assessment to identify the root causes of the hospital's failure to achieve accreditation. This assessment could include reviewing the hospital's policies, procedures, and operations, as well as conducting interviews with staff and patients.

2. **Implement ongoing monitoring and evaluation:** The hospital leaders and Quality Improvement officer should implement ongoing monitoring and evaluation to ensure that the hospital is making progress towards achieving accreditation. This could include regular site visits, audits, and performance assessments.

3. **Collaborate with other stakeholders:** The hospital leaders and Quality Improvement officer should collaborate with other stakeholders, such as the Ministry of Health, district authorities, and accreditation bodies, to ensure that everyone is working towards the same goal of achieving accreditation.

4. **Build a culture of quality improvement:** The hospital leaders and Quality Improvement officers should prioritize a culture of continuous quality improvement throughout the hospital. This could involve creating quality improvement teams, implementing regular staff training on quality improvement practices, and encouraging staff to identify opportunities for improvement. By taking these actions, the hospital leaders and Quality Improvement officer can support the hospital in improving its operations and achieving accreditation, which will ultimately result in better healthcare for the community it serves.

5. **Monitoring of standards implementation**: Executive committee to adopt a weekly monitoring of quality implementation and monitoring; decentralize quality implementation to units under the unit manager's coordination; self-assessment on biannual basis; Effective full-time Qis in all hospitals; hospital leaders and management at large to spearhead the incident reporting culture in their facilities.

6. CONCLUSION

Regarding the accreditation assessment findings for Fiscal Year 2022/2023, forty-four hospitals were targeting achieving level II of effort. Among them, five achieved the targeted level II (5/44), eleven maintained level II (11/44) twenty-six maintained level I (26/44) and two did not achieve any level (Mibilizi and Remera-Rukoma). Also, three hospitals namely, Gatunda DH, Nyarugenge DH and Gatonde DH, had a target of achieving level I in the current FY 2022/23 where Gatunda managed to achieve level I with an overall score of 90%. Although significant strides have been made in most hospitals, there is still need to institutionalize continuous quality improvement. All the hospitals that did not perform sufficiently at level II will need to commit and adhere to the recommendations put forth in the individual detailed progress reports. There is overwhelming evidence that Hospital leaders should understand the value of quality improvement so that they support their hospital quality improvement initiatives. Lastly, different stakeholders should continually support quality improvement initiatives to embrace quality improvement through the national accreditation program. This is necessary to create and sustain a safe environment for the public, patients, and staff and to ensure continuous quality improvement of healthcare services in Rwanda.

I. ANNEX

Annex *1*: Overall Level I, II & III achievement FY 2022/2023 for all the forty-four hospitals

At level II, each health facility is expected to achieve an average score above 70% for each of the 5 Risk areas. As shown in the table below, the scores reflect the overall average performance of all hospitals total of 44 hospitals.

Color codes: Green: Achieved Level II; Yellow maintained or achieved level I and did not meet level II; Red: Did not achieve any level. The order of presentation followed the level of compliance at Level II.

No	Hospitals	LI Score	LII_Score	LIII_Score
1	Kigeme DH	100%	94%	30%
2	Kirehe DH	100%	93%	57%
3	Mugonero DH	100%	92%	22%
4	Kacyiru	100%	88%	56%
5	Muhororo DH	99%	88%	27%
6	Rwinkwavu DH	98%	86%	53%
7	Kibungo L2TH	96%	85%	37%
8	Masaka DH	98%	84%	26%
9	Ruhengeri L2TH	100%	83%	43%
10	Kibagabaga L2TH	98%	83%	22%
11	Kibuye RH	98%	82%	20%
12	Kiziguro DH	98%	81%	26%
13	Gahini DH	100%	81%	13%
14	Shyira DH	97%	80%	21%
15	Byumba L2TH	97%	80%	28%
16	Butaro L2TH	96%	80%	22%
17	Ngarama DH	98%	80%	25%
18	Kibilizi DH	97%	79%	19%
19	Nyamata L2TH	96%	78%	26%
20	Kabaya DH	100%	77%	18%
21	Murunda DH	98%	77%	7%
22	Gitwe DH	97%	75%	25%
23	Kabgayi DH	97%	75%	23%
24	Kirinda DH	94%	74%	6%
25	Ruhango PH	92%	74%	33%
26	Ndera DH	92%	74%	13%

