



المجلس المركزي لإعتماد المنشآت الصحية

Central Board of Accreditation for Healthcare Institutions

# CENTRAL BOARD OF ACCREDITATION FOR HEALTHCARE INSTITUTIONS

## Hospital Standards 2<sup>nd</sup> Edition - June 2011



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## Forward

The Central Board of Accreditation for Healthcare Institutions (CBAHI) is dedicated to improve the health services in the Kingdom of Saudi Arabia. To fulfill our mission as a driver for continuous improvement, the development of CBAHI accreditation system is a dynamic process. CBAHI is intended to include all healthcare facilities in the accreditation program over time.

This set of CBAHI standards recognizes the significant role of Hospital Care in the Kingdom, in different settings, and with different entities in ownership and operations. These standards address the care of individuals in hospital environment and designed to ensure the provision of safe and high quality care. The intent of the Hospital standards is to keep them relevant and adaptable to all types of facilities licensed as hospitals in the Kingdom.

The development of accreditation standards for hospitals aims to facilitate self assessment against CBAHI standards, ongoing performance improvement and effective survey preparation.

This manual provides important information about CBAHI, the Hospital accreditation standards, eligibility for accreditation, scheduling accreditation surveys, survey preparation, the on-site survey, and the accreditation decision rules.

Our appreciation and gratitude goes to the CBAHI team that contributed to the development, compilation, design, review, revision, and production of this manual. We extend our appreciation to the healthcare professionals who were generous with their feedback and suggestions to ensure the fulfillment of our mission.

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## Introduction

### Definition of Accreditation

Accreditation is a self-assessment and external peer review process against stated peer-set standards. The accreditation survey is a formal process by which a recognized body assesses and recognizes that a health care organization meets applicable predetermined and published standards.

A standard is a statement of excellence, developed by peers against which conformity of the healthcare organization is evaluated.

The benefits of accreditation surveys extend far beyond their immediate purpose of assessment against a set of standards. Surveyed organizations have found that seeing their own operation through the eyes of experienced surveyors provided them with a useful, more objective assessment on their internal administrative and clinical processes and effective proposals for further improving their processes and services to the community.

### Objectives of Accreditation

“To ensure the quality of health care through the application of quality concepts”

“To foster a culture of patient safety and minimize the risk of medical errors”

“To achieve optimum organizational results with available resources”

“To increase accountability to patients and identified stakeholders”

### Scope of accreditation surveys

The scope of the CBAHI survey includes all standards-related functions of the surveyed hospitals. Each assessment survey is tailored to the type, size and range of services offered by the hospital. Applicable standards from this manual are determined by CBAHI based on the scope of the services provided by the hospital undergoing a survey. Additionally, the on-site survey team will consider the specific applicability of individual standards.

### Process of Standards Development

The CBAHI Accreditation Standards were developed by a consensus process of healthcare experts representing organizations concerned with healthcare in the Kingdom. The standards were developed following a comprehensive review of national and international accreditation standards. During the development process the standards went through reviews by various stakeholders. Recommendations for changes were reviewed, and if appropriate, were accepted and incorporated into the final manual. The



standards have been approved by the Healthcare Services Council, chaired by his Excellency the Minister of Health.

### **The Accreditation Manual Structure**

The CBAHI Hospitals Standards are assembled into (22) chapters around key services and functions common to hospitals:

1. Leadership
2. Medical Staff and Provision of Care
3. Nursing
4. Quality Management and Patient Safety
5. Patient & Family Education and Rights
  - (PFE) Patient & Family Education
  - (PFR) Patient & Family Rights
6. Anesthesia
7. Intensive Care Unit: Adult, Pediatric, Coronary Care Unit, Neonate.
  - (ICU/PICU) Adult, Pediatric Intensive Care Unit
  - (CUU) Coronary Intensive Care Unit
  - (NICU) Neonate Intensive Care Unit
8. Operating Room
9. Labour & Delivery
10. Hemodialysis
11. Emergency Room
12. Radiology
13. Burn Care
14. Medical & Radiation Oncology
15. Psychiatry
16. Specialized Areas: Respiratory Services, Dietary Service, Social Workers & Rehabilitation Service.
  - (RS) Respiratory Service
  - (DT) Dietary Service
  - (SC) Social Workers
  - (RH) Rehabilitation Service
17. Ambulatory Care Services:
  - (AM) Ambulatory Care
  - (DN) Dental Services
18. Management of Information and Medical Records:





- (MOI) Management of Information
- (MR) Medical Records

19. Infection Control

20. Pharmacy

21. Laboratory

22. Facility Management and Safety

Each chapter has an introduction which provides an explanation about the chapter's relevance and contribution to safety and high quality patient care. Each standard has statement and when required sub-standards are developed to clarify further requirements. Additionally, every standard has evidence(s) of compliance (EC) that is going to be scored during the survey. The statement on the right side of each EC is called Primary Source of Information (PSOI). It defines the main method and source of information that is usually used to assess compliance with EC during the survey. However, in certain circumstances, the surveyor may elect to use other PSOI.

### **Eligibility**

All hospitals in the Kingdom of Saudi Arabia will be eligible for CBAHI accreditation.

### **Scheduling of Surveys**

The Accreditation Department at CBAHI handles all scheduling arrangements for surveys in coordination with the hospitals' representatives. A survey notification letter will be sent to the organization's director detailing the date and time of the survey. The Accreditation Department offers the organization adequate time between the notification and the survey date.

### **Rescheduling and Postponements of Surveys**

Hospitals scheduled for surveys are encouraged to adhere to the proposed date by the Accreditation Department. However, rescheduling or postponement may be considered for major events. In this condition, the organization needs to submit in writing a request indicating the justification for postponement. Major events are defined as events that will hinder the flow of the survey process such as changes in the management team/leadership of the organization, natural or other disasters, or relocation of the organization to another building.

### **Accreditation Survey Process**

Prior to survey, the organization will receive electronic access to the standards. This will facilitate for the organization to:



- Gain better understanding of the standards' requirements and the survey process;
- Use the standards electronic application to conduct its self-assessment;
- Follow up the progress of implementation.

CBAHI will assign each organization scheduled for a survey an accreditation specialist, who will serve as a primary contact between the organization and CBAHI. The accreditation specialist will conduct a pre survey visit to validate the application information and clarify issues related to the survey process. This individual will coordinate survey planning and will be available to the organization to answer questions about policies, procedures or other accreditation issues.

An organization may request for consultation visit(s) and/or mock survey prior to its real accreditation survey. In this condition, a report describing the organization's compliance with the standards is provided to the organization's director in order for the organization to close identified gaps in this report.

### **The On-Site Survey**

A survey team conducts the on-site survey to determine the organization's compliance to the standards' requirements. The size of the survey team and specialty of surveyors differ according to the size of the organization and its scope of services.

Assessing compliance is accomplished through a number of methods including the following:

- Document Review
- Medical Record Review
- Personnel File Review
- Interviews
- Facility tour & Units Visits (observation)

### **Scoring Guidelines**

The organization must meet all applicable standards requirements at a satisfactory level to become accredited. Each standard requirement is scored on a four-point scale.

All standards have one or more evidence of compliance (ECs). The ECs are the elements of the standards that are scored by the surveyor on site. Each EC is scored on a four-point scale:

“3” = Fully Met when  $\geq 75$  % compliance with the EC for four months prior to the initial survey or one year for the triennial survey.

“2” = Partially Met when  $\geq 50$  to  $< 75$  % compliance with the EC for three months prior to the initial survey or nine months for the triennial survey.



“1” = Minimally Met when  $\geq 25$  to  $< 50$  % compliance with the EC for two month prior to the initial survey or six months for the triennial survey.

“0” = Not Met when  $< 25$  % compliance with the EC or compliance is less than two month to the initial survey or less than three months for the triennial survey.

“NA” = Not Applicable indicates that the standard/EC. does not apply to the organization.

Scoring guidelines apply a similar way to ECs requiring a sample for assessment of compliance. For example, if observations are positive in  $\geq 75$  % of cases, if interviewees provided proper answers in  $\geq 75$  % or if the average of positive findings in personnel records or medical records is  $\geq 75$  %, the EC.is scored as fully met.

### **The Score Aggregation Process**

All standards have equal weight within the same chapter. Each standard is assigned ONE point. The ONE point is equally divided between the ECs. An example is: Standard-A contains 5 ECs. Each EC has 20% of the standard score. If the surveyor selects NA for the entire standard, that standard will not be a part of the scoring equation. If the surveyor selects NA (not applicable) for an EC, the EC will not be a part of the scoring equation at all. A standard score represents the mean score of the applicable ECs scores.

All chapters have equal weight. The chapter score consolidates the scores of all standards within the chapter and is calculated as the mean of score of standards listed in the given chapter. The overall organization's score is calculated as the mean percentage scores of all scored chapters, which is used to determine the accreditation decision of the facility.

### **Survey Outcome and Accreditation Decision**

- Accredited – The organization is awarded accreditation if:
  - the overall compliance score equals to or more than 80 % and
  - no more than 2 chapters score less than 50%
- Accreditation Denied – The organization will be denied accreditation if:
  - the overall score is less 70 % or
  - more than 2 chapters score less than 50 %
- Organizations scoring from 70 to 79% are required to be resurveyed within 90 days of the result for chapters that score less than 50%.

### **Duration of Accreditation Award**

The CBAHI accreditation award is valid for 3 years.



## Appeal

The appeal to the CBAHI must be in writing and no later than one (1) month after receiving the accreditation results. The CBAHI will review the appeal and inform the organization of one of the following decisions:

- Accreditation decision upheld and re-survey DENIED.
- Accreditation decision to be reviewed within 90 days through performing a focus survey.

## Truthfulness and Ethics Clause

The organization is expected to provide accurate information to CBAHI surveyors and not to withhold or falsify any information. Prior to the survey, the CBAHI will send a list of the surveyors assigned to the facility. The organization is expected to disclose any conflict of interest on the part of the surveyors such as previous employment, whole or partial ownership of the facility, or having 1st degree relative(s) working at the facility.

If CBAHI discovers, at any time, that the organization has not been truthful; CBAHI will make a determination on the appropriate action.



# Leadership

## Introduction

For any hospital, quality and patient safety depend on effective leadership. It is important for all hospitals to have a clearly stated mission. It is the responsibility of the leadership of the organization to develop the mission and provide adequate resources to fulfill this mission. The leadership must come from the governing body and its executive management including the organization director, medical director, nursing director, administrator and department heads with the governing body has ultimate responsibility for quality and patient safety. To ensure quality and safety of healthcare services, the members of the leadership group must work collaboratively, communicate effectively through clear lines of authority, and coordinate and integrate services provided.

Hospitals may vary in size, type of ownership, and complexity of service. Each organization regardless of its complexity has a governing body, e.g., ministry of health or an owner(s). A large hospital may often have a governing body ultimately accountable for the operation and performance of the organization. In smaller organizations, these responsibilities may handled by just one or two individuals.

This chapter addresses the roles and responsibilities of the leadership group for the following processes:

- Organizational mission.
- Organizational structure
- Development and promotion of professional ethical conduct
- Formulation and construction of a strategic plan
- Planning and designing services and structures
- Processes for collaboration, coordination, and communication
- Financial management
- Contract oversight
- The responsibility of the governing body
- The responsibility of the organization director
- The responsibility of department heads



## Standards

### LD.1 The organization governing structure is defined.

#### Evidence of Compliance

LD.1.EC.1 The governing structure is defined in documents. Document Review

### LD.2 The organization governance and management have a defined and clear organizational structure that is known to all staff and includes the following:

LD.2.1 There is an organizational chart which identifies the names and titles of the hospital leaders, and department heads.

LD.2.2 The organizational chart is current.

LD.2.3 The organizational chart is explained to all employees as part of his/her orientation.

#### Evidence of Compliance

LD.2.EC.1 The organization has a current organizational chart. Document Review

LD.2.EC.2 The organizational chart has names and titles of those responsible for governance and management. Document Review

LD.2.EC.3 Lines of authority and responsibility of leaders are clearly identified in the organizational chart. Document Review

LD.2.EC.4 The organizational chart is known to all staff. Interview

### LD.3 The governing body responsibilities are defined in written documents such as bylaws, policies and procedures.

LD.3.1 The governing body responsibilities reflect its legal responsibility and accountability to the patients and its obligation to the community it is established to serve.

LD.3.2 The governing body responsibilities reflect its ultimate accountability and responsibility for the quality of care and patient safety.

#### Evidence of Compliance

LD.3.EC.1 Governance responsibilities and accountabilities are described in documents. Document Review

LD.3.EC.2 Governance responsibilities include legal responsibility and accountability to the patients and community it is established to serve. Document Review

LD.3.EC.3 Governance responsibilities include responsibility for the quality of care and patient safety. Document Review

### LD.4 The governing body approves (or develops) the organization mission.

LD.4.1 The governing body ensures the regular review of the organization mission.

LD.4.2 The governing body ensures communication of the organization mission.

#### Evidence of Compliance

LD.4.EC.1 There is a written mission for the organization. Document Review

LD.4.EC.2 The mission is approved and regularly reviewed by the governing body. Document Review

LD.4.EC.3 Staff are aware of the mission. Interview

LD.4.EC.4 The mission statement is publicly posted. Observation

### LD.5 The governing body approves the organization scope of services.

#### Evidence of Compliance

LD.5.EC.1 The organization scope of services is approved by the governing body. Document Review

### LD.6 The governing body approves the organization strategic and management plans and policies and



**procedures.**

LD.6.1 The governing body defines any approval authority delegation.

**Evidence of Compliance**

LD.6.EC.1	The organization strategic and management plans and policies and procedures are approved by governing body.	Document Review
LD.6.EC.2	The governing body defines any approval authority delegation.	Document Review

**LD.7 The governing body ensures provision of adequate resources (manpower, consumables, and capital assets) based on scope of services and to fulfill the organization mission.**

LD.7.1 The governing body approves the operating and capital budgets of the organization.

**Evidence of Compliance**

LD.7.EC.1	Adequate manpower is available in the organization according to its scope of services.	Document Review
LD.7.EC.2	Adequate consumables are available in the organization according to its scope of services.	Observation
LD.7.EC.3	Adequate capital assets are available in the organization according to its scope of services.	Observation
LD.7.EC.4	The organization operating and capital budgets are approved by the governing body.	Document Review

**LD.8 The governing body appoints a qualified director who is responsible for the management of the organization.**

LD.8.1 The governing body assures the director s effective performance through ongoing performance evaluation.

**Evidence of Compliance**

LD.8.EC.1	A qualified director is appointed by the governing body.	Document Review
LD.8.EC.2	There is evidence of ongoing director's performance evaluation by the governing body.	Personnel File

**LD.9 The governing body fosters communication and coordination between the organization governance and management.**

**Evidence of Compliance**

LD.9.EC.1	There is evidence of communication and coordination between the organization governance and management.	Document Review
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**LD.10 The governing body approves and promotes performance improvement, patient safety, and risk management program.**

LD.10.1 The governing body regularly receive, review and act upon the reports of performance improvement, patient safety, and risk management program.

**Evidence of Compliance**

LD.10.EC.1	There is regular reporting of performance improvement activities.	Document Review
LD.10.EC.2	There is regular reporting of patient safety activities.	Document Review
LD.10.EC.3	There is regular reporting of risk management activities.	Document Review
LD.10.EC.4	There is evidence of reports review and actions taken by the governing body.	Document Review

**LD.11 The governing body performs periodic evaluation to ensure its own effectiveness.**



**Evidence of Compliance**

LD.11.EC.1 There is evidence of periodic evaluation of governing body effectiveness. Document Review

**LD.12 The organization director exercises the authority delegated by the governing body to manage the organization.**

**Evidence of Compliance**

LD.12.EC.1 The authority delegated by the governing body to the organization director is clearly identified. Document Review

LD.12.EC.2 The director exercises the authority delegated by the governing body to manage the organization. Interview

**LD.13 The director has a job description, developed by the governing body, which states the responsibilities and qualifications.**

**Evidence of Compliance**

LD.13.EC.1 There is a written job description for the director Document Review

LD.13.EC.2 The director job description is developed by the governing body. Document Review

LD.13.EC.3 The director job description states the responsibilities and qualifications. Document Review

**LD.14 The facility is in compliance with all Saudi Arabian laws and health care regulating bodies.**

LD.14.1 The hospital director ensures the organization's compliance with laws and regulations.

**Evidence of Compliance**

LD.14.EC.1 The director ensures the organization's compliance with law and regulations. Interview

LD.14.EC.2 The hospital has a current MOH License. Document Review

LD.14.EC.3 The hospital adheres to Saudi Arabian laws: having current Building Safety certificate from Civil Defense. Document Review

**LD.15 The director provides oversight of the organization's day to day operations.**

**Evidence of Compliance**

LD.15.EC.1 There is evidence of managing the organization's day to day operations by the director. Interview

**LD.16 The director recommends and ensures that necessary policies and procedures are developed and implemented.**

LD.16.1 The director ensures compliance with approved policies.

LD.16.2 The director recommends to the governing body required new policies for approval.

**Evidence of Compliance**

LD.16.EC.1 The director establishes processes that ensure the compliance with approved policies. Interview

LD.16.EC.2 There is evidence that the director recommends to the governing body required new policies. Document Review

**LD.17 The director ensures appropriate response to reports from any inspecting or regulatory agencies, including accreditation.**





**Evidence of Compliance**

LD.17.EC.1 There is evidence of response to the reports of inspecting or regulatory agencies. Document Review

**LD.18 The director provides oversight of human, financial, physical, and other resources.**

LD.18.1 The director ensures that all physical properties are kept in good state of repair and operating condition.

LD.18.2 The director ensures availability of adequate and proper resources such as human resources, equipment, supplies and medications required for the planned services.

LD.18.3 The director manages adequately the organization's financial resources.

**Evidence of Compliance**

LD.18.EC.1 The director manages human, financial, physical, and other resources. Interview  
LD.18.EC.2 The physical properties are maintained in adequate working condition. Observation  
LD.18.EC.3 There is evidence of availability of adequate resources. Observation

**LD.19 Besides the hospital director, the following positions are identified (as executive committee or however named) by the organizational chart and hospital meetings as part of the leadership group:**

LD.19.1 Medical Director.

LD.19.2 Administrative Director.

LD.19.3 Nursing Director.

LD.19.4 Quality Management Director /leader.

LD.19.5 Department heads.

**Evidence of Compliance**

LD.19.EC.1 The following positions (Medical Director, Administrative Director, Nursing Director, Quality Management Director /leader, Department heads) are identified as part of the leadership group on the organizational chart. Document Review

**LD.20 The leadership meets regularly (at least monthly) in a minuted formal meeting (like an executive committee) to discuss all aspects of medical care, and services provided to patients.**

**Evidence of Compliance**

LD.20.EC.1 Leadership meeting (at least monthly), and the minutes contain aspects of medical care and services. Document Review

**LD.21 All members of the leadership group are qualified by appropriate education and experience.**

**Evidence of Compliance**

LD.21.EC.1 All members of the leadership group have proper qualification and experience (CV). Personnel File

**LD.22 Each member in the leadership group has a defined scope of responsibility as outlined in a current job description.**

**Evidence of Compliance**

LD.22.EC.1 There is current and approved job description for each member in the leadership group. Personnel File

**LD.23 The leadership group develops (or adopts from the governing body) the organization's mission and submit to the governing body for approval.**



LD.23.1 The leadership group communicates the mission to all staff and customers.

**Evidence of Compliance**

LD.23.EC.1 The organization's mission is developed by the leadership group (or adopted from the governing body). Document Review

**LD.24 The hospital mission, vision, and values statement is clearly written known to all staff, and:**

LD.24.1 The mission, vision and, values statement is clearly written.

LD.24.2 The mission, vision, values statement is publicly displayed to all staff and customers.

LD.24.3 All staff employed by the hospital can state the mission statement.

LD.24.4 The mission, vision and, values statement will be included in the orientation program

**Evidence of Compliance**

LD.24.EC.1 Current and approved mission, vision and values statement is clearly written. Document Review

LD.24.EC.2 The hospital mission, vision and values statement is publicly posted. Observation

LD.24.EC.3 Mission, vision and values statement is known to all staff and it is part of orientation program. Interview

LD.24.EC.4 Staff can state mission, vision and values. Interview

**LD.25 The leadership group plans with the community leaders and other identified customers to meet the current and future needs of the population(s) it serves.**

LD.25.1 The leadership group works with the community and other organizations to regularly assess the community's health needs.

LD.25.2 Planning includes soliciting inputs from staff, patients and families.

LD.25.3 Planning considers environmental and financial factors and is consistent with the hospital's mission and strategic direction.

LD.25.4 Planning considers cultural and spiritual needs of the populations served.

LD.25.5 Planning ensures coordination and integration of services throughout the hospital as well as with relevant external services.

**Evidence of Compliance**

LD.25.EC.1 There is evidence that the hospital's leaders collaborate with community leaders and other customers including patients to plan services required for the community considering elements LD.25.1 through LD.25.5. Interview

**LD.26 The leadership group uses evidence, and best practice information to develop and improve the Hospital's services.**

**Evidence of Compliance**

LD.26.EC.1 The leaders while designing and improving services use and encourage staff to use research and best practice information. Interview

**LD.27 The leadership group collaboratively develops the organization scope of services and includes:**

LD.27.1 The range of service i.e., Pediatrics, Gynecology or a general hospital.

LD.27.2 The age groups who receive care.

LD.27.3 The number of patients seen annually.

LD.27.4 The major diagnostics or therapeutic methods used.

LD.27.5 The scope of services is approved by the governing body.

**Evidence of Compliance**

LD.27.EC.1 Approved hospital's scope of service includes the range of service, the age groups who receive care, the number of patients seen annually, and the Document Review



major diagnostics or therapeutic methods used.

LD.27.EC.2 The written departmental scope of service that includes the range of service, age groups, number of patients seen annually, major diagnostics or therapeutic methods used, and is signed by the medical director, the Administrator, or both. Document Review

LD.27.EC.3 There is a current nursing scope of service developed by the nurse Leader and the leadership. Document Review

**LD.28 The leadership group provides patients with information on care and services provided as well as how to access these services.**

**Evidence of Compliance**

LD.28.EC.1 Patients are provided information on the care and services provided by the organization. Document Review

LD.28.EC.2 Patients are provided information on how to access services in the organization. Interview

**LD.29 The leadership has a 3 - 5 year strategic plan for the hospital that is updated every year and has the following components:**

LD.29.1 Guided by the Mission, and Vision of the organization.

LD.29.2 Based on the Strength, Weakness, Opportunity, Threat, (SWOT) analysis.

LD.29.3 Summarized by at least 5 strategic Directions (customer, community, employee, education, continuous improvement, and financial).

LD.29.4 Translated actions and timelines for implementation with identified staff responsibilities.

LD.29.5 A process is in place for the annual review of the strategic objectives to determine needs for the next annual operational plan.

LD.29.6 Department heads develop an annual departmental plans in line with the organization strategic plan.

**Evidence of Compliance**

LD.29.EC.1 The leadership has a 3-year strategic plan for the hospital that is guided by the mission, and vision of the organization and based on the (SWOT) analysis and summarized by at least 5 strategic directions. Document Review

LD.29.EC.2 The strategic plan is translated to actions and timelines for implementation with identified staff responsibilities. Document Review

LD.29.EC.3 The strategic plan is updated every year. Document Review

LD.29.EC.4 There is an annual departmental plan for each department. Document Review

**LD.30 The leadership group allocates resources for a safe and effective facility and this includes:**

LD.30.1 Planning and budgeting to meet applicable laws, regulations, and other requirements.

LD.30.2 Ensuring efficient use of different resources through regular review and evaluation against plans and budgets.

LD.30.3 Planning and budgeting for upgrade or replacement of buildings, equipment, or other resources.

**Evidence of Compliance**

LD.30.EC.1 The leaders demonstrate efficient allocation of resources that meets requirements LD.30.1 through LD.30.3. Interview

**LD.31 The leadership group develops a staffing plan for the organization to ensure that services meet the needs of the population(s) served.**

LD.31.1 The staffing plan defines the number, type, and qualifications of staff required and their role.

**Evidence of Compliance**

LD.31.EC.1 There is a written staffing plan developed by the leadership group. Document Review

LD.31.EC.2 The staffing plan defines the number, type, and qualifications of staff required and their role. Document Review



**LD.32 The hospital has the following essential committees that provide oversight and management for:**

LD.32.1 Pharmacy and Therapeutics Committee. discretionary

LD.32.2 Morbidity and Mortality Committee.

LD.32.3 Infection Control Committee.

LD.32.4 Cardio Pulmonary Resuscitation (CPR) Committee.

LD.32.5 Credentialing and Privileging Committee.

LD.32.6 Operating Room Committee.

LD.32.7 Tissue Review Committee.

LD.32.8 Blood Utilization Review Committee.

LD.32.9 Safety Committee.

LD.32.10 Quality Management Committee.

LD.32.11 Medical Record Review Committee.

LD.32.12 Patient Rights/Patient Advocacy/Patient Care Committee.

LD.32.13 Utilization Review Committee

\*The above committees can be combined as needed according to the hospital's scope of service and resources.

**Evidence of Compliance**

LD.32.EC.1 The hospital has essential committees according to the hospital's scope of service. Document Review

**LD.33 All of the Hospital-wide committees have terms of reference that:**

LD.33.1 Clearly outline the committee's functions.

LD.33.2 List the members and their titles.

LD.33.3 State the required percentage of attendance required to hold the meeting.

LD.33.4 State how often the committee is expected to meet (e.g. monthly for functional committees / quarterly for boards and councils).

LD.33.5 Outlines the distribution of the minutes to the Hospital Director, Medical Director, Quality Management Director/leader, and members.

**Evidence of Compliance**

LD.33.EC.1 Terms of reference of any hospital-wide committee includes: committee function, membership and titles, required percentage of attendance, meeting frequency, distribution of meeting minutes. Document Review

**LD.34 The hospital committees meet as outlined in the terms of reference (no less than quarterly).**

**Evidence of Compliance**

LD.34.EC.1 Hospital committees minutes demonstrate meeting as outlined in the terms of reference. Document Review

LD.34.EC.2 The essential committees meet at least 4 times/year. Document Review

**LD.35 There is a uniform method in a policy and procedure that addresses how the chairpersons of a committee receives and refers the committee recommendations for approval by the responsible decision makers.**

**Evidence of Compliance**

LD.35.EC.1 A policy and procedure that addresses how the chairpersons of committees receive and refer the committee recommendations for approval by the responsible decision makers. Document Review

**LD.36 There is an annual review of each committee's accomplishments written by the committee chairman and**



submitted to the committee's reporting authority and there is a policy to govern the process.

**Evidence of Compliance**

- LD.36.EC.1 There is a policy and procedure that addresses an annual review process of each committee. Document Review
- LD.36.EC.2 An annual review of each committee accomplishment is written by the committee chairman and submitted to the committees reporting authority (i.e. reports, action plans, etc.) Document Review

**LD.37 The hospital has a Finance Director who is qualified by experience and education (A Bachelor's degree in Finance with (2) years experience is preferred).**

**Evidence of Compliance**

- LD.37.EC.1 There is a qualified Finance Director (a Bachelor Degree and 2 years of experience in Finance). Personnel File

**LD.38 The hospital has a capital and operating budget process that addresses the manpower plan, consumable and capital assets resources and assigns resources to all patient care units based on the scope of care and complexity of patient needs.**

LD.38.1 The budget is approved by the governing body.

**Evidence of Compliance**

- LD.38.EC.1 There is evidence that the capital and operating budget process is based on the scope of care and complexity. Document Review

**LD.39 Members of the leadership group work collaboratively to fulfill the mission and provide quality care by:**

LD.39.1 Problem solving, planning together and documenting these meetings.

LD.39.2 Collaborating with each other to develop and carry out plans, policies and procedures.

LD.39.3 Collaborating with each other to develop budgets.

**Evidence of Compliance**

- LD.39.EC.1 Leadership meeting minutes reflect problem solving, and collaboration in planning, developing policies, developing budgets ( i.e. interdepartmental meetings). Document Review

**LD.40 There is a written policy for controlling the development and maintenance of policies and procedures for key functions and processes.**

LD.40.1 There is a unique identification for each policy with title, number, and dates of issue and updates.

LD.40.2 Policies are developed, approved, revised, and terminated by authorized individuals.

LD.40.3 Policies are revised according to a defined revision due date that does not exceed (2) years or when required.

LD.40.4 Policies are dated and current.

LD.40.5 Policies are communicated to staff and are obtainable.

LD.40.6 A process is in place to ensure that staff implement policies.

LD.40.7 A process is in place to ensure that only current versions of policies are available for use in the hospital.

LD.40.8 A similar process exists for the development and maintenance of other important documents (e.g., organizational plans)

**Evidence of Compliance**

- LD.40.EC.1 There is a policy on policies and procedures (how policies are created, approved, revised, composed, kept current, tracked, communicated, monitored, and terminated). Document Review
- LD.40.EC.2 A similar process is in place for other documents (e.g., plans) Document Review



**LD.41 The leadership has basic knowledge of Quality Management concepts and this includes:**

- LD.41.1 How to analyze data.
- LD.41.2 How to use an improvement cycle (PDCA) or other method to make improvements.
- LD.41.3 How to work in teams.
- LD.41.4 How to perform root cause analysis.

**Evidence of Compliance**

- LD.41.EC.1 Leaders have knowledge of quality management concepts. Interview

**LD.42 The hospital has an effective process for handling professional communication (vertical and horizontal) among hospital staff and that supports professional communication by:**

- LD.42.1 Documented staff meetings.
- LD.42.2 Policy and procedure development.
- LD.42.3 Hospital newsletters.

**Evidence of Compliance**

- LD.42.EC.1 Staff meeting minutes show that the hospital has an effective process for handling professional communication. Document Review
- LD.42.EC.2 There is multidisciplinary approval of policies. Document Review
- LD.42.EC.3 There is a Hospital newsletter that supports professional communication. Document Review

**LD.43 The hospital has a policy that outlines the roles and responsibilities for handling all incoming requests from outside agencies (other hospitals and government) in a timely manner and this includes but is not limited to:**

- LD. 43.1 Medico-legal cases.
- LD. 43.2 Receiving patients from other hospitals.
- LD. 43.3 Providing any services for outside hospitals.
- LD. 43.4 Participation with community events.
- LD. 43.5 Requests for reports from government agencies.

**Evidence of Compliance**

- LD.43.EC.1 There is approved policy that outlines the roles and responsibilities for handling all incoming requests from outside agencies in a timely manner. Document Review

**LD.44 The hospital has a duty manager who is qualified by experience and education to coordinate the care during off duty hours with a clear job description.**

**Evidence of Compliance**

- LD.44.EC.1 There is a qualified duty manager (degree in health institute administration or any other equivalent certificate with experience in leadership). Personnel file
- LD.44.EC.2 There is a duty manager job description. Personnel file

**LD.45 The duty manager has the necessary resources to perform his role and this includes:**

- LD.45.1 A dedicated office to perform his role in the hospital.
- LD.45.2 A dedicated phone number.

**Evidence of Compliance**

- LD.45.EC.1 The duty manager has adequate logistics to carry out his/her mandates (enough space, office equipment, computers, phone number). Observation



**LD.46 The hospital has a policy to handle cases of suspected child abuse and criminal acts and it complies with laws and regulations.**

**Evidence of Compliance**

LD.46.EC.1 There is a policy to handle cases of suspected child abuse, criminal acts and it complies with MOH regulation. Document Review

**LD.47 The leadership oversees any contracts for clinical or operational services and:**

LD.47.1 Ensure that the contracts clearly state the services to be provided by the contracted entity.

LD.47.2 Ensure relevant leaders' recommendations and approval.

LD.47.3 Ensure that the contracted entity and services provided meet applicable laws and regulations.

LD.47.4 Ensure that the services provided are consistent with the hospital's standards for accreditation and quality and safety that would be required if such services are provided by the hospital.

LD.47.5 Monitor compliance with the appropriate standards on a regular basis and take corrective actions for improvement when standards are not met.

LD.47.6 Document the contract oversight process.

**Evidence of Compliance**

LD.47.EC.1 There is evidence of leadership documentation of contract oversight process including LD.47.1 through LD.47.4. Document Review

LD.47.EC.2 There is contract monitoring process that is documented and corrective actions for improvement are taken when standards are not met. Document Review

**LD.48 Each administrative or clinical department is directed by an appropriately qualified individual.**

**Evidence of Compliance**

LD.48.EC.1 The department heads have proper qualifications and experience. Personnel File

**LD.49 The responsibilities of the head of each department include, but not limited to, the following:**

LD.49.1 Providing a written scope of services provided by the department.

LD.49.2 Ensuring coordination and integration of services within the department and with other departments.

LD.49.3 Defining and requesting space, equipment, supplies, staffing, and other resources.

LD.49.4 Ensuring that sufficient resources and staffing levels are available at all times to carry out safe medical practice.

LD.49.5 Developing departmental policies and procedures and ensuring their appropriate communication to relevant staff as well as implementation.

LD.49.6 Determining the necessary qualifications required by all categories of staff in the department: education, skills, training, experience, and license, certification or registration.

LD.49.7 Providing a written departmental staffing plan that defines the number, type, and qualifications required for each position to fulfill the department's responsibilities.

LD.49.8 Providing orientation, training, and continuing education for all persons in the department.

LD.49.9 Managing processes to systematically measure and improve the performance of important processes of the department as well as staff performance. These processes are consistent with the organization wide quality improvement and patient safety, and risk management plan(s), and:

LD.49.9.1 Based on department important activities and priorities.

LD.49.9.2 Include regular data collection and analysis about department performance and staff performance.

LD.49.9.3 The performance monitoring is reported periodically to leadership.

**Evidence of Compliance**

LD.49.EC.1 The job description of the department heads includes the above responsibilities (LD.49.1 to LD 49.9). Personnel File

LD.49.EC.2 There is written scope of services for each department signed by the department head. Personnel File

LD.49.EC.3 There is evidence that the department heads define and request space, equipment, supplies, staffing, and other resources. Document Review



LD.49.EC.4	There is evidence that the department heads determine the necessary education, skills, training, experience, and license, certification or registration.	Document Review
LD.49.EC.5	There is evidence that the department heads provide orientation, training, and continuing education for all persons in the department.	Interview
LD.49.EC.6	There is evidence that the department heads measure and improve the performance of important processes of the department as well as staff performance	Interview
LD.49.EC.7	There is evidence of data collection and analysis about department performance and staff performance.	Interview
LD.49.EC.8	There are periodic reports of department's performance monitoring.	Interview

**LD.50 All department heads have a comprehensive departmental manual that is available to staff and includes the following:**

LD.50.1 A mission, vision, values, and scope of service consistent with the hospital's mission.

LD.50.2 An organizational chart.

LD.50.3 Policies and procedures for staff members to implement that are current and clearly written.

**Evidence of Compliance**

LD.50.EC.1	There are updated (every 2 years) comprehensive departmental manuals (mission, vision, values, scope of services, organization chart and policy and procedures) are located in (medical record, human resources, quality management, social worker, and information technology) and available to all staff.	Document Review
LD.50.EC.2	Pharmacy internal policy and procedures are complete, updated (every 2 years) and approved.	Document Review
LD.50.EC.3	There are written multidisciplinary ICU policies and procedures in collaboration with other departments.	Document Review
LD.50.EC.4	There are written multidisciplinary CCU policies and procedures in collaboration with other departments	Document Review
LD.50.EC.5	There are written multidisciplinary NICU policies and procedures in collaboration with other departments.	Document Review
LD.50.EC.6	Sample of inter-departmental (multidisciplinary) policies with medical director review and approval.	Document Review
LD.50.EC.7	There are written policies and procedures on all available radiology services.	Document Review
LD.50.EC.8	There are written policies and procedures to guide care in the burn unit.	Document Review
LD.50.EC.9	There are written policies and procedures of rehabilitation services adequately covers safety, infection control guidelines and professional communications.	Document Review
LD.50.EC.10	Infection control policies are updated by infection control personnel based on scientific recommendations.	Document Review
LD.50.EC.11	There is accessible and approved, current or reviewed (every 2 year) lab procedure manual.	Document Review

**LD.51 All departmental manuals are reviewed every (2) years and revised as needed.**

**Evidence of Compliance**

LD.51.EC.1	Departmental manuals sampled are revised at least every two (2) years (as appropriate).	Document Review
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**LD.52 The hospital has a Human Resource Director qualified by appropriate experience and education.**

**Evidence of Compliance**

LD.52.EC.1	There is a qualified Human Resource Director (a Bachelor degree and experience in Human Resource Management or equivalent).	Personnel File
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- LD.53 The hospital has a Human Resource department or unit that is well staffed and equipped according to the size of the hospital.**
- Evidence of Compliance**
- LD.53.EC.1 Human Resources department has adequate resources to carry out its mandate (manpower, enough space, office equipment, computers, software to facilitate the HR processes). Observation
- LD.54 The hospital has a Human Resource "Employee" manual that is given to all new employees during hospital orientation.**
- Evidence of Compliance**
- LD.54.EC.1 The hospital has an employee manual. Document Review
- LD.54.EC.2 The employee manual oriented to staff as part of the General Hospital Orientation (GHO). Personnel File
- LD.55 The Human Resource "Employee" manual has a policy for handling staff complaints and/or dissatisfaction.**
- Evidence of Compliance**
- LD.55.EC.1 Human Resource Employee manual has a policy for handling staff complaints. Document Review
- LD.56 The hospital has a policy that requires a "dress code" for all categories of staff.**
- Evidence of Compliance**
- LD.56.EC.1 There is a hospital dress code. Document Review
- LD.57 The department of Human Resources has a program for recruitment, retention, and development of staff.**
- Evidence of Compliance**
- LD.57.EC.1 There is a written program for recruitment, retention, and development of staff. Document Review
- LD.58 The hospital has a policy that requires all categories of staff to have clearly written job descriptions that are reviewed and revised as needed at least every (3) years and:**
- LD.58.1 The job description is used when selecting employees for hire, internal promotions, and transfer.
- LD.58.2 The job description outlines the necessary knowledge, skills, and attitude to perform the role.
- LD.58.3 The job description is provided to every employee on hiring and is located in every employee's personnel file and departmental manual.
- LD.58.4 All job descriptions follow a prescribed format.
- LD.58.5 All job descriptions are competency based
- Evidence of Compliance**
- LD.58.EC.1 There is job descriptions management policy. Document Review
- LD.58.EC.2 All job descriptions follow a prescribed format that outlines the necessary knowledge, skills, and attitude to perform the role. Document Review
- LD.58.EC.3 All job descriptions are competency based and used when selecting employees for hire, internal promotions, and transfer and provided to them Personnel File



on hiring.

**LD.59 The organization maintains a personnel file for each employee.**

LD.59.1 The personnel file is complete and updated.

LD.59.2 The organization implements a policy to maintain the confidentiality of the personnel files.

**Evidence of Compliance**

LD.59.EC.1 There is a personnel file for each employee.

Personnel File

LD.59.EC.2 There is a written policy to maintain the confidentiality of the personnel files.

Document Review

**LD.60 The organization has an effective process for gathering, verifying, and evaluating the credentials (license, education, training, and experience) of those medical staff, nursing staff and other health professionals licensed to provide patient care.**

LD.60.1 To the extent possible, the credentials are verified from the original source.

LD.60.2 Job responsibilities and clinical work assignments are based on evaluation of the verified credentials.

LD.60.3 The organization ensures the registration of healthcare professionals with the Saudi Commission for Health Specialties in accordance with laws and regulations.

