STANDARDS FOR MARITIME CLINICS

CONTENTS

		Essential to meet IMHA membership	Standards required to be met for IMHA Accreditation
	Standard 1 CLINIC MANAGEMENT **The organisation is clear about the roles of those leading and are accountable for the quality of services provided.**		
1.1	In countries where clinic licensing is a requirement, the clinic holds a valid licence or otherwise has local or national registration as a healthcare premises *Documentary evidence is required for this criterion.* *Guidance* *The requirement for licensing or registration may depend on the size and scope of the premises. If a government license is held, this should be in date, and the responsible person (medical director or clinic manager) should be aware of the requirements for relicensing. If a licence is said not to be required it may be necessary to check this detail with other sources.* *Insurance should cover public and employers liability and any nationally required insurance.*		
1.2	The clinic holds ISO 9001:2008 certification and this is documented and reviewed every three years. *Documentary evidence is required for this criterion* *Guidance* *This is not essential, but will demonstrate a commitment to quality .*		
1.3	The clinic is accredited by a national accreditation body and this is documented and reviewed every three years. *Documentary evidence is required for this criterion* *Guidance* *This is not essential, but will demonstrate a commitment to quality which will inform the IMHA accreditation process.*		
1.4	There is medical negligence insurance cover in place for claims arising from negligent performance of clinical services provided under any required license. *Documentary evidence is required for this criterion.* *Guidance* *Management should demonstrate that they have taken into account the potential liabilities of both clinic and doctors*		
1.5	There are contracts in place for all services that the clinic uses that are provided by external providers. *Documentary evidence is required for this criterion.* *Guidance* *This should include a clear delineation of service standards expected eg checking identity of seafarers on arrival, time to provision of results or reports, and quality measures in place in the external facility such as*		

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	points and these are circulated to the clinic staff members. *Documentary evidence is required for this criterion.* *Guidance* *It is important that those who miss meetings are updated by means of these minutes. They can also be used in induction of new staff to introduce them to current issues. Clinical discussion meetings should at least have an action list from the meeting.*		

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	maintenance and calibration of equipment. A confidentiality agreement should also be documented and signed by both parties. The contract should also include provision for monitoring services provided		
1.6	The performance of external providers is regularly monitored *Documentary evidence is required for this criterion.* *Guidance* *Documented evidence of the result of the assessment should be available* *This is likely to include the results of any audits carried out on these providers by other quality assessors, national or international accreditation or certification, results from participation in any peer review or from participation in exercises where the analytical results on similar samples are compared by several laboratories.*		
1.7	There is a business development plan for the clinic which sets out annual objectives with timescales, responsibilities and resources needed for achievement. *Documentary evidence is required for this criterion.* *Guidance* *This will include plans for service development, staff development and training, recruitment, redecoration and equipment replacement*		
1.8	The director maintains links with IMHA with regard to the accreditation programme. *Guidance* *Information should be provided by the programme management team prior to the audit.*		
1.9	The organisation publishes and distributes a current practice information leaflet or guide. *Guidance* *Information must be factual and verifiable This may include hard copy leaflets or informational websites Information regarding fees should be clear and comprehensive Information provided for companies, individual seafarers and for others should all be reviewed.*		
	Staff Meetings		
1.10	There are regular meetings with all relevant staff where issues of management, clinical, seafarer experience and quality improvement are discussed. *Guidance* *Meetings should be held at least monthly, although weekly may be preferable. The following issues may be addressed through clinic discussions; staff issues, changes to policies, procedures and protocols, changes to the roles and responsibilities of team members, management arrangements, activity reports and training and development needs and feedback on quality improvement activities. Although this criterion is not relevant to a single handed practitioner, even those with only one staff member should comply*		
1.11	There are documented agendas and minutes of each scheduled meeting with provision for follow up on action		

	Standard 2 : Policies and Procedures The organisation is clear about the systems in place to enable the organisation to achieve its stated objectives to deliver a high quality seafarer service.		
2.1	There are dated, documented policies and procedures which provide the staff with the information required for the running of the clinic. These policies are developed in accordance with local guidelines. The policies and procedures are written/reviewed within the past three years. All staff are aware of these policies and procedures. *Guidance* *These should include administrative tasks such as booking appointments, guiding the patient through the examination process and record keeping as well as specific procedures for each test performed*		
2.2	Clinic staff are involved in the development and review of the policies and procedures.		
2.3	The policies and procedures are reviewed and revised as necessary but at least every three years.		
2.4	The policies and procedures are centrally indexed, compiled into a manual or computer file and are available to appropriate members of staff. *Guidance* *The policy and procedure manual should be seen to be available to all relevant staff, who should be able to demonstrate familiarity with its contents*		
2.5	Adherence to the documented clinic policies and procedures is monitored and audited to ensure compliance. *Guidance* *This should be carried out through a planned programme of internal audits monitoring work practice against the documented procedures.*		
2.6	There is a dated, documented policy on confidentiality of seafarer information which all members of staff understand.		
2.7	There is a signed declaration by all staff confirming their respect of the confidentiality of seafarer information. This declaration is filed in the staff member's personnel file. *Documentary evidence is required for this criterion.* *Guidance* *Staff need to be clear as to who has access to what information at what level, and how this is decided. Statements indicating that seafarer health information can only be communicated to employers or insurers with the consent of the seafarer should be included.*		
2.8	There is a dated documented policy on the acceptance and giving of gifts including those of a monetary value. *Documentary evidence is required for this criterion*		

	Guidance *Acceptance of gifts can lead to biased decision taking and misuse of clinic funds, so it should be made clear to all staff how they should proceed in this area.*		
2.9	There is a policy on the equality of service provision which ensures that all seafarers are treated fairly, uninfluenced by their age, beliefs, colour, culture, disability, gender, lifestyle, race, religion, sexuality and social or work status. The policy has been written/reviewed within the past three years. Staff are aware and there is evidence of implementation. *Guidance* *This should include what training staff receive and their signed statements of understanding of the policy. In addition, feedback should be obtained from staff and their representatives.*		