27	Gisenyi DH	95%	74%	19%
28	Bushenge PH	96%	73%	26%
29	Rwamagana L2TH	93%	71%	23%
30	Muhima DH	92%	69%	24%
31	Nyagatare DH	96%	68%	7%
32	Rutongo DH	93%	63%	11%
33	Kabutare DH	90%	62%	19%
34	Kinihira PH	89%	60%	9%
35	Gakoma DH	91%	56%	12%
36	Nyanza DH	86%	56%	10%
37	Remera Rukoma DH	84%	55%	10%
38	Nemba DH	89%	55%	13%
39	Munini DH	86%	55%	6%
40	Ruli DH	88%	52%	13%
41	Mibilizi DH	81%	50%	17%
42	Kibogora L2TH	85%	48%	17%
43	Kaduha DH	84%	44%	13%
44	Gihundwe DH	89%	42%	5%
	Grand Total	**93%**	**70%**	**20%**

Annex 2: **Detailed performance by standards for forty –four hospitals**

Risk area	LI Score	LII Score	LIII Score
Risk Area 1. Leadership Process and Accountability	**92%**	**63%**	**21%**
S.01 Leadership responsibilities and accountabilities identified	96%	79%	45%
S.02 Strategic and planning	94%	82%	24%
S.03 Management of policies, procedures, protocols, and clinical guidelines	88%	28%	2%
S.04 Management of health information	99%	91%	30%
S.05 Mentorship and oversight of healthcare facilities in catchment area	90%	47%	16%
S.06 Risk Management	87%	50%	5%
S.07 Financial management	91%	62%	2%
S.08 Efficient use of resources	88%	57%	10%
S.09 Leadership for quality and patient safety	97%	76%	25%
S.10 Quality requirements in contracts management	99%	94%	56%
S.11 Integration of quality, safety and risk management	83%	44%	18%
S.12 Compliance with national laws and regulations	97%	79%	30%

S.13 Commitment to patient and family rights	92%	68%	26%
S.14 Patient access to services	92%	65%	12%
S.15 Efficient admission and registration processes	96%	81%	28%
S.16 Effective inventory management	79%	49%	16%
S.17 Effective medical record management	91%	34%	15%
S.18 Oversight of human subject research	96%	22%	8%
Risk Area 2. Competent and Capable Workforce	93%	61%	14%
S.01 Personnel files available, complete, up to date	100%	79%	27%
S.02 Credentials of healthcare professionals	94%	74%	43%
S.03 Privileges for health professionals	88%	25%	6%
S.04 Orientation to hospital and job	90%	54%	7%
S.05 Trained and competent staff	80%	45%	4%
S.06 Sufficient Staff to meet patient needs	87%	56%	5%
S.07 Oversight of students/trainees	99%	84%	18%
S.08 Training in resuscitative techniques	95%	67%	11%
S.09 Staff performance management	95%	68%	6%
S.10 Staff health and safety program	99%	54%	9%
Risk Area 3. Safe Environment for Staff and Patients	**91%**	**71%**	**20%**
S.01 Infrastructure, utilities, resources, equipment, and furniture	62%	23%	5%
S.02 Regular inspection of environmental safety	87%	72%	23%
S.03 Management of hazardous materials	97%	74%	30%
S.04 Fire safety and disaster management	97%	70%	16%
S.05 Biomedical equipment safety	91%	62%	14%
S.06 Stable safe water sources	91%	70%	35%
S.07 Stable electricity sources	96%	89%	43%
S.08 Protection from aggression, violence, abuse and loss or damage to property	89%	50%	1%
S.09 Coordination of infection prevention and control program	96%	82%	30%
S.10 Reduction of health care-associated infections through hand hygiene	99%	85%	23%
S.11 Effective sterilization processes	89%	66%	26%
S.12 Effective laundry and linen services	97%	91%	21%
S.13 Reduction of health care-associated infections	85%	66%	13%
S.14 Barrier techniques available and used	96%	79%	9%
S.15 Proper disposal of sharps and needles	100%	90%	19%
S.16 Proper storage and disposal of infectious medical waste	95%	75%	15%