LD.60.4 The organization maintains a record (a credentials or other file) of the current professional license, certificate, or registration, when required by law, regulation, or by the organization, of every medical staff, nursing staff and other health professionals. This information is updated as appropriate.

LD.60.5 The process applies to all medical staff categories (e.g., full time, part time, locum, etc).

**Evidence of Compliance**

LD.60.EC.1 There is an implemented process for gathering, verifying, and evaluating the above credentials for medical, nursing staff and other licensed health professionals.

Interview

LD.60.EC.2 The credentials are verified from the original source to the extent possible.

Personnel File

LD.60.EC.3 Every professional staff member has a credentials or other file that contains current professional license, certificate, or registration, education and training and experience.

Personnel File

**LD.61 The hospital has a comprehensive mandatory general orientation that all new employees attend, and the content includes but is not limited to:**

LD.61.1 The hospital's mission, vision, values and organizational chart.

LD.61.2 Staff role in disasters and emergencies. (i.e., Fire).

LD.61.3 General information about hazardous materials including Material Safety Data Sheet (MSDS).

LD.61.4 General information on Infection control and sharps disposal.

LD.61.5 Electrical safety.

LD.61.6 General information on communication devices: paging, telephone system, and bleeps.

LD.61.7 General information on staff evaluation process.

LD.61.8 The definition of Adverse events and Sentinel events along with the process of reporting including Who should report, When to report, How to report, and to Whom the report is routed.

LD.61.9 The Policy on Abuse and Neglect of Children and Adults

LD.61.10 Overview of Credentialing, Privileging and Competency policies.

LD.61.11 General information about staff health clinic and its services.

LD.61.12 General information about the cultural and social issues in the Kingdom.

LD.61.13 General information about the quality and patient safety plan of the hospital and the importance of involvement of every member of staff.

LD.61.14 Information on the expected ethical conduct of the staff and the expected professional communication in his/her interactions with others.

LD.61.15 Information on protection of patient's rights, privacy and confidentiality.

**Evidence of Compliance**



LD.61.EC.1 There are attendance records that all new employees attend a mandatory general hospital orientation. Document Review

LD.61.EC.2 General Hospital Orientation program content includes (mission, vision, values and organizational chart, staff role in disasters, hazardous materials, infection control, electrical safety, communication devices, staff evaluation process, adverse and sentinel events, abuse of children and adults, credentialing, privileging and competency policies, staff health clinic, the cultural and social norms in the Kingdom, the quality plan, code of conduct, patients rights, privacy and confidentiality. Document Review

**LD.62 The hospital's general orientation is documented in each employee's personnel file.**

**Evidence of Compliance**

LD.62.EC.1 General hospital orientation is documented in employees file. Personnel File

**LD.63 All new employees receive a comprehensive departmental orientation conducted by the head of the department and/or designee as outlined by the departmental orientation policy that includes but is not limited to the following processes:**

LD.63.1 All new employees read the appropriate departmental policies and sign that they have read and understood them.

LD.63.2 All new employees read their job description and sign that they have read and understood it.

LD.63.3 All new employees receive an assessment of the knowledge, skills and attitude required of the employee to function successfully in his/her position.

LD.63.4 All new employees receive education on the proper use of equipment including troubleshooting and reporting malfunctions.

LD.63.5 All new employees receive more clarification as needed on all topics provided in the general orientation and this is signed by the employee and immediate supervisor.

LD.63.6 Orientation is provided when job responsibilities change.

LD.63.7 Orientation for new employees are located in the employee's personnel file.

**Evidence of Compliance**

LD.63.EC.1 There is a departmental orientation policy that includes (appropriate departmental policies, job description and sign that they have read and understood them, receive an assessment of the knowledge, skills and attitude required of the employee to function successfully in his/her position, receive education on the proper use of equipment, receive more clarification as needed on all topics provided in the General Orientation). Document Review

LD.63.EC.2 Departmental orientation is documented in employees file. Personnel File

**LD.64 The leadership supports continuing education for all categories of staff to pursue professional development and learning.**

LD.64.1 The leadership grants financial support and/or time off for staff to attend educational activities.

**Evidence of Compliance**

LD.64.EC.1 The educational activities have documented financial sponsorship or time off for staff to attend educational events. Document Review

LD.64.EC.2 Staff interview shows evidence of leadership support of staff education. Interview

**LD.65 The hospital has an educational program (academic program) with an ongoing schedule of educational activities and training based on hospital need.**

**Evidence of Compliance**

LD.65.EC.1 There is educational plan/academic program schedule. Document Review



**LD.66 Department heads recommend, implement and evaluate the necessary courses and skills to update and maintain staff's competence to provide care. This process is linked to performance improvement and documented in the employees file.**

**Evidence of Compliance**

LD.66.EC.1	There is recommendation of educational needs based on performance evaluation by department head.	Document Review
LD.66.EC.2	Attendance of educational program is documented in personnel file.	Personnel File

**LD.67 All staff members who provide direct patient care (medical staff, nursing staff, and other health professionals) have received training in basic cardiopulmonary resuscitation (BCLS) and the training is repeated every two years.**

**Evidence of Compliance**

LD.67.EC.1	The basic cardiopulmonary resuscitation training for staff members who provide direct patient care is valid and repeated every 2 years.	Personnel File
LD.67.EC.2	Other staff, where appropriate, are trained in relevant life support.	Personnel File

**LD.68 The organization identifies, where appropriate, other staff members to be trained in ACLS, NALS, PALS, and ATLS and provides training accordingly. Examples include, but not limited to, the following:**

LD.68.1 Supporting all critical care physicians and nurses to maintain additional certification in ACLS, and NALS as appropriate to the age groups.

LD.68.2 Supporting all Internal Medicine physicians to maintain additional certification in ACLS.

LD.68.3 Supporting all surgical physicians to maintain additional certification in ATLS.

LD.68.4 Supporting all pediatric physicians to maintain additional certification in NALS, PALS as appropriate to the age groups.

**Evidence of Compliance**

LD.68.EC.1	All ICU nursing staff have valid BLS certification and preferable ACLS (adults) PALS (Pediatrics).	Personnel File
LD.68.EC.2	All CCU physicians have valid BCLS and ACLS certification.	Personnel File
LD.68.EC.3	All CCU nursing staff have valid BCLS certification.	Personnel File
LD.68.EC.4	All NICU physicians have valid BCLS and NALS (NRP) certification.	Personnel File
LD.68.EC.5	All NICU nurses have valid BCLS certification.	Personnel File
LD.68.EC.6	All rehabilitation staff have valid BCLS certification.	Personnel File
LD.68.EC.7	All Recovery room medical and nursing staff are certified in BCLS and preferably ACLS.	Personnel File
LD.68.EC.8	Privileged physicians who perform conscious sedation are certified BCLS, ACLS or PALS , NALS.	Personnel File
LD.68.EC.9	All Burn Unit physicians have valid BCLS certification.	Personnel File
LD.68.EC.10	All Burn Unit nursing staff have valid BCLS and ACLS certification.	Personnel File
LD.68.EC.11	All nursing staff working in Burn Care are certified in BCLS and preferably ACLS, PALS and NRP.	Personnel File
LD.68.EC.12	All emergency physicians have valid BCLS and ACLS certification.	Personnel File
LD.68.EC.13	All emergency room nurses have valid BCLS.	Personnel File
LD.68.EC.14	All OR nurses have valid BCLS.	Personnel File
LD.68.EC.15	All hemodialysis nurses have valid BCLS.	Personnel File
LD.68.EC.16	All respiratory service staff have valid BCLS certificates.	Personnel File
LD.68.EC.17	All critical care physicians' staff have valid BLS certification and ACLS (adults), PALS (Pediatrics).	Personnel File
LD.68.EC.18	Nurses who perform conscious sedation are certified BCLS, ACLS or PALS , NALS.	Personnel File
LD.68.EC.19	Physician who is certified in PALS for pediatric codes.	Personnel File
LD.68.EC.20	All emergency physicians have valid PALS and NALS certification according to the scope of services.	Personnel File
LD.68.EC.21	Physician who is certified in NRP for neonatal codes.	Personnel File



**LD.69 The organization ensures that staff are educated on the safe operation of equipment.**

LD.69.1 Staff are trained on the safe operation of equipment, including medical devices.

LD.69.2 There is a process to ensure that only trained and competent staff operate specialized equipment.

LD.69.3 Training is provided when new equipment is introduced.

**Evidence of Compliance**

LD.69.EC.1 There is evidence of staff education on the safe operation of equipment together with tools to ensure competency of staff. Personnel File

**LD.70 The needs identified for training and education are based on, as appropriate:**

LD.70.1. The hospital mission, vision, and values

LD.70.2. The patient population served and the type and nature of care provided by the hospital and the department/service

LD.70.3. Individual staff member's education and training needs

LD.70.4. Information from quality assessment and improvement activities

LD.70.5. Needs generated by advancements made in health care management and health care science and technology

LD.70.6. Findings from department/service performance appraisals of individuals

LD.70.7. Findings from review activities by peers, if appropriate

LD.70.8. Findings from the organization's plant, technology, and safety management programs

LD.70.9. Findings from infection control activities

**Evidence of Compliance**

LD.70.EC.1 The education and training program is based on (the hospital mission, vision, and values, population served, staff training needs, quality assessment, advancements made in health care management and health care science and technology, appraisals of individuals, review activities by peers, the organizations plant, technology, and safety management programs, and infection control activities). Document Review

LD.70.EC.2 The educational activities and training are based on hospital needs. Document Review

**LD.71 The organization has processes in place to address the health and safety of staff consistent with laws and regulations and:**

LD.71.1 The program covers all employees.

LD.71.2 The program is based on assessment, and where necessary, reduction of occupational health and safety risks.

LD.71.3 The program is coordinated with the hospital's quality, safety, risk management, and infection control programs.

LD.71.4 The program includes, but not limited to, the following:

LD.71.4.1 Pre-employment medical evaluation of new employees.

LD.71.4.2 Response to the health problems of the employees through direct treatment (e.g., employee health clinic) or referral.

LD.71.4.3 Periodic medical evaluation of staff (at least once annually).

LD.71.4.4 Screening for exposure and/or immunity to infectious diseases.

LD.71.4.5 Staff preventive immunizations.

LD.71.4.6 Management of exposure to bloodborne pathogens and other work-related conditions.

LD.71.4.7 Measures to reduce occupational exposures and hazards, including use of protective equipment and clothing, stress management, and ergonomic.

LD.71.4.8 Staff education on the risks within the hospital environment as well as on their specific job-related hazards, e.g., lifting techniques, using equipment safely, and detecting, assessing, and reporting risks.

LD.71.4.9 Management and documentation of staff incidents, e.g., injuries or illnesses, taking corrective actions, setting measures in place to prevent recurrences.

LD.71.5 There is appropriate record keeping and management (employee health records that are filed separately).

**Evidence of Compliance**

LD.71.EC.1 There are health files for all employees with contents in LD.71.4.1 through LD.71.4.9. Document Review



**LD.72 The leadership has an effective process to evaluate staff within the probationary period of employment and this includes:**

LD.72.1 A policy that outlines the roles and responsibilities for evaluating staff during their probationary period.

LD.72.2 Documentation in the employee's personnel file.

**Evidence of Compliance**

LD.72.EC.1 Probationary period staff evaluation policy. Document Review

LD.72.EC.2 Documentation of probationary period staff evaluation in the employees personnel file. Personnel File

**LD.73 The leadership has an effective process to evaluate staff at least annually and this includes:**

LD.73.1 A policy that outlines the roles and responsibilities for evaluating staff at least annually.

LD.73.2 A comprehensive evaluation form that covers all aspects of expected performance levels as outlined in his/her job description (e.g. competence, attitude, etc).

LD.73.3 Documentation in the employee's personnel file.

LD.73.4 All staff reading and signing their evaluation.

**Evidence of Compliance**

LD.73.EC.1 Annual evaluation policy and evaluation form that covers all expected performance levels. Document Review

LD.73.EC.2 All employee files contain the completed annual evaluation form (as appropriate) with staff signature. Personnel File



## Medical Staff and Provision of Care

### Introduction

The medical staff has a major role in the effort to provide high quality medical care with a high degree of clinical safety. The standards in this chapter defines the medical staff leaders' roles and responsibilities in credentialing, privileging, bylaws development, committees and departments management, and performance improvement.

Hospitals vary in the scope of services they provide and thus the types of patients they may effectively serve. The organization should accept patients for services according to its capability to provide the services that meet the identified patient's needs.

Providing optimum care requires careful planning, coordination, and communication. The hospital must provide an appropriate and thorough assessment of each patient, and patient care must be planned and implemented to ensure the best possible outcome for the patient. To support continuity of care, patient assessment and care must be documented in a complete medical record for the patient. As the care process may need to occur between multiple providers, a collaborative process should be in place to promote continuity and coordination of care when the patient is referred, transferred, or discharged.

Important processes and activities addressed in this chapter include the following:

- Medical staff leaders' roles and responsibilities
- Medical staff evaluation, credentialing and privileging
- Medical staff committees
- Medical staff collaboration with other disciplines
- Access to care
- Scope and content of patient assessment and reassessment
- Plan of care
- High risk patients
- Patient discharge, transfer and referral within or outside the organization



## Standards

- MS.1 The Medical Director is qualified for the position by:**  
MS.1.1 Having the appropriate experience and education.  
MS.1.2 Having basic knowledge of quality management principles.
- Evidence of Compliance**
- |           |  |                |
|-----------|--|----------------|
| MS.1.EC.1 | The Medical Director has a qualification certificate in medicine.          | Personnel File |
| MS.1.EC.2 | The Medical Director has basic knowledge of quality management principles. | Interview      |
| MS.1.EC.3 | The Medical Director has appropriate experience and education.             | Personnel File |
- MS.2 The Medical Director has a written job description that clearly describes his roles and responsibilities. The job description is current (reviewed/revise at least every 3 years and as needed).**
- Evidence of Compliance**
- |           |  |                 |
|-----------|--|-----------------|
| MS.2.EC.1 | The Medical Director has a current (at least 3 years) written job description that clearly describes his roles and responsibilities. | Document Review |
|-----------|--|-----------------|
- MS.3 The Medical Director is responsible and accountable to the Governing Body, either directly or by appropriate delegation, for the clinical performance of the medical staff and their professional conduct.**
- Evidence of Compliance**
- |           |   |                 |
|-----------|---|-----------------|
| MS.3.EC.1 | The medical director reports to the Governing Body as identified in the organizational chart. | Document Review |
|-----------|---|-----------------|
- MS.4 The Medical Director holds regular formal at least (monthly) meetings with all clinical department heads to ensure that all department heads work together to coordinate the provision of care.**
- Evidence of Compliance**
- |           |   |                 |
|-----------|---|-----------------|
| MS.4.EC.1 | The monthly meeting minutes with all clinical department heads contain evidence of discussion of aspects of medical care and services provided to patients. | Document Review |
|-----------|---|-----------------|
- MS.5 The Medical Director reviews and approves policies and procedures written by the department heads when collaboration with other departments occurs.**
- Evidence of Compliance**
- |           |  |                 |
|-----------|--|-----------------|
| MS.5.EC.1 | Sample of inter-departmental (multidisciplinary) policies with Medical Director review and approval. | Document Review |
|-----------|--|-----------------|
- MS.6 The Medical Director supports the Hospital Quality Management plan and works closely with the Quality Director/leader and Nursing Director/leader to implement the plan. Formal meetings are documented.**
- Evidence of Compliance**
- |           |  |                 |
|-----------|--|-----------------|
| MS.6.EC.1 | There are meetings between medical director with quality director and nursing director discussing aspects of quality plan (meeting minutes). | Document Review |
|-----------|--|-----------------|
- MS.7 The Medical Director works closely with the Nursing Director/leader and the Quality Management Director/leader to implement the patient safety plan and formal meetings are documented.**
- Evidence of Compliance**





MS.7.EC.1 There are meetings between medical director with quality director and nursing director discussing patient safety issues (meeting minutes). Document Review

**MS.8 The Medical Director works closely with the Nursing Director/leader and the Quality Management Director/leader to implement the risk management plan. Formal meetings are documented.**

MS.8.1 Clinical risk assessment is conducted to identify risks with the potential to cause harm to patients.

MS.8.2 Interventions to safeguard patients from unintended consequences of care/treatment are developed, implemented, and evaluated.

**Evidence of Compliance**

MS.8.EC.1 There are meetings between medical director with quality director and nursing director discussing aspects of clinical risk management defined in MS.8.1 and MS.8.2 (meeting minutes). Document Review

**MS.9 The Medical Director works closely with the Quality Management Director/leader and Risk Manager in handling all near misses and incidents and:**

MS.9.1 Root cause analysis is performed when appropriate.

MS.9.2 Emphasis is placed on improving systems.

MS.9.3 The "Actions taken" are documented.

**Evidence of Compliance**

MS.9.EC.1 The medical director handles all near misses and incidents (sample of incident/OVR reports). Interview  
MS.9.EC.2 Root cause analysis is conducted for selected incidents. Document Review  
MS.9.EC.3 The actions taken in handling near misses are documented. Document Review

**MS.10 The Medical Director supports the Infection Control program by:**

MS.10.1 Empowering the Infection Control practitioner to perform his/her role and enforcing his/her recommendations.

MS.10.2 Approving required resources.

MS.10.3 Communicating with the Ministry of Health for reportable infectious diseases.

**Evidence of Compliance**

MS.10.EC.1 The Medical Director supports the Infection Control program by empowering the Infection Control practitioner to perform his/her role and enforcing his/her recommendations, approving required resources, and communicating with the Ministry of Health for reportable infectious diseases. Document Review

**MS.11 The Medical Director reviews all hospital committee minutes within his scope and uses this information for:**

MS.11.1 Guiding and prioritizing the services needed.

MS.11.2 Guiding the credentialing and privileging process.

**Evidence of Compliance**

MS.11.EC.1 There are meeting minutes reviewed by the medical director with actions for guiding and prioritizing the services needed. Document Review  
MS.11.EC.2 There are meeting minutes reviewed by the medical director with actions for guiding the credentialing and privileging process. Document Review

**MS.12 Every Department has a department head who is the qualified in his field and:**

MS.12.1 He has the appropriate experience and education (Saudi Board or equivalent).

MS.12.2 He has basic knowledge of quality management principles (participated or attended quality activities).

**Evidence of Compliance**



MS.12.EC.1	Qualification of medical department heads by Saudi Board or equivalent.	Personnel File
MS.12.EC.2	Department heads have basic knowledge of quality management principles.	Interview

**MS.13 The department head's managerial responsibilities include:**

MS.13.1 Recommending space, equipment, and supplies for the existing unit and new programs within the hospital scope.

MS.13.2 Recommending the necessary staffing for their area.

MS.13.3 Writing internal policies and procedures ensuring that they are consistent with hospital and other department's policies and procedures.

**Evidence of Compliance**

MS.13.EC.1	The department heads managerial responsibilities (job description) include recommending space, equipment, and supplies for the existing unit and new programs within the hospital scope, recommending the necessary staffing for their area, and writing internal policies and procedures.	Document Review
MS.13.EC.2	The department heads write internal policies and procedures ensuring that they are consistent with hospital and other departments policies and procedures.	Document Review

**MS.14 The department head's clinical responsibilities to evaluate the clinical standard within his/her department includes:**

MS.14.1 Defining the necessary skills required of the medical staff to safely provide care to patients and recommend the training programs as needed.

MS.14.2 Ensuring that the patient admitted by physicians within his/her service is within the staff's capabilities and the hospital's resources to meet their needs by periodic monitoring of admissions.

**Evidence of Compliance**

MS.14.EC.1	The job description of department heads reflects that they evaluate the clinical standard within his/her department including defining the necessary skills required of the medical staff, and recommending the training programs as needed.	Document Review
MS.14.EC.2	The job description of department heads reflect that they evaluate the clinical standard within his/her department including ensuring that the patient admitted by physicians within his/her service is within staff capabilities and hospital resources to meet their needs by periodic monitoring of admissions.	Document Review

**MS.15 All department heads ensure that the physicians working within their area limit their scope of practice to the clinical privileges assigned to them by the appropriate authority.**

**Evidence of Compliance**

MS.15.EC.1	All medical staff are working within the scope of practice according to the clinical privileges approved by the appropriate authority.	Personnel File
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**MS.16 The department head holds regular meetings with his staff (documented minutes) to ensure that they all work together to coordinate the provision of care.**

**Evidence of Compliance**

MS.16.EC.1	The departments' regular meeting minutes contain evidence of coordination of medical care and services provided to patients.	Document Review
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**MS.17 The department head has a written scope of service for his/her area and this includes:**

MS.17.1 The range of service i.e., Pediatrics, Gynecology or a general hospital.

MS.17.2 The age groups who receive care.

MS.17.3 The number of patients seen annually.

MS.17.4 The major diagnostics or therapeutic methods used.

MS.17.5 The scope of services is signed by the Medical Director, the Administrator, or both.



**Evidence of Compliance**

MS.17.EC.1 The written departmental scope of service that includes the range of service, age groups, number of patients seen annually, major diagnostics or therapeutic methods used, and is signed by the medical director, the administrator, or both. Document Review

**MS.18 The department head has a method (like a peer review committee) to:**

- MS.18.1 Assess the appropriateness of admissions.
- MS.18.2 Assess the appropriateness of care.
- MS.18.3 Assess the effectiveness of care and its outcome.
- MS.18.4 Assess the efficacy of care.
- MS.18.5 Assess the length of stay.
- MS.18.6 Assess appropriate utilization of services.

**Evidence of Compliance**

MS.18.EC.1 The heads of departments have a method to assess quality of clinical services. Interview

**MS.19 The department head shares his/her findings with the Medical Director and works closely to improve and correct their deficiencies.**

**Evidence of Compliance**

MS.19.EC.1 Communication between the head of department and medical director. Interview  
MS.19.EC.2 Sampling of quality improvement project in the medical departments. Document Review  
MS.19.EC.3 The meeting minutes where the department head shares his/her findings with the medical director. Document Review

**MS.20 The hospital has a set of documents that describes how the medical staff are organized and how the medical staff carry out the required functions of their service (Bylaws or other methods) and includes:**

- MS.20.1 The organizational structure of the medical division, and all the related medical sub units and the reporting relationships.
- MS.20.2 The qualification requirements for every type of medical staff position that is being considered for hire (credentialing).
- MS.20.3 The membership categories (e.g. full time, part time, locum, etc).
- MS.20.4 The roles and responsibilities of all levels of the medical staff.
- MS.20.5 The admitting, referral, transfer, and discharge process.
- MS.20.6 The list of medical departments and committees.
- MS.20.7 The medical record documentation guidelines.
- MS.20.8 The conduct of care expected for all levels of medical staff (e.g. daily rounds).
- MS.20.9 The professional conduct (e.g. handling ethical issues).
- MS.20.10 How the medical staff may be promoted, appointed, or reappointed.
- MS.20.11 The disciplinary process for the medical staff including corrective action and appeals.
- MS.20.12 How the scope of practice is determined for each medical staff position that is being considered for hire (privileging).
- MS.20.13 How privileges will be maintained and updated for each physician.
- MS.20.14 How temporary privileges are granted by the Credentialing and Privileging committee to the medical staff (locums and emergency situations).

**Evidence of Compliance**

MS.20.EC.1 There are hospital bylaws that include items in MS.20.1 through MS.20.14. Document Review  
MS.20.EC.2 The medical staff by-laws outline how temporary privileges are granted by the Credentialing and Privileging committee to the medical staff (locum and emergency situations). Personnel File



**MS.21 The organization has clearly defined and documented processes used to appoint and grant privileges to the medical staff. The medical staff includes licensed physicians, dentists, and other licensed individuals permitted by law to provide patient care services independently in the organization.**

MS.21.1 Medical staff appointments and granting privileges are in accordance with law and legal requirements.

MS.21.2 Medical staff appointments and granting privileges are based on evaluation of the verified credentials (license, education, training, and experience) as well as physical and mental health.

MS.21.3 Medical staff appointments and granting privileges are recommended by the medical staff leaders, e.g., credentialing and privileging committee and medical executive committee, and approved by the governing body, either directly or by appropriate delegation.

MS.21.4 The process applies to all medical staff categories (e.g., full time, part time, locum, etc).

**Evidence of Compliance**

MS.21.EC.1	There are documented processes for medical staff appointment and granting of clinical privileges. The processes are preceded by verification and evaluation of credentials and as well as physical and mental health.	Document Review
MS.21.EC.2	Medical staff appointments are approved by the governing body or by appropriately delegated authority.	Personnel File

**MS.22 The hospital has a Medical Credentialing and Privileging committee chaired by the Medical Director or his designee that ensures only qualified physicians are hired.**

**Evidence of Compliance**

MS.22.EC.1	Medical Credentialing and Privileging committee terms of reference.	Document Review
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**MS.23 Applications for credentialing require the submission of a complete set of documents by the candidate for hire and include:**

MS.23.1 The CV which contains the entire professional history of the candidate.

MS.23.2 Education, training, certificates, courses, experience credentials, and published research.

MS.23.3 A list of references and methods to contact them.

MS.23.4 A list of the privileges requested for approval and any requirements for skill upgrades.

**Evidence of Compliance**

MS.23.EC.1	There are medical staff application and completion of credentialing documents.	Personnel File
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**MS.24 The evaluation process for the Credentialing and Privileging committee ensures that every candidate undergoes the same standards for hire and includes the following:**

MS.24.1 The physician's credentials are verified to determine if he/she possesses the required qualifications.

MS.24.2 The physician's are registered with the Saudi Commission for Health Specialists.

MS.24.3 The physician's mental and physical capabilities are evaluated by obtaining letters of reference and making inquiries as needed.

MS.24.4 The physician's past experience is evaluated when "new" skill upgrade by the physician is required.

MS.24.5 The physician's continued scope of practice (privileging) is determined by his/her continued performance and outcomes of care rendered.

MS.24.6 Temporary or emergency privileges are approved by the Medical Director for up to 90 days while the physician's papers are being processed by the Credentialing and Privileging committee and are not renewable.

**Evidence of Compliance**

MS.24.EC.1	Credentialing and Privileging committee candidate evaluation process.	Personnel File
MS.24.EC.2	The medical staff candidates hiring process is implemented.	Personnel File
MS.24.EC.3	There are temporary or emergency privileges that are approved by the medical director for up to 90 days while the physician's papers are being processed by the Credentialing and Privileging committee and are not renewable.	Personnel File



**MS.25** The hospital ensures that all physicians working as locums, part time, or any physicians from outside institutions go through the Credentialing and Privileging process and follow the Bylaws to practice within the hospital.

**Evidence of Compliance**

MS.25.EC.1 All medical staff hired (locum, part time, physicians outside institutions) pass through the Credentialing and Privileging process. Personnel File

**MS.26** All medical staff members have current delineated clinical privileges:

MS.26.1 The clinical privileges are determined based on documented competency.

MS.26.2 The clinical privileges of the medical staff are recommended by the medical staff leaders and approved by the governing body, either directly or by appropriate delegation.

MS.26.3 The clinical privileges are reviewed and updated every (2) years, and as needed.

**Evidence of Compliance**

MS.26.EC.1 All medical staff members have delineated clinical privileges approved by the governing body or by appropriately delegated authority. Personnel File

MS.26.EC.2 Medical staff members work within the scope of practice according to the clinical privileges. Interview

MS.26.EC.3 The clinical privileges are current, no more than (2) years, and as needed. Personnel File

**MS.27** The Medical Director together with the clinical department heads evaluate the performance of each medical staff member to determine continued competence to provide patient care services.

MS.27.1 The performance of each medical staff member is reviewed at least annually and when indicated by findings of the performance improvement activities.

MS.27.2 The performance evaluation includes, but not limited to, the following:

MS. 27.2.1 Patient assessments.

MS. 27.2.2 Adverse events.

MS. 27.2.3 Conscious sedation

MS. 27.2.4 Quality of medical records.

MS. 27.2.5 Medication errors.

MS. 27.2.6 Sentinel events.

MS. 27.2.7 High-risk services and procedures (e.g. angiogram, ERCP, etc).

MS. 27.2.8 Mortality and morbidity.

MS. 27.2.9 Blood and blood product usage.

MS. 27.2.10 Outcomes of surgeries.

MS. 27.2.11 Any discrepancies between preoperative and postoperative diagnosis.

MS. 27.2.12 Appropriateness of admissions from the emergency room.

MS. 27.2.13 Appropriateness of admissions from the outpatient area.

**Evidence of Compliance**

MS.27.EC.1 The Medical Director collaborates with the department heads to evaluate the performance of each medical staff member. Interview

MS.27.EC.2 The medical staff evaluation includes at a minimum elements MS.27.2.1 through MS.27.2.13. Document Review

MS.27.EC.3 The medical staff evaluation is done annually and when indicated. Document Review

**MS.28** The Medical Director together with the clinical department heads uses the above information, to continuously improve the system, and this includes but is not limited to:

MS.28.1 Provide feedback to physicians regarding their performance.

MS.28.2 Counseling of staff regarding their performance.

MS.28.3 Amending clinical privileges as necessary through Credentialing Privilege Committee CPC.

MS.28.4 Studying and correcting variances in processes within the system.

MS.28.5 Recommending any necessary equipment to the appropriate area.



MS.28.6 Recommending training and refresher courses as needed.

MS.28.7 Other appropriate actions

MS.28.8 Improve the care processes in collaboration with the quality management staff and other disciplines as a part of the organization's quality monitoring and improvement activities.

MS.28.9 The outcomes of performance evaluation and actions taken including any impact on privileges are maintained in the physician's credentials file.

**Evidence of Compliance**

MS.28.EC.1	The medical director and clinical department heads use the information to continuously improve the system (counseling of staff, amending clinical privileges, studying and correcting variances, recommending any necessary equipment, and recommending training and refresher courses).	Interview
MS.28.EC.2	There is evidence about the use of the resulting data for decisions specified in MS.28.2 through MS.28.8.	Interview
MS.28.EC.3	The physicians credentials files contain the outcomes of performance evaluation and actions taken	Personnel File

**MS.29 The Medical Director co-signs all medical staff evaluations completed by department heads in the Medical Division.**

**Evidence of Compliance**

MS.29.EC.1	The medical director co-signs all medical staff evaluations (appraisal forms).	Personnel File
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**MS.30 The hospital has a Cardiopulmonary Resuscitation (CPR) committee that discusses all CPR codes. The summary of these discussions is sent to the Medical Director and the Quality Management Director/leader.**

**Evidence of Compliance**

MS.30.EC.1	All codes are discussed in the CPR committee and minutes are forwarded to the medical director and the quality management director/leader.	Document Review
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**MS.31 The Medical Director works closely with the Nursing Director/leader and other department heads as needed to ensure there is an effective system to handle all cases of CPR at all times (24 hours/day) and includes:**

MS.31.1 Standardization of all crash cart contents and includes medications, airway access, venous access, oxygen, and a defibrillator that is maintained and charged at all times.

MS.31.2 A process for checking the crash cart every shift by nursing or as appropriate by the pharmacy.

MS.31.3 A process for restocking the cart and/or exchanging the crash cart after use.

MS.31.4 A process to keep a defibrillator on each crash cart that is maintained and fully charged.

MS.31.5 A simple number such as 999 to call when summoning help for a code.

MS.31.6 Training for nurses on how to use the alarm system or call the code.

**Evidence of Compliance**

MS.31.EC.1	There is a comprehensive CPR protocol that includes standardization of all crash cart contents and includes medications, airway access, venous access, oxygen, and a defibrillator that is maintained and charged at all times, process for checking and restocking the crash cart every shift by nursing or as appropriate by the pharmacy, process to keep a defibrillator on each crash cart that is maintained and fully charged, and simple number such as 999 to call when summoning help for a code.	Document Review
MS.31.EC.2	There is training for nurses on how to use the alarm system or call the codes.	Document Review

**MS.32 The hospital has a Mortality/Morbidity committee that is chaired by the Medical Director or his designee.**

**Evidence of Compliance**

MS.32.EC.1	The hospital has a mortality and morbidity committee that is chaired by the medical director or his designee. (Terms of reference ).	Document Review
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- MS.33 The Mortality/Morbidity committee evaluates cases to see if the standard of care was met and makes recommendations for system improvement. The work of the committee includes the following:**  
MS.33.1 Referral sources for case review include the patient complaint committee, department heads (after performing departmental review) and the Medical Director.  
MS.33.2 Cases are evaluated for appropriateness of care, timeliness of care, and efficacy of care.  
MS.33.3 Findings are summarized and sent to the Medical Director and the Quality Management Director/leader.

**Evidence of Compliance**

- MS.33.EC.1 The mortality and morbidity committee meeting minutes reflect the functions per term of reference. Document Review

- MS.34 All departments have a monthly Mortality/Morbidity meeting which includes the following:**

- MS.34.1 The departmental Mortality/Morbidity meetings focus is educational.  
MS.34.2 Attendance at the Mortality/Morbidity meetings is considered essential and documented.  
MS.34.3 All cases of mortality and morbidity are reviewed and minutes are taken with corrective actions included.  
MS.34.4 The discussions at these meetings are confidential and kept in a locked file.

**Evidence of Compliance**

- MS.34.EC.1 There are monthly departmental mortality and morbidity meeting (minutes and attendance). Document Review  
MS.34.EC.2 All cases of mortality and morbidity are reviewed and minutes are taken with corrective actions included. Document Review  
MS.34.EC.3 The discussions at the mortality and morbidity meetings are confidential and kept in a locked file. Observation

- MS.35 The department head's responsibilities for case findings for the Morbidity and Mortality meeting includes:**

- MS.35.1 Working with the Medical Director to decide which cases are referred to the Hospital Mortality/Morbidity committee.  
MS.35.2 Sending a monthly summary report to the Medical Director and the Quality Management Director/leader.

**Evidence of Compliance**

- MS.35.EC.1 The cases selected for hospital mortality and morbidity review are in monthly summary reports. Document Review

- MS.36 The hospital has a Medical Record Review committee including the following members: Medical staff, Nursing staff and others who document in the medical record.**

**Evidence of Compliance**

- MS.36.EC.1 The Medical record review committee terms of reference outline the function and membership. Document Review

- MS.37 The Medical Record Review committee monitors completeness and evaluates the quality of the medical record documentation by reviewing a 5% sample (quarterly) of discharged patients and patients who are still in the hospital for:**

- MS.37.1 History and physical.  
MS.37.2 Admission assessments.  
MS.37.3 Operative notes.  
MS.37.4 Histopathology report.  
MS.37.5 Lab results.  
MS.37.6 Typed x-ray reports.  
MS.37.7 Discharge summaries.  
MS.37.8 Documentation of patient education activity.



MS.37.9 Progress notes.

MS.37.10 Plan of care.

**Evidence of Compliance**

MS.37.EC.1	The Medical record review committee reviews 5% sample quarterly of discharged patients and patients who are still in the hospital.	Document Review
MS.37.EC.2	The Medical record review form includes admission assessments, operative notes, histopathology report, lab results, typed x-ray reports, discharge summaries, documentation of patient education activity, progress notes, and plan of care.	Document Review

**MS.38 The hospital has a Pharmacy and Therapeutics committee.**

**Evidence of Compliance**

MS.38.EC.1	The hospital has a Pharmacy and Therapeutics committee (terms of reference).	Document Review
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**MS.39 The Pharmacy and Therapeutics committees' responsibilities include, but are not limited to:**

MS.39.1 Approving the hospital formulary.

MS.39.2 Approving any new additions or deletions from the formulary.

MS.39.3 Approving the policy for the use of antibiotics in the hospital.

**Evidence of Compliance**

MS.39.EC.1	The terms of reference for Pharmacy and Therapeutics committee outline the function by approving the hospital formulary, the additions or deletions from the formulary and the policy for the use of antibiotics.	Document Review
MS.39.EC.2	Functions of the Pharmacy and Therapeutics committee are clearly understood by the committee members.	Interview

**MS.40 The hospital has a Utilization Review committee that is chaired by the Medical Director or his designee, and has representation from medical, nursing and the paramedical division to ensure optimum use of resources. The monitoring includes and is not limited to:**

MS.40.1 Length of stay for selected types of patients and services.

MS.40.2 Appropriateness of admissions.

**Evidence of Compliance**

MS.40.EC.1	The Utilization Review committee terms of reference outlines the function and membership.	Document Review
MS.40.EC.2	There is monitoring of length of stay and appropriateness of admission.	Document Review

**MS.41 The Utilization Review committee studies all aspects of patient care, including drug usage and observes for:**

MS.41.1 Over utilization of resources.

MS.41.2 Under utilization of resources.

MS.41.3 Inefficient utilization of resources.

MS.41.4 Inefficient allocation of resources.

**Evidence of Compliance**

MS.41.EC.1	The Utilization Review committee meeting minutes reflects the discussion of all aspects of patient care, including drug usage and observes for over utilization, under utilization and inefficient utilization or allocation of resources.	Document Review
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**MS.42 The hospital has a Blood Utilization committee that has representation from medical, nursing, and laboratory departments and is chaired by the Medical Director or designee.**

**Evidence of Compliance**

MS.42.EC.1 The hospital has a Blood Utilization committee that has representation from medical, nursing, and laboratory departments and is chaired by the medical director or designee (formation order and meeting minutes). Document Review

**MS.43 The Blood Utilization committee approves and monitors all policies and procedures that involve the administration of blood in the institution and includes but is not limited to:**

MS.43.1 Taking blood samples from patients for type and cross matching; handling, storing and administration of blood products.

MS.43.2 Taking blood from the donors and processing it.

**Evidence of Compliance**

MS.43.EC.1 The Blood Utilization committee approves and monitors all policies that includes taking blood samples from patients for type and cross matching; handling, storing and administration of blood products. Document Review

MS.43.EC.2 The Blood Utilization committee approves and monitors all policies that include taking blood from the donors and processing it. Document Review

**MS.44 The Blood Utilization committee monitors the Blood Bank's performance and reviews all the procedures used for collecting, testing, and storing blood and blood products.**

**Evidence of Compliance**

MS.44.EC.1 The Blood Utilization Review committee monitors and reviews the blood bank performance (meeting minutes). Document Review

**MS.45 The hospital has a Tissue Review committee or ensures that the functions of the Tissue Review committee are handled by the Chief Pathologist or his designee.**

**Evidence of Compliance**

MS.45.EC.1 The hospital has a Tissue Review committee or ensures that the functions of the Tissue Review committee are handled by the Chief Pathologist or his designee (formation order and meeting minutes). Document Review

**MS.46 The Tissue Review committee or its equivalent ensures that specimens and/or tissues are obtained and handled according to a policy and this includes monitoring of:**

MS.46.1 The accuracy of the fine needle aspirations.

MS.46.2 Obtaining specimens and transporting them to the laboratory.

MS.46.3 The accuracy and completeness for Histopathology forms: site of biopsy, number of pieces taken, clinical history, previous biopsies, etc.

MS.46.4 Any variation between the preoperative, the postoperative and/or the pathological diagnosis.

MS.46.5 Any specimens or tissue removed during surgery are sent to the laboratory for Histopathological examination (e.g. hernia sac or any lump).

MS.46.6 Any "frozen section" specimens obtained from surgery.

**Evidence of Compliance**

MS.46.EC.1 There is a written policy on obtaining and handling specimens and /or tissues. Document Review

MS.46.EC.2 The Tissue Review committee monitors accuracy of FNA, obtaining and handling specimens, accuracy and completion of histopathology forms, variation between pathological and pre-operating and post-operative diagnosis, any specimen or tissue removed during surgery is sent for histopath examination, and any frozen section specimen obtained. Document Review



**MS.47** The hospital has an Operating Room (OR) committee that include the following members: medical staff, nursing staff, OR technician, infection control, and safety personnel.