	Standard 3: Staff **The service is managed and staffed effectively and efficiently in order to achieve its objectives.**		
	General		
3.1	There is a dated, documented organisational chart for the clinic staff team which is available to staff and seafarers and is reviewed annually or when there are changes in the clinic structure. *Documentary evidence is required for this criterion.* *Guidance* *This should include partners, employed staff and attached team members. The organisational chart should specify job titles and lines of accountability.*		
3.2	Doctors are approved by the appropriate national maritime administration (where such approval exists) to perform seafarer medical examinations. *Documentary evidence is required for this criterion.* *Guidance* *If not all doctors are approved, then the final decision on fitness must be made by the approved doctor. They should be able to demonstrate that they are fully responsible for meeting the requirements of the national authority concerned. Fitness decisions and the issue of statutory fitness certificates should not be made alone by a doctor who is not nationally approved.* *Where the administration requires that the medical is done by the doctor approved by them steps should be taken to see that this is the case. Where the administration allows delegation of responsibilities then there should be clear standing instructions indicating the task that has been delegated and how it is to be performed and reported.*		
3.3	The doctors performing seafarer examinations have occupational health qualifications, knowledge or experience. *Documentary evidence is required for this criterion.* *Guidance* *A degree or diploma in occupational health, or a diploma or Masters in Maritime Health are good indicators. Otherwise the doctor should demonstrate knowledge of maritime practice or have at least five years occupational health or medical examiner experience. Doctors in training may perform examinations but final decisions should only be made by those with the above credentials*		
3.4	Clinical students and unqualified staff working in the practice do so under the supervision of an appropriately qualified responsible person.		
	Staff Recruitment		
3.5	There is a dated, documented procedure for the recruitment and selection of all staff including contractors and trainees. *Documentary evidence is required for this criterion.*		

3.6	Clinical staff are registered and licensed with the national registration body prior to employment. *Guidance* *This should ensure that all doctors, nurses and technicians e.g. radiographers, laboratory staff are trained, registered and licensed appropriately.* Checks should be made with the relevant registration and licensing nationally appropriate body before the appointment of new clinical staff		
3.7	There is a system in place to check that up-to-date registration with relevant professional bodies is maintained by clinical staff on an annual basis and this is recorded in their personnel record.		
3.8	All staff have signed and are issued with a copy of the terms and conditions on which they are engaged whether employed, contracted or engaged on any other basis. *Guidance* *These may include the place and hours of work, rate of pay, frequency of payment and review, maternity leave, compassionate leave, disciplinary and grievance procedures, absence through sickness and payments throughout this period, annual leave, health and safety, confidentiality, termination of employment, re-deployment, redundancy, retirement arrangements and pension scheme and compliance with relevant clinic policies and procedures.*		
3.9	A personnel record is maintained for each member of staff in accordance with the prevailing legislation on data protection. *Guidance* *Staff documentation includes for example, CVs, qualifications, references, self declaration re criminal convictions or professional misconduct*		

3.10	All staff hold a job description which has been reviewed in the last three years.		
	Induction training		
3.11	There is a dated, documented induction programme for all new staff and on site contractors which includes the introduction to the clinic's policies and procedures. *Documentary evidence is required for this criterion.*		
3.12	All new staff take part in the clinic's induction programme, attendance at which is recorded. *Documentary evidence is required for this criterion.*		
3.13	The induction programme explains health and safety and emergency procedures to new staff. *Guidance* *This should include fire safety, health and safety, risk management and seafarer emergencies, for example, sudden collapse.*		
3.14	The induction programme includes training in the maritime work environment, and regulations and standards applicable to seafarers where relevant.		

3.15	The induction programme includes training in patient confidentiality. *Documentary evidence is required for this criterion.*		
	Ongoing training		
3.16	There is a documented annual schedule of mandatory training for clinic staff. *Documentary evidence is required for this criterion* *Guidance* *This should include arrangements for providing mandatory training such as basic life support, fire safety, lifting and handling, health and safety and infection control.*		
3.17	All staff receive training and annual updates in health and safety to include: fire safety, control of infection, risk management and moving and handling of patients, equipment or other heavy loads. Attendance at training is recorded. *Documentary evidence is required for this criterion.*		
3.18	Staff using specialised equipment are trained and competent in its use. *Documentary evidence is required for this criterion.* *Guidance* *This should include attendance by a representative from the manufacturer to train staff in the use of any new equipment as well as formal training for any staff member expected to use specialised equipment.*		
3.19	The clinic director is responsible for ensuring that there is a professional development plan for clinical staff.		
3.20	Doctors, nurses and technical staff have a continuing professional development programme in place so that they keep up to date with relevant maritime health topics *Guidance* *For IMHA accreditation doctors should demonstrate attendance at local, national or international meetings relevant to seafarers' health. It is acceptable for one doctor to attend meetings such as ISMH and feed back their findings to others at the clinic, but there should be documented evidence that this occurs. Familiarisation visits to ships to give staff an understanding of the working and living conditions aboard should be included.* *Compliance with advice on training from the authorities for whom certificates are being issued should be confirmed*		
3.21	Doctors, nurses and technical staff have a continuing professional development programme in place so that they keep up to date with relevant clinical topics. *Guidance* *Updating training can include relevant general medical topics such as obesity, hypertension and diabetes, infectious diseases and other areas relevant to seafarers health. This may be contained in a CPD folder and documented plan.*		
	Appraisal and Performance *These criteria would not be applicable in single handed practice, but if there are any staff, then a system is required*		
3.22	There is an annual appraisal/performance management programme which is undertaken by all staff.		

	Documentary evidence is required for this criterion. *Guidance* *An outcome of the meeting would be the continuing professional development required for the staff member.*		
3.23	There is a system in place to deal with poor performance, poor clinical performance and disciplinary issues. *Documentary evidence is required for this criterion.* *Guidance* *The procedures, or if none written, the actual approaches adopted if a member of staff is not performing satisfactorily should be reviewed*		
3.24	A personal and professional development plan is documented for each staff member and reviewed at appraisal.		

	Standard 4: Complaints **Systems are in place to ensure that complaints are handled and investigated through transparent and fair procedures and that the information about services arising from complaints is used to improve quality.**		
4.1	There is a designated person appointed to handle complaints for the clinic and to manage the complaints procedure.		
4.2	There is a documented procedure for dealing with complaints. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *The procedure should identify who deals with the complaint, how the investigation is undertaken, timescale for responding to the complainant and how the lessons learned from the complaint are used to improve the quality of service. All stages of the process should be identified.*		
4.3	The complaints procedure is made available to all clinic staff.		
4.4	The procedure on complaints includes how seafarers are informed about the investigation process. *Documentary evidence is required for this criterion.*		
4.5	There are notices displayed in the clinic advising seafarers how to make a complaint.		
4.6	Complaints are recorded, investigated and acted upon within agreed timescales as detailed in the complaints procedure. *Guidance* *This should include feedback to the complainant.*		
4.7	Complaints are regularly audited and findings acted upon by all staff concerned.		
4.8	A report collating all seafarers' complaints and suggestions is produced and reviewed by the staff on at least an annual basis.		
	Seafarer satisfaction		
4.9	There is a dated, documented procedure on obtaining feedback from seafarers. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation.		
4.10	There is an annual seafarer satisfaction survey undertaken		
4.11	There is a regular satisfaction survey undertaken of manning agencies and other stakeholders.		