S.17 Monitoring, reporting, and preventing the spread of communicable diseases	87%	57%	23%
Risk Area 4. Clinical Care of Patients	**95%**	**74%**	**20%**
S.01 Correct patient identification	96%	81%	13%
S.02 Informed consent	98%	65%	11%
S.05 Laboratory services are available and reliable	98%	83%	70%
S.06 Diagnostic imaging services available, safe, and reliable	99%	79%	53%
S.07 Written plan of care	96%	64%	18%
S.08 Clinical protocols available and used	100%	92%	8%
S.03 Medical, nursing and allied health professional assessment and reassessment of patients complete and timely	96%	69%	12%
S.04 Pain assessment, reassessment and appropriate management	92%	35%	7%
S.09 Protocols for managing high-risk patients/procedures	93%	84%	8%
S.10 Comprehensive management of reproductive and maternal health care	94%	93%	18%
S.11 Comprehensive management of newborn care	95%	87%	20%
S.12 Comprehensive management of child and adolescent health care	93%	86%	17%
S.13 Access to safe and adequate nutrition to hospitalized children	89%	54%	8%
S.14 Comprehensive HIV prevention and care	100%	97%	49%
S.15 Comprehensive tuberculosis (TB) prevention and care	86%	78%	43%
S.16 Anesthesia and sedation are used appropriately	94%	76%	23%
S.17 Surgical services are appropriate to patient needs	98%	83%	14%
S.18 Comprehensive management of emergency triage	100%	81%	13%
S.19 Essential emergency equipment and supplies	93%	64%	12%
S.20 Ambulance equipped	95%	67%	15%
S.21 Safe medication use	72%	52%	9%
S.22 Patients are educated to participate in their care	99%	52%	12%
S.23 Communication among those caring for patients	99%	85%	15%
S.24 Referral/Transfer Information Communicated	96%	84%	19%
S.25 Complete & thorough clinical documentation	93%	69%	12%
Risk Area 5. Improvement of Quality and Safety	**95%**	**79%**	**29%**
S.01 Quality and patient safety program	97%	84%	48%
S.02 Effective customer care program	98%	81%	34%
S.07 Staff demonstrate how to improve processes	96%	84%	16%
S.03 Patient satisfaction monitored	94%	76%	29%
S.04 Complaint, Compliment and suggestion process	92%	81%	23%

S.05 Clinical outcomes are monitored	94%	79%	53%
S.06 Incident, near miss and sentinel event reporting system	99%	67%	14%
S.08 Communicating quality and patient safety information to staff	91%	68%	10%
S.09 Staff satisfaction monitored	97%	89%	37%
Grand Total	**93%**	**70%**	**20%**

Hospital	Risk Area 1. Leadership Process and Accountability	Risk area 2. Competent and Capable Workforce	Risk Area 3. Safe Environment for Staff and Patients	Risk Area 4 Clinical Care of Patients	Risk Area 5. Improvement of Quality and Safety	Overal
Kigeme DH	92%	93%	92%	96%	93%	94%
Kirehe DH	96%	96%	84%	93%	100%	93%
Mugonero DH	90%	85%	96%	96%	85%	92%
Kacyiru	79%	97%	84%	90%	100%	88%
Muhororo DH	84%	70%	92%	92%	96%	88%
Rwinkwavu DH	82%	96%	78%	89%	93%	86%
Kibungo L2TH	78%	74%	76%	100%	81%	85%
Masaka DH	71%	78%	94%	85%	93%	84%
Ruhengeri L2TH	72%	73%	98%	79%	100%	83%
Kibagabaga L2TH	75%	70%	86%	84%	100%	83%
Kibuye RH	78%	87%	86%	76%	96%	82%
Kiziguro DH	71%	67%	90%	81%	96%	81%
Gahini DH	80%	73%	73%	84%	96%	81%
Shyira DH	71%	90%	92%	72%	89%	80%
Byumba L2TH	81%	77%	71%	81%	96%	80%
Butaro L2TH	73%	89%	82%	81%	78%	80%
Ngarama DH	67%	63%	88%	85%	93%	80%
Kibilizi DH	87%	80%	67%	81%	82%	79%
Nyamata L2TH	88%	81%	71%	71%	93%	78%
Kabaya DH	71%	77%	82%	75%	85%	77%
Murunda DH	80%	37%	98%	69%	96%	77%
Gitwe DH	63%	63%	73%	83%	96%	75%
Kabgayi DH	47%	57%	92%	89%	74%	75%
Kirinda DH	73%	48%	90%	79%	63%	74%
Ruhango PH	69%	37%	88%	79%	89%	74%
Ndera DH	44%	100%	65%	88%	89%	74%
Gisenyi DH	61%	57%	80%	77%	93%	74%

Bushenge PH	65%	59%	75%	72%	100%	73%
Rwamagana L2TH	85%	57%	51%	75%	85%	71%
Muhima DH	57%	57%	69%	83%	67%	69%
Nyagatare DH	55%	57%	59%	76%	96%	68%
Rutongo DH	45%	33%	63%	80%	81%	63%
Kabutare DH	53%	53%	45%	84%	63%	62%
Kinihira PH	47%	50%	59%	75%	56%	60%
Gakoma DH	55%	37%	59%	65%	52%	56%
Nyanza DH	37%	50%	73%	55%	70%	56%
Remera-Rukoma DH	29%	63%	82%	65%	19%	55%
Nemba DH	54%	27%	49%	61%	85%	55%
Munini DH	45%	43%	41%	79%	48%	55%
Ruli DH	51%	67%	49%	39%	81%	52%
Mibilizi DH	39%	30%	18%	92%	37%	50%
Kibogora L2TH	37%	23%	71%	43%	70%	48%
Kaduha DH	39%	0%	75%	36%	63%	44%
Gihundwe DH	37%	57%	31%	35%	78%	42%

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