**Evidence of Compliance**

MS.47.EC.1 The hospital has an Operating Room committee that includes the following members: medical staff, nursing staff, OR technician, infection control, and safety personnel (formation order and meeting minutes). Document Review

**MS.48** The Operating Room committee approves all of the policies for conducting the work in the operating room and include, but not limited to, the following:

MS.48.1 Infection control measures.

MS.48.2 Supply of equipments and disposables.

MS.48.3 Proper identification of patients, and site of surgery.

MS.48.4 Code of ethical conduct in the operating room to protect patient privacy, and dignity.

MS.48.5 Cancellation rate and designs process to reduce it.

**Evidence of Compliance**

MS.48.EC.1 Approved Operating Room policies by OR committee that includes infection control measures, supplies, patient identification code of conduct and cancellation rate. Document Review

## PROVISION OF CARE

**MS.49** The organization defines and displays the services that it can provide.

MS.49.1 The services being provided are clearly defined.

MS.49.2 The defined services are prominently displayed.

MS.49.3 The staff are oriented to these services.

**Evidence of Compliance**

MS.49.EC.1 There is evidence that the organization defines its services and communicates them to the patients, families, and the community at large. Interview

MS.49.EC.2 The staff are aware and familiar with the services provided. Interview

**MS.50** Patient care is uniform when similar care is provided and is guided by the applicable laws and regulations.

**Evidence of Compliance**

MS.50.EC.1 Patients are provided with similar care in all settings across the facility. Interview

**MS.51** Patient care is culturally and spiritually sensitive to the populations served and considers their special preferences.

MS.51.1 The hospital provides staff training on the cultural beliefs, values, and needs of different populations served.

MS.51.2 The hospital provides separate facilities for women where appropriate.

MS.51.3 The hospital has a process to provide access to spiritual care or advice that meets the needs of the different populations served.

**Evidence of Compliance**

MS.51.EC.1 The hospital provides training on the cultural beliefs, values, and needs of different populations served. Interview

MS.51.EC.2 Separate facilities are provided for women. Observation

**MS.52** Patients have access to services based on their health needs and services available.

MS.52.1 There is an appointment system.



MS.52.2 There is a written standardized process for registering patients for services.

MS.52.3 There is a written standardized process for admitting patients to the organization (routine, urgent and emergent admissions).

MS.52.4 The registration and admission policies address out-patients, in-patients, and emergency patients.

MS.52.5 Patients are accepted only when the organization can meet their health care needs.

MS.52.6 There is a process to handle patients when resources (e.g., beds) are not available.

**Evidence of Compliance**

MS.52.EC.1	There is an appointment system and registration process in place.	Observation
MS.52.EC.2	There is a written standardized process for admission that addresses out-patients, in-patients, and emergency patients.	Document Review
MS.52.EC.3	There is evidence that patients are accepted for services only when their needs can be met.	Interview
MS.52.EC.4	A process is in place for appropriate management of patients when resources are not available.	Interview

**MS.53 The hospital identifies and reduces physical, language, cultural and other barriers that prevent patients from accessing services.**

**Evidence of Compliance**

MS.53.EC.1	There is evidence that the hospital identifies common barriers that compromise patients from accessing services and develop processes to reduce these barriers.	Interview
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**MS.54 Clinical practice guidelines are used to guide clinical care for patients as appropriate to the organization's mission.**

MS.54.1 Clinical practice guidelines developed by the hospital are based on evidence based medicine whenever possible.

MS.54.2 The clinical practice guidelines are updated at least every 2 years or when needed.

MS.54.3 Staff follow the clinical practice guidelines.

**Evidence of Compliance**

MS.54.EC.1	There are clinical practice guidelines.	Document Review
MS.54.EC.2	The clinical practice guidelines are reviewed at least every 2 years or when needed	Document Review
MS.54.EC.3	There is evidence that staff follow the clinical practice guidelines.	Medical Record Review

**MS.55 There is a screening or triage process to identify patients with urgent or emergent care needs.**

MS.54.1 Patients with emergent or urgent needs are given priority for assessment and appropriate and timely care.

**Evidence of Compliance**

MS.55.EC.1	There is a process to identify patients in need for emergent or urgent needs.	Interview
MS.55.EC.2	The organization provides appropriate and timely care for emergent or urgent cases when needs are identified.	Observation

**MS.56 The hospital identifies the health care needs of its patients through an established assessment process. The hospital defines in policy and procedure:**

MS.56.1 Which healthcare provider is responsible for screening and assessment of patients in accordance with laws, regulations, and licensure.

MS.56.2 The scope and content of assessment by each discipline.

MS.56.3 The scope and content of assessment in different care settings: out-patients, in-patients, and emergency patients.

MS.56.4 The time frame for completion of assessment by each discipline.

MS.56.5 The frequency of reassessment of patients.

Note: Nursing and other professionals roles in assessment and care of patients are addressed in relevant chapters (e.g., Nursing [NR], Social Services [SC], Anesthesia [AN] and the like).



**Evidence of Compliance**

MS.56.EC.1	There is a written policy to define the scope and content of assessment by each discipline, time frame for completion of the assessment process and the frequency of reassessment.	Document Review
MS.56.EC.2	There is evidence of documented complete assessment of patients.	Medical Record Review

**MS.57 Each patient is screened for nutritional status, functional status, psychosocial needs, and potential abuse or neglect.**

MS.57.1 Policies and procedures define the initial screening criteria.

MS.57.2 The screening criteria are developed by qualified individuals.

**Evidence of Compliance**

MS.57.EC.1	There is evidence of documented complete screening for nutritional status, functional status, psychosocial needs, and social and psychological needs.	Document Review
MS.57.EC.2	There is evidence that the screening criteria are developed by qualified individuals.	Document Review

**MS.58 Patient allergies or prior adverse reactions are noted, documented and prominently and consistently displayed in a specified area of the patient's record.**

**Evidence of Compliance**

MS.58.EC.1	Patient allergies or prior adverse reactions are documented in a specified area of the patient's record.	Medical Record Review
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**MS.59 Patients are assessed, reassessed and managed for pain (acute/chronic) which includes:**

MS.59.1 The assessment and reassessment is appropriate to the patient's condition.

MS.59.2 The assessment of pain includes the pain intensity, frequency, location, duration, and type experienced by the patient (e.g. sharp/dull.)

MS.59.3 The process of pain assessment and management is documented in the medical record.

**Evidence of Compliance**

MS.59.EC.1	There is evidence of pain assessment and management as appropriate to the patient's condition.	Medical Record Review
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**MS.60 The hospital develops criteria that identify patients who require further assessment.**

MS.60.1 Patients are appropriately referred for further assessment if criteria are met.

**Evidence of Compliance**

MS.60.EC.1	There are criteria for referring patients for further assessment.	Document Review
MS.60.EC.2	Patients are referred for further assessment if criteria are met.	Medical Record Review

**MS.61 Medical assessments (history and physical examination) are complete and accomplished according to the following guidelines:**

MS. 61.1 The contents of the history and physical examination are determined by the department heads and includes at least the following:

MS. 61.1.1 Chief complaint and details of present illness.

MS. 61.1.2 Allergies, adverse drug reactions, and current medication profile.

MS. 61.1.3 Past history and family history.

MS. 61.1.4 Physical examination required elements.

MS. 61.1.5 Conclusions or impressions based on the admission history and physical examination.

MS. 61.1.6 Diagnostic and therapeutic orders



MS. 61.2 The assessment is done at the time of admission.

MS. 61.3 A history and physical examination completed prior to admission may be used provided it is no more than 30 days old and any significant changes in the patient's condition since the assessment are noted in the patient's record at admission.

MS. 61.4 The attending physician sees patients admitted within 24 hours for routine admissions, within 4 hours for urgent cases, and within 30 minutes for emergencies or earlier as per the patient's condition or hospital policy.

MS.61.5 The medical assessment is documented in the medical record.

#### Evidence of Compliance

MS.61.EC.1	There are written and updated policy and procedures on medical assessments.	Document Review
MS.61.EC.2	There is a complete medical assessment for patients according to their severity index (assessment on admission, attending physician sees patients within 24 hours for routine and 4 hours for urgent cases including social and psychological needs).	Medical Record Review
MS.61.EC.3	The medical assessment is documented in the medical record.	Medical Record Review

### **MS.62 The necessary diagnostic tests (laboratory and radiology) are performed on time to determine the diagnosis.**

MS.62.1 The hospital establishes turn around times for laboratory and radiology results.

MS.62.2 The turn around times are communicated to all medical staff.

MS.62.3 The turn around times are monitored.

MS.62.4 The attending physician is notified regarding PANIC laboratory and radiology values within one hour and immediately for life threatening results.

MS.62.5 The attending physician is notified timely regarding histopathology reports.

#### Evidence of Compliance

MS.62.EC.1	The medical staff are aware about the turn around times.	Document Review
MS.62.EC.2	There is a policy for timely notification of lab or X-ray panic findings within one hour and immediately for life threatening results.	Document Review
MS.62.EC.3	Histopathology test results that require special attention are communicated in accurate and timely manner Logbook/sheet.	Interview
MS.62.EC.4	There is reporting of laboratory and radiology values on time (laboratory and radiology values logbook).	Interview
MS.62.EC.5	There is evidence of monitoring of laboratory and radiology turn around times	Document Review

### **MS.63 All patients are reassessed at appropriate intervals to determine:**

MS.63.1 Response to treatment.

MS.63.2 Compliance to treatment.

MS.63.3 Complications and side effects.

MS.63.4 Plan for continued treatment or completion of treatment.

#### Evidence of Compliance

MS.63.EC.1	There is documentation in the medical records of reassessment findings including elements MS.63.1 through MS.63.4.	Medical Record Review
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### **MS.64 A care plan is developed to meet the needs of each patient.**

MS.64.1 The care plan is developed by the attending physician, nurse, and other disciplines participating in care.

MS.64.2 The care plan is based on the data from assessments and reassessments.

MS.64.3 The care plan contains measurable goals (desired outcomes) and is documented in the patient's record.

MS.64.4 The care planned for each patient is reviewed and verified by the attending physician at least daily with a notation in the progress notes.

MS.64.5 The plan of care is revised when any significant changes in the patient's condition occurs and when new treatments are added or discontinued.

MS.64.6 Care or treatment is provided in accordance with the plan.

MS.64.7 The care provided for each patient is documented in the patient's record.



**Evidence of Compliance**

MS.64.EC.1	Plan of care is documented in the patient's medical record.	Medical Record Review
MS.64.EC.2	There is evidence of plan of care revision during subsequent visits.	Medical Record Review

**MS.65 Patient care is integrated, coordinated, and continuous in nature.**

- MS.65.1 All patients are under an identified physician responsible for their care, referred to as, "The Most Responsible Physician" or "the Attending Physician".
- MS.65.2 Information about the patient's care and response to treatment is shared among medical, nursing, and other care providers.
- MS.65.3 There is a physician order sheet and only physicians write orders on it.
- MS.65.4 The patient's medical record is available to the authorized care providers to facilitate the exchange of information.
- MS.65.5 Documented information is exchanged each staffing shift, between shifts, and during transfers and referrals between health care providers.

**Evidence of Compliance**

MS.65.EC.1	There is evidence of appropriate communication of patients' information.	Medical Record Review
MS.65.EC.2	All patients are under an identified physician known to staff.	Interview
MS.65.EC.3	There is physician order sheet and only physicians write orders on it.	Medical Record Review

**MS.66 There is sufficient medical staff at all times to meet patient needs and with no significant variation for holidays or weekends coverage.**

**Evidence of Compliance**

MS.66.EC.1	Staffing plan guidelines/schedule in medical departments that covers weekends and holidays.	Document Review
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**MS.67 There is at least (1) qualified physician available at all times for each specialty according to the hospital's scope of service.**

**Evidence of Compliance**

MS.67.EC.1	There is on call duty rota for all specialties.	Document Review
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**MS.68 Physicians who are "on call" have to be physically available in the hospital within 30 minutes when called.**

**Evidence of Compliance**

MS.68.EC.1	The physicians are physically available in the hospital within 30 minutes from the call.	Interview
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**MS.69 Consultants see their patients in a timely manner and this includes the following:**

- MS. 69.1 Consultants see their patients at least daily for routine patient needs.
- MS. 69.2 Consultants see their patients anytime there is a significant change (deterioration) in the patient's condition.

**Evidence of Compliance**

MS.69.EC.1	The patients are seen by their consultant at least daily for routine and any time while significant change or deterioration happens.	Medical Record Review
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**MS.70 Every physician is assigned a hospital code number and preferably a stamp that is used to identify him/her for medication prescriptions and in all entries in the patient file.**

**Evidence of Compliance**

MS.70.EC.1	The physicians use the assigned hospital code number and preferably a stamp that is used to identify him/her for medication prescriptions	Medical Record Review
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and in all entries in the patients file.

**MS.71 The Medical Director works with the Nursing Director/leader and appropriate department heads to implement the following policies for Day Surgery:**

MS. 71.1 The types of surgical procedures that are performed as Day Surgery.

MS. 71.2 The kinds of patients who are NOT candidates for Day Surgery such as Sickle cell patients and patients who require greater than (2) hours of anesthesia.

MS. 71.3 The assessments required prior to Day Surgery are followed.

MS. 71.4 The process for patients who have to be admitted to the hospital from Day surgery.

**Evidence of Compliance**

MS.71.EC.1 Day surgery policies include the types of surgical procedures that are performed as Day Surgery, the kinds of patients who are NOT candidates for Day Surgery such as Sickle cell patients and patients who require greater than (2) hours of anesthesia, the assessments required prior to Day Surgery are followed, the process for patients who have to be admitted to the hospital from Day surgery. Document Review

MS.71.EC.2 Implementation of Day Surgery policies. Medical Record Review

**MS.72 Patients who are admitted for surgery have a medical assessment that includes a history and physical examination prior to surgery.**

**Evidence of Compliance**

MS.72.EC.1 There are medical assessments for patients who are admitted for surgery. Medical Record Review

**MS.73 Patients who are admitted for surgery have appropriate diagnostic tests performed and the results documented in the medical record prior to surgery.**

**Evidence of Compliance**

MS.73.EC.1 There is pre operative investigation and results documented for patients who are admitted for surgery. Medical Record Review

**MS.74 Patients who are admitted for surgery have an anesthesia assessment prior to surgery and includes:**

MS. 74.1 Notifying the anesthesia staff in a timely manner that allows a complete anesthesia assessment to be completed (unless there is an extreme emergency).

MS. 74.2 Determining if patient is a good candidate for surgery based on findings.

MS. 74.3 Recording the anesthesia assessment in the medical record.

**Evidence of Compliance**

MS.74.EC.1 There is medical record documentation of complete and timely preoperative anesthesia assessment (except during extreme emergencies) to determine good candidates for surgery. Medical Record Review

**MS.75 No patient has surgery (except extreme emergencies) without the following documents in the chart:**

MS. 75.1 History and physical examination.

MS. 75.2 The preoperative diagnosis.

MS. 75.3 Laboratory and X-ray results if applicable.

MS. 75.4 Signed informed consent.

**Evidence of Compliance**

MS.75.EC.1 All patients undergoing surgery (except extreme during emergencies) have a preoperative assessment which include; History and physical examination, the preoperative diagnosis, Laboratory and X-ray results if Medical Record Review



applicable, signed consent.

**MS.76 If surgical procedures are performed on patients, then:**

MS.76.1 Procedures and the anticipated outcomes including the benefits and risks are explained to the patient.

MS.76.2 Informed consent is taken according to the organization's policy.

MS.76.3 Procedures are described in the medical record and the patient's outcome is documented.

MS.76.4 If any local anesthetic is used, the physicians are expected to document the dose and type of the local anesthetic and its suitability to the patient's condition.

MS.76.5 Any postoperative care needed including required follow up and referrals are provided to the patient

**Evidence of Compliance**

MS.76.EC.1	There is a signed informed consent.	Medical Record Review
MS.76.EC.2	The procedure's description is documented in the medical record together with the patient's outcome.	Medical Record Review
MS.76.EC.3	If local anesthetic is used, the dose, type, and suitability to the patient are documented in the medical record.	Medical Record Review
MS.76.EC.4	Postoperative care needed including required follow up and referrals are documented in the medical record.	Medical Record Review

**MS.77 The attending physician or his designee provides adequate pain relief for patients following surgery and this includes:**

MS. 77.1 A pain assessment by the attending physician or his/her designee after the patient's surgery.

MS. 77.2 Adjustments to pain medications according to the patients' response by the attending or his designee.

**Evidence of Compliance**

MS.77.EC.1	There is adequate pain relief after surgery through pain assessment and adjusting pain medications according to patient response.	Medical Record Review
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**MS.78 The organization meets the unique needs of terminally ill patients in a culturally and age-appropriate manner by:**

MS.78.1 Assessing and respecting the unique needs of dying patients, including spiritual and cultural needs.

MS.78.2 Response to the psychological, social, emotional, spiritual needs.

MS.78.3 Effective management of pain and other distressing symptoms.

MS.78.4 Involvement of the family members in care decisions and teaching them how to care for their patient.

MS.78.5 Referral to outside sources for support is made when indicated.

**Evidence of Compliance**

MS.78.EC.1	The care plan for a terminally ill patient meets the needs of the patient and family during this phase of the illness.	Interview
MS.78.EC.2	The patient's record reflects referral to support services when indicated.	Medical Record Review

**MS.79 Policies and procedures guide the handling, use, and administration of blood and blood products and include:**

MS.79.1 Only physicians order blood and in accordance with a policy clarifying when blood and blood products may be ordered.

MS.79.2 Informed consent is obtained for transfusion of blood and blood products: the physician provides information and education to the patient about the need for blood, and the benefits and the associated risks involved in receiving blood.

MS.79.3 Two (2) staff members verify the patient's identity prior to blood drawing for cross match and prior to the administration of blood.

MS.79.4 Policy and procedure outlined by the Blood Utilization Review committee guides the administration and monitoring of blood transfusions.

MS.79.5 Transfusion reactions are reported and analyzed for preventive and corrective actions.

**Evidence of Compliance**





MS.79.EC.1	There are written criteria for ordering blood and blood products.	Document Review
MS.79.EC.2	There is a policy and procedure for the administration and monitoring of blood transfusions.	Document Review
MS.79.EC.3	There is an informed consent in the medical record.	Medical Record Review

**MS.80 The hospital has adequate equipment and supplies to safely provide care to patients who require Cardio Pulmonary Resuscitation (CPR) such as:**

MS.80.1 Crash carts which contain emergency medications, intubation equipment and, venous access equipment, IV fluids, that are age specific (e.g. neonate, infant, child, adult).

MS.80.2 Defibrillators that are in good working order.

MS.80.3 Oxygen cylinder.

MS.80.4 Portable suction machine.

**Evidence of Compliance**

MS.80.EC.1	The crash carts contain emergency medications.	Observation
MS.80.EC.2	The crash carts which contain intubation equipment.	Observation
MS.80.EC.3	The crash carts contain venous access equipment.	Observation
MS.80.EC.4	The crash carts contain IV fluids.	Observation
MS.80.EC.5	There is crash cart adequately equipped and available in all the critical areas that are age specific (e.g. neonate, infant, child, adult).	Observation
MS.80.EC.6	There are defibrillators that are in good working order.	Observation
MS.80.EC.7	The crash oxygen cylinder in all the critical areas.	Observation
MS.80.EC.8	The crash portable suction machine in all the critical areas.	Observation

**MS.81 Staff who are on the code team have the proper educational training and the CPR team is led by:**

MS.80.1 A physician or an Anesthetist who is certified in ACLS for adult codes.

MS.80.2 A physician who is certified in PALS for pediatric codes.

MS.80.3 A physician who is certified in NRP for neonatal codes.

**Evidence of Compliance**

MS.81.EC.1	There is a CPR/ code team schedule.	Document Review
MS.81.EC.2	There is a physician or an anesthetist who is certified in ACLS for adult codes.	Personnel File
MS.81.EC.3	There is a physician who is certified in PALS for pediatric codes.	Personnel File
MS.81.EC.4	There is a physician who is certified in NRP for neonatal codes.	Personnel File

**MS.82 The roles and responsibilities of the following staff handling CPR are outlined in the hospital policy:**

MS.82.1 The staff who first discover the code.

MS.82.2 The code team leader.

MS.82.3 The code team members.

**Evidence of Compliance**

MS.82.EC.1	Hospital CPR policy that outlines the staff roles and responsibilities of the staff during codes.	Document Review
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**MS.83 The documentation for CPR is standardized by using a "CPR form" and includes the following:**

MS.83.1 The name of the patient, time and location of the code.

MS.83.2 The names of the responders to the code.

MS.83.3 The medications used, and a record of all treatments given (electrical shocks, central lines inserted, intubation, etc the times administered).

MS.83.4 The outcome of the code.



**Evidence of Compliance**

MS.83.EC.1 Documentation for CPR is standardized by using a CPR form that includes name of the patient, time and location, names of responders of the code, the medications used, and a record of all treatments given (electrical shocks, central lines inserted, intubation, the times administered) and the outcome of the code. Document Review

**MS.84 The Medical Director works closely with the Nursing Director/leader and other department heads to develop and maintain the following policies for the care of vulnerable dependent patients (Immune-compromised, comatose, elderly and/or frail, terminally ill, neonates, Infants, and children). The policies include the following:**

MS.85.1 Infection control guidelines.

MS.85.2 Security and safety guidelines.

MS.85.3 Ethical guidelines.

**Evidence of Compliance**

MS.84.EC.1 There is medical director involvement in the development of infection control guidelines (policy) for the care of vulnerable dependent patients (immune-compromised, comatose, elderly and/or frail, terminally ill). Document Review

MS.84.EC.2 There is medical director involvement in the development of security and safety guidelines (policy) for the care of vulnerable dependent patients. Document Review

MS.84.EC.3 There is medical director involvement in the development of ethical guidelines (policy) for the care of vulnerable dependent patients. Document Review

**MS.85 The hospital has policies and procedures to handle suspected abuse or neglect that comply with laws and regulations.**

**Evidence of Compliance**

MS.85.EC.1 There are policies and procedures to handle suspected abuse or neglect that comply with laws and regulations. Document Review

## Referral, Discharge, and Transfer

**MS.86 The consultation requests clearly state the question of the consultation or define the services requested, from the consultant, and are handled in a timely and appropriate manner.**

**Evidence of Compliance**

MS.86.EC.1 The consultation requests clearly state the question of the consultation or define the services requested, from the consultant, and are handled in a timely and appropriate manner. Medical Record Review

**MS.87 Consultation requests provide appropriate answers to the issues raised by the Attending physician regarding the plan of care for the patient. Consultants respond within 24 hours for routine cases and 30 minutes for emergency cases after receiving proper notification.**

**Evidence of Compliance**

MS.87.EC.1 The consultants respond within 24 hours for routine cases and 30 minutes for emergency cases after receiving proper. Medical Record Review

**MS.88 The Medical Director, the Nursing Director/leader, and the department heads work together to ensure that each patient receives the same standard of care when moved from one service to another during the course of treatment and this includes the following policies:**

MS. 88.1 Admission and discharge criteria for intensive care.



MS. 88.2 Transfer of patients within the hospital.

MS. 88.3 Admission of patients from the emergency room to the various services within the hospital.

**Evidence of Compliance**

MS.88.EC.1	There are policies and forms for (Admission and discharge criteria for intensive care).	Document Review
MS.88.EC.2	There are policies and forms for (Transfer of patients within the hospital).	Document Review
MS.88.EC.3	There are policies and forms for (Admission of patients from the emergency room to the various services within the hospital).	Document Review

**MS.89 The medical record contains the following information for patients transferred from one service to another:**

MS. 89.1 Reason for the patient's admission.

MS. 89.2 Patient diagnosis.

MS. 89.3 Brief summary of hospitalization (therapies, consultations, non-invasive procedures to date).

MS. 89.4 Medication list.

MS. 89.5 Condition at the time of transfer.

MS. 89.6 Reason for transfer.

**Evidence of Compliance**

MS.89.EC.1	Medical record documentation of patient transfer information from one service to another (includes: reason for admission, diagnosis, hospitalization summary, medication list, transfer condition, transfer reason).	Medical Record Review
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## TRANSFER TO ANOTHER INSTITUTION

**MS.90 The hospital has informal or formal arrangements with other institutions to accept patients for transfer when the care required is beyond the scope of service provided by the hospital and includes communication of arrangements for care with other institutions to the concerned department heads.**

MS.90.1 Policies and procedures guide the transfer of patients to other organizations and include:

MS.90.2 Transfers are based on the patient's needs for continuing care and the organization's capabilities.

MS.90.3 Written criteria for transfer for staff to follow.

MS.90.4 There is clear acceptance of responsibility for the patient's care by the receiving provider/organization.

**Evidence of Compliance**

MS.90.EC.1	There are written policies and procedures on patient transfer to other hospitals when the required care is beyond the scope of service provided.	Document Review
MS.90.EC.2	There is transfer communication between the transfer and receiving hospital documented in the medical record.	Medical Record Review

**MS.91 Arrangements for patient transport include an estimation of the length of time required for transport, and an assessment of patient needs during transfer and includes:**

MS. 91.1 An assessment of the patient's needs for Medivac-transfer.

MS. 91.2 Communication of the patient's needs during transfer to appropriate staff.

MS. 91.3 An attending physician determining the patient's need for transfer to another institution, the most suitable time for transfer, and if the receiving institution is able to meet the patient's needs.

MS. 91.4 Staff accompany patient are chosen according to patient condition.

**Evidence of Compliance**

MS.91.EC.1	There is a comprehensive assessment of patient needs during transfer..	Medical Record Review
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**MS.92 Receiving institutions receive the necessary information to provide care to the patient and this includes the following:**

MS. 92.1 Reason for the patient's admission.

MS. 92.2 Patient diagnosis.

MS. 92.3 Brief summary of hospitalization (therapies, consultations, non-invasive procedures to date).

MS. 92.4 Medication list and time of last dose given.

MS. 92.5 Condition at the time of transfer.

MS. 92.6 Reason for transfer.

MS. 92.7 Copy of the patient's Laboratory investigation and X-rays are sent with the patient to avoid further delay in treatment.

**Evidence of Compliance**

MS.92.EC.1 There is a completed hospital transfer form documenting the following; reason for the patients admission, diagnosis, summary of hospitalization, medication list, condition at the time of transfer, reason for transfer, and copy of the patients Laboratory investigation and X-rays are sent with the patient to avoid further delay in treatment.

Medical Record Review

**MS.93 Transfers are done quickly and safely especially in emergency cases (e.g. trauma, or cardiac emergency) and the medical staff ensure that the patient's needs are met by:**

MS. 93.1 Assigning a qualified physician or paramedic (as appropriate) to accompany the patient and handle any emergency that might happen during transfer.

MS. 93.2 Assigning a physician certified in BCLS (preferably ACLS) to accompany all critically ill patients or intubated patients.

MS. 93.3 Having adequate equipment and supplies on the ambulance.

**Evidence of Compliance**

MS.93.EC.1 There is a physician certified in BCLS (preferably ACLS) for emergency transfer.

Personnel File

MS.93.EC.2 There is a fully equipped Ambulance.

Observation

MS.93.EC.3 There is a qualified physician or paramedic for emergency transfer.

Document Review

**MS.94 The patient is continuously monitored by qualified physician during the transfer.**

MS.94.1 The transfer process is documented in the medical record.

**Evidence of Compliance**

MS.94.EC.1 There is continuous monitoring of patient during transfer by a qualified physician.

Medical Record Review

**MS.95 The hospital has a written policy and procedure regarding the acceptance of patients from other hospitals and the transfer of inpatients to other hospitals.**

**Evidence of Compliance**

MS.95.EC.1 There is a written policy and procedure for transfer patients to other hospitals.

Document Review

## DISCHARGE

**MS.96 The organization has a documented discharge process that identifies the post-service needs and support continuity of care by**

MS.96.1 Involving the patient and/or the family as appropriate

MS.96.2 Assessing the patients' ongoing needs as early in the care process as possible

MS.96.3 Ensuring coordination with various departments involved in the discharge process.

MS.96.4 Ensuring coordination with outside organizations as appropriate to the patient's needs.



**Evidence of Compliance**

MS.96.EC.1 There is a documented discharge process that includes MS.96.1 through MS.96.4. Document Review

**MS.97 The attending physician ensures that patient's discharge needs are met and communicates the patient's readiness for discharge home to appropriate hospital staff.**

**Evidence of Compliance**

MS.97.EC.1 There is communication between hospital staff and the attending physician for proper patients discharge process. Medical Record Review

**MS.98 The attending physician educates his / her patient on the following issues prior to discharge:**

- MS. 98.1 The patient's illness and how to provide self-care.
- MS. 98.2 Times to take the medication and any special instructions.
- MS. 98.3 Any equipment that the patient will use at home.
- MS. 98.4 When to call the physician and how to obtain "urgent" care.
- MS. 98.5 Why the patient needs to see any sub specialist. (If applicable).
- MS. 98.6 The reason the patient needs to be transferred to another institution (if applicable).
- MS. 98.7 Involving the family members whenever patients cannot fully understand the information provided to them (if applicable).
- MS. 98.8 Documenting all education and information provided to the patient and/or family in the medical record.

**Evidence of Compliance**

MS.98.EC.1 There is patient and family education prior to discharge.(patient illness, self care and support, medication use, equipment, emergency all, referral, transfer). Medical Record Review

**MS.99 The attending physician ensures that continuity of care occurs after discharge or referral by:**

- MS. 99.1 Assigning the follow up appointment for the patient.
- MS. 99.2 Arranging any referral services for the patient.
- MS. 99.3 Communicating with other receiving physicians in case of transfer.
- MS.99.4 The organization provides the patient and, when appropriate, the family with follow-up instructions in an understandable manner.
- MS.99.5 The patient receives information on how and when re-access services.

**Evidence of Compliance**

MS.99.EC.1 There is continuity of care after discharge as defined in MS.99.1 through MS.99.5. Medical Record Review

**MS.100 After the patient is discharged, a discharge summary is written in the medical record by the attending physician and includes:**

- MS. 100.1 The reason for the patient's admission.
- MS. 100.2 The patient's diagnosis.
- MS. 100.3 A brief summary of hospitalization (therapies, consultations, non-invasive interventions and results of any important diagnostic testing).
- MS. 100.4 A list of medications used.
- MS. 100.5 Any surgery or procedures performed.
- MS. 100.6 The outcome of surgery and treatment.
- MS. 100.7 The patient's condition at discharge.
- MS. 100.8 All the medications to be taken by the patient after discharge.
- MS. 100.9 Any special care the patient requires after discharge.
- MS. 100.10 A copy of the discharge summary kept by the medical record department.



MS. 100.11 A copy of the discharge summary is provided as appropriate to the practitioner responsible for the patient's continuing or follow-up care.

**Evidence of Compliance**

MS.101.EC.1 There is a comprehensive discharge summary report provided to the patient (reason for admission, diagnosis, hospitalization summary, medication list, outcome of surgeries, discharge condition, discharge medications, special care, copy of discharge summary).

Medical Record Review



## Nursing

### Introduction

The Nursing Director/Leader is considered a member of the hospital leadership. His/her role is essential in achieving high quality clinical care. The Nursing Director is responsible and accountable for the standard of nursing care in the hospital along with the Medical Director and Quality Director/leader. All should work as one team to monitor and observe the clinical standards. The Nursing Director and her Nurse Managers are considered the “gatekeepers” of the hospital because it is the nurses who are closest to the patient.

Nurses have the responsibility to ensure that quality standards are adhered to in order to minimize risk and provide safe care to our patients. A big role is expected from the Nursing staff in almost all aspects of the Quality program and Nursing is expected to participate fully in the implementation of the quality standards.

This chapter defines the important processes required by the nursing department:

- Nursing department organization
- Nursing department staffing
- Collaboration with other departments/committees
- Standards of practice
- Participation in quality improvement and patient safety activities
- Nursing education



## Standards

- NR.1 A Nursing organizational chart is available that clearly displays the lines of authority and:**
- NR.1.1 The organizational chart is approved and signed by administration (Hospital Director and Director of Nursing).  
NR.1.2 The nursing organizational chart includes all direct patient care areas and indirect nursing services (i.e., Operating Room, Endoscopy, Renal Dialysis Unit, Recovery Room).  
NR.1.3 The names/titles of the nursing leaders are clearly displayed on the organizational chart up to Head nurse level /nurse manager/nursing educator and patient educator etc.
- Evidence of Compliance**
- NR.1.EC.1 There is an approved Nursing Organizational chart with names/titles of nursing leaders. Document Review
- NR.2 There is a Nurse Leader (Nursing Director/Nurse Executive) who is a registered nurse qualified by appropriate education and experience (minimum BSN and (5) years experience preferred).**
- NR. 2.1 There is a job description for the Nurse Leader delineating the qualifications and experience required.
- Evidence of Compliance**
- NR.2.EC.1 There is a BSN, Registered Nurse by the Saudi Commission for Health Specialties (SCFHS) as Nursing Director with 5 years experience required by job description. Personnel File
- NR.3 The Nursing department has an approved mission, vision, values, goals and objectives consistent with the administration and these are known to all Nursing staff.**
- NR. 3.1 There are written mission, vision, values, goals and objectives for the Nursing Department consistent with the administration and approved and signed by the hospital administration.
- Evidence of Compliance**
- NR.3.EC.1 There is an approved mission, vision, values and goals. Document Review  
NR.3.EC.2 Nursing staff can state the nursing department mission, vision, values and goals. Interview
- NR.4 There is a strategic plan reflecting the mission, values, goals and objectives of the Nursing Department approved and signed by the hospital administration.**
- Evidence of Compliance**
- NR.4.EC.1 There is an approved nursing strategic plan by the Hospital Director. Document Review
- NR.5 The Nurse Leader develops and maintains an operational plan with other nurse leaders in the hospital:**
- NR.5.1 The Nurse Leaders participate in developing and implementing an operational plan.  
NR.5.2 There is a written operational plan for nursing department.
- Evidence of Compliance**
- NR.5.EC.1 There is a written operational plan for Nursing department. Document Review  
NR.5.EC.2 Operational plan is prepared with nursing leaders (head nurses) participation. Interview
- NR.6 The Nurse Leader/representative is part of the leadership group and participates in the following committees:**
- NR.6.1 All the committees of the hospital:  
NR.6.1.1 Pharmacy and Therapeutics.  
NR.6.1.2 Morbidity and Mortality.  
NR.6.1.3 Infection Control.





- NR.6.1.4 Cardio Pulmonary Resuscitation (CPR).
- NR.6.1.5 Operating Room.
- NR.6.1.6 Tissue Review.
- NR.6.1.7 Blood Utilization Review.
- NR.6.1.8 Safety.
- NR.6.1.9 Quality Management.
- NR.6.1.10 Medical Record Review.
- NR.6.1.11 Patient Rights/Patient Advocacy/Patient Care Committee.
- NR.6.1.12 Utilization Review.

NR.6.2 The hospital's strategic planning process.

NR.6.3 The budget planning for the Nursing division.

**Evidence of Compliance**

NR.6.EC.1 The Nursing Leader/representative participates on essential committees (hospital-wide committees) as reflected in the terms of reference and meeting minutes. Document Review

**NR.7 The Nurse Leader collaborates with the leadership and develops and maintains a current scope of service for the Nursing department.**

NR. 7.1 There is a scope of service that identifies the type of services of the department.

**Evidence of Compliance**

NR.7.EC.1 There is a current Nursing scope of service developed by the Nurse Leader and the leadership. Document Review

**NR.8 The Nurse Leader develops and maintains a current standard of practice for each nursing unit (e.g. intensive care, medical surgical, emergency room).**

NR.8.1 There is a unit specific nursing practice standard.

**Evidence of Compliance**

NR.8.EC.1 There is development of units' current standards of care clearly written and based on the scope of service of the hospital. Document Review

**NR.9 The Nursing department has the following essential policies and procedures that are approved and signed by the Nursing Director. The policies and procedures are reviewed and updated every two (2) years and include but are not limited to the following:**

- NR.9.1 Patient admission procedure.
- NR.9.2 Basic hygiene of patients and skin care.
- NR.9.3 Role in Patient and Family Rights and Responsibilities.
- NR.9.4 How to transcribe physician's orders.
- NR.9.5 Guidelines on how to assess, teach, and evaluate patient education provided to patients.
- NR.9.6 General Infection Control policies.
- NR.9.7 How to call a physician.
- NR.9.8 Transfer policy, internal and external.
- NR.9.9 Discharge policy.

**Evidence of Compliance**

- NR.9.EC.1 Patient admission policy is available and current (approved by Nursing Director and reviewed every 2 years). Document Review
- NR.9.EC.2 Basic hygiene of patients and skin care policy is available and current (approved by Nursing Director and reviewed every 2 years.) Document Review
- NR.9.EC.3 Policy defines nursing role in Patient and Family Rights and Responsibilities (approved by Nursing Director and reviewed every 2 years). Document Review
- NR.9.EC.4 Physicians' orders transcription policy is available and current (approved by Document Review



	Nursing Director and reviewed every 2 years).	
NR.9.EC.5	Guidelines of nursing patient education are available (approved by Nursing Director and reviewed every 2 years).	Document Review
NR.9.EC.6	General Infection Control policies are available and current (approved by Nursing Director and reviewed every 2 years).	Document Review
NR.9.EC.7	Policy on physician call is available and current (approved by Nursing Director and reviewed every 2 years).	Document Review
NR.9.EC.8	Intra facility patient transfer policy is available and current (approved by Nursing Director and reviewed every 2 years).	Document Review
NR.9.EC.9	Discharge policy is available and current (approved by Nursing Director and reviewed every 2 years).	Document Review
<b>NR.10</b>	<b>The Nursing Department has an effective process for handling professional communication between the nursing staff and nurse managers:</b>	
NR.10.1	Nursing staff meetings are held on a regular basis.	
NR.10.2	There are documented minutes of meetings.	
NR.10.3	Nursing Management meetings are held on a regular basis.	
	<b>Evidence of Compliance</b>	
NR.10.EC.1	Nursing staff meetings are held on a regular basis and reflected in meeting minutes.	Document Review
NR.10.EC.2	Nursing management meetings are held on a regular basis and reflected in meeting minutes.	Document Review
<b>NR.11</b>	<b>The Nurse Leader develops a Quality Plan that is consistent with the overall Hospital Quality Management Plan and ensures essential monitoring is done and this includes but is not limited to the following:</b>	
NR.11.1	Medication errors.	
NR.11.2	Patient falls.	
NR.11.3	Pressure ulcers.	
NR.11.4	IV therapy (adherence to the policy).	
NR.11.5	Hand washing (adherence to the policy).	
NR.11.6	Nurses role in cardiopulmonary resuscitation (adherence to the policy).	
NR.11.7	Infection Control.	
	<b>Evidence of Compliance</b>	
NR.11.EC.1	Nursing quality plan is developed and in line with hospital wide quality plan.	Document Review
NR.11.EC.2	There is indicators monitoring and reporting (of medication errors, patient falls, pressure ulcers, IV therapy, hand washing, CPR, infection control).	Document Review
<b>NR.12</b>	<b>The Nursing Department has aggregated data and information that supports patient care, nursing management, and quality improvement activity.</b>	
NR.12.1	The information documented is appropriate to the nursing department size and complexity.	
	<b>Evidence of Compliance</b>	
NR.12.EC.1	There is data aggregation and analysis by Nursing department and is used for decision making for improvement.	Document Review
<b>NR.13</b>	<b>There is a nurse that oversees all infection control activities. This nurse is qualified in infection control practice through education, training, experience, or certification.</b>	
NR.13.1	There is a job description for the infection control nurse.	
NR.13.2	There is documentation reflecting the activity of the infection control nurse.	
	<b>Evidence of Compliance</b>	
NR.13.EC.1	Head Nurses received training by Infection Control staff.	Personnel File



NR.13.EC.2 Training involve how do the head nurses advocate for the infection control. Personnel File  
NR.13.EC.3 Documented infection control activities. Interview

**NR.14 The Nurse Leader has an effective method to organize the delivery of patient care (e.g. functional, team, primary care).**

NR.14.1 There is a policy and procedure that addresses the method of the patient care delivery system.