	Standard 5: Clinic facilities **The environment, facilities and equipment ensure safe, efficient and effective care for seafarers and staff.**		
	Premises		
5.1	The clinic is well signposted and is easy to find. *Guidance* *Public transport and parking should be reviewed here.*		
5.2	All clinic areas are clean and in good decorative order.		
5.3	Lighting is appropriate for staff and seafarer comfort and efficiency		
5.4	Heating if required is appropriate for staff and seafarer comfort and efficiency		
5.5	Air-conditioning if required is appropriate for staff and seafarer comfort and efficiency		
5.6	Noise levels are appropriate for staff and seafarer comfort and efficiency		
5.7	Clinical areas provide an appropriate level of space and privacy. *Guidance* *This should include not only examination rooms but also facilities for the provision of blood and urine specimens, and any other necessary tests or investigations, and also areas where personal details may be discussed*		
5.8	There are designated consulting rooms and treatment areas.		
5.9	The waiting area is of an appropriate size for the number of seafarers waiting for an appointment.		
5.10	There is adequate storage space.		
5.11	There are toilet facilities solely for the use of patients. *Guidance* *This will depend on the size of the premises and number of cases seen but in larger establishments should be considered essential* *These should be inspected and should be clean, supplied with paper, soap and hand driers or disposable paper towels and have sufficient privacy to safeguard modesty.*		
5.12	There are toilet facilities solely for the use of staff. Guidance *This will depend on the size of the premises and number of cases seen but in larger establishments should be considered essential*		
5.13	Notices and educational displays in the waiting area are informative, clear, kept up to date and in good condition.		
5.14	Seafarers who have been fasting for tests have access to drinks and snacks either in the clinic or near by. *Guidance* *Some clinics are in buildings with food and drink outlets easily available in which case it would not be essential to provide facilities on the clinic site. However water from a safe source should always be available.*		

5.15	There is a planned programme for building maintenance including internal and external redecoration and repairs to the building. *Documentary evidence is required for this criterion*		
5.16	There is a dated, documented procedure for dealing with interruption to power and water supplies. *Documentary evidence is required for this criterion*		
	Equipment *Guidance* *Ideally an examination should be observed, including the correct use of all equipment. If not possible then the correct use of all equipment should be demonstrated.*		
5.17	There is an examination couch of appropriate size. *Guidance* *The examination couch should have disposable covering and be able to be curtained off or otherwise made private.*		
5.18	A functioning stethoscope is available		
5.19	Sphygmomanometer is available.		
5.20	Ophthalmoscope is available		
5.21	Otoscope is available.		
5.22	Height measure is available *Guidance* *The measure itself cannot be recalibrated, but the height from the floor should be checked on a regular basis (e.g. annually) to ensure that there has been no slippage and that it remains accurate. Whether shoes are removed should be noted.*		
5.23	Scales, are available. *Guidance* *What items are removed should be discussed*		
5.24	Snellen chart is available. If acceptable to the relevant administration alternative testing methods such as Keystone machines may be used. *Guidance* *The distance for the patient to stand should be accurately measured and clearly marked. Chart should be in good condition. Lighting should be appropriate, and procedure should be clearly explained by the staff member responsible for testing*		
5.25	Near vision test is available. *Guidance* *The chart should be in good condition, and available in appropriate languages. Lighting should be adequate in the testing area, and procedure should be clearly explained by the staff member responsible for testing*		
5.26	Ishihara or other nationally approved colour vision test is available. *Guidance* *The test material should be in good condition. Lighting should be*		

	appropriate in the testing area either daylight or equivalent colour balance, and procedure should be clearly explained by the staff member responsible for testing *The details of the way in which the test is administered should be checked to ensure that the scope for cheating is minimised.* *Where supplementary tests are recommended by the authority whose certificate is being issued, staff should be aware of these, have arrangements for access and take account of the results when taking decisions on fitness.*		
5.27	Audiometry equipment is available. *Guidance* *Referral is an acceptable alternative. Unless only used for screening a booth should be available, and ambient noise levels should be suitable.*		
5.28	Spirometry equipment is available . *Guidance* *Referral is an acceptable alternative.*		
5.29	ECG equipment is available. *Guidance* *Referral is an acceptable alternative.*		
5.30	Exercise tolerance test is available for seafarers either on site or by referral. *Guidance* *If stress test being done on cardiac patients there should be a clear procedure for transfer to a specialist unit if required.Resuscitation drugs and equipment should be available for use by suitably trained staff who are regularly updated..*		
5.31	Physical capability testing is available on site or by referral. *Guidance* *This could include modified Chester step test or alternative known test.*		
5.32	Basic dental inspection equipment is available and is included in a documented programme of, upgrade and replacement. If the dental service is not provided the service can be referred. *Guidance* *Where in house dental services undertake work for which they charge seafarers or employers there should be audit systems in place to check that the work is clinically needed.*		
5.33	Specialised equipment is used only by staff trained and competent in its operation. The evidence of this training is in their staff file. Guidance *Staff records should include documented evidence of this training, and at interview staff should be able to confirm that they have received this training and can demonstrate competency in operation of the equipment*		
5.34	Up to date instruction manuals are available for all equipment used by staff. *Guidance* *These manuals should be available near the relevant equipment, or staff should be aware of where they can be found*		

	Standard 6: Health and Safety **The organisation has systems in place for the management of health and safety issues in accordance with statutory requirements; these include training of staff in health and safety measures as required for their work**		
6.1	There is a dated, documented Health and Safety Policy for clinic and staff which is reviewed on an annual basis and includes the management of risk. *Documentary evidence is required for this criterion.* *Guidance* *This policy should be in line with local and national requirements*		
6.2	The clinic director has responsibility for the health and safety and risk policies and practice for the clinic.		
6.3	A nominated person(s) has responsibility for risk management including the regular assessment of risk for the clinic.		
6.4	Arrangements are in place to obtain competent health and safety advice. *Guidance* *This includes advice from infection control experts and those advising on health and safety issues relevant to the clinic*		
6.5	Health and safety risk assessments are regularly undertaken and the results of these are documented and acted upon. *Documentary evidence is required for this criterion*		
6.6	The reporting of injuries, diseases and dangerous occurrences is carried out in accordance with the current local regulations. *Guidance* *This should include near misses*		
6.7	There is a documented assessment of all chemicals / products in use and their storage which is in line with the manufacturers instructions. *Guidance* *This includes cleaning products and laboratory chemicals*		
6.8	There is an appointed person(s) who takes charge of first-aid arrangements. *Guidance* *There should be an appropriate number of staff trained in first aid and on duty when the clinic is open.*		
	Fire safety		

	Standard 6: Health and Safety **The organisation has systems in place for the management of health and safety issues in accordance with statutory requirements; these include training of staff in health and safety measures as required for their work**		
6.1	There is a dated, documented Health and Safety Policy for clinic and staff which is reviewed on an annual basis and includes the management of risk. *Documentary evidence is required for this criterion.* *Guidance* *This policy should be in line with local and national requirements*		
6.2	The clinic director has responsibility for the health and safety and risk policies and practice for the clinic.		
6.3	A nominated person(s) has responsibility for risk management including the regular assessment of risk for the clinic.		
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6.7	There is a documented assessment of all chemicals / products in use and their storage which is in line with the manufacturers instructions. *Guidance* *This includes cleaning products and laboratory chemicals*		
6.8	There is an appointed person(s) who takes charge of first-aid arrangements. *Guidance* *There should be an appropriate number of staff trained in first aid and on duty when the clinic is open.*		
	Fire safety		

6.9	There is a dated, documented emergency procedure to follow in the event of a fire. The procedure is regularly reviewed. All staff are aware of the procedure and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
6.10	Competent advice on fire safety is obtained and the arrangements for this are documented.		
6.11	Fire escape routes in the clinic are free of obstruction and accessible at all times and are clearly signposted.		
6.12	Fire fighting equipment is in place and appropriate to the type of fire most likely to occur in the area in which it is located. *Guidance* *Fire fighting equipment includes fire extinguishers and fire blankets. It should be clearly marked with regard to the type of appliance with instructions for use.* *Particular attention should be paid to hazardous areas, such as kitchens, health record storage areas, refuse collection area and treatment rooms where potentially hazardous gases are used.*		
6.13	There is a fire alarm system that is regularly tested and subject to a full annual maintenance check.		
6.14	Fire fighting equipment is serviced annually by a qualified person and records of checks are maintained. *Documentary evidence is provided for this criterion.*		
6.15	All staff participate in fire drills on an annual basis.		
	Security		
6.16	There is a security system in place to ensure the security of the clinic. *Guidance* *This could be through the use of secure locks and an intruder alarm or security guard. Procedure for locking or securing the clinic out of hours should be discussed with staff.*		
6.17	There are security systems to protect staff working in the dispensary.		
6.18	There is a dated, documented procedure on access to keys and key holders, including access out-of-hours. The procedure has been written/reviewed within the past three years. All staff are aware of the procedure and there is evidence of implementation.		

	Documentary evidence is required for this criterion.		
6.19	A staff identification system is in place in clinics with more than five staff.		

	Standard 7: Infection Control There are system in place to ensure that the risks to seafarers and staff are minimised		
7.1	There are hand-washing facilities in all treatment and examination areas *Guidance* *A clean hand basin with hot and cold running water, soap (preferably liquid soap in a dispenser) and disposable towels or hot air dryer should be available. Where this* is not feasible, in some circumstances alcohol gel may be used as long as handwashing *facilities are nearby.*		
7.2	There are separate clean and dirty utility facilities. *Guidance* *This is required where specimens are dealt with, or when laundry is stored.*		
7.3	Appropriate containers are used for the disposal of sharps and kept in close proximity to the area where contaminated sharps are generated. *Guidance* *Thses should be used appropriately, properly put toegether,not overfilled and kept in a safe place.*		
7.4	There are separate areas for refrigerated storage for specimens, food items and drugs. *Guidance* *Specimens and reagents should not be kept in the same refrigerator as food and drink for either staff or patients*		
7.5	There is a dated, documented procedure on protection of staff and seafarers from infection risks, which is line with national guidelines. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion*		
7.6	There is a dated, documented procedure covering the prevention of and action to deal with sharps incidents (including needle-stick injuries). The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion*		
7.7	There is a dated, documented procedure for the safe and secure storage and disposal of clinical waste including the disposal of sharps in appropriate containers. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion*		
7.8	There is a dated, documented procedure covering accidental spillage of blood and body fluids. The procedure		

	has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion*		
7.9	There is a dated documented procedure covering the decontamination and storage of medical devices. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *Items designated as single use should not be processed for re-use.*		
7.10	All relevant clinical staff are appropriately vaccinated against Hepatitis B, and response to vaccination checked and recorded. *Guidance* *The clinic could also consider the need for immunisation regarding, polio, TB, tetanus and rubella. Staff should be vaccinated according to risk.*		

	Standard 9: Finance There are process in place for financial management which enable the organisation to meet its financial objectives.		
9.1	Responsibility for the financial management of the clinic is clearly defined.		
9.2	There is a dated, documented procedure for recording and monitoring of income and expenditure. *Documentary evidence is required for this criterion.*		
9.3	There is a dated, documented procedure for the authorisation of expenditure. *Documentary evidence is required for this criterion.*		
9.4	There is a dated, documented procedure for the management of invoicing and collection. *Documentary evidence is required for this criterion.* *Guidance* *This should include how the invoicing frequency is agreed and consistently applied.*		
9.5	There is a dated, documented procedure for the auditing of accounts. *Documentary evidence is required for this criterion* *Guidance* *This should include both internal audit and external audit should be considered.*		
9.6	There is a dated, documented procedure for the handling of petty cash. *Documentary evidence is required for this criterion.*		
9.7	There is a dated, documented procedure for paying salaries. *Documentary evidence is required for this criterion.*		
9.8	There is an annual audit of the financial procedures to ensure compliance.		