**Evidence of Compliance**

NR.14.EC.1 Patient care delivery system policy is available and current. Document Review  
NR.14.EC.2 Implementation of patient care delivery system functional team, total care. Observation

**NR.15 The Nurse Leader develops a staffing plan that maintains an adequate staffing level on all units.**

NR. 15.1 There is a defined policy in regard to the assessment of patient acuity and defining the unit staffing based on pre-established criteria (e.g. patient care hours, Full time employment).

NR. 15.2 Clinical work assignments are based on nursing staff member credential and skills.

**Evidence of Compliance**

NR.15.EC.1 There is a defined policy in regard to the assessment of patient acuity defining the unit staffing based on pre-established criteria (e.g. patient care hours, full time employment). Document Review  
NR.15.EC.2 Criteria based staffing plan is available. Document Review  
NR.15.EC.3 Clinical work assignments are based on nursing staff member credential and skills. Document Review  
NR.15.EC.4 There are calculations prior to nursing staff allocation Document Review

**NR.16 The Nurse Leader is responsible for recruitment of nursing staff by assessing, evaluating, and verifying the nursing credentials prior to hire. This includes:**

NR.16.1 Requesting staff depending on identified departmental needs.

NR.16.2 Checking the nurses' credentials and licenses' by Kingdom rules.

NR.16.3 Ensuring that the references are checked from previous employment.

NR.16.4 Checking the time frames of past employment.

**Evidence of Compliance**

NR.16.EC.1 The Nursing Recruitment process is based on credentials, departmental needs, reference checking, and past employment checks. Interview  
NR.16.EC.2 The Nursing Recruitment process is based on credentials, departmental needs, reference checking, and past employment checks. Document Review

**NR.17 The Nurse leader develops a plan that ensures staff retention and job satisfaction.**

NR.17.1 There is a written and approved plan for retention.

NR.17.2 There is a monitoring mechanism for the effectiveness of the retention plan.

**Evidence of Compliance**

NR.17.EC.1 There is a written and approved plan for retention plan Document Review  
NR.17.EC.2 Nursing retention plan monitoring mechanism (i.e. satisfaction surveys, complaints processing). Document Review

**NR.18 The Nurse Leader allocates nursing staff according to skill level and appropriate qualifications based on the laws, regulations, and nursing licensing boards that includes but is not limited to:**

NR.18.1 Reviewing all staff documents for skill level and scope of practice.

NR.18.2 Allocating staff according to patient type and acuity on unit.



NR.18.3 Approving allocation with signatures in personnel file.

**Evidence of Compliance**

- NR.18.EC.1 There is a standardized method for Nurse assignment (based on skill level, appropriate qualifications, and nursing licensing boards). Document Review
- NR.18.EC.2 Allocating staff is according to patient type and acuity on unit. Interview

**NR.19 There is a scheduling policy that nursing staff follow that includes but is not limited to:**

- NR.19.1 Definitions of the shifts to be worked (e.g. 12 hours or 8 hours).
- NR.19.2 Assignment of overtime when needed.
- NR.19.3 On-call requirements.
- NR.19.4 Vacation schedules.
- NR.19.5 Method for approving change of schedule.
- NR.19.6 Education/training activities.
- NR.19.7 Participation in designated committees, departmental meetings, and quality management activities.

**Evidence of Compliance**

- NR.19.EC.1 There is a comprehensive Nursing scheduling policy for productive and nonproductive time including education/training and committee and meetings Document Review

**NR.20 There is documented evidence that nurses assigned out of their normal work area have the appropriate competency level to care for patients safely that includes but is not limited to:**

- NR.20.1 Maintaining a list of cross-trained nurses posted in the central nursing office and/or Units.

**Evidence of Compliance**

- NR.20.EC.1 There are cross-trained nurses' competencies in central nursing office and/or units. Document Review

**NR.21 Nurses safely delegate care to non-nursing staff and this includes:**

- NR.21.1 A clearly written job description for the non-nursing staff.
- NR.21.2 An educational program for the non-nursing staff to orient him/her to their role.
- NR.21.3 Supervision of the non-nursing staff by a registered nurse at all time.

**Evidence of Compliance**

- NR.21.EC.1 There is delegation to non-nursing staff assignments under supervision of registered nurse. Interview
- NR.21.EC.2 There is an educational program for the non-nursing staff. Document Review

**NR.22 There is a system for coordinating nursing activities after duty hours to handle administrative and clinical issues which includes but is not limited to:**

- NR.22.1 Patients who present with or demonstrate medical/surgical emergencies or change of condition.
- NR.22.2 Dying patients.
- NR.22.3 Violent patients.
- NR.22.4 All incident reports completed by nurses.
- NR.22.5 Any adverse medication incidents.
- NR.22.6 Any Sentinel events.

**Evidence of Compliance**

- NR.22.EC.1 Roles and responsibilities of Nursing supervisor/coordinator after working hours include (medical/surgical emergencies, dying patients, violent patients, adverse medication incidents, sentinel events). Personnel File



**NR.23 There is a head nurse/nurse manager (with 3 years experience) handling administrative and clinical issues at unit level.**

NR.23.1 There is a job description for the head nurse/nurse manager.

**Evidence of Compliance**

NR.23.EC.1 A qualified head nurse/nurse manager with 3 years experience at unit level , clearly stated in the Job description. Personnel File

**NR.24 There is a qualified registered nurse assigned to be in charge of the nursing unit at all times (minimum 2 year clinical experience within the area of practice preferred).**

NR.24.1 Assignment of Nurse in Charge is identified by Job Description or unit assignment.

**Evidence of Compliance**

NR.24.EC.1 A qualified charge nurse with 2 years experience at unit level within the area of practice, clearly stated in the Job description. Personnel File

**NR.25 There is a qualified and competent staff nurse with one year as a minimum experience in the area of specialty.**

NR.25.1 There is a job description that reflects the staff nurse role in the area of specialty.

**Evidence of Compliance**

NR.25.EC.1 A qualified staff nurse with one year as a minimum experience in the area of specialty clearly stated in the Job description. Personnel File

**NR.26 There is a performance appraisal conducted on a regular basis for all nursing staff.**

NR.26.1 The performance appraisal reflects feedback from multiple resources (Peer review, other health professionals and Supervisors).

**Evidence of Compliance**

NR.26.EC.1 There is nursing staff regular performance appraisal process with feedback from multiple sources. Personnel File

**NR.27 The Nurse Leader participates in allocating the following resources with the hospital leadership:**

NR. 27.1 Space

NR. 27.2 Staffing

NR. 27.3 Supplies

**Evidence of Compliance**

NR.27.EC.1 Nurse participation in location of staff, space needs and equipment allocation. Document Review

**NR.28 There are current job descriptions that are reviewed and updated at least every (3) years for every category of nursing staff and:**

NR.28.1 Current job descriptions are used for recruiting, evaluating, and appointing nursing staff.

**Evidence of Compliance**

NR.28.EC.1 Current job descriptions are reviewed and updated at least every (3) years for every category of nursing staff. Personnel File

**NR.29 There are adequate supplies and equipment for nurses to safely care for patients and this includes:**



- NR.29.1 Scales appropriate to the age group and mobility needs of the patient.
- NR.29.2 Stretchers with safety straps.
- NR.29.3 Equipment for taking vital signs.
- NR.29.4 Wheelchairs with safety straps.
- NR.29.5 Sharp Box.
- NR.29.6 Foot Stools.
- NR.29.7 Lifting device.
- NR.29.8 Soft restraints.
- NR.29.9 Bed rails.
- NR.29.10 Devices for treatment and prevention of skin break down.
- NR.29.11 Patient call bell.
- NR.29.12 Oxygen and suction.
- NR.29.13 Emergency call.

**Evidence of Compliance**

- NR.29.EC.1 There are all adequate basic supplies and equipment of unit stock (patient scales, stretchers with safety straps, vital sign equipment, wheelchairs with safety straps, sharp box, foot stools, lifting device, soft restraint, bed rails, devices equipment to prevent skin breakdown, patient call bells, oxygen and suction, emergency call). Observation

**NR.30 All nursing units have a clean locked room for storing sufficient amounts of clean linen and equipment for patients and dirty utility room.**

- NR. 30.1 There is a designed clean utility room.
- NR. 30.2 There is a designed dirty utility room.

**Evidence of Compliance**

- NR.30.EC.1 There are clean and dirty utility room meets the standard requirement. Observation

**NR.31 Every Nursing unit has the following reference manuals and/or policies:**

- NR.31.1 Nursing policy and procedure manual.
- NR.31.2 Current nursing practice books (not less than 5 years old) in the unit.
- NR.31.3 An infection control manual.
- NR.31.4 A safety manual or safety policies.
- NR.31.5 Operating manuals or information on the safe use of equipment.
- NR.31.6 Lab information to assist the nurses in correctly obtaining specimens.
- NR.31.7 Dietary manual.

**Evidence of Compliance**

- NR.31.EC.1 There are all reference manual and/or policies in each nursing unit (policy and procedure manual, current nursing practice books, infection control, safety manual, operating manuals for equipment, lab information, dietary). Observation

**NR.32 The Nursing department has a method to maintain adequate supplies and linen to meet patient needs that includes:**

- NR.32.1 Par levels (minimum levels) established.
- NR.32.2 Ordering required supplies and linen when par levels are reached and as needed.
- NR.32.3 An emergency back up method when there are problems receiving supplies from the primary supplier.
- NR.32.4 A method to track problems with supplies and linen so that patterns can be studied for quality improvement (e.g. no linen on every weekend due to short staffing in the laundry).

**Evidence of Compliance**

- NR.32.EC.1 Documented method of maintaining adequate supplies (par levels) including Document Review



emergency situation.

NR.32.EC.2 Nursing department monitors the supplies provision process and takes necessary actions for improvement.

Document Review

**NR.33 The Nursing staff recognize and support patient and family rights by:**

NR.33.1 Knowing the process of informed consent.

NR.33.2 Communicating to the appropriate staff any patient/family concern.

NR.33.3 Documenting in the Medical Record.

**Evidence of Compliance**

NR.33.EC.1 Nursing staff adhere patient and family rights policies (informed consent, communication of patient/family concern and documentation in the medical record).

Interview

**NR.34 Nurses provide effective methods to protect patient's privacy:**

NR.34.1 There is a physical separation between each patient.

NR.34.2 Male and female room are identified.

**Evidence of Compliance**

NR.34.EC.1 There are adequate patient spaces to ensure patients privacy with male and female rooms identified.

Observation

**NR.35 Nurses implement processes that support patient confidentiality by:**

NR.35.1 Not allowing unauthorized access to the medical record.

NR.35.2 Not talking about patients in areas than can be overheard.

NR.35.3 Not allowing public postings with patient's personal information in view.

**Evidence of Compliance**

NR.35.EC.1 Implementation of patient confidentiality process (no evidence of unauthorized access to the medical record, no public conversations concerning patients, no public postings of patient's information).

Observation

**NR.36 Nursing follows the occurrence variance reporting mechanism of the hospital that includes the following written procedures:**

NR.36.1 List of reportable occurrences (medication error, patient fall, wrong procedure, etc.)

NR.36.2 identifies the person responsible for initiating the report.

NR.36.3 Identifies who is responsible for investigating the Occurrence.

NR.36.4 Describes how the occurrence is to be investigated (i.e. algorithm).

NR.36.5 Outlines the expected corrective action plan and assigned responsibility.

NR.36.6 Outlines the review process.

**Evidence of Compliance**

NR.36.EC.1 Nurses are aware of and implement the OVR system (able to complete the report/form).

Interview

NR.36.EC.2 The OVR system contains list of reportable occurrences, person initiating the report, person investigating, investigation algorithm, action plan, and review process.

Document Review

**NR.37 Nursing staff demonstrate understanding of how to handle a sentinel event:**

NR.37.1 Ability to verbalize definition of a "Sentinel event".

NR.37.2 Know whom to contact when a sentinel event occurs.

NR.37.3 Know how to correctly complete the incident form.



**Evidence of Compliance**

NR.37.EC.1 Nurses are aware of and implement the sentinel event system (able to complete the report/form, nurses must know sentinel event definition, who to contact for sentinel event). Interview

**NR.38 Nurses only accept a standardized and approved list of abbreviations when receiving orders or documenting in patient file as approved by the hospital authority.**

NR.38.1 There is a written approved and signed abbreviation list.

**Evidence of Compliance**

NR.38.EC.1 There is a current and approved list of hospital abbreviation. Document Review  
NR.38.EC.2 Nurses adhere to approved abbreviation list. Medical Record Review

**NR.39 Vulnerable children, disabled individuals, and the elderly populations receive appropriate protection.**

NR.39.1 There is a written policy that addresses nurse's actions and responsibilities in the prevention of infant/child abduction.

NR.39.2 Preventing unauthorized access to the area.

NR.39.3 Providing visitors with identification badges issued by the hospital.

NR.39.4 Assigning a hospital code such as "Code Pink" in case abduction occurs.

**Evidence of Compliance**

NR.39.EC.1 There is a written policy for prevention of infant/child abduction. Document Review  
NR.39.EC.2 Nurses are aware of and implement patients protection process (vulnerable children, disabled individuals, and the elderly populations). Observation  
NR.39.EC.3 Visitors are provided ID badges and unauthorized access is not allowed to the area. A code is used for child abduction. Observation

**NR.40 Nurses ensure safety of medical equipment by:**

NR.40.1 Maintaining his/her skill level in the use of the equipment including trouble shooting problems.

NR.40.2 Knowing how to report mal-functioning equipment.

NR.40.3 Labeling any malfunctioning equipment so other staff members do not use it.

**Evidence of Compliance**

NR.40.EC.1 There is nurses' orientation of medical equipment use, trouble shooting and report of mal-functioning. Interview

**PRACTICE:**

**NR.41 There is a nursing policy that defines the nursing documentation content and standards in the clinical record and includes;**

NR.41.1 Legible handwriting.

NR.41.2 Signature of the nurse, date, and time for each entry.

NR.41.3 The patient's response to any treatment.

NR.41.4 How to make corrections in the medical record.

NR.41.5 Not using white out to make any corrections in the medical record.

NR.41.6 One language used in the Medical Record that is understood by all staff (English or Arabic).

**Evidence of Compliance**

NR.41.EC.1 There is a comprehensive nursing documentation policy (legible handwriting, signature, date, time, response to treatment, corrections, no use of white out, one approved language for documentation). Medical Record Review  
NR.41.EC.2 There is implementation of nursing documentation. Medical Record Review





**NR.42 There is a comprehensive written nursing assessment completed within established time frame (no longer than the end of shift) defined by policy of the admission and includes, but not limited to, the following:**

- NR.42.1 History of the patient's main complaint.
- NR.42.2 Patient's drug allergies.
- NR.42.3 Patient's physical condition.
- NR.42.4 Patient's psychosocial status.
- NR.42.5 Patient's pain assessment.
- NR.42.6 Patient's nutritional Status.
- NR.42.7 Discharge planning.

**Evidence of Compliance**

- NR.42.EC.1 There is a written policy and procedures on nursing assessment of admitted patients (patient history, drug allergies, patient condition, psychosocial status, pain assessment, nutritional status, discharge planning). Document Review
- NR.42.EC.2 There is a comprehensive written nursing assessment. Medical Record Review

**NR.43 All patients are reassessed at appropriate intervals (at least every shift) to determine their response to treatment and to plan for continued treatment and discharge.**

- NR.43.1 There is nursing reassessment and documentation as defined by policy.

**Evidence of Compliance**

- NR.43.EC.1 Nursing reassessment at appropriate interval is well defined in the written policies. Document Review
- NR.43.EC.2 There is implementation of nursing reassessment. Medical Record Review

**NR.44 There is a nursing care plan for each patient who stays in the hospital more than twenty-four (24) hours and includes:**

- NR.44.1 The policy and procedure that guides patient care plan.
- NR.44.2 The written plan of care which includes input from physicians, other health care disciplines and nursing assessment.
- NR.44.3 Review of the patient care plan every shift and when any significant changes in the patient's condition occurs.
- NR.44.4 Review of the patient care plan when new treatments are added or discontinued.
- NR.44.5 Documenting all findings.

**Evidence of Compliance**

- NR.44.EC.1 There is a written policy and procedure that guides patient care plan. Document Review
- NR.44.EC.2 There is implementation of written plan of care (the care plan is interdisciplinary and is reviewed each shift or when significant changes occur). Medical Record Review

**NR.45 Nurses use a preoperative checklist to assess if the patient is ready for surgery that includes but is not limited to checking:**

- NR.45.1 Proper identification of the patient name and number (patient is asked to state his/her name and operation to be done for him).
- NR.45.2 Consent form for completion.
- NR.45.3 The operation procedure and the surgeon's name.
- NR.45.4 The site of surgery and its preparation and whether it is marked or not.
- NR.45.5 The X-ray jacket to see if it accompanies the patient.
- NR.45.6 The lab results and pregnancy tests results to see if they are in the medical record.
- NR.45.7 The pre-anesthesia sheet for completion.
- NR.45.8 The history and physical examination for documentation in the medical record.
- NR.45.9 The blood to see if blood is reserved in the blood bank.



**Evidence of Compliance**

- NR.45.EC.1 There is adherence to preoperative preparation (preoperative checklist contains evidence of proper ID process for the patients, type of operation/surgeons name, site or surgery and marking, x-ray jacket for accompanying the patient to surgery, lab results, pre anesthesia sheet. History and physical, blood requirements). Medical Record Review
- NR.45.EC.2 There is implementation of preoperative preparation policy. Observation

**NR.46 The administration and monitoring of medications are guided by policies and procedures.**

NR.46.1 There is a written and approved policy and procedure that addresses medication administration.

**Evidence of Compliance**

- NR.46.EC.1 There is a written current policy on medication administration. Document Review
- NR.46.EC.2 There is implementation of medication administration policies. Observation

**NR.47 When administering medications nurses reduce risk of medication errors:**

- NR.47.1 Patients are identified before medication administration using patient ID band (name and medical record number).
- NR.47.2 Nurses double-check with each other for any dosage calculations of high-risk medications and both nurses' sign.
- NR.47.3 Nurses use the (7) "R"s rule when administering medications: right patient, right medication, right dosage, right route, right time, right frequency, and right documentation.

**Evidence of Compliance**

- NR.47.EC.1 There is implementation of medication administration policies emphasizing the 7 rules of medication administration. Interview
- NR.47.EC.2 There is implementation of high-risk medications guidelines Interview

**NR.48 The Nursing department ensures that basic safety precautions are followed for medications:**

- NR.48.1 Medication storage areas are locked at all times except when nurses are preparing medications.
- NR.48.2 Medication preparation areas have good lighting, are clean and located in a closed area to avoid distraction.
- NR.48.3 There is a standard medication list for stock medications.

**Evidence of Compliance**

- NR.48.EC.1 There is proper environment for medication storage and preparation. Observation
- NR.48.EC.2 There is a standard medication list for floor stock medications. Observation

**NR.49 The distribution, storage, and safe use of narcotics on the nursing unit adhere to strict policies that includes the following:**

- NR.49.1 Controlled drugs have a specific policy delineating each staff nurse responsibility in Control (key) access, administration and documentation of these medications.
- NR.49.2 The storage cabinet is safe, secure with double locks.
- NR.49.3 The keys of the narcotic cabinet are kept with the charge nurse at all times.
- NR.49.4 The nurse in charge of each shift counts the narcotics and verifies the narcotic count with the incoming nurse in charge and documents.
- NR.49.5 Documentation of used and unused (wastage) narcotics and controlled substances must adhere to MOH laws and regulations.

**Evidence of Compliance**

- NR.49.EC.1 There is a policy of narcotics and controlled substances management that is in line with MOH laws and regulations. Document Review
- NR.49.EC.2 There is compliance with narcotics and controlled substances management policy. Interview
- NR.49.EC.3 There is narcotic safe box /storage spaces, secure with double /doors locks. Observation



**NR.50 Nursing collaborates with pharmacy to monitor and regulate the stocking and maintenance of the crash cart. The policy and procedure includes but is not limited to:**

NR.50.1 Cardio respiratory equipment /supplies have a written policy for frequency and method of checks and the checks are documented. This includes checking equipment for functioning and drug expiry dates.

NR.50.2 Every shift, nursing staff checks and documents the defibrillator battery, full oxygen tank, suction machine, pharmacy lock number, ambu bags and reservoirs, and drug calculation charts, ET tube (for neonates, pediatrics, and adults) sharp box.

NR.50.3 Routine (minimum monthly) checking and documentation of all medications and equipment in the crash cart.

**Evidence of Compliance**

NR.50.EC.1	There is a written multidisciplinary policy and procedure of restocking of crash cart medications and equipment.	Document Review
NR.50.EC.2	There is compliance with policy and procedure of checking and restocking of crash cart.	Interview
NR.50.EC.3	There are routine (minimum monthly) checking and documentation of all medications and equipment in the crash cart.	Observation

**NR.51 There is a policy and procedure that addresses the telephone orders by physicians that includes but is not limited to:**

NR.51.1 A verification "read back" of the entire order to the physician by the person receiving the order on the phone.

NR.51.2 All telephone orders signed by the physician within 24 hours.

NR.51.3 Verification by two nurses with signatures.

**Evidence of Compliance**

NR.51.EC.1	There is a written multidisciplinary policy and procedure on telephone orders (read back, co-sign with 24 hours, 2 nurses verified the order).	Document Review
NR.51.EC.2	There is compliance with telephone orders policy.	Medical Record Review

**NR.52 There is a policy and procedure that addresses the verbal order by physicians that includes but is not limited to:**

NR.52.1 A verification "repeat back" of the entire order to the physician by the nurse receiving the order.

NR.52.2 Signature by the physician immediately after the emergency is over and before the physician leaves the unit for the verbal orders.

**Evidence of Compliance**

NR.52.EC.1	There is a written multidisciplinary policy and procedure on verbal orders (repeat back, signature by the physician immediately after the emergency is over).	Document Review
NR.52.EC.2	There is compliance with verbal orders policy.	Medical Record Review

**NR.53 Policies and procedures guide the handling, use, and administration of blood and blood products.**

NR.53.1 Two (2) patient identifiers (e.g. medical record number and patient's name) used when verifying the patient's identity.

NR.53.2 Two (2) staff members verify the patient's identity prior to blood drawing for cross match.

NR.53.3 Two (2) nurses or (1) nurse and two (2) staff members verify the patient's identity prior to the administration of blood

**Evidence of Compliance**

NR.53.EC.1	There is a written multidisciplinary policy and procedure on Blood and Blood Products (handling, use, administration, 2 patient identifiers, 2 nurses verify patient identity prior to blood drawing and administration).	Document Review
NR.53.EC.2	There is proper patient identification process (two identifiers - medical record number and patient's name).	Observation
NR.53.EC.3	There is verification of patient identity by two hospital staff prior to blood drawing for cross match and prior to administration of blood.	Observation

**NR.54 All nursing staff who restrain patients are trained and competent. Restraining is done in a professional**



**manner and this includes but is not limited to the following process:**

- NR.54.1 Policies and procedures guide use of restraint and the care of patients in restraint.
- NR.54.2 A physician order with the type of restraint and keep the length of time the restraint will be used.
- NR.54.3 A documented nursing assessment/reassessment of patients during restraint usage (prior restraints and ongoing until removed).
- NR.54.4 Assessment on a frequent basis (at least every hour) with circulation checks to any limb restraint and patient's response documented in the medical records.
- NR.54.5 Appropriate intervention when the patients' circulation is being impaired.
- NR.54.6 Appropriate interventions for side effects related to major tranquilizers (Haldol, Thorazine, etc.)
- NR.54.7 Patient's dignity and rights are protected that includes, covering patient when attending to patients physical needs.
- NR.54.8 An alarm system is available in the room and at the nursing station for immediate help and/ or assistance.
- NR.54.9 All of the above are documented in the patient's file.

**Evidence of Compliance**

- |            |   |                       |
|------------|---|-----------------------|
| NR.54.EC.1 | There is a written policy and procedure on patient restraint (physician order with type of restraint/length of time restraint used, nursing assessment/reassessments, assessment with circulation checks at least every hour, interventions for side effects related to major tranquilizers, dignity and rights protected, alarm system). | Document Review       |
| NR.54.EC.2 | There is training for nurses on patient restraint.  | Personnel File        |
| NR.54.EC.3 | There is nurses' competency assessment on patient restraint.  | Personnel File        |
| NR.54.EC.4 | There is compliance with patient restraint policy.  | Medical Record Review |
| NR.54.EC.5 | There is compliance with patient restraint policy.  | Observation           |

**NR.55 The Nursing department establishes policy and procedure to address the identification of a newborn by:**

- NR.55.1 Placing the ID band on IMMEDIATELY after the baby is born.
- NR.55.2 Placing the identity of the baby (ID band) on a limb keeping the initial ID band that identifies the mother.
- NR.55.3 Using ID bands that are waterproof.

**Evidence of Compliance**

- |            |  |                 |
|------------|--|-----------------|
| NR.55.EC.1 | There is a written policy and procedure on newborn identification. | Document Review |
| NR.55.EC.2 | There is compliance with newborn identification policy.            | Observation     |

**NR.56 The staff nurse discharges the baby to the parents after verifying the following that includes but is not limited to:**

- NR.56.1 Matching baby's name bracelet with mother's name bracelet and the Medical Record.
- NR.56.2 Reviewing education provided to mother about the baby's care.
- NR.56.3 Documenting in the medical record the signature of the qualified nurse on the Discharge Note form.
- NR.56.4 Keeping the patient covered when attending to his/her physical needs.

**Evidence of Compliance**

- |            |   |                       |
|------------|---|-----------------------|
| NR.56.EC.1 | There is implementation of new born verification process at discharge (bracelet matching, mother education on baby care). | Medical Record Review |
| NR.56.EC.2 | Keeping the patient covered when attending to his/her physical needs.   | Observation           |

**NR.57 Policies are established that guide the transfer of patients within the facility.**

- NR.57.1 The nurses can state the current attendant's name and the name of who will be the new attendant's name of the new service.
- NR.57.2 Nurses clarify any physician's order that is not clear during the transfer process.
- NR.57.3 The transferring nurse provides a complete report on the patient's current status to the receiving nurse.
- NR.57.4 Transfer information is documented in the medical record and other areas as appropriate.



**Evidence of Compliance**

- NR.57.EC.1 There is a written multidisciplinary policy and procedure on patient transfer within the facility. Document Review
- NR.57.EC.2 There is implementation of patient transfer policy within the facility. Medical Record Review

**NR.58 Patients and, as appropriate, their families are given understandable follow-up instructions at referral or discharge as approved by the hospital authority. (e.g. Patient Education Committee/group)**

- NR.58.1 Providing information to the patient regarding his/her medication.
- NR.58.2 Providing information to the patient about the safe use of medical equipment.
- NR.58.3 Providing information to the patients about self-care methods for activities of daily living.
- NR.58.4 Documenting in the medical record.

**Evidence of Compliance**

- NR.58.EC.1 There is patient and family education( at discharge and referral). Medical Record Review

**NR.59 All nursing staff are sensitized to the needs of patient at the end of life.**

- NR.59.1 Assess and document the response to the psychological, emotional, spiritual and cultural concerns of the patient and family.

**Evidence of Compliance**

- NR.59.EC.1 Nursing awareness of end of life care and assessment and documentation in the response to the psychological, emotional, spiritual and cultural concerns of the patient and family. Interview

**NR.60 All nursing staff are competent and knowledgeable about pain management.**

- NR.60.1 There is education about pain management documented in staff files.
- NR.60.2 There is written criteria identifying the assessment and reassessment of pain intensity and quality such as pain character, frequency, location and duration.
- NR.60.3 The patient and family are educated about pain, other symptoms and managing Pain and documented in the medical record.

**Evidence of Compliance**

- NR.60.EC.1 There is nursing training on pain management. Personnel File
- NR.60.EC.2 There is nursing competency on pain management. Personnel File
- NR.60.EC.3 There is written criteria for assessment and reassessment of pain intensity, pain character, frequency, location and duration also, patient education. Medical Record Review
- NR.60.EC.4 There is documentation of pain management. Medical Record Review

## EDUCATION

**NR.61 All nursing staff attend the hospital orientation.**

- NR.61.1 There is documentation in the nurses' personnel file for hospital orientation.

**Evidence of Compliance**

- NR.61.EC.1 There is evidence of nursing staff attendance at hospital orientation. Personnel File

**NR.62 There is a planned documented orientation program for every nursing staff member. All new hires must attend nursing orientation that includes but is not limited to:**

- NR.62.1 The overview of the Hospital systems, policies and procedures.
- NR.62.2 The Nursing Quality plan and the Hospital Quality Management plan.
- NR.62.3 Individual explanations of the job descriptions.



NR.62.4 CPR training according to Saudi Heart Association Standards.

NR.62.5 Infection control policies and procedures such as hand washing, standard precautions, cleaning blood and body fluid spills.

NR.62.6 Fire training and fire plan.

**Evidence of Compliance**

NR.62.EC.1 There is a comprehensive nursing orientation for all new hires (hospital system overview, nursing and hospital quality plan, job description, CPR training, infection control policies and procedures, fire plan and fire training). Personnel File

**NR.63 All nursing staff attends unit specific orientation period.**

NR.63.1 There is assessment and documentation of competencies for assigning unit in their files.

**Evidence of Compliance**

NR.63.EC.1 There is a unit specific orientation program for all new hires. Personnel File

NR.63.EC.2 Nursing competency assessment is documented in the personnel file. Personnel File

**NR.64 There is a nursing education program that includes but is not limited to:**

NR.64.1 Skill training on equipment.

NR.64.2 Selected Infection Control policies.

NR.64.3 Re-certification of BCLS every Two (2) years.

NR.64.4 The expected knowledge, skills and attitudes required of nurses to perform their role in the various settings (i.e., competencies).

NR.64.5 Quality Improvement (QI) training and involvement with QI projects.

NR.64.6 Fire and evacuation plan.

NR.64.7 Disaster plan.

NR.64.8 Safety plan (staff and patient).

NR.64.9 Blood transfusion and handling blood products.

NR.64.10 Hazardous Material.

NR.64.11 Use of restraints.

NR.64.12 Lifting and transferring patient.

NR.64.13 Unit specific.

**Evidence of Compliance**

NR.64.EC.1 There is a comprehensive Nursing education program (include training on equipment, infection control, BCLS every 2 years, competencies in settings assigned, quality improvement, fire safety, disaster, blood, hazardous materials, restraints, lifting and transferring patients, and unit specific requirements). Document Review

**NR.65 The Nursing department has policies and procedures and a competency assessment program (e.g. written test, return demonstration, etc.) on an ongoing basis (every two (2) years) and/or as needed according to staff needs to ensure that nursing skills and knowledge remain current. The policies and procedures and competencies include but are not limited to:**

NR.65.1 Monitoring patient vital signs and knowledge of deviations.

NR.65.2 Assessment/reassessment of patients according to scope of service (e.g. intensive care, labor and delivery, etc).

NR.65.3 Medication administration.

NR.65.4 IV therapy (insertion, maintenance, discontinuing).

NR.65.5 Infection Control guidelines.

NR.65.6 Patient falls (assessment of risk and methods to prevent falls).

NR.65.7 Use of pulse Oximetry.

NR.65.8 Nurses role in cardiac/respiratory arrest.

NR.65.9 Nasogastric (N/G) tubes and gastrostomy tubes (GT) and feedings.

NR.65.10 Urinary catheters.



- NR.65.11 Sterile dressings.
- NR.65.12 Skin care and the prevention and care of pressure ulcers.
- NR.65.13 Nurses role in disaster, fire, and other emergencies.
- NR.65.14 Use of restraints.
- NR.65.15 Operation of blood sugar testing equipment.
- NR.65.16 How to safely clean up chemical spills.
- NR.65.17 Blood and blood product (Phlebotomy and Blood Administration).
- NR.65.18 Documentation.

**Evidence of Compliance**

- NR.65.EC.1 There is a comprehensive written policy and procedures on Nursing competencies (assessment and reassessment, medications, IV therapy, infection control, fall, oximetry, placement of tubes and catheters, sterile dressing, skin care, blood sugar testing, chemical spills, blood and blood products). Document Review
- NR.65.EC.2 There is nursing competency assessment (written test, return demonstration). Personnel File

**NR.66 Staff members are trained and knowledgeable about their roles in the organization's plan for fire safety, security, hazardous material and emergencies:**

- NR.66.1 There is instruction on what to do in the event of fire: RACE (rescue, alarm, contain, evacuate).
- NR.66.2 There is instruction on how to pull the alarm and call the number to report a fire.
- NR.66.3 There is instruction on how the O<sub>2</sub> Gas valve is shut off.
- NR.66.4 There is instruction on how to operate and maintain medical equipment.
- NR.66.5 There is documentation reflecting mock training events.

**Evidence of Compliance**

- NR.66.EC.1 There is training of nursing staff about safety, security and medical equipment operation and maintenance. Personnel File
- NR.66.EC.2 There is awareness of nursing staff about safety, security and medical equipment operation and maintenance. Interview

**NR.67 Staff members are trained and knowledgeable about their roles in the organization's plan for major disaster.**

- NR.67.1 There is documentation reflecting mock event.

**Evidence of Compliance**

- NR.67.EC.1 There is training of nursing staff on their role during disasters (mock event). Personnel File
- NR.67.EC.2 There is awareness of nursing staff on their role during mock event. Interview

**NR.68 All nursing staff receive annual education on occupational hazards (e.g. needle stick, back injury, infection, prevention and control and etc...) to help reduce worker injury.**

- NR.68.1 There is documentation of training occupational hazards in staff files.
- NR.68.2 There is documentation of all employee injuries with preventative actions taken for future risk reduction.

**Evidence of Compliance**

- NR.68.EC.1 There is an annual nursing education on occupational hazards. Personnel File
- NR.68.EC.2 There is documentation of all employee injuries with preventative actions taken for future risk reduction. Document Review



## Quality Management and Patient Safety

### Introduction

This chapter addresses the senior leaders and everyone's responsibility towards implementing a program that effectively improve quality and safety and reduce risks. The organization's leadership has a very essential role in ensuring the basis and the direction towards achieving this goal. When the organization's leaders are personally involved and encourage and support everyone in the organization to be involved in the quality management initiative; a general atmosphere of confidence and inspiration to work harder and to achieve high quality and care and maximum degree of safety is established. Leadership, therefore, has to set up a planned and ongoing program where processes and systems are the focus of the operation.

To be able to effectively improve quality of care and safety, and reduce risks, the organization must constantly use indicators to measure its performance and use that information to identify processes which can be improved. The organization must also be able to identify significant unexpected or adverse events and intensively analyze them to understand their underlying causes and, as a result, make the necessary improvement changes.

This chapter defines the processes required to improve quality and safety and reduce risks:

- A planned and organization wide approach
- The required structure (committee)
- Leadership and other staff quality concepts education
- Data collection for structure, process and outcome indicators of quality
- Prioritization and implementation of appropriate improvements
- Risk management
- Identification and analysis of significant events
- Patient safety
- Defining and adopting International Patient Safety Goals





## Standards

**QM.1 There is a qualified and experienced Quality Management Director or leader who can apply quality concepts and principles and includes the following:**

QM.1.1 The Quality Management Director has a degree in Healthcare Administration, Quality Management or Related healthcare field and/or certification in Quality Management and/or Risk Management.

QM.1.2 The Quality Management Director or leader has at least three years experience in Healthcare Quality Management or Improvement.

### Evidence of Compliance

QM.1.EC.1 Quality Director is qualified for the position (has a degree in Healthcare Administration, Quality Management or related healthcare field and/or certification in Quality Management and/or Risk Management, has at least three years experience in Healthcare Quality Management or Improvement). Personnel File

**QM.2 The QM Director or leader reports to the Hospital Director.**

### Evidence of Compliance

QM.2.EC.1 QM Director reports to the Hospital Director (organizational chart) or through QM Director interview. Document Review

**QM.3 The QM department has the following resources (and others as needed) to carry out its scope of service.**

QM.3.1 The QM department has sufficient working and meeting space to carry out its scope of service.

QM.3.2 The QM department has sufficient computers, photocopier, printers, phones, faxes as needed to carry out its' scope of service.

QM.3.3 The QM department has Internet access.

### Evidence of Compliance

QM.3.EC.1 QM department has sufficient space, computers, printers, phones and access to internet and photocopier that is adequate according to hospital size (QM department visit). Observation

**QM.4 The QM department has an operating budget recommended by the QM Director/leader addressing manpower, consumables, capital assets and educational needs.**

### Evidence of Compliance

QM.4.EC.1 QM operating budget, hospital budget or other documents that prove supplying required resources. Document Review

**QM.5 The QM department has sufficient staff to carry out its scope of service.**

### Evidence of Compliance

QM.5.EC.1 QM department has sufficient staff according to the hospital size as evident in QM department organizational chart or scope of service. Document Review

**QM.6 The hospital develops and implements a quality improvement plan that is systematic, continuous, organization-wide, supports innovation, and covers all aspects of performance. The plan includes, but is not limited to, the following:**

QM.6.1 Identifying goals and objectives.

QM.6.2 Defining the scope of activities.

QM.6.3 Identifying all levels of staff roles and responsibilities.

QM.6.4 Outlining the educational activities about quality concepts.

QM.6.5 Describing the criteria used for selection of indicators, collection of data, data analysis, and implementation and evaluation of improvements.



- QM.6.6 Identifying monitoring indicators (including high risk processes).
- QM.6.7 Describing how problem identification, information gathering, implementing actions, and evaluation of actions taken will occur (models like FOCUS – PDCA or other).
- QM.6.8 Outlining how improvement projects are identified and prioritized by the leadership
- QM.6.9 Outlining that all improvement teams report to the quality improvement committee.
- QM.6.10 Describing how improvement activities will be communicated to everyone in the organization (flow of information).
- QM.6.11 Describing how the plan is approved by the committee and the organization director.
- QM.6.12 Reviewing the plan on an annual basis and making revisions as necessary.

**Evidence of Compliance**

- QM.6.EC.1 There is an organization wide quality improvement plan that includes elements QM.6.1 through QM.6.12. Document Review

**QM.7 There is a Quality Management committee consisting of the leadership group that implements the QM plan and the hospital standards and this includes at least the following:**

- QM.7.1 All of the hospital leaders (the Hospital Director, Medical Director, Nursing Director, Quality Management Director/leader, Medical Records Director/leader, departmental heads).
- QM.7.2 The Quality Management committee approves all Quality Management initiatives and provides oversight for the Quality Management program.
- QM.7.3 The Quality Management committee receives reports from all teams, heads of departments, and other members assigned quality improvement projects.
- QM.7.4 The Quality Management committee approves all hospital wide teams that are formed to solve a particular issue.
- QM.7.5 The Quality Management committee provides feedback to their staff on quality improvement projects.