	Standard 8: Information Technology There is a systematic approach to the management of information and electronic information systems		
8.1	There are documented instructions/procedures for the use of the information technology system within the clinic. *Documentary evidence is required for this criterion.*		
8.2	There are documented instructions/procedures which describe the central systems and procedures for routinely backing up or preserving and restoring key information technology systems and data. *Documentary evidence is required for this criterion.*		
8.3	There are documented instructions/procedures on the confidentiality, management and safe-keeping of health records. *Documentary evidence is required for this criterion* *Guidance* *This should include mention of the requirement that no information should be released without written informed consent. A valid exception to this would be a clinician who is asked for a single report on a seafarer for whom they have cared The Procedures should include the process for the retiresment of the doctor or closure of the business*		
8.4	Computer equipment is available and fit for purpose. (detail operating system)		
8.5	Microsoft Office or other word processing and spreadsheet software is available within the clinic.		
8.6	Internet access is available to staff within the clinic. *Guidance* *Relevant staff should be able to access relevant web based information on maritime health*		
8.7	There is a system in place for accessing help in the event of a technology system failure.		
8.8	All electronic record information systems are password protected.		
8.9	All electronc seafarer health records are kept confidential, and access is only permitted to staff who are authorised by the medical director or clinic director		
8.10	The appropriate sections of the seafarer's health record are available for all consultations held in the clinic.		
8.11	There is a dated documented procedure on the length of		

	time that records are kept and the secure destruction of records after that period. All relevant staff are aware. *Documentary evidence is required for this criterion.*		
8.12	There is a procedure for the erasure of the hard disc on any computer that is disposed of or moved to another service		

	Standard 10: Clinical Practice **Clinical services are provided by trained staff in an environment which facilities high quality care.** *Guidance:* *The doctor who undertakes medical examinations should be asked to describe the procedures followed and be asked questions about how they undertake particular parts of the examination. This should be done in a way that will enable those aspects of the standards being applied that can be detected at clinical examination to be assessed. There should be discretion to undertake a more detailed examination where this is indicated by the medical history, clinical tests or examination findings. The time allocation for the examination should be noted and its compatibility with the examination required under the standards used be assessed. It is useful to have a number of scenarios or problems that may arise during the clinical examination and to ask the examiner how they would handle them.*		
	Appointments		
10.1	The clinic offers seafarers a range of times when appointments can be booked during the week. *Guidance:* *Staff making bookings should be asked about how these are made, about the instructions they give to those attending and about any procedural instructions that they have to inform them of the requirements for the medical examination*		
10.2	There is a facility for making urgent appointments when required for those seafarers who are called back to sea at short notice. *Guidance* *This should not allow for a poor decision to be made due to lack of time, so appointments should be refused if an unreasonable request is made.*		
10.3	Seafarers are offered the opportunity to see a doctor of the same sex if they wish when making their appointment. *Guidance:* *Although this will very depending on the cultural environment it should be considered as best practice but is not essential. This is plainly not applicable in a single handed or very small practice.*		
10.4	Chaperones are made available to seafarers upon request. *Guidance* *Although this will vary depending on the cultural environment it should be considered as best practice. Alternatively, the seafarer could be encouraged to bring their own chaperone to the examination*		
10.5	Staff Duty rotas are compiled for clinic operating hours and are available for all staff.		
10.6	There is a system that records messages about appointments and requests for visits. The system ensures that the appropriate doctor or team member receives and acts upon the message.		
10.7	There is a confidential consulting room provided for all seafarer consultations and clinical examinations.		
10.8	All staff recognise and respond to seafarers' needs for personal privacy and dignity at all times.		

10.9	Seafarer confidentiality is respected at all times by all members of the clinic. *Guidance* *A valid exception to this would be a clinician who is asked for a single report on a seafarer for whom they have cared.*		
10.10	There is a consent form which details who is able to be provided with information about the seafarer, and what level of fitness can be provided *Guidance* *This applies to the release of fitness decision to an employer or manning agency or specific clinical details to a company doctor if applicable*		
10.11	Seafarers are informed about how their personal health information is recorded and used, how to access their personal information and their rights in relation to how their personal health information is used and shared *Guidance* *Evidence may include copies of leaflets which define seafarers rights and documentation of how these leaflets are distributed* *Health questionnaires and other health forms that are given to seafarers contain explicit statements to describe how personal health information is used and how they may access that information* *Minutes of meetings with seafarers and/or their representatives to demonstrate that such information has been communicated* *A protocol which defines how seafarers are informed about: how their personal health information is used and how workers may access that information and documented evidence of adherence to that protocol.*		
10.12	All seafarers are required to provide photographic proof of identity by means of passport, seaman's book or driving licence.		
10.13	Examination forms are identified with a photograph of the seafarer or other unique biometric data. *Guidance* *This is particularly important where the seafarer is seen and examined by a number of different people. In the absence of this acceptable alternative arrangements for avoiding impersonation must be demonstrated*		
10.14	History taking is either performed by the doctor responsible, or delegated to a specifically trained clinical staff member and then checked by the doctor making the fitness decision *Guidance.* *The interaction between the history taker and the seafarer should form an important part of the process and the patient record should detail which clinician undertook which part of the process.* *The history taker should be asked to describe the process of history taking that they use. Its compatibility with the standards being applied should be confirmed. They or any other clinical staff member who sees the seafarer should have the time and freedom to explore any points raised during the history taking in more detail, not only those that relate specifically to the standards but also those that relate to any concerns about health that the seafarer may have. The method adopted by the history-taker when they are uncertain about the answer given by a seafarer should be discussed. It is useful to have a number of scenarios of particular history taking difficulties available to ask how these are handled in practice.*		

10.15	Request forms for external investigations are completed in full. *Guidance* *This may be achieved by completing a simple request in the notes where investigations are performed in house whereas more detail will be required for outside tests in order to aid interpretation by external specialists.*		
10.16	Clinical staff are aware and comply with the relevant international, national or company prescribed fitness standards/guidelines. *Documentary evidence is required for this criterion.* *Guidance* *In some areas the national standards will be the only ones used, whereas clinics performing examinations for a number of different organisations may need to hold copies of other national standards as well as international conventions and guidelines from UN agencies, and company requirements. Standards relevant to the specific certificate must be followed.* *Staff should be questioned on the standards used, their understanding of them and how they resolve any difficulties in their application. Scenarios of problem situations are a useful way of exploring understanding. This aspect may need to be re-visited once the clinical records have been reviewed in the light of decisions taken and any inconsistencies identified*		
10.17	The national and local clinical and best practice guidelines are available for all clinical staff.		
10.18	The clinic has documented guidelines as to how to proceed following abnormal clinical findings. *Documentary evidence is required for this criterion* *Guidance* *There is a duty to act on abnormal findings and ensure that a care pathway is instigated. Confidentiality must be observed.* *Discussion of scenarios with the staff responsible may help assess how these guidelines are applied. Further discussion after clinical records have been examined may also be useful.*		
10.19	There is a procedure for collecting and processing blood samples. All relevant staff are aware of the procedure. *Documentary evidence is required for this criterion*		
10.20	There is a procedure for collecting and processing urine samples. This procedure includes chain of custody of samples if testing for drugs and alcohol is required. The procedure has been written/reviewed within the past three years. All relevant staff are aware of the procedure. *Documentary evidence is required for this criterion*		
10.21	In clinics performing drug and alcohol testing there are guidelines covering action for positive findings, and there is a medical review officer involved in the process. *Guidance.*		

10.22	There is a written procedure for carrying out all tests performed, for example ECG, audiometry, X-ray. *Documentary evidence is required for this criterion* *Guidance* *The procedure should include advice on action where the result is abnormal or where difficulty is encountered in performing the test itself.*		
10.23	There is a dated, documented procedure for gaining the seafarer's consent for specific tests. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *This should include which procedures require written consent (eg HIV testing), who should obtain that consent and how it is to be recorded, guidance for staff and parents/ guardians on obtaining informed consent or from giving information on the potential risks and side effects of the treatment/ procedure, information that can, or cannot be given to relatives and or carers.*		
10.24	There is a dated, documented procedure for recording and acting on reports or results of investigations. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
10.25	There is a dated, documented procedure for giving the results of investigations to seafarers. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *This should include how information is provided in writing to all seafarers who fail their medical examination or who have restrictions placed on their work at sea.*		
10.26	The clinic has a documented procedure for the resolution of disagreements on certification decisions. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion* *Guidance* *This is separate to the clinic's complaints procedure. This is to ensure that it is clear what action if any may be taken by the seafarer in this position Examples should be reviewed to assess their application in practice. This is not essential if there is a locally accessible statutory appeals process but there needs to be a documented link to the process.*		
10.27	There is a dated, documented procedure for making referrals, including monitoring and follow up. The procedure has been written/reviewed within the past three years. All		

	staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion* *Guidance* *If referral is required, it should be made quite clear to the seafarer from the outset who will be responsible for any expenses incurred. This should be in accord with national legislation and with the requirements of the relevant international conventions. Where referrals are made the clinic should have arrangements in place to ensure that only clinically justifiable investigations and treatments are performed*		
10.28	The clinic has a list of specialists or specialist facilities to whom they can refer a seafarer when necessary. *Documentary evidence is required for this criterion* *Guidance* *The services listed should hold a contract/service level agreement with the clinic and meet the required quality standards.*		
	Quality Improvement		
10.29	Information on waiting times of seafarers in the waiting room is collected, evaluated and acted upon. *Guidance* *Short waiting times can be a good indication of efficient clinic organisation. Evaluation of waiting times provides the opportunity to review clinic practice.*		
10.30	The clinic identifies the number of medical examinations on seafarers performed per year. *There is documentary evidence for this criterion.* *Guidance.* *Returns to the national authority should be reviewed if these are a national requirement*		
10.31	The organisation has identified the number of seafarers passed fit or unfit with reasons. *There is documentary evidence for this criterion.* *Guidance* *The use of this information is important and should be discussed. The files of unfit seafarers should be reviewed by an appropriate clinician to ensure consistency of assessment.*		
10.32	Data on reasons for unfitness are analysed so that trends and areas for concern can be identified and acted upon		
10.33	The timescale required by the clinic in providing a fitness decision is identified and documented.		
10.34	Examinations or tests carried out by a third party are monitored and details are documented. *Documentary evidence is required for this criterion*		

	Guidance *This should include information about errors, late results or any other problems*		

	Standard 11: Health Record There is an accurate and legible record for every seafarer which ensures that the service provided to the seafarer is recorded in detail. The data recorded can be used in disputes or legal proceedings.		
11.1	There is a single record held for each seafarer. *Guidance* *The record can either be electronic or paper, according to clinic practice.*		
11.2	Each paper document is firmly fixed within the folder.		
11.3	All health records are stored confidentially.		
11.4	All entries in the health record are dated, timed and signed.		
11.5	Records contain full seafarer demographic information. *Guidance* *This includes full name, address, date of birth, gender and nationality*		
11.6	The health record contains a unique seafarer number. *Guidance.* *Seamans' book is satisfactory or state identity document or a unique clinic reference number.*		
11.7	The health record contains the seafarer's address, postal code and telephone.		
11.8	The health record contains the seafarer's date of birth.		
11.9	Fitness certificates are completed accurately and in full *Guidance* *Completion should be in accord with the standards for the authority that issues the certificate and be compatible with the findings in the clinical record. Where certificates are issued for more than one authority after a medical examination, each should be issued if the requirements of that authority are met and they should not be withheld because the seafarer does not meet the requirements of other certificates being issued at the same time.* *When duplicate copies are held the quality of reproduction should be such that all the wording is legible*		
11.10	Each seafarer contact with a clinician is recorded in the seafarer's record including consultations and telephone advice. *Guidance* *All such records should be legible. If original hand written records are transcribed by administrative staff onto the computer there should be some method of checking that this has been done accurately, and the original record made during the examination should be kept*		
11.11	The health record, where relevant, contains information from other health professionals, including hospital letters and investigation reports.		
11.12	The health record lists all medicines that a seafarer is taking and all prescription details.		
11.13	There is a system of allergy 'alert' notation in place, which is used consistently in all health records and on prescriptions.		

11.14	Any drugs administered are recorded, including dosage and batch number.		
11.15	Details of any specimens taken are recorded.		
11.16	The name of the doctor undertaking any procedure is recorded.		
11.17	The name of the doctor making the fitness decision is recorded		
11.18	The basis for a decision of unfitness is clearly recorded, along with advice to the seafarer about any specific action that should be taken		
11.19	The health records are regularly audited against the criteria in this standard. *Guidance* *This should include legibility, accuracy of transcription and the distribution of results in relation to accepted norms. Results of health record audits should be part of regular review with documented action plan for improvement. The results of this audit process should be reviewed and the actions taken based on its findings assessed.*		
11.20	The results of the audit are reported and used to inform improvements in the recording by clinicians.		