**Evidence of Compliance**

- QM.7.EC.1 Quality Management committee terms of reference reflect its membership and functions (Medical Director, Nursing Director, Quality Management Director, Medical Record Director / leader and dept. heads. That approves QM initiatives, receive reports on QM projects, approve hospital wide teams and provide feedback to staff on QI projects). Document Review
- QM.7.EC.2 QM Committee meeting minutes reflect discussion of QM and PS plan implementation. Document Review

**QM.8 The leadership supports the hospital-wide Quality Management and Patient Safety plan by:**

- QM.8.1 Providing the necessary resources for the Quality Management department.
- QM.8.2 Actively participating in Quality Improvement projects.
- QM.8.3 Implementing the recommendations made by the QI committee (when feasible).

**Evidence of Compliance**

- QM.8.EC.1 The hospital leaders provide evidence of documentation (meeting minutes, memos, reports---etc.) related to any improvement action based on QI committee recommendations. Document Review
- QM.8.EC.2 The leaders provide adequate human, informational ,physical, and financial resources. Observation

**QM.9 The hospital leaders are actively involved in the quality campaign efforts and participate in:**

- QM.9.1 Quality Management, Risk Management and Patient Safety educational activities.
- QM.9.2 FOCUS–PDCA based quality improvement teams.

**Evidence of Compliance**

- QM.9.EC.1 There are attendance records/certificates of Hospital leaders in quality activities. Document Review
- QM.9.EC.2 Leadership shows participation in quality improvement projects and good understanding of FOCUS-PDCA or a similar methodology. Interview
- QM.9.EC.3 There are numerous quality improvement (PDCA) projects by staff. Document Review



**QM.10 The hospital leaders encourage all hospital staff to participate in:**

QM.10.1 Quality Management, Risk Management and Patient Safety educational activities.

QM.10.2 FOCUS-PDCA based quality improvement teams.

**Evidence of Compliance**

QM.10.EC.1 There is holding and presenting of quality educational activities or other evidence of training on different aspects of quality and patient safety. Interview

QM.10.EC.2 Staff demonstrate participation in quality improvement teams. Interview

**QM.11 The hospital has a risk management plan that addresses all potential operational, financial, clinical and safety risks faced by the hospital and includes:**

QM.11.1 Scope and objectives of the plan.

QM.11.2 Staff responsible for the plan.

QM.11.3 A systematic process to identify and analyze potential risks for severity and likelihood of occurrence.

QM.11.4 Development of interventions to manage potential risks (e.g., reduction, prevention).

QM.11.5 Documentation of risk management activities.

QM.11.6 Staff education on their roles and responsibilities related to the plan.

QM.11.7 Regular review of the plan to ensure that the plan is effective:

QM.11.7.1 Regular measurement of performance compared with required performance.

QM.11.7.2 Using monitoring information to make improvements.

QM.11.8 Strategies for communicating risk management activities to different groups.

**Evidence of Compliance**

QM.11.EC.1 There is evidence that the leaders use a planned approach to identify, analyze potential risk process(s). Interview

QM.11.EC.2 There is evidence that the leaders develop and implement interventions to eliminate or minimize the identified potential risks. Interview

**QM.12 The hospital has an incident (occurrence/variance/accident) reporting system (policy and form) that staff follow and use when reporting adverse events and near misses.**

QM.12.1 Reportable incidents are identified.

QM.12.2 An identified staff member is responsible for managing the incident reporting system.

QM.12.3 All incidents are reported and investigated in a timely way.

QM.12.4 Immediate actions are taken as well as actions to prevent recurrence of incidents.

QM.12.5 Patients are informed when involved in incidents with documentation in the medical records.

QM.12.6 Incidents are monitored over time and information is used for improvements.

QM.12.7 All staff are educated on the incident reporting system.

**Evidence of Compliance**

QM.12.EC.1 There is an incident reporting system (policy and form). Document Review

QM.12.EC.2 There are aggregated incident reports. Document Review

**QM.13 Sentinel events are identified in a policy that includes but is not limited to:**

QM.13.1 Unexpected deaths.

QM.13.2 Suicide of a patient.

QM.13.3 Infant abduction or discharge to a wrong family.

QM.13.4 Hemolytic transfusion reaction.

QM.13.5 Surgery on the wrong patient or the wrong body part.

QM.13.6 Serious injury with loss of limb or function.



**Evidence of Compliance**

QM.13.EC.1 Sentinel events policy states a list of reportable sentinel events that includes at least events listed in QM.13.1 through QM.13.5. Document Review

**QM.14 The hospital has a process to handle Sentinel events and it includes:**

QM.14.1 Formation of a team for studying the causes of the event (root cause analysis)

QM.14.2 Root cause analysis is to be performed within 10 working days

QM.14.3 Developing an action plan and review systems for improvement.

**Evidence of Compliance**

QM.14.EC.1 The sentinel event process of handling sentinel events include formation of a team for studying the causes of the event (root cause analysis) within 10 working days and is documented in minutes, reports, or other documents. Interview

QM.14.EC.2 Previous sentinel event handled according to policy including development of root cause analysis and an action plan (reflected in minutes and/or reports). Document Review

**QM.15 The hospital supports Patient Safety by:**

QM.15.1 Defining and adopting selected International Patient Safety Goals in the Quality and Patient Safety Plan.

QM.15.2 Establishing a Patient Safety Committee/Team with representation from medical, nursing, and pharmacy and safety departments.

QM.15.3 Charging the Patient Safety Committee/Team with implementing and monitoring the patient safety goals and recommending actions for improvement.

**Evidence of Compliance**

QM.15.EC.1 Patient safety team/committee terms of reference or other document that reflects membership and functions required. Document Review

QM.15.EC.2 International Patient Safety goals (IPSGs) defined in the QM and Patient Safety plan. Document Review

**QM.16 There is a written policy on verbal and telephone orders and includes:**

QM.16.1 The attending physician or his designee signs off on the entire verbal and telephone orders.

**Evidence of Compliance**

QM.16.EC.1 There is a written policy on verbal and telephone orders that includes physician signing off on entire verbal and telephone orders. Document Review

QM.16.EC.2 There is timely authentication of verbal and telephone orders according to the policy. Medical Record Review

**QM.17 The hospital adopts a process that requires (2) patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products or performing a procedure.**

**Evidence of Compliance**

QM.17.EC.1 Observations of lab specimens and medications to be administered (have two patient identifiers). Interview

QM.17.EC.2 Hospital staff are aware about the two patient identifiers and when to be used. Interview

**QM.18 There is a process for preventing wrong site, wrong procedure, and wrong person surgery that includes:**

QM.18.1 Documentation of the verification process pre-operatively of the correct person, procedure, and site.

QM.18.2 A process to mark the operative site in a standardized method and symbol with permanent ink by the person performing the operation and/or procedure.

QM.18.3 A documented "time out" conducted in the location where the procedure will be done, just before starting the operation,



and involves the entire operating room staff using speech to verify correct patient identity, correct site, agreement on the procedure to be done, correct patient position, and availability of any needed equipment.

**Evidence of Compliance**

- |            |   |                       |
|------------|---|-----------------------|
| QM.18.EC.1 | The process of verification, marking and time out is documented in the medical records in a checklist or other form.  | Medical Record Review |
| QM.18.EC.2 | There is a process to mark the operative site in a standardized method and symbol with permanent ink by the person performing the operation and/or procedure. [for organs, mark on the Body Diagram form in the appropriate area (left or right)] | Interview             |

**QM.19 The hospital has a process for effective identification, assessment, and interventions for patients who are risk for falling.**

**Evidence of Compliance**

- |            |  |           |
|------------|--|-----------|
| QM.19.EC.1 | There is a process for effective identification of patients who are at risk for falling.       | Interview |
| QM.19.EC.2 | There is a process for assessment, and interventions for patients who are at risk for falling. | Interview |

**QM.20 The hospital has a policy that guides staff to practice proper hand hygiene techniques to reduce the risk of healthcare-associated infections.**

**Evidence of Compliance**

- |            |  |                 |
|------------|--|-----------------|
| QM.20.EC.1 | There is a written policy for hand hygiene.      | Document Review |
| QM.20.EC.2 | The hand hygiene policy is properly implemented. | Observation     |

**QM.21 The hospital has a process for the safe storage and handling of high alert medications.**

- QM.21.1 Concentrated electrolytes are removed from patient care areas.  
QM.21.2 Concentrated medications have additional safety measures to prevent inadvertent use.

**Evidence of Compliance**

- |            |  |             |
|------------|--|-------------|
| QM.21.EC.1 | There is process for safe storage and handling of high alert medications.                    | Interview   |
| QM.21.EC.2 | No concentrated electrolytes in patient care areas.  | Observation |
| QM.21.EC.3 | There are additional safety measures to prevent inadvertent use of concentrated medications. | Observation |

**QM.22 There is a standardized list of abbreviations, acronyms, and symbols that are permitted for use in the hospital and it includes a list of abbreviations, acronyms, and symbols NOT to be used.**

**Evidence of Compliance**

- |            |  |                       |
|------------|--|-----------------------|
| QM.22.EC.1 | List of abbreviations, acronyms, and symbols to be permitted and list of those NOT to be used. | Document Review       |
| QM.22.EC.2 | Prohibited abbreviations, acronyms, and symbols are not used in medical records.               | Medical Record Review |

**QM.23 Infusion pumps have “free-flow” protection.**

**Evidence of Compliance**

- |            |  |             |
|------------|--|-------------|
| QM.23.EC.1 | Observation in the patient care areas (ICU, ER, OR, L & D etc.) for availability of IV free-flow protection. | Observation |
|------------|--|-------------|



**QM.24 All alarm systems for patient care equipment (such as Infusion Pumps heart monitors, ventilators and pulse oximeters), have documented preventative maintenance, inspection and testing on a regular basis.**

**Evidence of Compliance**

QM.24.EC.1 Patient care equipment preventative maintenance is documented (PPM sticker). Observation

**QM.25 All staff are trained in the safe use of alarm systems for patient care equipment and the use of appropriate settings for sound.**

**Evidence of Compliance**

QM.25.EC.1 Training of staff using the equipment is evident in training records, attendance lists, competency assessment or other documents. Document Review

QM.25.EC.2 Staff interviewed are able to demonstrate knowledge of the use of alarms in patient care equipments. Interview

**QM.26 There are coordinated, comprehensive, and continuous educational activities on quality concepts and tools taught by staff who are qualified in the field and educational activities include:**

QM.26.1 Concepts of Quality Management, Patient Safety and Risk Management

QM.26.2 How to work in teams.

QM.26.3 Use of data, display of data

QM.26.4 Quality Improvement tools.

QM.26.5 Risk Management tools.

**Evidence of Compliance**

QM.26.EC.1 There is a coordinated, comprehensive, and continuous hospital-wide QM education program (working in teams, data usage, QI tools, and RM tools). Document Review

QM.26.EC.2 Hospital-wide QM education program is taught by qualified staff in the field. Document Review

**QM.27 The hospital leaders develop and implement a set of indicators (measures) that are collected and aggregated on a regular basis and are used for quality improvement as well as strategic and operational planning.**

QM.27.1 The indicators represent key care and service structures, processes and outcomes.

QM.27.2 The indicators focus on important managerial and clinical areas.

QM.27.3 The clinical indicators are referenced to current evidence based practice.

QM.27.4 Data are gathered from qualitative and quantitative sources.

QM.27.5 Data are coordinated with other performance monitoring activities such as patient safety and risk management.

QM.27.6 Each indicator has a definition, sample size, data collection method, frequency, analysis and expression (e.g., expressed as a ratio, with defined numerator denominator).

**Evidence of Compliance**

QM.27.EC.1 Leaders set (approve) list of indicators to be monitored in the organization. Document Review

QM.27.EC.2 Leaders explain using data in quality improvement and strategic planning. Interview

**QM.28 There are structure indicators (measures) based on the mission and scope of services that may include but is not limited to:**

QM.28.1 Availability of essential supplies and equipment.

QM.28.2 Availability of medical records.

QM.28.3 Availability of blood and blood products.

QM.28.4 Availability of emergency medications.

QM.28.5 Vacancy rates in all departments.



**Evidence of Compliance**

QM.28.EC.1 There are structure measurements (indicators) [aggregated, analyzed -reports and reflected in minutes of the hospital committees]. Document Review

**QM.29 There are process indicators (measures) based on the mission and scope of services that may include but is not limited to:**

- QM.29.1 The timing and use of antibiotics prior to surgery.
- QM.29.2 Blood and blood products administration.
- QM.29.3 Documentation in the medical record.
- QM.29.4 Delays of physician answering nurses phone calls/beeps, and/or pages.

**Evidence of Compliance**

QM.29.EC.1 There are process measurements (indicators) [aggregated, analyzed reports and reflected in minutes of the hospital committees]. Document Review

**QM.30 There are outcome indicators (measures) based on the mission and scope of services that may include but is not limited to:**

- QM.30.1 Mortality rates.
- QM.30.2 Nosocomial Infection rates.
- QM.30.3 Staff satisfaction.
- QM.30.4 Patient satisfaction.
- QM.30.5 Unplanned returns to operating room.
- QM.30.6 Unplanned transfer to critical care area.
- QM.30.7 Resuscitation of patients (Cardiac/respiratory arrest).
- QM.30.8 Readmission to the hospital within 3 days of discharge.
- QM.30.9 Adverse events (falls, injuries, pressure ulcers).
- QM.30.10 Sentinel events.
- QM.30.11 Patient complaints.
- QM.30.12 Medication errors.
- QM.30.13 Conscious sedation.
- QM.30.14 All invasive and high-risk procedures.
- QM.30.15 Increased length of stay.

**Evidence of Compliance**

QM.30.EC.1 There are outcome measurements (indicators) [aggregated, analyzed -reports- and reflected in minutes of the hospital committees]. Document Review

**QM.31 There are quality control results from the laboratory and radiology.**

**Evidence of Compliance**

- QM.31.EC.1 There are lab quality control data or minutes of the concerned committee (data are aggregated and analyzed). Document Review
- QM.31.EC.2 There are radiology quality control data or minutes of the concerned committee (data are aggregated and analyzed). Document Review

**QM.32 Data are systematically aggregated and analyzed by qualified staff.**

- QM.32.1 Data are analyzed into useful information for trends and variances on a regular basis.
- QM.32.2 Data are compared internally by historical trends and externally by benchmarks (when available).
- QM.32.3 Information are provided to the appropriate users in a way they can understand and use.



**Evidence of Compliance**

QM.32.EC.1 There are well analyzed data reports reflecting qualified staff.

Document Review

**QM.33 The Quality Management Committee identifies and prioritizes recommendations for quality improvement projects based on the organization's prioritization criteria and the analysis of trends.**

QM.33.1 Sustained performance improvements (including accreditation status) are communicated to the staff, public, community, and other customers.

**Evidence of Compliance**

QM.33.EC.1 Review of documents such as quality improvement committee terms of reference and meetings minutes identify the responsibility and the use of analyzed data in prioritization and selection of quality improvement projects.

Document Review

QM.33.EC.2 Leadership group interview shows the prioritization and assignment mechanisms used for selection and implementation of quality improvement projects.

Interview

**QM.34 Quality Management teams are selected by the leadership and these teams use quality tools to improve processes.**

QM.34.1 Membership of the quality improvement teams is determined by the leadership.

QM.34.2 The teams include staff who have working knowledge of the process.

QM.34.3 The teams include a facilitator.

QM.34.4 The teams include a designated team leader who is an identified leader within the organization.

QM.34.5 The teams use the quality learning and improvement cycle.

QM.34.6 The teams use CQI tools (Pareto charts, brainstorming, affinity diagrams, fishbone charts, multivote, etc).

**Evidence of Compliance**

QM.34.EC.1 Review of documents as minutes, reports or quality improvement projects reflect proper structure of quality improvement teams and use of quality tools (proper structure; team members with working knowledge of the process, facilitator, team leaders, use of PDCA cycle, and CQI tools).

Document Review

QM.34.EC.2 Staff and particularly leadership interview show proper selection of team members, understanding and use of quality tools.

Interview





## Patient and Family Education and Rights

### Introduction

#### Patient and Family Education (PFE)

Patients have a right to receive appropriate education, so they can utilize their knowledge to participate in their care and make informed care decisions. Additionally, patient education improves health by encouraging compliance with medical treatment. To ensure appropriate patient and family education, the organization should provide adequate resources, identify patient/family educational needs, develop individualized education plan and provide education accordingly, and evaluate the effectiveness of the education process.

This chapter outlines the following processes and activities:

- Educational resources
- Assessment of educational needs
- Education plan
- Effectiveness of education

#### Patient and Family Rights (PFR)

Every patient is unique with his/her own needs, values and spiritual beliefs. In alignment with these issues, the hospital is responsible for ensuring that patient and family rights are defined and respected within the organization.

The healthcare providers need to establish confidence, trust and clear communication with patients and to understand and protect each patient's cultural, psychosocial and spiritual beliefs. Outcomes of patient care are safer and much improved when patients, and where appropriate, their families or others who make decisions on their behalf and participate in their care decisions and plans.

This chapter addresses standards for:

- Defining and supporting patient and family rights
- Defining treatments/procedures requiring informed consent and obtaining informed consent when indicated
- Protection of vulnerable patients
- Pain management
- Protection of patient belongings
- Regular conduction of patient and family satisfaction surveys and making improvements accordingly
- Establishing a process for resolution of patient complaints
- Making sure that patients and their families are fully informed and protected when they are involved in research projects



## Patient and Family Education Standards

### PFE.1 The leadership supports patient education by:

PFE.1.1 Providing funding for patient education materials.

PFE.1.2 Ensuring the creation and implementation of a patient educational plan.

#### Evidence of Compliance

PFE.1.EC.1	There is approved patient educational plan	Document Review
PFE.1.EC.2	Leadership support for patient education by providing adequate education materials.	Observation
PFE.1.EC.3	There are documented patient education activities.	Document Review

### PFE.2 There is an appropriate structure or mechanism of patient/family education throughout the organization:

PFE.2.1 There are efficient resources for patient/family education according to the organization needs.

PFE.2.2 The job description of the healthcare professional reflects their role in patient/family education.

PFE.2.3 There is adequate staff to cover the needs of patient/family education (diabetic educator, patient educator).

#### Evidence of Compliance

PFE.2.EC.1	The education department has adequate resources to carry out its mandate (enough space, office equipment, computers, health publications, educational pamphlets and adequate staff [diabetic educator, patient educator]).	Observation
PFE.2.EC.2	All healthcare providers have their role in patient/family education included in their job descriptions.	Personnel File
PFE.2.EC.3	Appropriate mechanism of patient/family education in policy or plan.	Document Review

### PFE.3 Medical and nursing staff are knowledgeable about their essential role in patient education and this includes but is not limited to:

PFE.3.1 Discussion of patient education efforts in formal meetings as an integral part of the care process.

#### Evidence of Compliance

PFE.3.EC.1	The medical and nursing staff are knowledgeable on patient/family education (i.e. meeting minutes that address PFE, educational plan for each patient in Medical Record).	Medical Record Review
PFE.3.EC.2	Medical and nursing staff interviewed can state their role in patient education.	Interview

### PFE.4 The administration appoints the necessary number of professional staff to help educate patients, (e.g. Diabetic educators, patient educators, dietitians, nurse educators).

#### Evidence of Compliance

PFE.4.EC.1	There are trained diabetic educators, patient educators, dietitians, nurse educators according to hospital scope of service.	Personnel File
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### PFE.5 The patient and/or his family are given the following necessary education and information by healthcare professionals as appropriate:

PFE.5.1 Giving the patient appropriate information about their illness and complications that might happen.

PFE.5.2 Teaching the patient infection control practices, especially basic hand washing.

PFE.5.3 Explaining the necessary treatments, and procedures and providing pamphlets or diagrams if available.

PFE.5.4 Explaining and teaching the appropriate use of the medical equipment or appliances (e.g. colostomy bag) with return demonstration.

PFE.5.5 Any surgical procedure needed and its benefits and potential risks involved with the surgical procedure.

PFE.5.6 The pre-operative preparations needed and their importance.



PFE.5.7 Postoperative care, i.e., breathing exercises, diet and wound care.

PFE.5.8 The necessary medications that are needed to be given pre-operatively and post-operatively and the medication's potential side effects.

PFE.5.9 The medications used to treat an illness, the frequency of taking the medication, the side effects, and precautions.

PFE.5.10 X-ray procedures; their benefits and the potential risks involved.

PFE.5.11 Any restrictions of the diet and the reasons why the restrictions are necessary.

PFE.5.12 Explaining the conditions in which the patient needs to seek medical assistance by telephone and/or seek medical assistance by reporting to the Emergency room.

PFE.5.13 Ensuring that patients have his/her follow up clinic appointment.

#### Evidence of Compliance

PFE.5.EC.1 There is comprehensive patient and family education provided by care givers (giving appropriate information about illness and possible complications, hand washing technique, treatment and possible surgical procedures, use of equipment, pre-operative preparations and post-operative care, proper use of post-operative medications, x-ray procedures, dietary restrictions, when to seek medical assistance, and follow up appointment). Interview

PFE.5.EC.2 Patient/family education is documented in the medical record . Medical Record Review

#### PFE.6 The patient can state the name of his/her attending physician.

##### Evidence of Compliance

PFE.6.EC.1 Patient can state the name of his/her attending physician. Interview

#### PFE.7 Each patient's educational needs are assessed and documented in his/her medical record by:

PFE.7.1 Assessing who will provide care after discharge (caregiver and/or patient).

PFE.7.2 Assessing learning needs.

PFE.7.3 Assessing literacy skills.

PFE.7.4 Assessing caregiver/patient's readiness and ability to learn.

PFE.7.5 Providing the caregiver/patient with educational materials that meet their learning skills (written, verbal, pictures, demonstration, etc.)

PFE.7.6 Assessing understanding of education provided by observation and feedback (verbal/return demonstration) from the caregiver/patient.

PFE.7.7 Documenting the assessment in the medical record.

##### Evidence of Compliance

PFE.7.EC.1 There is comprehensive patient education needs assessment (assessment of literacy skills, learning needs, readiness and ability to learn. provision of educational materials and assessment of patient understanding). Medical Record Review

#### PFE.8 All patient education activities provided by healthcare professionals including the patient's response are documented in the patient's medical record.

PFE.8.1 There is documentation about the patient's response to education in the patient medical record.

##### Evidence of Compliance

PFE.8.EC.1 Medical records documentation of patient response to education. Medical Record Review

#### PFE.9 Instructions are provided to the family/caregiver when the patient is unable to comprehend the instructions in patient populations such as:

PFE.9.1 Comatose patients

PFE.9.2 Neonates/infants



PFE.9.3 Mentally disabled or impaired

**Evidence of Compliance**

PFE.9.EC.1 The instructions are provided to the family/caregiver of patient populations (comatose patient, neonate/infant, Mentally disabled or impaired). Medical Record Review

**PFE.10 There are guidelines for health educators (nurses, physicians, dietitians, etc.) on how to teach the patient/family that includes but is not limited to:**

PFE.10.1 How to teach the patient provided in an easy language so the patient/family can understand.

PFE.10.2 How to provide sufficient time to allow the patient to absorb the information given to him.

PFE.10.3 How to provide enough time to interact with their patient/family.

PFE.10.4 How to use pamphlets, diagrams, models to practice on, or other teaching methods.

PFE.10.5 How to obtain feedback from the patient/family to ensure he/she/they understand by repeating or demonstrating.

**Evidence of Compliance**

PFE.10.EC.1 There is comprehensive written guidelines for health educators i.e. nurses, physicians, dietitians, on how to teach the patient/family in an easy understandable language, time needed for the patient to absorb, time to interact with patient, types of educational material, and how to obtain feedback from the patient. Document Review

**PFE.11 Each patient and his or her family receive education to help them give informed consent, participate in care process, and understand any financial implications of care choices.**

PFE.11.1 Patients and families learn about informed consent.

PFE.11.2 Patients and families learn about participation in care decisions.

PFE.11.3 Patients and families learn about participation in the care process.

PFE.11.4 Patients and families learn about any financial implications of care decisions.

PFE.11.5 All patient and family education are documented in his/her medical file.

**Evidence of Compliance**

PFE.11.EC.1 There is patient/family involvement in the care provided to him/her (informed consent, care decision, financial implications of care choices). Medical Record Review

**PFE.12 Nurses provide patient education to patients in a manner that supports patient and family participation in care decisions and this includes:**

PFE.12.1 Assessing the patient's capability and motivation to provide self-care.

PFE.12.2 Teaching the patient about medications including food/drug interactions.

PFE.12.3 Teaching the patient about the safe use of any medical equipment.

PFE.12.4 Teaching the patient how to carry out activities of daily living.

PFE.12.5 Assessing the comprehension of the patient and relatives through return demonstration and feedback.

PFE.12.6 Documenting all patient education assessments and the patient's response in the clinical record

**Evidence of Compliance**

PFE.12.EC.1 There is comprehensive nurses' provision and documentation of patient/family education (assessing motivation, medications, safe use of medical equipment, activities of daily living, and return demonstrations with feedback). Medical Record Review



## Patient and Family Rights Standards

### PFR.1 The hospital leaders are involved in supporting and protecting patient family rights by:

PFR.1.1 Developing and maintaining a Patient Rights and Responsibility statement and policies to outline and support patient rights.

PFR.1.2 Discussing aspects of patient's rights in selected workshops and or meetings.

PFR.1.3 Assigning a committee (e.g. Ethics Committee, Patient Rights/Patient Advocacy/Patient Care Committee etc.) the responsibility to clarify and help resolve issues that involve patient's rights where needed.

PFR.1.4 Ensuring patients are informed about their rights and responsibilities in a manner they can understand as part of the admission or registration processes.

PFR.1.5 Making patient rights and responsibilities available to patients and families.

PFR.1.6 Providing staff training and education on patient and family rights and responsibilities.

#### Evidence of Compliance

PFR.1.EC.1 Terms of reference of Patient Rights/Advocacy committee include items in PFR.1.1 through PFR1.6 Document Review

PFR.1.EC.2 There is a written Patient Rights and Responsibility statement and policies. Document Review

PFR.1.EC.3 Staff receive training and education on patient and family rights Interview

### PFR.2 An administrative policy is developed and implemented regarding everyone's roles and responsibilities in supporting patient and family rights.

#### Evidence of Compliance

PFR.2.EC.1 There is an administrative policy outlines roles and responsibilities in implementing patient and family rights. Document Review

### PFR.3 The patient is provided with continuous and organized healthcare at all levels of treatment.

#### Evidence of Compliance

PFR.3.EC.1 There is a uniform and organized healthcare at all levels of treatment. "Continuous care reflected in the medical records" (same are provided to all patients). Health Record Review

### PFR.4 The patient is truthfully informed when his/her needs exceed the hospital's capability for care.

#### Evidence of Compliance

PFR.4.EC.1 Staff are knowledgeable on how to handle patients when services needed are not available. Interview

### PFR.5 The hospital offers equal treatment to patients and the patient knows the estimated cost of treatment in advance.

#### Evidence of Compliance

PFR.5.EC.1 There are standardized processes for patients care. Interview

PFR.5.EC.2 Patients are informed about the cost of treatment. Interview

### PFR.6 The hospital staff members allow patients and, when appropriate, their families to fully participate in decisions about their care, treatment, and services.

PFR.6.1 Patients are informed about their diagnosis, options for care, treatment, and services (in simple layman's terms and how they can participate in care decisions.

PFR.6.2 Patients are supported to discuss their plan of care with the physician and have all their questions answered.

PFR.6.3 Staff members respond appropriately to requests of a second consultation for opinion if necessary.



PFR.6.4 Patients' preferences and choices are respected.

**Evidence of Compliance**

PFR.6.EC.1 The patient is informed about his/her rights (consent policy or other document instructing staff to discuss with patients/families their plan of care, diagnosis, condition, treatment and support their rights in care planning and decision making). Document Review

**PFR.7 The hospital provides appropriate protection for vulnerable patients such as infants, children, disabled individuals, and the elderly.**

PFR.7.1 There is a written policy that addresses actions and responsibilities in the prevention of infant/child abduction.

PFR.7.2 Having security available in sensitive and remote areas, especially female wards, delivery room, pediatric and neonate areas.

PFR.7.3 Preventing unauthorized access to sensitive areas.

PFR.7.4 Providing visitors with identification badges issued by the organization.

PFR.7.5 Protecting infants, small children and dependents from abduction.

PFR.7.6 Protecting vulnerable patients from abuse or neglect.

**Evidence of Compliance**

PFR.7.EC.1 There is a written policy that addresses actions and responsibilities in the prevention of infant/child abduction. Document Review

PFR.7.EC.2 There is security available in all sensitive areas to protect patients and assist disabled patients. Observation

PFR.7.EC.3 All visitors are provided with identification badges. Observation

PFR.7.EC.4 There is a protection mechanism against abuse. Interview

**PFR.8 The hospital assists disabled patients by offering the necessary assistance to patients with special needs where needed (e.g., identified parking spaces near the entrance).**

**Evidence of Compliance**

PFR.8.EC.1 The facility is friendly for disabled and elderly patients (e.g. identified parking spaces near the entrance, etc.). Observation

**PFR.9 The hospital implements general principles of patients rights which includes:**

PFR.9.1 Treating patients with respect and dignity at all times.

PFR.9.2 Respecting patient's cultural, psychosocial, spiritual and personal values and beliefs.

PFR.9.3 Providing all the information regarding the identity and the professional status of his/her treating physician and how to contact him/her.

PFR.9.4 Respecting the patient's need for privacy and not exposing any private parts unnecessarily during the treatment.

PFR.9.5 Respecting patient's right for pain assessment and management.

PFR.9.6 Ensuring complete patient confidentiality of all patient's treatment by never discussing the patient in public, never revealing the patient name or any information about his illness, and not publicizing any information.

PFR.9.7 Not neglecting patient's demands and/or needs, and respecting their right to complain.

PFR.9.8 Allowing patients to submit verbal or written complaints or proposals with no effect on the quality of care provided.

PFR.9.9 Allowing patients to refuse to talk to any individual that has no relationship to the care provided.

PFR.9.10 Protecting patients from verbal abuse by physicians, nurses, or any other staff.

PFR.9.11 Providing the patient with a complete medical report and accurate check up results.

**Evidence of Compliance**

PFR.9.EC.1 Staff are aware of general principles of patients' rights. Interview

PFR.9.EC.2 There is evidence of hospital implementation of general principles of patients' rights. Observation

**PFR.10 The hospital has a generalized consent form that provides authorization for general treatment and a**



policy to govern its use and completion.

**Evidence of Compliance**

PFR.10.EC.1 There is a policy to govern the general consent form use and completion. Document Review  
(review the consent form and policy)

**PFR.11 There is a policy that identifies an up-to-date list of high risk treatments and procedures as well as sedation and anesthesia that requires informed consent and include but are not limited to:**

- PFR.11.1 Surgery, under general anesthetic.
- PFR.11.2 Surgery, under local anesthetic.
- PFR.11.3 Blood and blood products infusion.
- PFR.11.4 FNA (fine needle aspiration).
- PFR.11.5 True-cut biopsy.
- PFR.11.6 Interventional X-ray procedure, e.g. draining an abscess under CT guidance.
- PFR.11.7 CT examination with contrast.
- PFR.11.8 MRI examination with or without contrast.
- PFR.11.9 Angiogram (diagnostic or therapeutic).
- PFR.11.10 Bone marrow aspirate.
- PFR.11.11 Epidural injections and anesthesia.
- PFR.11.12 Receiving chemotherapeutic and radio-active material
- PFR.11.13 Insertion of central lines.

**Evidence of Compliance**

PFR.11.EC.1 There is a written policy for high risk treatments and procedures requiring informed consent that includes items in PFR.11.1 through PFR.11.13. Document Review

**PFR.12 The informed consent process is done by:**

- PFR.12.1 Fully informing the patient about the risks, benefits, and alternatives.
- PFR.12.2 Signing the consent form prior to any surgical or invasive procedure, anesthesia, or other high risk treatments and procedures with exception of emergency and trauma.

**Evidence of Compliance**

PFR.12.EC.1 Informed consent is obtained and documented in accordance with the organization's policy: prior to any surgery or invasive procedure, anesthesia, or other high risk treatments and procedures with exception of emergency and trauma. Medical Record Review

**PFR.13 The informed consent is signed by the patient or his/her designee as defined by hospital policy and witnessed before any of the above listed procedures are done and this includes:**

- PFR.13.1 Proper identification and a clearly written name when any other family member signs the consent on behalf of the patient.

**Evidence of Compliance**

PFR.13.EC.1 The informed consent is signed by the patient or his/her designee as defined by hospital policy and witnessed for all high risk procedures using a legible written name. Medical Record Review

**PFR.14 Written consent is obtained prior to photography of patients (especially the face).**

**Evidence of Compliance**

PFR.14.EC.1 Consent is obtained for medical photography. Medical Record Review



**PFR.15 Staff respect and protect patient privacy and confidentiality throughout provision of care.**

**Evidence of Compliance**

PFR.15.EC.1 Patients are provided with privacy and their information are kept confidential across the facility. Observation

**PFR.16 The hospital has an effective structure to handle patient complaints that includes the following:**

PFR.16.1 There is a specific unit or person in the organization (e.g. Patient Relations, Social Worker, Quality department) responsible for complaint management.

PFR.16.2 There is a committee (e.g. Patient Rights/Patient Advocacy/Patient Care Committee) that has oversight of the patient complaint process and outcomes and the membership includes at least Medical, Nursing, Patient Relations, and Quality Management

PFR.16.3 The unit or person responsible for patient complaints routes patient complaints that have a non medical implication to the concerned department/section leader who will investigate and help resolve the issues

PFR.16.4 The unit or person responsible for patient complaints routes patient complaints that have a medical implication to the Medical Director to handle the clinical review process of the case.

PFR.16.5 The Medical Director routes all complaints that have been identified as mortality and or morbidity cases by the clinical review process, to the Mortality and Morbidity committee.

PFR.16.6 The hospital investigates immediately and finalizes the non medical cases no later than one week from receiving the complaint and gives feedback to the complainant.

PFR.16.7 The hospital investigates immediately and finalizes the medical cases by no later than one month from receiving the complaint and gives feedback to the complainant.

PFR.16.8 The Committee with oversight of patient complaints receives a confidential summary report of the complaint cases reviewed from the Mortality/Morbidity committee chairman with copies to the Hospital Director the Medical Director and the Quality Management Committee.

PFR.16.9 The Chairman of the committee with oversight for patient complaints receives quarterly trended, aggregated and analyzed summaries from the unit or person responsible for complaint management for discussion in the committee meetings.

PFR.16.10 The Chairman of the committee with oversight for patient complaints routes trended reports concerning patient complaints to department heads as needed and receives written feedback from them.

PFR.16.11 The Chairman of the committee with oversight for patient complaints routes copies of the minutes to the Hospital Director, Medical Director, Administrative Director, and Quality Management Director/leader.

PFR.16.12 The hospital leaders ensure taking quality improvement and strategic actions based on monthly, quarterly and annual trended report data.

**Evidence of Compliance**

PFR.16.EC.1 There is a specific unit or person in the organization responsible for complaint management. Interview

PFR.16.EC.2 There is an interdisciplinary mechanism that has oversight of the patient complaint process and outcomes (terms of reference). Document Review

PFR.16.EC.3 There is a policy that guides the handling of patients' complaints. Document Review

PFR.16.EC.4 There are trended reports concerning patients' complaints. Document Review

**PFR.17 The hospital has a system including policy, forms and process to conduct ongoing patient satisfaction surveys and makes improvements based on the trended survey results.**

**Evidence of Compliance**

PFR.17.EC.1 There is policy and form for ongoing patient satisfaction survey. Document Review

PFR.17.EC.2 There are patient satisfaction trended reports that include improvement actions taken based on the trended survey results. Document Review

**PFR.18 The hospital develops and implements an Administrative Policy (APP) for protection of patient belongings that includes but is not limited to outlining:**

PFR.18.1 The location where the patient belongings are kept.

PFR.18.2 Who is responsible for obtaining the required signatures on the form when receiving and handing over the patient's belongings.

PFR.18.3 How the valuables of trauma patients, vulnerable patients (comatose patients, confused patients, elderly, and children) are handled.





**Evidence of Compliance**

- PFR.18.EC.1 There is a policy for protection of patient belongings that includes PFR.18.1 through PFR.18.3. Document Review
- PFR.18.EC.2 Implementation of patient belongings policy (location, safety, handling belongings of trauma and vulnerable patients). Observation

**PFR.19 The patient identifies his designee and decision maker upon admission.**

**Evidence of Compliance**

- PFR.19.EC.1 The patient identifies his designee and decision maker upon admission (the requirement may be checked in relevant to identification of patient designee). Medical Record Review

**PFR.20 Physicians and Nurses involve the patient, the patient's designee, and /or the patient's family as appropriate, to assist the patient in making informed decisions about treatment offered, by giving them accurate and honest information for:**

- PFR.20.1 Their illness.
- PFR.20.2 The proposed treatment.
- PFR.20.3 Potential benefits.
- PFR.20.4 Potential complications.
- PFR.20.5 Likelihood of success of treatment.
- PFR.20.6 Their attending Physician's name and other Consultants' names involved in their care.
- PFR.20.7 Change or transfer of the patient care from one Consultant to another.

**Evidence of Compliance**

- PFR.20.EC.1 Patients and/or their designees are involved in making decisions and this is documented in the medical records (signed consent forms). Medical Record Review

**PFR.21 There is a policy to deal with patients who refuse treatment, or discontinuing treatment and:**

- PFR.21.1 Patients have the right to refuse treatment offered.
- PFR.21.2 The consequences of treatment refusal are explained to patients.
- PFR.21.3 Patients are informed about available care and treatment alternatives.
- PFR.21.4 Family members, when appropriate, are involved in the process.
- PFR.21.5 Patient and family choices are respected.
- PFR.21.6 The above discussion is documented in the patient's file.

**Evidence of Compliance**

- PFR.21.EC.1 There is a policy to deal with patients who refuse treatment or discontinuing treatment (right to refuse treatment, consequences of refusal are explained to patients, and respect for decisions of the patient/family members). Document Review
- PFR.21.EC.2 The discussion with the patient/family is documented in the medical record. Medical Record Review

**PFR.22 The hospital has a policy regarding withholding resuscitation efforts for the terminally ill, or dying patients (No code policy) that is consistent with governmental and local (fatwa).**

**Evidence of Compliance**

- PFR.22.EC.1 There is an updated policy for "No code" consistent with Fatwa Document Review

**PFR.23 The hospital supports and cares for the patient in pain and this includes:**

- PFR.23.1 Assessing patients upon admission and continuously afterwards.
- PFR.23.2 Quick pain relief experienced by the patient.



- PFR.23.3 Assessing the response of the patient to pain medications.  
PFR.23.4 Dealing with side effects from pain medications administered.  
PFR.23.5 Providing advice on how to deal with chronic pain.  
PFR.23.6 Referring the patient to the pain clinic, as appropriate.  
PFR.23.7 Educating the patient regarding his/her pain and how to minimize it.

**Evidence of Compliance**

- PFR.23.EC.1 There is pain management policy. Document Review  
PFR.23.EC.2 There is documentation of patient education for management of chronic pain and referrals to other healthcare settings. Medical Record Review

**PFR.24 The organization's leaders develop and / or adopt the ethical standard in dealing with patients and their supporters and sponsors by:**

- PFR.24.1 Accurately billing for services. Availing the price list for patients and their sponsors.  
PFR.24.2 Honestly portraying its services to patients.  
PFR.24.3 Performing ethical marketing.  
PFR.24.4 Ensuring that the provision of care is not affected by the patient's inability to pay.