	Standard 12 - Laboratory service Laboratory services are provided by appropriately qualified and trained staff using safe and effective techniques, facilities and equipment.		
12.1	Facilities are available either in house or externally to provide the following tests in areas where these are required either by company or national standards.		
12.2	Haematology		
12.3	Biochemistry		
12.4	Hepatitis A		
12.5	Hepatitis B		
12.6	Hepatitis C		
12.7	HIV		
12.8	VDRL		
12.9	Food handlers screen		
12.10	Drug and alcohol testing		
12.11	Urinalysis		
12.12	Where the laboratory service is provided by an external organisation there is a documented contract which details the service to be provided and the timescales for receiving the results. *Documentary evidence is required for this criterion.*		
12.13	The external laboratory service has received quality certification from a body approved nationally for pathology services if this exists. *Documentary evidence is required for this criterion.*		
12.14	The laboratory service ensures that the procedures for specimen collection are accessible to all staff involved in obtaining specimens from seafarers and transporting specimens to the laboratory service.		
12.15	The organisation keeps records of all specimens forwarded to other laboratories.		
	When the laboratory service is provided by the clinic the following standards are relevant:		
12.16	The laboratory service holds a nationally recognised certification from a body approved for laboratory services if this exists. *Guidance* *If the clinic holds a current certification such as CPA or, Sanas, then the following standards will be deemed to be met, as long as the certificate is in date and the report of the previous visit is available for inspection by the IMHA assessor.*		
12.17	The laboratory safety rules are regularly reviewed and given to all laboratory staff on appointment and when revisions are made. There is a system for alerting staff to revisions and there is evidence of implementation.		

12.18	There are dated, documented procedures for the performance of each test, including equipment preparation, samples, reagents and calculation of results. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *This includes, biochemistry, haematology, HIV testing, Hepatitis A, B, C, VDRL, Food handlers screen, drug testing, alcohol testing, urinalysis.*		
12.19	There are written procedures for blood, urine and stool specimen collection and storage. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *This includes, biochemistry, haematology, HIV testing, Hepatitis A, B, C, VDRL, Food handlers screen, drug testing, alcohol testing, urinalysis.*		
12.20	There are appropriate areas for handling and storage of specimens.		
12.21	There are dated, documented procedures for the completion of test request forms and specimen labels. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
12.22	There is a dated, documented procedure for the recording and reporting of test results. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
12.23	There are dated, documented procedures for the receipt and rejection of samples and request forms including the receipt of high-risk specimens. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
12.24	The laboratory keeps records of all specimens received in accordance with national requirements.		
12.25	There is a dated, documented procedure for the retention of specimens, records and reports. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		

12.26	There are dated, documented procedures for the disposal of specimens and reagents used, including the disposal of clinical and other waste arising in the laboratory. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
12.27	There are dated, documented procedures for the management of materials used by the service. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion* *Guidance* *This includes the quantities of laboratory reagents ordered, received and how these quantities accord with the number of tests performed and recorded in clinical files..*		
12.28	Within the laboratory, a designated area is available for receiving, dispatching and handling specimens, including a separate area for dealing with high-risk specimens.		
12.29	Within the laboratory, a designated area is available for storage of specimens, reagents and records, including a separate storage area for high-risk specimens.		
12.30	Within the laboratory, facilities are available for the safe disposal of cultures, potentially infectious clinical material, organic solvents and radioactive materials.		
12.31	The laboratory has an effective system for drainage and control of effluent.		
12.32	The laboratory environment supports staff working with regard to ventilation systems, particularly for fume extraction, heating and lighting.		
12.33	The laboratory has temperature-controlled facilities for storage of specimens and temperatures are recorded on a daily basis. *Guidance* *There should be a completed temperature log for each refrigerator*		
12.34	Appropriate protective clothing and personal protective equipment are provided to staff. *Guidance* *For example, gloves, aprons*		
12.35	There are dated, documented procedures for the calibration of all test equipment including tolerance levels and actions to be taken if results are outside recommended limits. The procedure has been written/reviewed within the past three years. All staff are aware and there is evidence of		

	Implementation. *Documentary evidence is required for this criterion.*		
12.37	There is an internal quality control system in place.		
12.38	The laboratory participates in national or other QA schemes based on exchange of samples and correlation of findings. Action is taken if out of compliance with norms.		
12.39	Staff participate in clinical audit meetings with other services in the clinic.		

	Standard 13: X-Ray service X-ray is undertaken by qualified staff in a risk-managed environment in accordance with published professional guidance.		
13.1	Practice conforms to local regulations governing the use of radiation.		
13.2	Practice ensures dose minimisation is considered. *Guidance.* *This includes replacement of old equipment with lower dose alternatives, and use of X-rays limited to acceptable situations with reference to good practice guidance.*		
13.3	Imaging procedures are performed only upon written request from an approved and suitably qualifed referral source.		
13.4	There are dated, documented, safety procedures specific to the work of the department and the equipment used. The procedure has been written/reviewed within the past three years. Staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
13.5	There is a dated, documented procedure for verifying the identity of seafarers to be exposed to ionising radiation. The procedure has been written/reviewed within the past three years. Staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
13.6	There are prominently displayed signs warning pregnant women of the dangers of radiation to the foetus. Where appropriate, these signs are multilingual.		
13.7	Appropriate shielding and protective clothing is provided in the presence of radiographic equipment and practice conforms to local or national guidelines.		
13.8	Staff working with radiological equipment wear dosemeters. *Guidance:* *Every effort should be made to obtain dosemeters if it is not a national requirement in order to work towards IMHA accreditation. Exemption to this standard will only apply if there is documented evidence that it is not possible to obtain dosemeters nationally.*		
13.9	The radiation monitoring devices are assessed periodically in accordance with national regulations and reports are made. *Guidance:* *Reports should be made to the person in charge of X-ray and also to the staff concerned*		

13.10	Continuous records of the assessments of the monitoring devices are kept for the working lifetime of classified workers employed by the service. *Documentary evidence is required for this criterion.*		
13.11	All equipment is calibrated in accordance with regulations, and records of calibration checks are kept.		
13.12	Records of safety assessments are kept.		
13.13	Clinic staff (doctors or radiologists) performing X-Rays are trained for the equipment used and hold the relevant certificate.		
13.14	The clinical justification for requests is assessed in accordance with locally approved guidelines.		

	Standard 14: Immunisation service Arrangements are in place to ensure the safe and secure provision of the immunisation service by qualified/experience staff.		
14.1	There is a protocol for vaccine management which includes ordering and receiving vaccines, maintaining correct temperature of stored vaccines, handling vaccines during immunisation sessions, disposal of vaccines, actions in the event of interruption of the cold chain and the treatment of anaphylaxis. The protocol has been written / reviewed within the last three years. All relevant staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
14.2	Staff administering vaccines have been trained for each vaccine administered. *Guidance* *Evidence of training should include records of internal training against the protocol for vaccine management.*		
14.3	Batch numbers are recorded for all vaccines administered. *Guidance* *The batch number should be included in the seafarer record as well as any vaccine requirement for recording.*		
14.4	There is a system in place to ensure that sufficient supplies of vaccinations are available to meet seafarer needs. *Guidance* *The system should ensure that when seafarers attend for vaccinations and immunisations that the correct medicine is available for administration following booking.*		

	Standard 15: Pharmacy service: Arrangements are in place to ensure the safe and secure provision of medicines by qualified/experience staff.		
15.1	The pharmaceutical service is managed by a qualified pharmacist where a pharmacy service is in place.		
15.2	There is a system for obtaining current legislation and guidance relating to medicines management.		
15.3	There is a dated, documented stock control procedure, which includes the ordering of drugs and vaccines, and the safe disposal of out of date stock. The procedure has been written/reviewed within the past three years. Relevant staff are aware of the procedure and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
15.4	There is a dated, documented procedure on dispensing drugs. The procedure has been written/revlewed within the past three years. Relevant staff are aware of the procedure and there is evidence of implementation. *Documentary evidence is required for this criterion.* *Guidance* *The procedure should include who can dispense drugs and what training is required for them to undertake the task.*		
15.5	There is a dated, documented procedure for maintaining the cold chain. This includes destruction of drugs or vaccines that have not been held at the correct temperature. The procedure has been written/reviewed within the past three years. Relevant staff are aware of the procedure and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
15.6	There is a dated, documented procedure for the safe disposal of medicines. The procedure has been written / reviewed within the last three years. Relevant staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
15.7	There is a dated, documented procedure on drug defect and adverse reaction reporting which complies with national and local guidelines. The procedure has been written / reviewed within the last three years. Relevant staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		

15.8	There is a dated, documented procedure on the regular cleaning of the floor, shelving and utensils used. The procedure has been written / reviewed within the last three years. Relevant staff are aware and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
15.9	Keys to the pharmacy department or drugs cupboards are held through a secure process which is documented. *Documentary evidence is required for this criterion*		
15.10	Medications are kept in the dispensary in their original packaging.		
15.11	Stock levels and expiry dates are regularly monitored.		
15.12	There is secure storage for medicines and prescription stationery, which conforms to national requirements.		
15.13	Hazardous material is stored appropriately, e.g. reagents, oxygen.		
15.14	Vaccines and other medicines requiring refrigerated storage are kept in designated refrigerators in accordance with manufacturers instructions.		
15.15	There are written records of readings of maximum and minimum temperature of each refrigerator. *Guidance* *The records should be taken on every working day, together with a note of the corrective action taken if the temperature is found to fall outside of the agreed range.*		
15.16	Dispensary staff have a valid, recognised dispensing qualification.		
15.17	Dispensary staff act in accordance with legislation affecting pharmacy practice and current professional guidelines.		
15.18	Dosage dispensers are available when drugs requiring their use are dispensed.		
15.19	Dispensing errors are recorded, investigated and reviewed.		
15.20	Supplementary labels / information leaflets from the manufacturer are included with the prescribed medication.		
15.21	The seafarer is given clear written and verbal dosage instructions and counselling on his/her medication.		
15.22	Pharmaceutical records are kept in accordance with legal requirements.		

15.23	The dispensing surface is made of smooth, impervious material.		
15.24	The dispensary area has a sink with hot and cold water supply.		
15.25	The dispensary area is equipped with weighing, measuring and counting equipment.		
15.26	There is a systematic review of medicines usage, for example, drug utilisation evaluation and monitoring adverse reactions.		
15.27	The pharmacy service is involved in the clinic's audit programme		

	Standard 16: Quality improvement and audit **There is a regular review programme of the service provided by the organisation and this review informs the development of the service.**		
16.1	There is a dated, documented programme on quality improvement and audit for the clinic which involves all departments within the clinic. All staff are aware of the programme. *Guidance* *This will identify and address key priorities for action to improve its service and be drawn from national and local legislation. All clinic staff should participate in the* programme of quality audit. The programme should also include the action plan to achieve IMHA accreditation.		
16.2	The clinic director is responsible for formulating and monitoring the clinic's quality improvement and audit programme.		
16.3	There is a planned programme of clinical audit involving all clinical departments in the clinic which includes the identification of areas for audit. *Guidance* *This will include the audit of seafarer records, adverse events, needlestick injuries, complaints.*		
16.4	The results of the quality audit and the actions to be taken are circulated to the clinic team members .		
16.5	There is a procedure for dealing with adverse incidents and near misses in the clinic. The procedure has been written/reviewed within the last three years. All staff are aware of the procedure and there is evidence of implementation. *Documentary evidence is required for this criterion.*		
16.6	Adverse incidents and near misses are reported, recorded and action is taken as a result. *Documentary evidence is required for this criterion.*		
16.7	All adverse events are collated and a report is sent to the national reporting agency if required by local legislation.		
16.8	The clinic is involved in developing and delivering improvements to seafarers health. *Guidance* *The clinic should contain a clear objective of how the seafarers medical examination will be improved with expected improvements in efficiency and effectiveness and how this will be measured, an assessment of risks, liaison with other associated services.*		
	Clinic development		
16.9	There is a dated, documented organisational development		

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	plan which takes account of national and local targets and priorities and and this is reviewed annually. *Documentary evidence is required for this criterion.* *Guidance* *The plan should focus on health outcomes for the seafarer and include health improvement plans, prescribing, clinical governance, seafarer satisfaction, staffing, premises, and partnership with seafarers.*		