**Evidence of Compliance**

- PFR.24.EC.1 The hospital has a code of ethics that includes elements PFR.24.1 through PFR.24.4 Document Review

**PFR.25 The hospital has a defined process for informing patients and, when appropriate, families of the outcome of care including significant adverse medical events and unanticipated negative outcomes.**

**Evidence of Compliance**

- PFR.25.EC.1 The hospital informs patients on the outcome of care including any unanticipated adverse outcome. Interview

**PFR.26 The leadership develops a professional code of conduct for all employees which describes the hospital's expectations of the staff regarding their behavior and communication with each other and with their patients.**

- PFR.26.1 The organization has a policy that addresses methods for resolution of conflict between staff.

**Evidence of Compliance**

- PFR.26.EC.1 There is written set of values and professional code of conduct. Document Review  
PFR.26.EC.2 There is a written employee conflict resolution policy. Interview

**PFR.27 The hospital informs the staff and the patients and their family the choices and procedures of organ donations and includes:**

- PFR.27.1 Who is responsible to inform the patient about organ donation.  
PFR.27.2 Providing the family with all the necessary information about the religious Fatwa in Saudi Arabia on Donation.  
PFR.27.3 Providing the family with all the necessary information about what can be donated, who can donate, how to donate and the procedures involved in the donation process.

**Evidence of Compliance**

- PFR.27.EC.1 Promotion of organ donation in cooperation with SCOT (staff and patient interviews). Interview  
PFR.27.EC.2 There are written brochures and religious Fatwa on organ donation. Document Review

**PFR.28 The organization has policies and procedures regarding organ donation that includes:**



- PFR.28.1 Application of Kingdom rules on who should make the necessary tests to confirm brain death.  
PFR.28.2 The necessary tests to be performed to confirm brain death.  
PFR.28.3 The necessary equipment being available to make the diagnosis of brain death.  
PFR.28.4 Training professional staff to deal with such cases.  
PFR.28.5 Informing the patients and families about organ donation in a gentle professional manner.  
PFR.28.6 Respecting the family decision.  
PFR.28.7 How to make the communication with the agency for organ donation.

**Evidence of Compliance**

- PFR.28.EC.1 There are policies and procedures regarding organ donation that includes (application of Kingdom rules, the necessary tests, the necessary equipment, training professional staff to deal with such cases, informing the patients and families, respecting the family decision and how to make the communication). Document Review

**PFR.29 The Hospital has a Research Committee or a team that decides on any research, new procedure, or new drugs that involve use of patients to ensure that the research is appropriate and safe by the following actions:**

- PFR.29.1 They meet to discuss and evaluate the scientific evidence of the new research.  
PFR.29.2 They study the potential benefits and risks involved with the new drug, equipment, or procedure for the patient.  
PFR.29.3 They have a process to ensure that the involved patient's consent form is designed to have the patient's signature after fully explaining the benefits and the risks involved relating to the research protocol.  
PFR.29.4 Patient wishes are respected.

**Evidence of Compliance**

- PFR.29.EC.1 There are research committee terms of reference. Document Review  
PFR.29.EC.2 The research committee meeting minutes reflects that they discuss and evaluate the scientific evidence of the new research, benefits and risks of any research and explanation of benefits/risks of patient participation with informed consent. Document Review  
PFR.29.EC.3 Informed consent is taken for patients involved in research (patients consent form is designed). Medical Record Review

**PFR.30 Patients are informed of their responsibilities in following:**

- PFR.30.1 Hospital policies and procedures (such as Patient rights and responsibilities, visiting hours, smoking policy, use of electrical appliances, home brought medications, safety of belongings etc.) preferably by a patient information handbook  
PFR.30.2 The plan of care given to them (preferably by a patient education handout/form)

**Evidence of Compliance**

- PFR.30.EC.1 There is a patient handbook and /or documents that inform patient the hospital rules and regulations and the care process, as part of the admission process (patient interview). Interview

**PFR.31 The hospital adopts the system of providing emergency medical care in the emergency room for all life threatening cases (Based on the MOH policy regardless of their ability to pay in private hospital).**

**Evidence of Compliance**

- PFR.31.EC.1 Policy on providing emergency care to patients regardless of availability of fund. Document Review  
PFR.31.EC.2 Implementation of provision of service to those with life threatening condition and cannot pay. Interview



## Anesthesia

### Introduction

Although anesthesia is necessary for many procedures, it is important to acknowledge that undergoing anesthesia is not a simple procedure. Patients can have adverse reactions to the anesthesia drugs administered before, during and after surgery. Despite the potential hazards, anesthesia can be relatively safe if proper standards are followed. To decrease the likelihood of anesthesia related complications, the standards address pre-anesthetic assessment performed prior to the administration of sedation or anesthetic; patient monitoring during and after surgery until appropriate recovery; and anesthetic supplies and equipment.

Additionally, the standards require that staff be trained in cardiopulmonary resuscitation (CPR) to ensure the availability of a trained staff during normal hours of operation.

This chapter addresses the following processes:

- Anesthesia Staff
- Equipment
- Preanesthesia assessment
- Monitoring of patients receiving anesthesia
- Conscious sedation
- Recovery room



## Standards

### AN.1 A qualified Anesthetist administers all anesthesia.

#### Evidence of Compliance

AN.1.EC1 A qualified privileged anesthetist administers all anesthesia.

Personnel File

### AN.2 One Anesthetist is physically present inside the operating room throughout the operation.

#### Evidence of Compliance

AN.2.EC1 OR staffing plan and schedule outlines that one anesthetist is physically present throughout the operation.

Document Review

### AN.3 The Anesthetist position is at the level of a consultant when providing anesthesia to major operations or sub specialty services like Pediatric Neurosurgery, Cardiac and Thoracic surgery.

#### Evidence of Compliance

AN.3.EC1 Anesthetist consultant privileges for major operations.

Personnel File

AN.3.EC2 Review some of medical records clarified the presence of anesthetist consultant when providing anesthesia of major operations or sub specialty services like pediatric neurosurgery, cardiac and thoracic surgery.

Medical Record Review

### AN.4 There is a policy on the proper storage and handling of anesthetic agents.

#### Evidence of Compliance

AN.4.EC1 Policy for proper storage and handling of anesthetic agents.

Document Review

### AN.5 The department head of Anesthesia recommends the anesthesia equipment.

#### Evidence of Compliance

AN.5.EC1 Anesthesia department head recommends anesthesia equipment.

Document Review

### AN.6 The anesthesia machine and the Operating room have the following equipment to meet the needs of the patient's condition:

AN.6.1 Oxygen analyzer.

AN.6.2 Pressure and disconnect alarm.

AN.6.3 Pin index safety system.

AN.6.4 Gas scavenger system.

AN.6.5 Oxygen pressure system.

AN.6.6 Oximetry.

AN.6.7 Capnography.

AN.6.8 On line Gas analyzer.

AN.6.9 Agent analyzer.

AN.6.10 ECG machine.

#### Evidence of Compliance

AN.6.EC1 The anesthesia machine and the operating room have the needed equipment (Oxygen Observation analyzer, Pressure and disconnect alarm, Pin index safety system, Gas scavenger system, Oxygen pressure system, Oximetry, Capnography, On line Gas analyzer, Agent analyzer, and ECG machine).



**AN.7 The following equipment is available for difficult intubations:**

- AN.7.1 Laryngeal mask.
- AN.7.2 Gum elastic bogie.
- AN.7.3 Lighted stylet.
- AN.7.4 Crico-thyroidotomy kit.
- AN.7.5 Fiber optic intubations scope.

**Evidence of Compliance**

AN.7.EC1 Availability of equipment for difficult intubations Laryngeal mask, gum elastic bogie, lighted stylet, crico-thyroidotomy kit, and fiber optic intubations scope. Observation

**AN.8 All anesthesia machines are regularly checked and maintained and there is a record of preventive maintenance (PPM) and checking for every machine.**

**Evidence of Compliance**

AN.8.EC1 Preventative maintenance records of anesthesia machines (PPM tags and records). Observation

**AN.9 The head of anesthesia implements the Infection control guidelines inside the operating room to include but not limited to proper sterilization of the anesthesia machines.**

**Evidence of Compliance**

AN.9.EC1 Implementation of infection control guidelines including sterilization of the anesthesia machines and other anesthetic equipment. Interview

**AN.10 Pre-anesthesia assessment is performed not more than (30) days prior to the surgery date by the anesthetist who decides together with the surgeon as to the type of anesthesia to be used and the pre anesthesia assessment form is completed and includes the**

- AN.10.1 The anesthesia risk category according to the patient's condition.
- AN.10.2 Any consultations needed (Cardiology, hematology, etc.)
- AN.10.3 The anesthesia plan.
- AN.10.4 The potential complications and risks, which are communicated to the patient and his/her family for obtaining informed consent.

**Evidence of Compliance**

AN.10.EC1 Comprehensive pre-anesthesia assessment that includes risk category, any consultations needed, anesthesia plan are documented in the Anesthesia assessment form not more than 30 days prior to surgery. Medical Record Review

**AN.11 There is an anesthesia form in the medical record and the following essential information is recorded:**

- AN.11.1 The anesthetic agent.
- AN.11.2 The dosage of all of the medications and agents used.
- AN.11.3 The techniques used to administer the anesthesia.
- AN.11.4 If blood is used, the amount of blood and the time given.
- AN.11.6 Any investigations carried out e.g. blood glucose, blood gases.
- AN.11.5 Any unusual events.
- AN.11.7 The status of patient at the end of the procedure.
- AN.11.8 The amount and type of IV fluids given.

**Evidence of Compliance**



AN.11.EC1 Availability of complete anesthesia form (anesthetic agent, dosage, techniques, blood Medical Record Review administered, investigations, unusual events, status of patient at the end of the procedure, IV fluids given).

**AN.12 The patient's condition is continuously monitored during surgery, and the following are documented on the anesthesia sheet:**

- AN.12.1 The patient's vital signs.
- AN.12.2 The patient's End tidal CO<sub>2</sub>.
- AN.12.3 The patient's oxygen saturation.
- AN.12.4 The patient's ECG.

**Evidence of Compliance**

AN.12.EC1 Continuous monitoring of patients during surgery including vital signs, end tidal CO<sub>2</sub>, Medical Record Review and ECG.

**AN.13 A qualified anesthetist is in charge of the Recovery room at all times.**

**Evidence of Compliance**

AN.13.EC1 Availability of anesthetist in charge of the Recovery Room (schedule). Document Review

**AN.14 Post anesthesia status is monitored in the Recovery room.**

**Evidence of Compliance**

AN.14.EC1 Post anesthesia monitoring of patients in the Recovery Room. Medical Record Review

**AN.15 The recovery room has the following equipment to meet the needs of the patient's condition:**

- AN.15.1 Pulse Oximetry
- AN.15.2 Automated blood pressure monitor
- AN.15.3 EGG machine
- AN.15.4 Crash cart with defibrillator
- AN.15.5 Wall suction or suction equipment
- AN.15.6 Oxygen

**Evidence of Compliance**

AN.15.EC1 Availability of Recovery Room equipment (pulse oximetry, automated blood pressure Observation monitor, EGG machine, crash cart with defibrillator, wall suction or suction equipment, oxygen).

**AN.16 The Head of Anesthesia and the nurse manager (head nurse) write all of the policies and procedures for patient care in the recovery room (RR).**

**Evidence of Compliance**

AN.16.EC1 Collaboration between head of anesthesia and the OR/RR nurse manager in Document Review preparing policy and procedures of Recovery Room (counter signature).

**AN.17 All Recovery Room staff (medical and nursing) are certified in BCLS and preferably ACLS.**

**Evidence of Compliance**

AN.17.EC1 All Recovery Room medical and nursing staff are certified in BCLS and preferably Personnel File ACLS.



**AN.18 Only the qualified anesthetist discharges the patient from the Recovery room.**

**Evidence of Compliance**

AN.18.EC1 Qualified anesthetists discharge patients from the Recovery Room-RR form. Medical Record Review

**AN.19 Each patient's physiological status is continuously monitored during and immediately after surgery and written in medical record.**

- AN.19.1 The time of admission and the time of discharge.
- AN.19.2 The patient's vital signs, including pain.
- AN.19.3 The patient's level of consciousness.
- AN.19.4 Any unusual events.
- AN.19.5 Oxygen saturation.
- AN.19.6 ECG.

**Evidence of Compliance**

AN.19.EC1 Monitoring patients physiological status during and after surgery (including time of admission and time of discharge, vital signs, level of consciousness, unusual events, oxygen saturation, and ECG). Medical Record Review

**AN.20 Each patient's post anesthesia status is monitored and documented, and a qualified individual discharges the patient from the recovery area using established criteria.**

- AN.20.1 Assessment/reassessment of vital signs, oxygen saturation, level of consciousness, pain, tolerating fluids, and voiding.

**Evidence of Compliance**

AN.20.EC1 Monitoring post anesthesia status with documentation. Medical Record Review

**AN.21 There is written criteria for the discharge of patients from the Recovery room and all staff who work in the recovery area can state it.**

**Evidence of Compliance**

AN.21.EC1 Written criteria on patient discharge from the Recovery Room. Interview  
AN.21.EC2 Staff awareness of written criteria for discharge from Recovery Room. Interview

**AN.22 The recovery room has a method to call for help quickly through an alarm system or paging system without leaving the patient's bedside.**

**Evidence of Compliance**

AN.22.EC1 Effective emergency call system in Recovery Room. Observation

**AN.23 Patients who have infectious conditions are separated appropriately in the recovery room.**

**Evidence of Compliance**

AN.23.EC2 Appropriate separation of infectious cases in the Recovery Room. Observation

**AN.24 Each staff member receives ongoing in-service and other education and training to maintain or advance his or her skills and knowledge.**

- AN.24.1 Observing and recognizing any arrhythmias.
- AN.24.2 Reading from the Oximetry.
- AN.24.3 Administering blood and blood products.
- AN.24.4 ACLS certification.





AN.24.5 Infection control practices.

AN.24.6 The dosage and use of narcotics.

AN.24.7 Recognition of critical findings from physical assessment, assessments from monitoring equipment, or diagnostic tests and the appropriate interventions.

AN.24.8 The maintenance and preparedness of emergency equipment and drug supply.

**Evidence of Compliance**

AN.24.EC2 Training and competency assessment for the staff regarding the required skills in the Personnel File Recovery Room.

**AN.25 Conscious Sedation in the hospital has policies and guidelines approved by the Head of Anesthesia, the nurse manager, and the appropriate department heads.**

**Evidence of Compliance**

AN.25.EC1 Written policy on conscious sedation approved by the head of anesthesia, the nurse manager, and the appropriate department heads. Document Review

**AN.26 Conscious sedation is performed only in areas identified in policy and the following equipment is available to provide safe care:**

AN.26.1 Wall suction or suction equipment.

AN.26.2 Oxygen.

AN.26.3 Pulse Oximetry.

AN.26.4 Automated blood pressure monitor or means of taking blood pressure.

AN.26.5 ECG Monitor

**Evidence of Compliance**

AN.26.EC1 Conscious sedation is performed only in areas identified in the policy. Observation

AN.26.EC2 Availability of conscious sedation equipment in the area where conscious sedation is being performed (including wall suction, oxygen, pulse oxymetry, blood pressure and ECG monitors. Observation

**AN.27 There is a crash cart with defibrillator, medications, IV access, and intubation equipment that is appropriate to the age of the patient available where sedation/analgesia is being performed.**

**Evidence of Compliance**

AN.27.EC1 Availability of fully equipped crash cart (including defibrillator, medications, IV access, and intubation equipment appropriate to the age group) in the area where conscious sedation is being performed. Observation

**AN.28 There is a list of all medications used in conscious sedation and includes the route administered along with dosage appropriate to the age groups available where conscious sedation is performed.**

**Evidence of Compliance**

AN.28.EC1 There is a list of all medications used in conscious sedation and includes the route administered along with dosage appropriate to the age groups available where conscious sedation is performed. Document Review

**AN.29 Staff who participate in caring for patients receiving conscious sedation have the following certifications:**

AN.29.1 Physicians who perform conscious sedation are certified as appropriate in BCLS, ACLS, PALS, NALS and have privileges granted to perform conscious sedation.

AN.29.2 Nurses who assist with sedation/analgesia are certified in BCLS, and preferably ACLS or PALS, according to the age of the patient.



**Evidence of Compliance**

AN.29.EC1 Privileged physicians who perform conscious sedation are certified BCLS, ACLS or PALS, NALS. Personnel File

AN.29.EC3 Nurses who perform conscious sedation are certified BCLS, ACLS or PALS, NALS. Personnel File

**AN.30 Conscious sedation is only used for patients having short diagnostic or therapeutic procedures.**

**Evidence of Compliance**

AN.30.EC1 Conscious sedation is only used for patients having short diagnostic or therapeutic procedures. Medical Record Review

**AN.31 Preparation before the conscious sedation procedure includes the following:**

AN.31.1 Availability of crash cart with defibrillator, medications, IV access and intubation and other equipment that is appropriate to the age of the patient where sedation/analgesia is being performed.

AN.31.2 Informed consent is obtained after the physician educates the patient regarding the risk and benefits of the sedation/analgesia and the consent is signed by the patient, guardian, or next of kin if the patient is unable to sign.

AN.31.3 An IV is inserted and venous access is maintained in case of emergency.

**Evidence of Compliance**

AN.31.EC1 Comprehensive preparation for conscious sedation include: availability of crash cart with defibrillator, medications, IV access and intubation and other equipment that is appropriate to the age of the patient where sedation/analgesia is being performed. Observation

AN.31.EC2 Comprehensive implementation of informed consent process. Medical Record Review

**AN.32 The physician obtains a history and physical examination within the first 4 hours of admission and checks:**

AN.32.1 The history of medication allergy.

AN.32.2 Any history of systemic illness or major organ impairment that might be risky for the patient.

**Evidence of Compliance**

AN.32.EC1 Physician history and physical examination within the first 4 hours of admission. Medical Record Review

**AN.33 The physician performs a physical exam and checks:**

AN.33.1 Vital signs.

AN.33.2 Age and weight.

AN.33.3 ECG findings.

**Evidence of Compliance**

AN.33.EC1 Physicians perform and document a physical exam for vital signs, age and weight and ECG findings. Medical Record Review

**AN.34 During the procedure, the following is required:**

AN.34.1 The physician performs a physical exam.

AN.34.2 One registered nurse who is certified with BCLS and preferably ACLS or PALS is at the patient side constantly and continuously monitors the patient.

AN.34.3 One physician is physically present and close by the patient.

AN.34.4 The IV is maintained and kept patent in case of emergency.

AN.34.5 The patient is continuously monitored for level of consciousness, vital signs, oxygen saturation and skin color and this is documented by the physician and nurse.

**Evidence of Compliance**

AN.34.EC1 Availability of a physician who performs physical exam and constantly and Medical Record Review



continuously monitors the patient.

AN.34.EC2 Availability of one registered nurse who is certified with BCLS and preferably ACLS/PALS is at the patient side constantly and continuously monitors the patient. Observation

AN.34.EC3 Constant and continuous monitoring and documentation of level of consciousness, vital signs, oxygen saturation and skin color. Medical Record Review

**AN.35 After the procedure, the following is required:**

AN.35.1 The physician documents the status of the patient post procedure and includes vital signs, level of consciousness, and ECG findings.

AN.35.2 The nurse documents the status of the patient post procedure and includes vital signs, level of consciousness, and ECG findings.

AN.35.3 The physician writes a discharge order or transfers the patient back to the unit with follow up instructions for the nurses (vital signs, oxygen saturation, etc.)

**Evidence of Compliance**

AN.35.EC1 Physician documentation of patient status post procedure including vital signs, level of consciousness, and ECG. Medical Record Review

AN.35.EC2 Nurse documentation of patient status post procedure including vital signs, level of consciousness, and ECG. Medical Record Review

AN.35.EC3 Physician discharge order or transfers the patient back to the unit with follow up instructions. Medical Record Review

**AN.36 The nurse carries out the physicians orders and monitors the patient post procedure:**

AN.36.1 Assessment/Re-assessment of vital signs, Oxygen saturation, level of consciousness, pain, tolerating fluids, and voiding.

AN.36.2 The nurse provides education and discharge instruction to the patient and family that includes follow up and emergency number to call, if needed.

**Evidence of Compliance**

AN.36.EC1 The nurse carries out the physician instructions including assessment/reassessment of vital signs, oxygen saturation, level of consciousness, pain, fluid tolerance, and voiding. Medical Record Review

AN.36.EC2 The nurses perform discharge patient and family education including follow ups and emergency number to call. Medical Record Review



## Intensive Care Unit: Adult, Pediatric, Coronary Care Unit, Neonate

### Introduction

The standards in this chapter are designed to promote the provision of the highest quality of intensive care to critically ill patients. The intensive care unit must be capable of providing services unique to its setting such as mechanical ventilation and invasive cardiovascular monitoring. The standards in this chapter are intended to promote and improve the safe and effective practice of intensive care units including adult, pediatric, neonatal intensive care units as well as coronary care units.

This chapter addresses the following:

- Staff qualifications and plan
- Equipment and supplies
- Admission and discharge criteria
- Discharge procedures



## Adult, Pediatric Intensive Care Unit (ICU/PICU) Standards

**ICU.1 The department head is a qualified physician by training.**

**Evidence of Compliance**

ICU.1.EC1 Qualified and trained ICU department head (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**ICU.2 A qualified registered nurse with training in critical care is the nurse manager.**

**Evidence of Compliance**

ICU.2.EC1 Qualified, trained and registered nurse manager in ICU (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**ICU.3 All physicians working in the unit are well trained in critical care and are certified in BCLS, ACLS (for adults)/PALS (for pediatrics).**

**Evidence of Compliance**

ICU.3.EC1 All physicians are trained in ICU. Personnel File  
ICU.3.EC2 All critical care physicians staff have valid BLS certification and ACLS (adults), PALS (Pediatrics). Personnel File

**ICU.4 The nurse manager develops policies and procedures for the unit and collaborates with other departments as needed for this (e.g. infection control).**

**Evidence of Compliance**

ICU.4.EC1 Written multidisciplinary ICU policies and procedures in collaboration with other departments. Document Review

**ICU.5 All nursing staff in the critical care unit (ICU/CCU/PICU) are certified in BCLS and preferably ACLS (for adults) PALS (for pediatric).**

ICU.5.1 There is a copy of the staff certificate for BCLS and if obtained, ACLS (for adults) PALS (for pediatric) in their personnel file.

**Evidence of Compliance**

ICU.5.EC1 All ICU nursing staff has valid BLS certification and preferable ACLS (adults) PALS (Pediatrics). Personnel File

**ICU.6 The medical staff has a staffing plan based on patient volume and patient acuity.**

**Evidence of Compliance**

ICU.6.EC1 Availability of medical staffing plan based on patient volume and acuity. Document Review

**ICU.7 There is a nurse staffing plan that is based on patient volume and patient acuity.**

**Evidence of Compliance**

ICU.7.EC1 Availability of nursing staffing plan based on patient volume and patient acuity. Document Review

**ICU.8 There is written Admission and Discharge criteria.**

**Evidence of Compliance**



ICU.8.EC1 Availability of written critical care admission and discharge criteria.

Document Review

**ICU.9 There is 24-hour physician coverage for the unit that is physically present in the vicinity.**

**Evidence of Compliance**

ICU.9.EC1 24-hour critical care coverage by physician (i.e schedule).

Document Review

**ICU.10 There is evidence that nursing staff in critical care units receive continuous training with competency assessment (e.g. written test, return demonstration, etc) and education in the following for the nursing staff:**

ICU.10.1 Using pulse Oximetry.

ICU.10.2 Recognizing arrhythmias

ICU.10.3 Assisting physician in placing central lines or arterial lines.

ICU.10.4 Obtaining blood gases ABG's.

ICU.10.5 Reading central venous pressure (CVP).

ICU.10.6 Knowledge of medications that include vasopressors, narcotics, and controlled substances.

ICU.10.7 Infection control principles.

ICU.10.8 Blood transfusions.

ICU.10.9 Exchange transfusion (neonate).

ICU.10.10 Glasgow coma scale (GSC).

ICU.10.11 Use of the defibrillator.

ICU.10.12 Care of patients on ventilators.

ICU.10.13 Care of patients with tracheotomies.

**Evidence of Compliance**

ICU.10.EC1 Comprehensive training and education of all critical care nurses (pulse Oximetry, arrhythmias, Assisting physician in placing central lines or arterial lines, ABGs, CVP, ICU medications, Infection control, Blood transfusions, Glasgow coma scale, defibrillator, Care of patients on ventilators, Care of patients with tracheotomies). Personnel File

ICU.10.EC2 Competency assessment (written test, return demonstration of all critical care nurses). Personnel File

**ICU.11 The critical care unit has the following necessary equipment and supplies:**

ICU.11.1 Ventilators

ICU.11.2 Tracheostomy set

ICU.11.3 Crash cart that includes all emergency supplies and medications.

ICU.11.4 Defibrillators

ICU.11.5 Pulse Oximetry and vital signs monitor.

ICU.11.6 Transfusion pumps

**Evidence of Compliance**

ICU.11.EC1 Availability of all ICU essential equipment and supplies (ventilators, tracheostomy set, defibrillators, pulse oximetry, vital signs monitor, transfusion pumps). Observation

ICU.11.EC2 Availability of a crash cart with all emergency supplies and medications. Observation

**ICU.12 The availability and functionality of all tools and equipment needed for intubations and ventilation are regularly checked.**

**Evidence of Compliance**

ICU.12.EC1 Availability of functional tools and equipment for intubation and ventilation. Observation

ICU.12.EC2 Regular inspection of intubations, ventilation tools and equipments. Observation



**ICU.13** Isolations rooms (preferably negative pressure) are used for all patients (Adult/Peds) with communicable diseases or infections and infection control disease guidelines are applied.

**Evidence of Compliance**

ICU.13.EC1 Availability of ICU isolation room for patients with infectious or communicable diseases. Observation

ICU.13.EC2 Implementation of infection control guidelines. Observation

**ICU.14** The physician in charge of the ICU together with the Most Responsible Physician (MRP) jointly makes the decision to admit and discharge patients from the unit.

**Evidence of Compliance**

ICU.14.EC1 ICU admission and discharge decision is made by the physician in charge of the ICU in collaboration with the MRP. Interview

**ICU.15** When the patient is discharged from the unit the ICU physician ensures that the receiving team on the floor is well informed about the patient's status and ongoing patient needs.

ICU.15.1 The patient's plan of care and medications are written in detail by the physician including how to continue them on the floor.

ICU.15.2 Any special care requirements are documented (e.g. to watch for drainage tubes) in the medical record.

**Evidence of Compliance**

ICU.15.EC1 Clear documentation of the patients status, plan of care, medications, and special care requirements at the discharged from the ICU. Medical Record Review



## Coronary Care Unit (CCU) Standards

**CCU.1 The department head is a qualified Cardiologist with training in coronary care.**

**Evidence of Compliance**

CCU.1.EC1 Qualified and trained Cardiologist headed the CCU (licensed by the Saudi Council for Certification of Health Care Specialties). [Personnel File](#)

**CCU.2 A qualified registered nurse with training in critical care is the Nurse Manager.**

**Evidence of Compliance**

CCU.2.EC1 Qualified and trained registered nurse manages the CCU (licensed by the Saudi Council for Certification of Health Care Specialties). [Personnel File](#)

**CCU.3 The nurse manager develops policies/procedures for the unit and collaborates with other departments as needed (e.g. infection control).**

**Evidence of Compliance**

CCU.3.EC1 Written multidisciplinary policies and procedures in collaboration with other departments. [Document Review](#)

**CCU.4 All physicians working in the unit are well trained in coronary care and are certified in BCLS, ACLS.**

**Evidence of Compliance**

CCU.4.EC1 All CCU physicians have valid BCLS and ACLS certification. [Personnel File](#)

**CCU.5 All nursing staff are certified in BCLS and preferably, ACLS.**

CCU.5.1 There is a copy of the staff certificate for BCLS and if obtained, ACLS (for adults) in their personnel file..

**Evidence of Compliance**

CCU.5.EC1 All CCU nursing staff have valid BCLS certification. [Personnel File](#)

**CCU.6 The unit has the following necessary equipment and supplies:**

CCU.6.1 Ventilators

CCU.6.2 Tracheostomy set

CCU.6.3 Crash cart that includes all emergency supplies and medications.

CCU.6.4 Defibrillators

CCU.6.5 Pulse Oximetry and vital signs monitor.

CCU.6.6 Transfusion pumps

**Evidence of Compliance**

CCU.6.EC1 Availability of all CCU essential equipment (ventilators, tracheostomy set, defibrillator, pulse oximetry, transfusion pumps). [Observation](#)

CCU.6.EC2 Availability of crash cart with all emergency supplies and medications. [Observation](#)

**CCU.7 The medical staff has a staffing plan based on patient volume and patient acuity.**

**Evidence of Compliance**

CCU.7.EC1 Availability of medical staffing plan based on patient volume and acuity. [Document Review](#)





- CCU.8 There is a nurse staffing plan that is based on patient volume and patient acuity.**
- Evidence of Compliance**  
CCU.8.EC1 Availability of CCU nursing staffing plan based on patient volume and acuity. Document Review
- CCU.9 There is written Admission and Discharge criteria.**
- Evidence of Compliance**  
CCU.9.EC1 Written CCU admission and discharge criteria. Document Review
- CCU.10 There is 24-hour physician coverage for the unit that is physically present on the vicinity.**
- Evidence of Compliance**  
CCU.10.EC1 Availability of 24-hour CCU coverage by in-house physicians (CCU schedule). Document Review
- CCU.11 The availability and functionality of all tools and equipment needed for intubations and ventilation are regularly checked.**
- Evidence of Compliance**  
CCU.11.EC1 Availability of functional tools and equipment for intubation and ventilation. Observation  
CCU.11.EC2 Regular inspection of intubation and ventilation tools and equipment. Document Review
- CCU.12 Isolation rooms are used for all patients with communicable diseases or infections and infection control disease guidelines are applied.**
- Evidence of Compliance**  
CCU.12.EC1 Availability of CCU isolation room for patients with communicable diseases or infections. Observation  
CCU.12.EC2 Implementation of infection control guidelines in CCU. Observation
- CCU.13 When the patient is discharged from the CCU the physician ensures that the receiving team on the floor is well informed about the patient's status and ongoing patient needs.**
- CCU.13.1 The patient's medications are written in detail by the physician including how to continue them on the floor.  
CCU.13.2 Any special care requirements are documented in the medical record.
- Evidence of Compliance**  
CCU.13.EC1 The receiving team on the floor is informed about the patients status at discharge from the CCU by the ICU physician. Medical Record Review  
CCU.13.EC2 Documentation of plan of care, medications and special instructions on patient discharged from the CCU. Medical Record Review
- CCU.14 There are policies and procedures that include but not limited to:**
- CCU.14.1 Coronary Angiogram with its sequale  
CCU.14.2 Temporary pace maker  
CCU.14.3 Permanent pace maker  
CCU.14.4 Conscious sedation
- Evidence of Compliance**  
CCU.14.EC1 Written policy and procedure on Coronary Angiogram. Document Review



CCU.14.EC2 Written policy and procedure on temporary and permanent pace maker.  
CCU.14.EC3 Written policy and procedure on conscious sedation.

Document Review  
Document Review

**CCU.15 A crash cart is available in the vicinity.**

**Evidence of Compliance**

CCU.15.EC1 Availability of equipped and accessible crash cart.

Observation



## Neonatal Intensive Care Unit (NICU) Standards

### NICU.1 The department head is a qualified physician with training in neonatology

#### Evidence of Compliance

NICU.1.EC1 Qualified and trained neonatologist headed the NICU (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### NICU.2 A qualified registered nurse with training in neonatal intensive care is the Nurse Manager.

#### Evidence of Compliance

NICU.2.EC1 Qualified, trained and registered nurse manages the NICU (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### NICU.3 The nurse manager develops policies/procedures for the unit and collaborates with other departments as needed (e.g. infection control)

#### Evidence of Compliance

NICU.3.EC1 Written multidisciplinary NICU policies and procedures in collaboration with other departments. Document Review

### NICU.4 All NICU physicians are certified in BCLS and NALS (NRP).

#### Evidence of Compliance

NICU.4.EC1 All NICU physicians have valid BCLS and NALS (NRP) certification. Personnel File

### NICU.5 All NICU nurses are certified in BCLS and preferably NALS (NRP).

NICU.5.1 There is a copy of BCLS and if obtained, NALS (NRP) Certificates in the staff personnel file.

#### Evidence of Compliance

NICU.5.EC1 All NICU nurses have valid BCLS certification. Personnel File

### NICU.6 The medical staff has a staffing plan based on patient volume and patient acuity.

#### Evidence of Compliance

NICU.6.EC1 Availability of NICU medical staffing plan based on patient volume and acuity. Document Review

### NICU.7 There is a nurse staffing plan based on patient volume and patient acuity.

#### Evidence of Compliance

NICU.7.EC1 Availability of NICU nursing staffing plan based on patient volume and acuity. Document Review

### NICU.8 There is written criteria for the admission to and discharge from the NICU.

#### Evidence of Compliance

NICU.8.EC1 Written NICU admission and discharge criteria. Document Review

### NICU.9 There is 24-hour physician coverage for the unit that is physically present on the vicinity.



**Evidence of Compliance**

NICU.9.EC1 24-hour coverage of NICU by physicians (work schedule).

Document Review

**NICU.10 There is evidence that staff nurses in NICU receive training with competency assessment (e.g. written test, return demonstration, etc) and education on the following:**

- NICU.10.1 Use of pulse Oximetry.
- NICU.10.2 Assisting physicians when placing central lines and /or umbilical arterial lines/venous lines.
- NICU.10.3 Drawing ABG's.
- NICU.10.4 Knowledge of critical medications that include, surfactant, narcotics...etc
- NICU.10.5 Infection control.
- NICU.10.6 Blood transfusions.
- NICU.10.7 Endo Tracheal tube (ETT) Care.
- NICU.10.8 Exchange transfusion.
- NICU.10.9 Blood draw from Umbilical Catheter (arterial or venous).
- NICU.10.10 Care of patient on ventilator.
- NICU.10.11 Care of patient in incubator.

**Evidence of Compliance**

- NICU.10.EC1 Comprehensive training and education of NICU nurses (Pulse oximetry, Assisting physicians when placing central lines and /or umbilical arterial lines/venous lines, Drawing ABG, Critical medications, Infection control, Blood transfusions, Endo tracheal tube care, Exchange transfusion, Blood draw from umbilical catheter, Care of patient on ventilator, on incubator). Personnel File
- NICU.10.EC2 Comprehensive competency assessment of NICU nurses (written test, return of demonstration). Personnel File

**NICU.11 The unit has the following necessary equipment and supplies:**

- NICU.11.1 Ventilators.
- NICU.11.2 Crash cart that includes all emergency supplies and medications.
- NICU.11.3 Pulse oximetry/monitor.
- NICU.11.4 Infant resuscitator
- NICU.11.5 Incubators
- NICU.11.6 Portable incubator with portable ventilator
- NICU.11.7 Infusion pumps/ syringe pumps.
- NICU.11.8 Trach Sets.

**Evidence of Compliance**

- NICU.11.EC1 Availability of all essential NICU equipment and supplies (Ventilators, Pulse oximetry, Infant resuscitator, Incubators, Portable incubators with portable ventilators, Infusion pump/syringe pumps, Trach sets). Observation
- NICU.11.EC2 Availability of crash cart with emergency supplies and medications. Observation

**NICU.12 The availability and functionality of all tools and equipment needed for intubations and ventilation are regularly checked.**

**Evidence of Compliance**

- NICU.12.EC1 Availability of functional tools and equipment of intubation and ventilation in NICU. Observation
- NICU.12.EC2 Regular inspection of NICU tools and equipment of intubation and ventilation. Observation

**NICU.13 Neonates with infectious conditions are cared for in isolation and infection control disease guidelines are applied.**

**Evidence of Compliance**



NICU.13.EC1 Availability of NICU isolation area for neonates with communicable diseases or infections. Observation

NICU.13.EC2 Implementation of infection control guidelines. Observation

**NICU.14 The NICU staff encourages mother-infant bonding that includes but is not limited to:**

NICU.14.2 Breast feeding by either direct breast feeding or by teaching mother how to express and store breast milk for baby.

**Evidence of Compliance**

NICU.14.EC1 NICU staff encourages mother-infant bonding (e.g. breast feeding). Interview



## Operating Room

### Introduction

The quality and standard of surgical care in hospitals is an important issue. It is important to address the fact that patient safety should not change based on hospital size. Surgeries should be performed in a safe environment by qualified physicians who have been granted privileges to perform those surgeries and in accordance with the organization's license and scope of services.

This chapter addresses the following:

- Staffing
- Requirements prior to surgery
- Documentation
- Post-operative care



## Standards

**OR.1 The department head is the Chief of Surgery or the Chief of Anesthesia.**

### Evidence of Compliance

OR.1.EC1 OR head is either the Chief of Surgery or Chief of Anesthesia.

Personnel File

**OR.2 There is a policy for patient acceptance into the operating room (OR) that is written collaboratively with the Chief of Surgery, Chief of Anesthesia, and the nurse manager (head nurse).**

### Evidence of Compliance

OR.2.EC1 There is a policy for patient acceptance into the operating room (OR) that is written collaboratively with the Chief of Surgery, Chief of Anesthesia, and the Nurse Manager (head nurse).

Document Review

**OR.3 There is a qualified nurse with training in operative care in charge of the unit.**

### Evidence of Compliance

OR.3.EC1 Qualified and trained nurse in charge of OR (licensed by the Saudi Council for Certification of Health Care Specialties).

Personnel File

**OR.4 The head nurse /nurse manager of the Operating Room develops all of the necessary and related policies and procedures for the nursing care and responsibilities in the unit that includes but is not limited to:**

OR.4.1 Checking the patients' identity in the holding bay.

OR.4.2 Infection control guidelines.

OR.4.3 Sterilization of equipment, tools, surgical instrument.

OR.4.4 Sponge and instrument counts.

### Evidence of Compliance

OR.4.EC1 Policy and procedures on OR nursing care written by Head Nurse/Nurse Manager: checking patient identity in holding bay, infection control guidelines, sterilization of equipment tools, surgical instruments, sponge and instrument counts.

Document Review

**OR.5 The patient is accepted into the OR only after:**

OR.5.1 Identification of the patient by name and medical record number is checked by patient ID band and asking the patient to state his/her name and operation to be done for him/her.

OR.5.2 The consent form is checked for completion.

OR.5.3 The operation procedure and the surgeon's name is checked.

OR.5.4 The site of surgery and its preparation and whether it is marked or not is checked.

OR.5.5 The x-ray jacket is checked to see if it accompanies the patient as required.

OR.5.6 The lab results and pregnancy test as appropriate are checked to see if they are in the medical record.

OR.5.7 The pre-anesthesia sheet is checked for completion.

OR.5.8 The history and physical examination is checked for documentation in the medical record.

OR.5.9 The requisition for blood is verified to ensure blood is reserved in the blood bank, if needed.

### Evidence of Compliance

OR.5.EC1 Availability of approved OR patient acceptance criteria/checklist.

Document Review

OR.5.EC2 The patient is accepted into the OR only after proper identification, checking consent form for completion, checking operation procedures and surgeon name, surgery site, x-ray jacket, lab results, pre-anesthesia sheet, history and physical exam, and reserved blood.

Interview

**OR.6 All nurses working in the Operating Room are certified in BCLS and preferably ACLS.**



OR.6.1 There is a copy of the certificate for BCLS and if obtained, ACLS in staff personal file.

**Evidence of Compliance**

OR.6.EC1 All OR nurses have valid BCLS .

Personnel File

**OR.7 There is evidence that there is continuous training with competency assessment (e.g. written test, return demonstration, etc.) for the following but not limited to:**

- OR.7.1 Use of equipment.
- OR.7.2 Use of defibrillator.
- OR.7.3 Use of pulse oximetry.
- OR.7.4 Use of diathermy.
- OR.7.5 Infection control including sharp disposal, use of antiseptics, etc.
- OR.7.6 CSSD policy.
- OR.7.7 Maintain a sterile field.
- OR.7.8 Safety issues including electrical, fire plan, etc.
- OR.7.9 Draping and gowning.
- OR.7.10 Positioning of the patient.

**Evidence of Compliance**

OR.7.EC1 There is a comprehensive OR nursing training, use of equipment, defibrillator, pulse ox, diathermy, infection control and sharp disposal, use of antiseptics, CSSD policy, sterile field, safety issues of fire, electrical, fire plan, draping and gowning, positioning the patient.

Personnel File

OR.7.EC2 There is OR competency assessment (written test and return demonstration).

Personnel File

**OR.8 Surgeons, anesthetists, anesthesia technicians, and nurses check the availability and functionality of all tools and equipments needed for the operation before induction of anesthesia.**

**Evidence of Compliance**

OR.8.EC1 All OR staff check the availability and functionality of necessary OR equipment before induction of anesthesia.

Observation

**OR.9 The policy on sponge and instruments count is strictly enforced and all sponge and instrument counts are documented.**

**Evidence of Compliance**

- OR.9.EC1 Written policy and procedures for sponge and instrument count.
- OR.9.EC2 Strict implementation of sponge count (sponge count log sheet or form to check).
- OR.9.EC3 There is an instrument count (instrument log sheet or form to check).

Document Review

Observation

Observation

**OR.10 Nurses and surgeons strictly follow the Infection control guidelines in the Operating room.**

**Evidence of Compliance**

OR.10.EC1 Strict adherence to infection control guidelines by all OR staff.

Observation

**OR.11 In the OR there is a policy for infectious diseases that include but not limited to: TB, HIV, Viral Hepatitis B & C.**

**Evidence of Compliance**

OR.11.EC1 Written policy and procedures on OR handling of infected patients (TB, HIV, Viral hepatitis).

Document Review





## Labour and Delivery

### Introduction

The quality and standard of obstetric care in hospitals is an important issue. It is important to address the fact that patient safety should not change based on hospital size. Deliveries should be conducted in a safe environment by qualified physicians, nurses and midwives who have been granted privileges to provide such services in accordance with the organization's license and scope of services.

This chapter addresses the following:

- Staff qualifications and plan
- Policies and procedures
- High risk patients
- Equipment and supplies
- Necessary medications



## Standards

**L&D.1 The department head of Obstetrics & Gynecology is a qualified physician.**

**Evidence of Compliance**

L&D.1.EC1 Obstetric and Gynecology head of department is a qualified physician (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**L&D.2 There is a qualified nurse with training in L&D in charge of the unit.**

**Evidence of Compliance**

L&D.2.EC1 Qualified and trained nurse in-charge of Labour and Delivery unit (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**L&D.3 The medical staff has a staffing plan based on patient volume and patient acuity.**

**Evidence of Compliance**

L&D.3.EC1 Availability of medical staffing plan for L&D unit based on patient volume and acuity. Document Review

**L&D.4 There is a nurse staffing plan that is based on patient volume and patient acuity.**

**Evidence of Compliance**

L&D.4.EC1 Availability of nursing staffing plan for L&D unit based on patient volume and acuity. Document Review

**L&D.5 There is written Admission and Discharge criteria.**

**Evidence of Compliance**

L&D.5.EC1 Written criteria for admission to and discharge from the L&D unit. Document Review

**L&D.6 The department head in collaboration with others as needed, writes all of the policies and procedures that include but are not limited to:**

- L&D.6.1 Ante partum hemorrhage.
- L&D.6.2 The use of Syntocinon.
- L&D.6.3 Caesarian section and repeated C-section.
- L&D.6.4 Emergency hysterectomy.
- L&D.6.5 Fetal distress.
- L&D.6.6 Sedation used.
- L&D.6.7 Spinal and epidural anesthesia.
- L&D.6.8 The use of CTG monitor.
- L&D.6.9 The use of episiotomy.

**Evidence of Compliance**

L&D.6.EC1 Comprehensive written multidisciplinary policy and procedures "antepartum hemorrhage, syntocin use, C section, primary and repeat, emergency hysterectomy, fetal distress, sedation, spinal and epidural anesthesia, use of CTG monitor use of episiotomy". Document Review

**L&D.7 The department head in collaboration with others as needed, writes all of the policies and procedures that are related to the clinical care of the unit that include but are not limited to:**

- L&D.7.1 The use of amniotomy.
- L&D.7.2 Vaginal examination.
- L&D.7.3 Call the Pediatrician to the Labour and Delivery area.



- L&D.7.4 Preeclampsia.
- L&D.7.5 Eclampsia
- L&D.7.6 Assist in delivery and use of suction machine or instrument.
- L&D.7.7 Multiple births.
- L&D.7.8 Abnormal presentation.
- L&D.7.9 Infection control

**Evidence of Compliance**

- L&D.7.EC1 Comprehensive written multidisciplinary policy and procedures " amniotomy, vaginal exam, summoning pediatrician to labor and delivery, pre eclampsia, assist of delivery with suction/instrument, multiple births, abnormal presentations infection control". Document Review

**L&D.8 There is evidence that there is continuous training with competency assessment (e.g. written test, return demonstration, etc.) for the following:**

- L&D.8.1 Neonatal assessment.
- L&D.8.2 Interpretation of CTG reading.
- L&D.8.3 Advanced medication administration, including syntocinon.
- L&D.8.4 Nursing management of delivery emergency situations.
- L&D.8.5 Infection control, including sharp disposal, discarding placenta, etc.
- L&D.8.6 CSSD policy.
- L&D.8.7 Maintain a sterile field for C-sections.
- L&D.8.8 Safety issues, including electrical.
- L&D.8.9 Use of equipment, including infant resuscitator.
- L&D.8.10 Care of eclampsia and pre-eclampsia patients.
- L&D.8.11 Positioning of the patient.
- L&D.8.12 Vaginal examination.
- L&D.8.13 Cord blood sampling.

**Evidence of Compliance**

- L&D.8.EC1 Comprehensive training of all L&D nurses "including neonatal and CTG assessments, administration of medications and syntocinon, nursing management emergency deliveries, infection control and sharp disposal, discarding placenta. CSSD policy, safety issues, electrical, eclampsia and pre eclampsia patients positioning of patient, vaginal exam, cord blood sampling". Personnel File
- L&D.8.EC2 Comprehensive competency assessment of all L&D nurses "return demonstration and tests". Personnel File

**L&D.9 Midwives are qualified by education and experience in L&D (registered nurses with experience in Midwifery).**

**Evidence of Compliance**

- L&D.9.EC1 Midwives are qualified, experience, and registered nurses (Licensed by the Saudi Council for certification of health care specialties). Personnel File

**L&D.10 Midwives are allowed to deal with only uncomplicated deliveries, and physician back up is immediately available.**

- L&D.10.1 There is a protocol that reflects the scope of practice for nurse midwives.

**Evidence of Compliance**

- L&D.10.EC1 Written protocol of scope of practice for nurse midwives conducting uncomplicated delivery. Document Review
- L&D.10.EC2 The Midwives are allowed to deal with only uncomplicated deliveries, and physician back up is immediately available. Interview



**L&D.11 Pediatrician coverage is readily available to attend to labour and delivery, and in the case of caesarian section, has to be physically present in the room.**

**Evidence of Compliance**

L&D.11.EC1 Availability of pediatricians during caesarian section deliveries.

Document Review

**L&D.12 The unit has the following necessary equipment:**

L&D.12.1 Crash cart fully stocked with emergency supplies and medications, defibrillator.

L&D.12.2 Monitor for vital signs, including pulse oximetry.

L&D.12.3 Infusion pump.

L&D.12.4 Glucometer

L&D.12.5 CTG monitor/CTG for twins.

L&D.12.6 Amniohook

L&D.12.7 Instruments for assisting delivery (forceps and Ventose).

L&D.12.8 Infant resuscitator

**Evidence of Compliance**

L&D.12.EC1 Availability of all L&D necessary equipment "vital signs monitor, pulse oximetry, infusion pump, glucometer, CTG monitor/CTg for twins, amnihook, assist delivery instruments , forceps and ventose, infant resuscitator".

Observation

L&D.12.EC2 Availability of crash cart fully stocked with emergency supplies and medications, defibrillator in the labor ward.

Observation

**L&D.13 The following medications are available:**

L&D.13.1 Syntocinon

L&D.13.2 Methergin

L&D.13.3 Magnesium Sulphate

L&D.13.4 Calcium gluconate

L&D.13.5 Ritodrin

L&D.13.6 Xylocaine

L&D.13.7 Hydralazin

L&D.13.8 Valium

L&D.13.9 Prostaglandin

L&D.13.10 Narcan

**Evidence of Compliance**

L&D.13.EC1 Available of all essential medications in L&D unit "syntocinon, methergin, magnesium sulphate, calcium gluconate, ritodrin, xylocaine, hydralazin, valium, prostoglandin, narcan".

Observation

**L&D.14 There is a qualified and competent nurse or midwife to receive the newborn who can perform the following:**

L&D.14.1 Suctioning of newborn.

L&D.14.2 Placing ID band with medical record number.

L&D.14.3 Perform APGAR score.

L&D.14.4 Obtain newborn footprint and mother's thumbprint.

**Evidence of Compliance**

L&D.14.EC1 Availability of qualified and competent nurse or midwife to receive the newborn "who can perform newborn suctioning, placing ID band on newborn with medical record number, assign APGAR score, obtain newborn footprint/mother thumbprint".

Personnel File

**L&D.15 A partogram is used for every patient who is in labour.**



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**Evidence of Compliance**

L&D.15.EC1 A partogram is used for every patient who is in labour.

Medical Record Review



## Haemodialysis

### Introduction

The standards in this chapter focus on a hospital-based dialysis unit. The dialysis unit must meet specified safety and quality standards as defined in this chapter.

This chapter addresses the following:

- Staff qualifications
- Policies and procedures
- Water management
- Infection control



## Standards

### HM.1 The department head is a qualified Nephrologist.

#### Evidence of Compliance

HM.1.EC1 Qualified nephrologist heads the hemodialysis unit (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### HM.2 A qualified registered nurse with training in Haemodialysis is the nurse manager.

#### Evidence of Compliance

HM.2.EC1 Qualified and trained registered nurse manages the hemodialysis unit (Licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### HM.3 All nursing staff are registered nurses, qualified by experience and education.

#### Evidence of Compliance

HM.3.EC1 All hemodialysis nurses are qualified and experienced registered nurses. Personnel File

### HM.4 All nurses working in Haemodialysis are certified in BCLS and preferably ACLS.

HM.4.1 There is a copy of certificate for BCLS and if obtained, ACLS in staff personal file.

#### Evidence of Compliance

HM.4.EC1 All hemodialysis nurses have valid BCLS . Personnel File

### HM.5 The nurses working in Haemodialysis receive continuous education and training with competency assessment (e.g. written test, return demonstration, etc.) in the following areas:

- HM.5.1 Care of patients with AV fistula/AV graft.
- HM.5.2 Dialysis procedures.
- HM.5.3 Care of tunneled/non-tunneled catheters.
- HM.5.4 Peritoneal dialysis.
- HM.5.5 Assessment of patient's volume status.
- HM.5.6 Management of anticoagulation.
- HM.5.7 Management of clotted access.
- HM.5.8 Hyperkalemia.

#### Evidence of Compliance

HM.5.EC1 Documented comprehensive training and education of all hemodialysis nurses (AV fistula/AV graft, dialysis procedures, tunneled, non tunneled catheters, peritoneal dialysis, patients volume status assessment, hyperkalemia, management of anticoagulation and clotted access) Personnel File

HM.5.EC2 Documented comprehensive competency assessment (written test, return of demonstration) of all hemodialysis nurses. Personnel File

### HM.6 There is written Admission and Discharge criteria.

#### Evidence of Compliance

HM.6.EC1 Written criteria for admission to and discharge from hemodialysis unit. Document Review

### HM.7 There are policies and procedures on the unit that include but not limited to maintaining, inspecting, and disinfecting equipment.



**Evidence of Compliance**

HM.7.EC1 Written policy and procedure on maintaining, inspecting, and disinfecting hemodialysis equipment. Document Review

**HM.8 Crash carts with defibrillators are in the vicinity.**

**Evidence of Compliance**

HM.8.EC1 Availability of fully equipped and accessible crash carts at the hemodialysis unit Observation

**HM.9 Water quality is checked according to a written policy with a charted standard of metal concentration. A complete chemical analysis is done on initial set up and at least once per year.**

**Evidence of Compliance**

HM.9.EC1 Written policy and procedures on hemodialysis water quality (including charted standard of metal concentration). Document Review

HM.9.EC2 Complete chemical analysis initially and annually thereafter. Document Review

**HM.10 Microbiology testing of the water is done monthly.**

HM.10.1 The microbiology test record is available in the unit.

**Evidence of Compliance**

HM.10.EC1 Monthly microbiologic testing of hemodialysis water available on the unit. Document Review

**HM.11 Infection control guidelines are followed closely to include:**

HM.11.1 Wearing of gloves, gowns and masks.

HM.11.2 Separating the machines used for blood-borne infectious diseases (such as hepatitis and HIV/AIDS patients).

HM.11.3 Proper disposal of needles and sharps.

HM.11.4 Cleaning up blood spills.

HM.11.5 Hand washing before and after contact with each patient.

HM.11.6 Disinfecting the BP cuff and the machine control panels after each use.

HM.11.7 The proper handling of supplies and equipment.

HM.11.8 Documented routine and yearly staff checkups for Hepatitis B, Hepatitis C, and HIV/AIDS status.

**Evidence of Compliance**

HM.11.EC1 Strict adherence to the infection control guidelines "PPE usage, needle and sharp disposal, separating machines used for blood borne infectious diseases , cleaning up blood spills". Observation

HM.11.EC2 Documented routine and yearly staff checkups for Hepatitis B, Hepatitis C, and HIV/AIDS status. Medical Record Review

**HM.12 All equipment and machines in the unit are regularly maintained with PPM schedule.**

**Evidence of Compliance**

HM.12.EC1 Documented scheduled preventive maintenance of all equipment and instruments (log book). Observation

HM.12.EC2 Performing periodic preventive maintenance of all equipment and instruments (PPM tag on the equipment). Document Review





## Emergency Room

### Introduction

To meet the needs of the patient population being served, the hospital has to handle emergency cases that require immediate examination and treatment. The hospital must provide emergency services by setting up an emergency room that is well staffed and equipped. The emergency room services should be organized to provide optimum care for patients in a safe, appropriate, efficient, effective, responsive and caring manner and, directed and coordinated in a collaborative manner.

A reliable and consistent triage system performed by qualified staff should be established and used to assess all patients on arrival. It is essential that the patient's problems are assessed and the appropriate treatment arranged taking into account the degree of urgency and clinical condition of the patient. For all patients, documentation should be detailed, accurate, professional and maintained.

This chapter addresses the following:

- Staff qualifications, plan and availability
- Equipment and supplies
- Triage
- Policies and procedures
- Patient assessment and care
- Medical records documentation



## Standards

**ER.1 The department head is a qualified Physician.**

### Evidence of Compliance

ER.1.EC1 Qualified physician heads the Emergency Room department (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**ER.2 A qualified emergency physician with an experience of at least (2) years is present at each shift.**

### Evidence of Compliance

ER.2.EC1 Availability of qualified and experienced (at least 2 years) emergency physician all the time (licensed by the Saudi Council for Certification of Health Care Specialties). Interview

**ER.3 All Emergency physicians are certified in Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and Neonatal Advanced Life Support (NALS).**

### Evidence of Compliance

ER.3.EC1 All emergency physicians have valid BCLS and ACLS certification. Personnel File

ER.3.EC2 All emergency physicians have valid ATLS certification according to the scope of services. Personnel File

ER.3.EC3 All emergency physicians have valid PALS and NALS certification according to the scope of services. Personnel File

**ER.4 The Nurse Manager of the Emergency Room (ER) is a registered nurse, qualified by experience and education.**

### Evidence of Compliance

ER.4.EC1 Qualified and experienced registered nurse manager (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**ER.5 All nursing staff working in emergency room is certified in BCLS and preferably ACLS, PALS & NRP.**

ER.5.1. There is a copy of certificates for BCLS and if obtained, ACLS, PALS & NRP in personnel file.

### Evidence of Compliance

ER.5.EC1 All emergency room nurses have valid BCLS. Personnel File

**ER.6 The unit has an established policy on how to triage patients and prioritize their needs.**

ER.6.1 There is a written policy addressing the patient triage.

### Evidence of Compliance

ER.6.EC1 Written policy and procedures on patient triage and prioritization. Document Review

**ER.7 The medical staff has a staffing plan based on patient volume and patient acuity.**

### Evidence of Compliance

ER.7.EC1 Availability of medical staffing plan for emergency department based on patient volume and acuity. Document Review

**ER.8 The nursing staff has a staffing plan based on patient volume and patient acuity.**



**Evidence of Compliance**

ER.8.EC1 Availability of nursing staffing plan for emergency department based on patient volume Document Review and acuity.

**ER.9 Both the department head and the nurse manager write the policies and procedures on how to provide the clinical care in the unit with collaboration with other department heads as appropriate. These policies include and are not limited to:**

- ER.9.1 Management of medico-legal cases like alcohol, narcotic abuse, sexual abuse, family and child abuse etc.
- ER.9.2 The management of trauma.
- ER.9.3 Patients who leave against medical advice.
- ER.9.4 Care of patients not competent to care for themselves.
- ER.9.5 Care of minors.
- ER.9.6 Patients who leave without being seen.
- ER.9.7 Protocols for some of the important and common emergencies; asthma, chest pain, coma, stroke, tetanus etc.

**Evidence of Compliance**

- ER.9.EC1 Written multi-disciplinary policy and procedures on management of medico-legal cases. Document Review
- ER.9.EC2 Written multi-disciplinary policy and procedures on management of trauma. Document Review
- ER.9.EC3 Written multi-disciplinary policy and procedures on care of minors and patients not competent to care for self. Document Review
- ER.9.EC4 Written multi-disciplinary policy and procedures on against medical advice (AMA) and patient who leave without being seen. Document Review
- ER.9.EC5 Written multi-disciplinary policy and procedures on management of important and common emergencies. Document Review

**ER.10 There is an emergency assessment sheet/form that is documented for every patient presenting for care in the emergency room and includes:**

- ER.10.1 Time of arrival and means of arrival.
- ER.10.2 Vital signs.
- ER.10.3 History of illness.
- ER.10.4 Allergies to medications, environment, foods.
- ER.10.5 Physical assessment/reassessment.
- ER.10.6 Suspected diagnosis.
- ER.10.7 Any investigations requested.
- ER.10.8 Treatment given.
- ER.10.9 Time of the consultation, per arrival of consulting service.
- ER.10.10 Time of admission to a unit and/or discharge from ER.
- ER.10.11 Documentation of patient condition at time of discharge or transfer to unit or other facility.

**Evidence of Compliance**

ER.10.EC2 Implementation (full documentation) of emergency assessment sheet/form with time of arrival, means of arrival, vital signs, history of illness,, allergies, physical assessment and reassessments, suspected diagnosis, investigations, treatments, time of consultation and arrival of consultation service, time of admission to a unit and/or discharge from ER and patient condition at time of discharge or transfer to unit other facility. Medical Record Review

**ER.11 At every visit of the patient his prior records are readily available to the emergency physician.**

**Evidence of Compliance**

ER.11.EC1 Availability of patient medical records to the ER physician at every visit. Observation

**ER.12 There is a system to obtain an emergency CAT scan for trauma cases within 30 minutes.**



**Evidence of Compliance**

ER.12.EC1 There is a system to obtain an emergency CAT scan for trauma cases within 30 minutes. Document Review

**ER.13 There is a system to provide the ER staff with the lab results within one hour for -urgent cases and within 30 minutes in critical cases.**

**Evidence of Compliance**

ER.13.EC1 ER staff are able to receive STAT lab results within 30 minutes for critical cases. Document Review  
ER.13.EC2 ER staff are able to receive Lab results within one hour for urgent cases. Document Review

**ER.14 There is an established policy on how to call consultants for opinions.**

**Evidence of Compliance**

ER.14.EC1 Written policy on calling consultants for opinions in ER. Document Review

**ER.15 On call rotas for all specialties are available and posted in the Emergency room.**

**Evidence of Compliance**

ER.15.EC1 Written ER on-call schedule is available and posted. Observation

**ER.16 The specialists respond to calls within 30 minutes.**

**Evidence of Compliance**

ER.16.EC1 Specialist responds to emergency room calls within 30 minutes. Document Review

**ER.17 Resuscitation / trauma rooms have adequate space to perform resuscitation.**

**Evidence of Compliance**

ER.17.EC1 Availability of adequate space for resuscitation/trauma rooms. Observation

**ER.18 The Emergency room has the following necessary equipment:**

- ER.18.1 Crash cart.
- ER.18.2 ECG machine
- ER.18.3 Monitor.
- ER.18.4 Defibrillator.
- ER.18.5 Pulse Oximetry.
- ER.18.6 Surgical instruments.
- ER.18.7 Chest tubes of different sizes.
- ER.18.8 Intubation equipment (Adult).
- ER.18.9 Intubation equipment for (children).
- ER.18.10 All emergency drugs (e.g. valium, morphine, etc).

**Evidence of Compliance**

ER.18.EC1 Availability of all essential emergency room equipments (crash cart with defibrillator, and emergency drugs, pulse oximetry, intubation equipment and chest tubing). Observation

**ER.19 The emergency room has the following necessary equipment but not limited to:**

- ER.19.1 Portable X-ray machine.



- ER.19.2 Abdominal lavage set.
- ER.19.3 Infusion pumps.
- ER.19.4 Thrombolytic therapy.
- ER.19.5 Wall Oxygen or cylinder.
- ER.19.6 Wall suction or suction machine.
- ER.19.7 Immobilization device: hard board, C-Spine collars, etc.
- ER.19.8 Poison antidote.
- ER.19.9 Delivery set.
- ER.19.10 Set for IV Axes including cut down set and intraosseous needles.

**Evidence of Compliance**

- ER.19.EC1 Availability of all essential emergency room equipment (portable x-ray, abdominal lavage set, infusion pumps, oxygen, suction, immobilization device, delivery set, IV access set, poison antidotes and thrombolytics). Observation

**ER.20 There is at least one ER physician physically present in the ER 24 hours/day.**

**Evidence of Compliance**

- ER.20.EC1 Availability of emergency physician in-house 24-hours daily (schedule). Document Review

**ER.21 All X-rays ordered are read within 24 hours by the Radiologist.**

**Evidence of Compliance**

- ER.21.EC1 All emergency room x-rays are read within 24 hours. Medical Record Review

**ER.22 All ECGs ordered are read by the Cardiologist (or Internist) within 24 hours.**

**Evidence of Compliance**

- ER.22.EC1 Reading all ECGs ordered by cardiologist (or internist) within 24 hours. Medical Record Review

**ER.23 There is a written policy by health care professions to identify the various roles of the health care team in regards on how to transfer patients in case the hospital cannot adequately provide the care needed.**

- ER.23.1 There is a written policy for patient transfers out of the emergency room.

**Evidence of Compliance**

- ER.23.EC1 Written policy on patients transfer to another hospital when the required care is not available. Document Review

**ER.24 Medical bags in the ER Department are updated and checked daily, and after each use (the medical bags contain all of the essential medications).**

**Evidence of Compliance**

- ER.24.EC1 Regular check of readiness of ER medical bags (at least daily and after each use). Observation

**ER.25 Ambulances are checked daily and are equipped with the following:**

- ER.25.1 Oxygen supply.
- ER.25.2 Intubation set.
- ER.25.3 C-spine cuff.
- ER.25.4 Spinal board.
- ER.25.5 Suction equipment.



**Evidence of Compliance**

ER.25.EC1 Daily check of essential ambulance equipment including oxygen, intubation set, C-spine cuff, spinal board, and suction machine (log book). Observation



## Radiology

### Introduction

The assessment/reassessment of patients to determine the proper diagnosis, the course of treatment, and evaluation of treatment plan for future decisions may require radiology services. To meet the patient needs, the hospital should offer radiology services required by its patient population, clinical services offered, and healthcare provider needs. The department from a building perspective is expected to meet the necessary national guidelines on radiation safety.

This chapter addresses the following:

- Staffing
- Policies and procedures
- Safety program
- Interventional procedures
- Results reporting (including panic findings)



## Standards

**RD.1 The department head is a radiologist physician.**

### Evidence of Compliance

RD.1.EC1 Qualified radiology physician heads the Radiology department (licensed by the Saudi Council for Health Specialties). Personnel File

**RD.2 There are written policies and procedures related to the work in the department.**

### Evidence of Compliance

RD.2.EC1 Written policies and procedures on all available radiology services. Document Review

**RD.3 There are written protocols for the following procedures:**

- RD.3.1. Angiogram.
- RD.3.2. Cat Scan.
- RD.3.3. MRI.
- RD.3.4. Interventional procedure.
- RD.3.5. Fluoroscopy.
- RD.3.6. Contrast agent reaction.

### Evidence of Compliance

RD.3.EC1 Availability of written protocol for radiological studies according to scope of service (angiogram, cat scan, MRI, interventional procedure, fluoroscopy, contrast agent reaction). Document Review

**RD.4 Physicians requesting the x-ray procedures write all the necessary information on the X ray request form.**

### Evidence of Compliance

RD.4.EC1 All necessary information is written on the x-ray request by the requesting physician. Observation

**RD.5 The radiological studies are reported by the radiologist within 24 hours.**

### Evidence of Compliance

RD.5.EC1 There is reporting of all radiologic studies within 24 hours by the radiologist. Medical Record Review

**RD.6 There is a master X-ray jacket or an access to all achieve previous radiological studies for every patient for the Radiologist every time he reports a new study.**

### Evidence of Compliance

RD.6.EC1 All archived radiology studies in master x-ray jacket of a patient are accessible to the radiologist at the time of reporting any new study. Observation

**RD.7 There is 24-hour coverage by a radiologist and a technologist.**

### Evidence of Compliance

RD.7.EC1 Availability of radiologist 24 hours daily (schedule). Document Review  
RD.7.EC2 Availability of radiology technician 24 hours daily (schedule). Document Review

**RD.8 All ultrasound examinations are read by a radiologist.**





**Evidence of Compliance**

RD.8.EC1 The radiologist reads and reports all ultrasound studies.

Medical Record Review

**RD.9 A crash cart is available in the vicinity.**

**Evidence of Compliance**

RD.9.EC1 Availability of fully equipped and accessible crash cart in the vicinity.

Observation

**RD.10 All radiologists' clinical privileges to do all x-ray procedures are checked through the Credentialing and Privileging committee.**

**Evidence of Compliance**

RD.10.EC1 There is credentialing and privileging all radiologists, each for the radiologic procedures assigned).

Personnel File

**RD.11 There is a radiation safety protocol or plan in place that includes the following:**

RD.11.1 All equipment is inspected and checked regularly with the experienced Safety Officer.

RD.11.2 All radioactive material is used according to the guidelines and the Safety Officer oversees the activity in the unit.

RD.11.3 Safety warnings are posted on the doors.

RD.11.4 Women are checked for the possibility of being pregnant prior to having X-ray tests and the X-ray form demands that the physicians check this point.

RD.11.5 Personnel are monitored for radiation exposure.

**Evidence of Compliance**

RD.11.EC1 Written comprehensive radiation safety protocol or plan in place (equipment checked and inspected by safety officer, radioactive material used by guidelines with safety officer oversight, safety warnings posted on doors, women screened for pregnancy prior to x-ray).

Document Review

RD.11.EC2 Implementation of the radiation safety protocol or plan.

Observation

RD.11.EC3 There is monitoring of personnel exposure to radiation.

Document Review

**RD.12 There is a protocol that all patients going for any interventional procedure have:**

RD.12.1. The physician explains the risks and the benefits of the procedure to the patient.

RD.12.2. The consent form is signed by the patient.

RD.12.3. The patient's coagulation parameters are checked: e.g. PT, PTT, platelets.

RD.12.4. Any history of previous allergic reactions are included as part of the history.

RD.12.5. The physician write the request for the procedure with details about the chief history and point out the reason why the procedure is needed.

**Evidence of Compliance**

RD.12.EC1 Written comprehensive protocol for any interventional procedure (informed consent with explanation of risks and benefits, coagulation checks, allergy history, justification for the procedure by the physician).

Document Review

**RD.13 The Radiologist consulted to do any interventional procedure documents all the details in the patient file before and after the procedure and informs the patient about the potential benefits and risks of the procedure.**

**Evidence of Compliance**

RD.13.EC1 There is medical record documentation of the detailed pre and post interventional procedure by the radiologist.

Medical Record Review

RD.13.EC2 There is medical record documentation that the patient informed about the potential benefits and risks of the procedure.

Medical Record Review



**RD.14 Any new interventional procedure to be performed by the Radiologist is reviewed and approved by the Credentialing and Privileging committee.**

**Evidence of Compliance**

RD.14.EC1 There is credentialing and privileging of radiologist for every new interventional procedure.

Personnel File

**RD.15 The radiologist routinely reports films on weekends and on holidays.**

**Evidence of Compliance**

RD.15.EC1 There is routine reporting of radiology studies during weekend and holidays

Interview

**RD.16 There is a policy that "panic" findings on the X ray films are reported immediately to the specialty requesting the examination: e.g. air under the diaphragm.**

**Evidence of Compliance**

RD.16.EC1 Written policy for immediate reporting of "panic findings" to requesting team.

Document Review

RD.16.EC2 Implementation of panic finding policy.

Interview



## Burn Care

### Introduction

Burn care is a high risk service that requires adherence to certain requirements to be safe, efficient, and effective. When the hospital provides burn care, the unit should be staffed with qualified individuals. Additionally, policies and procedures should guide staff for appropriate burn care.

This chapter addresses the following:

- Staff qualifications and plans
- Admission and discharge criteria
- Policies and procedures
- Collaboration with different disciplines
- Infection control



## Standards

### BC.1 The department head is a plastic Surgeon.

#### Evidence of Compliance

BC.1.EC1 Qualified plastic surgeon is in charge of the burn unit (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### BC.2 The nurse manager is a qualified registered nurse with training in Burn Care.

#### Evidence of Compliance

BC.2.EC1 Qualified registered nurse with training in burn care manages burn unit nursing services (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### BC.3 There are written admission and discharge criteria.

#### Evidence of Compliance

BC.3.EC1 Written admission and discharge criteria to burn unit. Document Review

### BC.4 The staff on the unit are qualified and experienced in burn care.

#### Evidence of Compliance

BC.4.EC1 Qualified and experienced nursing and medical staff to work in burn care(licensed by the Saudi council for Certification of Health Care Specialties). Personnel File

### BC.5 Social and Rehabilitation services provide support to the unit.

#### Evidence of Compliance

BC.5.EC1 Social service support to burn unit (sample medical records). Medical Record Review

BC.5.EC2 Rehabilitation services support the burn unit (sample medical records). Medical Record Review

### BC.6 The medical staffing plan is based on patient volume and patient acuity.

#### Evidence of Compliance

BC.6.EC1 The medical staffing plan for Burn Unit is based on patient volume and patient acuity. Document Review

### BC.7 The nurse staffing plan is based on patient volume and patient acuity.

#### Evidence of Compliance

BC.7.EC1 The nursing staffing plan for Burn Unit is based on patient volume and patient acuity. Document Review

### BC.8 Physicians in the unit are BCLS certified.

#### Evidence of Compliance

BC.8.EC1 All Burn Unit physicians have valid BCLS certification. Personnel File

### BC.9 All nursing staff is certified in BCLS and ACLS.

#### Evidence of Compliance



BC.9.EC1 All Burn Unit nursing staff have valid BCLS and ACLS certification.

Personnel File

**BC.10 All nursing staff working in Burn Care is certified in BCLS and preferably ACLS, PALS & NRP.**

BC.10.1 There is a copy of certificates for BCLS and if obtained, ACLS, PALS & NRP in personnel file.

**Evidence of Compliance**

BC.10.EC1 All nursing staff working in Burn Care are certified in BCLS and preferably ACLS, PALS & NRP.

Personnel File

**BC.11 There is a 24-hour coverage by a physician.**

**Evidence of Compliance**

BC.11.EC1 24-hour coverage by physicians.

Document Review

**BC.12 There are policies and procedures that guide the care in the Burn unit.**

**Evidence of Compliance**

BC.12.EC1 Written policies and procedures to guide care in the Burn Unit.

Document Review

**BC.13 The following protocols are available on how to treat and manage:**

BC.13.1 Inhalation injury.

BC.13.2 Varying degrees of burns.

BC.13.3 Infection.

**Evidence of Compliance**

BC.13.EC1 Written protocols on management and treatment of inhalation injury, varying degrees of burns and infection.

Document Review

**BC.14 There are policies and procedures in place with strict infection control guidelines that are enforced by all staff that includes but is not limited to:**

BC.14.1 Separation of cases.

BC.14.2 Use of masks, gowns and gloves, by the staffs.

BC.14.3 Cleaning and disinfecting all equipment and tools.

BC.14.4 Visitor restrictions.

BC.14.5 Aseptic dressing change.

BC.14.6 Pre & post skin graft care.

BC.14.7 Transport of patient in and out of the unit.

BC.14.8 Burn bath management.

**Evidence of Compliance**

BC.14.EC1 Written policy & procedures for strict infection control guidelines (PPE, separation of cases, cleaning and disinfecting equipment, aseptic dressing changes, pre/post skin graft care, transport of patients, burn baths, and visitor restriction).

Document Review

**BC.15 The unit is under positive pressure with HEPA filters.**

**Evidence of Compliance**

BC.15.EC1 Evidence of positive pressure with HEPA filters in the Burn Unit.

Observation



**BC.16 A crash cart is located in the vicinity.**

**Evidence of Compliance**

BC.16.EC1 Availability of fully equipped and accessible crash cart in the vicinity.

Observation

**BC.17 Nurses working in Burn Care Unit check the crash cart and document.**

BC.17.1 Crash cart with defibrillator is available in the Burn care unit.

**Evidence of Compliance**

BC.17.EC1 Regular inspection of the crash cart with defibrillator in Burn Care Unit (Log sheet).

Observation

**BC.18 There are written policies on the use of skin or synthetic grafts.**

**Evidence of Compliance**

BC.18.EC1 Written policies on the use of skin graft and synthetic graft.

Document Review



## Medical & Radiation Oncology

### Introduction

Medical and radiation oncology is a high risk service that requires adherence to certain requirements to be safe, efficient, and effective. When the hospital provides medical and radiation oncology, the unit should be staffed with qualified individuals. Additionally, policies and procedures should guide staff for appropriate medical and radiation oncology care.

This chapter addresses the following:

- Staff qualifications
- Safety plan
- Admission and discharge criteria
- Policies and procedures



## Standards

### MRO.1 The department head is an Oncologist.

#### Evidence of Compliance

MRO.1.EC1 Qualified oncologist heads of the department (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### MRO.2 The nurse manager is a registered nurse with training in Oncology.

#### Evidence of Compliance

MRO.2.EC1 Qualified, trained and registered nurse manages oncology nursing (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

### MRO.3 Staff that work in the department are professionally trained in their fields.

#### Evidence of Compliance

MRO.3.EC1 Medical and Radiation Oncology trained staff. Personnel File

### MRO.4 The Radiation oncology unit is staffed with the following appropriate personnel:

- MRO.4.1 Medical Physicist.
- MRO.4.2 Dosimeters.
- MRO.4.3 Radiation therapist.
- MRO.4.4 Mould room technician.
- MRO.4.5 Radiation officer.

#### Evidence of Compliance

MRO.4.EC1 Radiation Oncology organization chart is complete (medical physicist, dosimeters, radiation therapist, radiation officer, and mould room technician). Document Review

### MRO.5 The Radiation Oncology unit has a written safety plan which includes:

- MRO.5.1 Periodic inspection, maintenance and calibration of the linear accelerator and other radiation equipment.
- MRO.5.2 Guidelines on how to inspect and monitor the medical equipment.
- MRO.5.3 Management of nuclear material used for therapeutic and diagnostic purposes, especially in regard to its handling, storing, and transportation.
- MRO.5.4 Monitoring of the treatment with I131 for radiation exposure in the vicinity.

#### Evidence of Compliance

MRO.5.EC1 Written comprehensive safety plan (Periodic inspection, maintenance and calibration of the linear accelerator and other radiation equipment; Guidelines on how to inspect and monitor the medical equipment; Management of nuclear material used for therapeutic and diagnostic purposes, especially in regard to its handling, storing, and transportation; Monitoring of the treatment with I131 for radiation exposure in the vicinity). Document Review

### MRO.6 There are nursing policies and procedures that guide the care of Oncology patients that includes the following but is not limited to:

- MRO.6.1 Chemotherapy medications, administration, side effects, teaching, safety precautions.
- MRO.6.2 Radiation therapy and safety precautions.

#### Evidence of Compliance

MRO.6.EC1 Written Nursing policy and procedures for Chemotherapy medications, administration, side effects, teaching, safety precautions. Document Review





MRO.6.EC2 Written Nursing policy and procedures for radiation therapy and safety precautions. Document Review

**MRO.7 Nurses working in the Medical and Radiation Oncology unit receive continuous education and training with competency assessment (e.g. written test, return demonstration, etc.) that include but are not limited to:**

MRO.7.1 Central line management.

MRO.7.2 Venous Access Device (VAD or Portacath) management.

MRO.7.3 Tracheostomy care and management.

MRO.7.4 Chest tube management.

MRO.7.5 Advanced medication administration, including inotropes, chemotherapy.

MRO.7.6 Line management, including extravasations.

MRO.7.7 Infection control, including hazardous material and blood spill.

**Evidence of Compliance**

MRO.7.EC1 There is nursing continuing education and training (including Central line management; Venous Access Device management; Tracheostomy care and management; Chest tube management, Advanced medication administration, including inotropes, chemotherapy; Line management, including extravasations; Infection control, including hazardous material and blood spill). Document Review

MRO.7.EC2 There is nursing competency assessment on Medical and Radiation Oncology. Personnel File

**MRO.8 There is written criteria for patient admission to, and discharge from an oncology unit prepared jointly by the medical and nursing staff.**

**Evidence of Compliance**

MRO.8.EC1 There is admission and discharge criteria written collaboratively by the medical and nursing staff. Document Review

**MRO.9 A copy of radiation manual therapy is available to staff**

**Evidence of Compliance**

MRO.9.EC1 Availability of Radiation therapy manual to staff. Observation

MRO.9.EC2 Staff awareness of Radiation therapy manual. Interview

**MRO.10 A multidisciplinary committee, including the nurse manager for the unit and nursing educator, oversees and guides the ongoing administrative and clinical functions of the area.**

MRO.10.1 The committee meets at least four times a year.

MRO.10.2 The committee assists in developing, reviewing, and revising policies and procedures for the provision of patient care.

MRO.10.3 The committee ensures enforcement of these policies.

MRO.10.4 The committee chairperson or oncologist director of this committee signs off, in addition to nursing, on any policies and/or procedures that have any direct or indirect involvement of physician role.

**Evidence of Compliance**

MRO.10.EC1 Active Medical radiation and oncology multidisciplinary committee oversees and guides the administrative and clinical functions of the area (Meets no less than 4 times/year, assists in policy development and enforcement; committee chairman or oncology director approves physician related policies). Document Review

**MRO.11 A crash cart is available in the vicinity.**

**Evidence of Compliance**

MRO.11.EC1 Availability of fully equipped and accessible crash cart in the vicinity. Observation



## Psychiatry

### Introduction

Psychiatric patients have unique needs and care. Such service requires adherence to certain requirements to be safe, efficient, and effective. When the hospital provides psychiatric care, the unit should be staffed with qualified individuals. Additionally, policies and procedures should guide staff for appropriate psychiatric care.

This chapter addresses the following:

- Staff qualifications
- Admission and discharge criteria
- Restraints and seclusion
- Policies and procedures



## Standards

### PS.1 The department head is a specialist Psychiatrist.

#### Evidence of Compliance

PS.1.EC1 Qualifications, training and experience of the department head (licensed by the Saudi Council Health Specialties). Personnel File

### PS.2 The nurse manager is a registered nurse with training in Psychiatry.

#### Evidence of Compliance

PS.2.EC1 Qualification, training and experience of the nurse manager in Psychiatry (licensed by the Saudi Council for Health Specialties). Personnel File

### PS.3 There is written Admission and Discharge criteria.

#### Evidence of Compliance

PS.3.EC1 Written admission and discharge criteria for the psychiatric ward Document Review

### PS.4 There are policies and procedures that guide the care in the unit and includes the following but is not limited to:

- PS.4.1 Use of patient restraints.
- PS.4.2 Use of sedation.
- PS.4.3 Management and care of violent patients.
- PS.4.4 Management of patients with depression.
- PS.4.5 Management of suicidal patients.
- PS.4.6 Risk assessment for suicidal patients.
- PS.4.7 Environmental assessment for suicidal patients.
- PS.4.8 Management of patients with psychosis (thought disorders).
- PS.4.9 Use of safe seclusion.
- PS.4.10 Guidelines for the use of ECT.

#### Evidence of Compliance

PS.4.EC1 Written policy and procedures (including use of restraints, sedation, seclusion, and ECT, risk and environmental assessment of suicidal patients). Document Review

PS.4.EC2 Written policy and procedures to address management and care of violent, depressed, suicidal, and psychotic patients. Document Review

PS.4.EC3 The staff are aware of the appropriate care provided for psychiatric patients Interview

### PS.5 Nurses working in the Psychiatry unit receive continuous education and training with competency assessment (e.g. written test, return demonstration, etc.) that include but are not limited to:

- PS.5.1 Assessment of psychiatric patients.
- PS.5.2 Management of the violent patient including use of restraints.
- PS.5.3 Management of patients with depression.
- PS.5.4 Management of suicidal patients.
- PS.5.5 Management of patients with psychosis (thought disorders).
- PS.5.6 Risk assessment for suicidal patients and their environment.

#### Evidence of Compliance

PS.5.EC1 There is continuous education and training of psychiatry nurses (assessment and management of psychiatric, depressed, suicidal, psychosis patients and violent patients), risk assessment of patients and environment). Personnel File

PS.5.EC2 There is competency assessment of psychiatry nurses. Personnel File



**PS.6 Restraint orders are written by a physician, who assesses the need for restraints, the type of restraints, and the length of time the restraints will be used.**

**Evidence of Compliance**

PS.6.EC1 There is written comprehensive medical order for patient restraint (need assessment, Medical Record Review restrain type, duration and length of time restraints used are specified).

**PS.7 All staff who restrain patients are trained and competent. Restraining is done in a professional manner. This standard includes but is not limited to the following processes:**

PS.7.1 Proper application of restraints.

PS.7.2 Documented assessment /reassessment of patients during restraint usage (prior to restraints and ongoing until removed).

PS.7.3 Assessments on a frequent basis (at least every hour) with circulation checks to any limb restrained and patient's response documented in the medical record.

PS.7.4 Appropriate interventions when the patient's circulation is being impaired.

PS.7.5 Appropriate interventions for side effects related to major tranquilizers (Haldol, Thorazine, etc).

PS.7.6 Patients are monitored during the period he/she is restrained.

PS.7.7 Physician assessment and reassessment of patients as appropriate.

PS.7.8 The least restrictive and most effective means of restraint is used.

PS.8.9 Patient's dignity and rights are protected that includes but is not limited to, covering patient when attending to patients physical needs.

PS.7.10 An alarm's system is available in the room and at nursing station for immediate help and/or assistance.

PS.7.11 The above is documented in patient's file.

**Evidence of Compliance**

PS.7.EC1 Training and competency of staff who restrain patients.

Document Review

PS.7.EC2 There is appropriate restraint application, assessment and timely reassessment (at least every hour).

Medical Record Review

PS.7.EC3 There is appropriate interventions (impaired circulation, adverse reactions to major tranquilizers).

Medical Record Review

PS.7.EC4 Patients' dignity and rights are protected (when restrained).

Observation

PS.7.EC5 An alarm system is available in the room and at nursing station for immediate help and/or assistance.

Observation

**PS.8 Seclusion areas are well lit and protected for patient and staff safety.**

**Evidence of Compliance**

PS.8.EC1 Well lit and protected seclusion area.

Observation

**PS.9 The physical layout of the unit allows for:**

PS.9.1 Quiet and separate counseling of patients and families.

PS.9.2 Access only by authorized staff.

PS.9.3 Quick assistance from security.

PS.9.4 Seclusion rooms made with special safety features.

PS.9.5 A means to separate adults from pediatrics.

**Evidence of Compliance**

PS.9.EC1 Psychiatry unit is safe and secure (limited access, security support, safe seclusion).

Observation

PS.9.EC2 Privacy for patients and family counseling.

Observation

PS.9.EC3 Availability of separate areas for adults and pediatrics.

Observation

**PS.10 Plan of patient care is outlined and documented in the medical record.**



**Evidence of Compliance**

PS.10.EC1 Medical Record documentation of plan of patient care.

Medical Record Review

**PS.11 A Crash cart is available in the vicinity.**

**Evidence of Compliance**

PS.11.EC1 Availability of well equipped crash cart in the vicinity.

Observation



## Specialized Areas: Respiratory Services, Dietary Service, Social Workers, Rehabilitation Service

### Introduction

Hospitals vary in size and services provided according to the population served. However, the following services are required to be provided in a hospital setting in coordination and integration with other services.

### Specialized Services

- Respiratory Services
- Dietary Service
- Social Workers
- Rehabilitation Service



## Respiratory Services Standards

### RS.1 The hospital has a Respiratory Therapy unit, with 24-hour coverage.

#### Evidence of Compliance

RS.1.EC1 Availability of respiratory therapy services.

Observation

RS.1.EC2 There is 24-hour coverage.

Document Review

### RS.2 A qualified Pulmonologist/ Internist or an Anesthetist is the department head.

#### Evidence of Compliance

RS.2.EC1 Qualified Pulmonologist/ Internist or an Anesthetist head of Respiratory Therapy unit (licensed by the Saudi Council for Health Specialties). Personnel File

### RS.3 Policy and procedures guide the work in the unit and includes but is not limited to:

RS.3.1 Use of equipment.

RS.3.2 Pulmonary function test.

RS.3.3 Coughing and breathing exercise.

RS.3.4 Obtaining arterial blood gasses.

RS.3.5 Mechanical ventilator support.

RS.3.6 Dealing with open T.B. cases.

#### Evidence of Compliance

RS.3.EC1 Written policy and procedures (including equipment use, PFT, ABG, mechanical ventilation, pulmonary exercise, and dealing with open TB). Document Review

### RS.4 Personnel in the unit are trained professionals in this field.

#### Evidence of Compliance

RS.4.EC1 Qualification, training and experience of Respiratory Therapy staff (licensed by the Saudi Council for Health Specialties). Personnel File

### RS.5 There is education and training with competency assessment (e.g. written test, return demonstration, etc.) that includes:

RS.5.1 Obtaining (ABG's) Arterial Blood Gases.

RS.5.2 Using pulse oximeter.

RS.5.3 Using humidifiers.

RS.5.4 Performing pulmonary function tests.

RS.5.5 Performing mechanical ventilator checks.

RS.5.6 Performing pulmonary toilet.

RS.5.7 Performing airway maintenance.

RS.5.8 Knowledge and application of infection control policies.

RS.5.9 Performing equipment maintenance and safety.

RS.5.10 Performing emergency airway interventions.

#### Evidence of Compliance

RS.5.EC1 Availability of well structured education and training program for respiratory therapists. Document Review

RS.5.EC2 There is staff competency assessment (including ABGs, pulse oximetry, humidifiers, PFT, mechanical ventilation, pulmonary toilet, airway maintenance, infection control) Personnel File

RS.5.EC3 There is staff knowledge of equipment maintenance and safety. Interview



**RS.6 Respiratory services are carried out on the order of physicians who indicate the dose, frequency, and route and the patient's response to treatment is documented in the patient's record.**

**Evidence of Compliance**

RS.6.EC1 Written physician order for respiratory therapy (including dose, frequency and route). Medical Record Review

RS.6.EC2 There is monitoring of patient's clinical response to treatment. Medical Record Review

**RS.7 There is regular calibration of respiratory equipment.**

**Evidence of Compliance**

RS.7.EC1 There is periodic calibration of all respiratory equipment. Observation

**RS.8 All staff are BCLS certified.**

**Evidence of Compliance**

RS.8.EC1 All respiratory service staff have valid BCLS certificates. Personnel File





## Dietary Services Standards

### DT.1 There is a qualified (BS Nutrition) dietitian supervising the aspect of dietary service.

- DT.1.1 Patients interviewing/visiting.
- DT.1.2 Nutritional screening.
- DT.1.3 Nutritional assessment and reassessment.
- DT.1.4 Developing nutritional care plan.
- DT.1.5 Highlight "food-drug interaction" to physicians and document this in the medical record.
- DT.1.6 Making recommendations related to patient dietary needs.
- DT.1.7 Follow-up with patient care team when an abnormality is recognized during screening.
- DT.1.8 NPO monitoring.
- DT.1.9 Education (patients/families/other members of the health care team).
- DT.1.10 Participating in development of and enforcing policies and procedures.
- DT.1.11 Developing menus.
- DT.1.12 Evaluating and documenting patient's dietary intake when on specific diets.

#### Evidence of Compliance

- DT.1.EC1 Comprehensive job description of dietary supervisor. Personnel File
- DT.1.EC2 Qualified, trained and experienced dietitian supervisor (licensed by the Saudi Council for Health Specialties). Personnel File

### DT.2 The job description for dietitian includes but is not limited to:

- DT.2.1 Approval of all menus including any modified diets.
- DT.2.2 Interviewing and visiting patients.
- DT.2.3 Performing nutritional assessment and reassessments of patients as needed.
- DT.2.4 Developing a nutritional care plan.
- DT.2.5 Evaluating and document patient's caloric intake when on specific diets.
- DT.2.6 Educating other health staff, patients and families.
- DT.2.7 Reviewing, and updating the dietary manual.

#### Evidence of Compliance

- DT.2.EC1 Comprehensive job description of dietitian (including menu approval, patient interviews, nutritional assessment & reassessment, developing care plan, evaluation of caloric intake, staff & patient education, updating dietary manual). Personnel File

### DT.3 All patients at nutrition risk receive a dietitian's assessment within twenty four hours (24 hr), which include.

- DT.3.1 For All patients with ordered therapeutic diets, a documented dietitian's assessment is done within 48 hours of order, which includes:
  - DT.3.1.1 Nutrition status, using:
    - DT.3.1.1.1 Height and weight chart for children.
    - DT.3.1.1.2 BMI for adults.
  - DT.3.1.2 Eating habits.
  - DT.3.1.3 Food allergies.
  - DT.3.1.4 Need for therapeutic diet.
  - DT.3.1.5 Physical difficulties with eating and drinking.
  - DT.3.1.6 Need for equipment to assist eating and drinking.

#### Evidence of Compliance

- DT.3.EC1 Comprehensive nutritional assessment within 24 hours for all patients at nutrition risk. Medical Record Review



**DT.4 The dietitian in collaboration with other health care professionals, develops a suitable nutritional plan of care for the patient which includes but is not limited to:**

- DT.4.1 Monitoring the patient's response to the therapeutic diet.
- DT.4.2 Making adjustments in the plan of therapeutic diet as needed.
- DT.4.3 Documenting the patient's response to the plan to therapeutic diet in the medical record.

**Evidence of Compliance**

- DT.4.EC1 Comprehensive nutritional plan of care (including therapeutic monitoring, nutritional adjustment, and documentation of clinical response). Medical Record Review

**DT.5 The hospital has a dietary manual written by the dietitian and appropriate staff and contains the following information and reviewed every two (2) years:**

- DT.5.1 Different types of diets used in the hospital.
- DT.5.2 Nutritional supplements used and how to use them.
- DT.5.3 Appropriate storage method for snacks and beverages
- DT.5.4 Working hours of the kitchen and mealtimes.
- DT.5.5 Food preparation, handling, storage, and distribution are safe and comply with laws, regulations, and current acceptable practices.

**Evidence of Compliance**

- DT.5.EC1 Availability of updated and comprehensive dietary manual (including types of diets and supplements, appropriate storage and use, kitchen working hours and mealtimes). Document Review
- DT.5.EC2 There is staff compliance with the dietary manual guidelines. Observation

**DT.6 Physicians are responsible for ordering therapeutic hospital and discharge diets based on diets listed in the therapeutic dietary manual.**

- DT.6.1 The calories needed.
- DT.6.2 Any restrictions.
- DT.6.3 The route.
- DT.6.4 The frequency of the meals or the feed.

**Evidence of Compliance**

- DT.6.EC1 There is physician ordering of therapeutic hospital diets. Medical Record Review
- DT.6.EC2 There is physician ordering of therapeutic discharge diets. Medical Record Review

**DT.7 Discharge teaching is provided by dietitians for all patients/families, and cultural preferences are incorporated into the plan, which is based on patient's medical status and ability to eat. This is documented in the patient record as a part of multidis**

- DT.7.1 Providing patient and/or family education on therapeutic diets.
- DT.7.2 Documenting the patient's response to education in the patient's medical record.

**Evidence of Compliance**

- DT.7.EC1 There is a patient response to education on therapeutic diets. Medical Record Review
- DT.7.EC2 Dietitians participate in the discharge process (including cultural issues, mental status and ability to eat). Medical Record Review



## Social Workers Standards

### SC.1 The hospital has a Social Work unit.

- SC.1.1 The unit is well staffed according to the hospitals size and complexity of care provided.
- SC.1.2 The unit is well equipped with necessary equipment like computers, printer telephones.
- SC.1.3 The unit has enough space according to the needs of the staff.
- SC.1.4 Social Workers are available during day and evening to patients and patients' families.
- SC.1.5 Social workers comply with the hospital's patient safety and infection control standards.
- SC.1.6 Education programs for social work department/service personnel are based, at least in a part, on the findings from

#### Evidence of Compliance

- SC.1.EC1 Availability of social work unit (space, layout, equipment). Observation
- SC.1.EC2 Adequate number of social work staff (organizational chart). Document Review
- SC.1.EC3 There is staff compliance with patient safety and infection control guidelines. Interview

### SC.2 Social worker service is directed and staffed by licensed, experienced and qualified individuals.

- SC.2.1 Head of department has to be qualified with experience not less than 3 years as a social worker.
- SC.2.2 He/she is skilled in the approaching, analyzing and recording the case.
- SC.2.3 Social skills depends on educational, social programs (communication skills, ` - Body language, decision maker, etc.)

#### Evidence of Compliance

- SC.2.EC1 Qualified, trained and experienced social worker director (licensed by the Saudi Council for Health Specialties). Personnel File
- SC.2.EC2 All social worker staff are qualified, trained and experienced (licensed by the Saudi Council for Health Specialties). Personnel File

### SC.3 There is a job description for each staff member including the head of the department.

#### Evidence of Compliance

- SC.3.EC1 There is an updated and signed job description for each social work staff. Personnel File
- SC.3.EC2 There is an updated and signed job description for the head of social work. Personnel File

### SC.4 The Social Worker works collaboratively with the physicians and nurses and helps them with the psychosocial needs of the patient.

#### Evidence of Compliance

- SC.4.EC1 Patient's psycho-social needs are determined in collaboration with physicians and nurses. Medical Record Review

### SC.5 The Social Worker assesses the social needs of the patient so they can help the physicians to develop a plan of care for the patients.

- SC.5.1 Interviews the patient and his/ her family to understand the patient psychosocial needs.
- SC.5.2 Explains the patient needs to the physician to develop a plan depends on the patients needs.

#### Evidence of Compliance

- SC.5.EC1 The social needs assessment is considered for the plan of care. Medical Record Review

### SC.6 The Social Worker educates the patient about the agencies available which provide assistance to the patients.

- SC.6.1 Explains to the patient the governmental and the private agencies services



SC.6.2 Guides or/ and advises the patient the most suitable agencies services depends on his/her needs.

**Evidence of Compliance**

SC.6.EC1 There is appropriate patient education on available assistance from agencies. Medical Record Review

**SC.7 The Social Worker assesses and helps the financial status of the patient and / or find a fund to buy certain drugs, equipments or appliances.**

SC.7.1 Contacts the governmental and/ or private agencies and/ or a sponsor.

SC.7.2 Informs the sponsor or/ and the agencies about the patient needs by reporting them.

SC.7.3 Follows-up the patient support services.

**Evidence of Compliance**

SC.7.EC1 The social workers assess and help the financial needs of the patient. Medical Record Review

**SC.8 The Social Worker assesses the patient's home situation and the patient's non-compliance to treatment.**

SC.8.1 Interviews the patient to clarify his/ her home situation.

SC.8.2 Evaluates the patient home situation depends on the patients interview or/ and home visit.

**Evidence of Compliance**

SC.8.EC1 The social workers assess patient's home situation and non-compliance to treatment (via patient interview or home visit). Medical Record Review

**SC.9 The Social Worker assesses the patient's emotional and psychological factors that could impact the patient's self care ability.**

SC.9.1 Interviews the patient to understand his/her emotional and psychosocial factors

SC.9.2 Evaluates the patient psychosocial needs

SC.9.3 Develops a plan covers all the patients needs

**Evidence of Compliance**

SC.9.EC1 The social workers assess the patient's emotional and psychological factors affecting the self care plan. Medical Record Review

**SC.10 The Social Worker assists in the discharge planning process by:**

SC.10.1 Finding any social factor that might delay the discharge of patients.

SC.10.2 Making necessary arrangements to facilitate timely discharge.

SC.10.3 Identifying community resources.

SC.10.4 Evaluation of home situation.

**Evidence of Compliance**

SC.10.EC1 The social worker assists in the discharge planning process. Medical Record Review

**SC.11 The Social Worker facilitates the continuity of care to the patient and expedites it by responding to the needs of the patient.**

**Evidence of Compliance**

SC.11.EC1 Social worker facilitates the continuity of care. Medical Record Review

**SC.12 The Social Worker evaluates the disability of the patient and helps reduce the impact of it on the patient by:**



SC.12.1 Liaising and helping the patient to overcome his/her disability.

SC.12.2 Identifying community resources

SC.12.3 Patient and family education

**Evidence of Compliance**

SC.12.EC1 The social worker evaluates patients' disabilities and helps reduce its impact.

Medical Record Review

**SC.13 Social work services records all relevant patient data in the patient record to include:**

SC.13.1 Reason for referral.

SC.13.2 Summary of initial patient and/ or family assessment.

SC.13.3 Goals of assistance, interventions, and plan.

SC.13.4 Routine and regular progress notes that include patients/ family understanding, progress or needs for different or additional confidential social / counseling services.

**Evidence of Compliance**

SC.13.EC1 There is complete documentation of social worker services activities in the patient's medical record.

Medical Record Review



## Rehabilitation Services Standards

### RH.1 The hospital has a Rehabilitation unit.

#### Evidence of Compliance

RH.1.EC1 Availability of rehabilitation/physical therapy unit.

Observation

### RH.2 A qualified therapist is the department head.

#### Evidence of Compliance

RH.2.EC1 Qualified, trained and experienced head of the rehabilitation department (licensed by the Saudi Council for Health Specialties).

Personnel File

### RH.3 There is a written scope of service.

#### Evidence of Compliance

RH.3.EC1 Clearly written rehabilitation scope of service.

Document Review

### RH.4 The staff in the unit are qualified by appropriate education and experience with rehabilitation.

#### Evidence of Compliance

RH.4.EC1 All staff are qualified, trained and experienced.

Personnel File

### RH.5 Staff are BCLS certified.

#### Evidence of Compliance

RH.5.EC1 All rehabilitation staff have valid BCLS certification.

Personnel File

### RH.6 Treatment is offered only after referral by a physician.

#### Evidence of Compliance

RH.6.EC1 There is rehabilitation treatment based on referral order.

Medical Record Review

### RH.7 Each case referred receives a documented assessment.

#### Evidence of Compliance

RH.7.EC1 There is a documented assessment of all referred cases.

Medical Record Review

### RH.8 Each case contains a treatment plan designed with measurable goals.

#### Evidence of Compliance

RH.8.EC1 There is a clear documentation of treatment plan and measurable goals.

Medical Record Review

### RH.9 Each patient has a clinical record that contains the reason for referral, the initial assessment made, the treatment plans, the goals achieved and the response of the patient to the treatment.

#### Evidence of Compliance

RH.9.EC1 There is clear documentation of referral reason, initial assessment, treatment plans,

Medical Record Review



achieved goals, response to treatment.

**RH.10 Space and equipment are recommended by the Head of the Rehabilitation to meet the scope of service.**

**Evidence of Compliance**

RH.10.EC1 Adequate space and equipment for the scope of service.

Observation

RH.10.EC2 Space and equipment are recommended by head of department.

Document Review

**RH.11 There is appropriate communication between the ordering physicians and all the staff on the unit for optimum implementation of the plan of care with evidence of interdisciplinary planning to meet the patient's needs.**

**Evidence of Compliance**

RH.11.EC1 The medical records contain evidence of interdisciplinary planning to meet the patient needs. Medical Record Review

**RH.12 The patient's response to therapy is documented.**

**Evidence of Compliance**

RH.12.EC1 There is documentation of patient's response to therapy.

Medical Record Review

**RH.13 Patients are educated about the plan of care, the procedures and the rehabilitative exercises.**

**Evidence of Compliance**

RH.13.EC1 There is patient education (plan of care, rehabilitation exercises).

Medical Record Review

**RH.14 Policies and procedures cover:**

RH.14.1 Safety measures.

RH.14.2 Infection control guidelines.

RH.14.3 Communication with the physicians.

**Evidence of Compliance**

RH.14.EC1 Written policies and procedures of rehabilitation services adequately covers safety, infection control guidelines and professional communications. Document Review

**RH.15 Policies and/or protocols exist for the management of:**

RH.15.1 Strokes.

RH.15.2 Hip replacements.

RH.15.3 Knee replacements.

RH.15.4 Back pain.

**Evidence of Compliance**

RH.15.EC1 Written policy and/or protocol for the management of stroke.

Document Review

RH.15.EC2 Written policy and/or protocol for the management of hip replacement.

Document Review

RH.15.EC3 Written policy and/or protocol for the management of knee replacement.

Document Review

RH.15.EC4 Written policy and/or protocol for the management of back pain.

Document Review

**RH.16 A crash cart is available.**



**Evidence of Compliance**

RH.16.EC1 Availability of a well equipped and accessible crash cart.

Observation





# Ambulatory Care Services: Ambulatory Care, Dental Services

## Introduction

Ambulatory care services represents a point of entry to the hospital. Patients attending ambulatory care should care that is similar to care provided in other departments.

The standards in this chapter address the following:

- Scope of services
- Access (appointment system)
- Patient assessment and care
- Documentation in medical records
- Patient education
- Procedures performed as outpatient procedures



## Ambulatory Care Standards

### AM.1 There is a written scope of service.

#### Evidence of Compliance

AM.1.EC1 Written Ambulatory Care scope of service.

Document Review

### AM.2 There is a nurse in charge of Ambulatory Care Services who handles administrative and clinical issues related to nursing.

AM.2.1 There is a job description for the nurse leader describing the role and responsibility.

#### Evidence of Compliance

AM.2.EC1 There is a nurse in charge of Ambulatory Care Services who handles administrative and clinical issues related to nursing.

Personnel File

AM.2.EC2 A job description for the Ambulatory Care nurse in charge.

Personnel File

### AM.3 There is an appointment system.

#### Evidence of Compliance

AM.3.EC1 Availability of functional appointment system.

Interview

### AM.4 Policies and procedures cover:

AM.4.1 Verification of patient identification at each visit.

AM.4.2 Infection control guidelines.

AM.4.3 Use of any sedation.

#### Evidence of Compliance

AM.4.EC1 Written policy and procedures that cover verification of patient identity at each visit, infection control guidelines and use of any sedation.

Document Review

### AM.5 On the first visit, the attending physician performs a comprehensive history and physical examination.

#### Evidence of Compliance

AM.5.EC1 A comprehensive history and physical examination by the attending physician on the first visit.

Medical Record Review

### AM.6 The history and physical examination with preliminary or final diagnosis are documented in the clinical record including the problems' list.

#### Evidence of Compliance

AM.6.EC1 Documentation in the medical record of history, physical examination, diagnosis, and problem list.

Medical Record Review

### AM.7 The attending physicians inform & educate their patients (in the language they understand) about:

AM.7.1 The nature of their illness.

AM.7.2 Diagnosis.

AM.7.3 Treatment plan.

AM.7.4 Medications used, their side effects and response to therapy.

#### Evidence of Compliance



AM.7.EC1 Patient education by the attending physician (including nature of illness, diagnosis, treatment plan, and medications) in the patient own language. Medical Record Review

**AM.8 If admission is needed, the patient is informed about:**

- AM.8.1 Expected length of stay.
- AM.8.2 Any surgery to be done.
- AM.8.3 Benefits and complications of the treatment plan (including surgery).
- AM.8.4 Cost attached.

**Evidence of Compliance**

AM.8.EC1 Patient education on expected length of stay, any surgery to be done, benefits and complications of the treatment plan (including surgery) and cost attached. Medical Record Review

**AM.9 If an Outpatient procedure is planned to be done, then:**

- AM.9.1 Procedures are explained to the patient.
- AM.9.2 Consent is taken.
- AM.9.3 Clear follow-up instructions are given.
- AM.9.4 Follow-up appointment is given.

**Evidence of Compliance**

AM.9.EC1 Patient education on outpatient procedures. Medical Record Review  
AM.9.EC2 Availability of signed consent for any outpatient procedure. Medical Record Review  
AM.9.EC3 Follow up appointment after outpatient procedures. Medical Record Review  
AM.9.EC4 Clear follow-up instructions are given. Interview

**AM.10 If any local anesthetic will be used, the physicians are expected to document:**

- AM.10.1 Dose of the local anesthesia to be used.
- AM.10.2 The type of the local anesthesia and its suitability to the patient's condition.

**Evidence of Compliance**

AM.10.EC1 Documentation of anesthesia administered (type, dose, and appropriateness). Medical Record Review

**AM.11 For the use of any sedation on the patient, the hospital policy regarding the use of conscious sedation is followed.**

**Evidence of Compliance**

AM.11.EC1 Written hospital-wide conscious sedation policy. Document Review  
AM.11.EC2 Compliance with the hospital-wide conscious sedation policy. Medical Record Review

**AM.12 There is a crash cart available in the vicinity.**

**Evidence of Compliance**

AM.12.EC1 Availability of fully equipped and accessible crash cart. Observation

**AM.13 All nurses working in the Ambulatory Care unit check the crash cart and that includes all emergency supplies and medications each shift.**

- AM.13.1 There is written documentation of the checklist.

**Evidence of Compliance**



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AM.13.EC1 Crash cart check (equipment and medications) every shift by ambulatory care nurses. Observation



## Dental Services Standards

**DN.1 A qualified dentist is in-charge of the dental services.**

**Evidence of Compliance**

DN.1.EC1 Qualified Dentist in-charge of the dental unit (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**DN.2 Qualified staff dental technicians are available in the Dental services.**

**Evidence of Compliance**

DN.2.EC1 Qualified dental staff (licensed by the Saudi Council for Certification of Health Care Specialties). Personnel File

**DN.3 There is a written scope of service for the Dental Unit.**

**Evidence of Compliance**

DN.3.EC1 Written scope of service for Dental service. Document Review

**DN.4 There is one dental assistant per chair.**

**Evidence of Compliance**

DN.4.EC1 Assignment of a dental assistant per chair. Observation

**DN.5 The crash cart with defibrillator is available in the vicinity and is checked and maintained.**

**Evidence of Compliance**

DN.5.EC1 Availability of equipped and accessible crash cart in the vicinity. Observation  
DN.5.EC2 Crash cart check and maintenance. Observation

**DN.6 All dental staff are privileged through the Privileging committee to perform the different types of dental procedures.**

**Evidence of Compliance**

DN.6.EC1 Privileging of all dental staff is available. Personnel File

**DN.7 Patients are educated and informed about:**

- DN.7.1 The nature of problem.
- DN.7.2 Treatment and procedures needed.
- DN.7.3 Time needed to finish the course of treatment.
- DN.7.4 Cost attached.

**Evidence of Compliance**

DN.7.EC1 Patient education (on the nature of the problem, treatment and procedure, time needed and cost). Medical Record Review

**DN.8 Each patient has a dental record written that includes:**

- DN.8.1 History of allergic reactions.
- DN.8.2 Any chronic illnesses, e.g., Congenital Heart Disease, Rheumatic Heart Diseases and Diabetes.



- DN.8.3 Any hematological illnesses, e.g., hemophilia.
- DN.8.4 Chief complaints of patients.
- DN.8.5 Treatment plan.
- DN.8.6 X-rays needed.
- DN.8.7 Treatment or Planned procedure to be performed.
- DN.8.8 Dose of local anesthesia, the tooth treated and the material used.

**Evidence of Compliance**

- DN.8.EC1 Comprehensive Patient Dental record which include detailed medical history and management plan, allergy history, chronic illnesses/ blood disorders, chief complaints, treatment plan, x-rays needed, anesthesia dose, tooth treated and material used. Medical Record Review

**DN.9 Consent is obtained for all high-risk procedures.**

**Evidence of Compliance**

- DN.9.EC1 Patient written consent for high-risk dental procedures. Medical Record Review

**DN.10 Infection Control guidelines are strictly enforced. The guidelines include but are not limited to:**

- DN.10.1 Using gloves and masks for each case.
- DN.10.2 Wearing protective eyewear.
- DN.10.3 Providing eye protection for patients.
- DN.10.4 Wearing gowns in the dental suite.
- DN.10.5 Sterilizing all reusable instruments after each patient according to a written protocol.
- DN.10.6 Cleaning all items in the ultrasonic unit.
- DN.10.7 Sterilizing all hand pieces, nose cones between patients.
- DN.10.8 A written protocol for sterilizing the instrument to indicate time and method of use for sterilization.
- DN.10.9 Cleaning surfaces of working area between patients.

**Evidence of Compliance**

- DN.10.EC1 Implementation of infection control guidelines that include (Using gloves and masks for each case ,wearing protective eye wear, providing eye protection for patients, wearing gowns in the dental suite) Observation
- DN.10.EC2 A written protocol for sterilizing the instrument to indicate time and method of use for sterilization. Document Review
- DN.10.EC3 Sterilizing all reusable instruments after each patient according to a written protocol, cleaning all items in the ultrasonic unit, sterilizing all hand pieces, nose cones between patients). Observation
- DN.10.EC4 Evidence of implementation of Infection Control guide lines e.g. Cleaning surfaces of working area between patients. Observation

**DN.11 There is a policy on the use of I.V. sedation or nitrous oxide and only privileged dentists are allowed to administer it.**

**Evidence of Compliance**

- DN.11.EC1 Written policy on the use of conscious sedation. Document Review
- DN.11.EC2 Conscious sedation is administered by privileged dentist. Personnel File

**DN.12 Dental procedures requiring general anesthesia should be done according to hospital policies and procedures.**

**Evidence of Compliance**

- DN.12.EC1 Implementation of hospital policy and procedures for general anesthesia for dental procedures requiring general anesthesia. Medical Record Review



**DN.13 The need for antibiotic prophylaxis is assessed for each patient.**

**Evidence of Compliance**

DN.13.EC1 Assessment of the need for prophylactic antibiotics for each patient.

Medical Record Review

**DN.14 Safety rules are applied in the Dental lab, and includes but is not limited to:**

- DN.14.1 Wearing of protective eye wear.
- DN.14.2 Fire extinguishers
- DN.14.3 Cautionary signs posted.
- DN.14.4 A hooded exhaust in the casting area.
- DN.14.5 Oxygen cylinders safely stored.
- DN.14.6 Safe evacuation of fumes exists.
- DN.14.7 Fire blanket is available.
- DN.14.8 Eye washing sink is available.
- DN.14.9 Emergency gas is available.

**Evidence of Compliance**

DN.14.EC1 Implementation of dental lab safety measures (includes protective eye wear, fire extinguishers, caution signs, hooded exhaust casting area, safe storage oxygen cylinders, safe evacuation fumes, fire blanket, eye washing sink, emergency gas are available).

Observation



# Management of Information and Medical Records

## Introduction

### Management of Information (MOI)

One of the most valuable resources that the leadership can have is information. Accurate information is necessary for the leadership to support decision making. Information that is trended over time can be evaluated to see if any improvements need to be made or to evaluate the effectiveness of an improvement that has been done. The hospital should have a process to meet the information needs of its clinical and managerial leaders and to compare its performance with other databases when relevant.

Among the main requirements of this function:

- Information needs assessment
- Information planning
- Data collection and analysis
- Information flow and reporting requirements
- Security, integrity, and confidentiality

### Medical Records (MR)

Medical Records is the backbone of the hospital and considered one of the important elements in the quality program. The quality of the medical records is essential. Health care providers must be able to have access to information in the medical record in order to provide safe care. Also, this is vital for the patient continuity of care and communication between care providers so that health care providers can find the necessary information for every patient encounter. To ensure appropriate management of medical records, the organization should have processes for access to records, entries into the record, and use of medical records information.

The medical records standards in this chapter address the following processes and activities:

- Medical records department staffing
- Initiation, construction and contents of medical records
- Criteria for medical records documentation
- Coding
- Availability of medical records
- Storage and retention
- Security, safety, and confidentiality of medical records
- Medical records quality improvement





## Management of Information Standards

**MOI.1 The leadership develops and implements an information management plan to meet the information needs of all those who provide clinical services and for those who manage the hospital and the plan includes:**

- MOI.1.1 A definition of data, information, security, confidentiality and integrity.  
MOI.1.2 A categorization of data available (both manual and computerized).  
MOI.1.3 An assessment of information needs by both clinical and managerial staff within the hospital.  
MOI.1.4 A description of how confidentiality, security, and integrity of the data and information will be maintained.  
MOI.1.5 A description of the various kinds of reports, the frequency of the reports, and who will receive them.  
MOI.1.6 An educational/training schedule for decision makers and other appropriate staff on the principles of data management for decision-making.  
MOI.1.7 A description of the technology and other resources required to implement the plan.  
MOI.1.8 A description of the roles and responsibilities of the leadership and department heads in relation to implementation and evaluation.

### Evidence of Compliance

- MOI.1.EC.1 There is a comprehensive information management plan developed by the leadership (definition and maintenance of data, information, security, confidentiality and integrity; data categorization, assessment of information needs; types, frequency, and distribution of reports, training/education schedule, description of available technology and role of leadership in implementation). Document Review
- MOI.1.EC.2 There is implementation of the MOI plan through leadership interview. Interview

**MOI.2 Appropriate clinical and managerial staff participates in selecting, integrating, and using information management technology.**

### Evidence of Compliance

- MOI.2.EC.1 Participation of clinical and managerial staff in selecting, integrating, and using information management technology. Interview

**MOI.3 The leadership supports the Hospital-wide information plan by:**

- MOI.3.1 Participating in defining the terminology related to management of information including data, information, aggregated data, correlated data, confidentiality, integrity and security.  
MOI.3.2 Approving the Hospital wide Management of Information (MOI) plan.  
MOI.3.3 Providing the necessary resources to implement the hospital wide information plan.

### Evidence of Compliance

- MOI.3.EC.1 Leaders support the hospital wide Management of Information (MOI) plan by approving plans. Document Review
- MOI.3.EC.2 Leaders support the hospital wide Management of Information (MOI) plan by participating in plan development. Interview
- MOI.3.EC.3 Leaders support the hospital wide Management of Information (MOI) plan by providing resources. Observation

## DATA MANAGEMENT

**MOI.4 The leadership works with all of the department heads to identify the necessary data that will be used for decision-making on a regular basis and this includes:**

- MOI.4.1 The identification of necessary data based on the hospitals scope of service and complexity of care.

### Evidence of Compliance

- MOI.4.EC.1 There is collaboration with department heads to assess the information needs Interview



for decision making.

**MOI.5 If data is collected manually (or when data is entered into a computer), the leadership determines the roles and responsibilities for data entry (completion of forms), data collection, data analysis, and report generation and this includes:**

MOI.5.1 Data elements being defined and forms developed for designated staff to enter the necessary data.

MOI.5.2 Establishing time frames for collecting data.

MOI.5.3 Displaying and analyzing data using software programs (e.g. excel).

MOI.5.4 The leadership deciding the routing of the reports.

**Evidence of Compliance**

MOI.5.EC.1 The leadership determines the data management process involving (data element definition, establishing time frame, data analysis and the type and report routing). Document Review

**MOI.6 The hospital provides for aggregation of data to support patient care and management decisions.**

MOI.6.1 Aggregate data and information include information requirements specified in this manual (for example, facility management and safety, infection control, clinical data and information, identified hospital-wide indicators, department-specific indicators, physician-specific information).

MOI.6.2. Aggregated data is used for self-comparison over time and benchmarking against similar hospitals as well as best practices.

**Evidence of Compliance**

MOI.6.EC.1 Aggregate data are available. Document Review

MOI.6.EC.2 The leaders use aggregate data for self-comparison and comparison with similar hospitals and best practices. Interview

**MOI.7 The leadership analyzes the information with the assistance of the Quality Management Director or leader.**

**Evidence of Compliance**

MOI.7.EC.1 The leadership analyzes information with assistance of the quality management director (i.e. available reports). Interview

**MOI.8 The leadership uses the information to make decisions, strategically plan, and identify and prioritize quality improvement projects.**

MOI.8.1 Planning is based on analysis of patient demographics and services required data.

**Evidence of Compliance**

MOI.8.EC.1 There are documents such as quality improvement committee, leadership, committees, departmental meetings minutes, reports or other documents. Document Review

MOI.8.EC.2 The leadership uses information to make decisions, strategic planning and identify and prioritize QI projects (aggregate reports are analyzed and used by leadership to make decisions). Interview

**MOI.9 The leadership and all staff receive education on data management appropriate to his/her roles and responsibilities within the hospital.**

**Evidence of Compliance**

MOI.9.EC.1 There is provision of data management education for leadership and relevant staff (educational certificate, record). Personnel File

MOI.9.EC.2 Discussions with leadership and staff reflect knowledge and understanding on data management. Interview



## SYSTEM MANAGEMENT

**MOI.10 The hospital maintains a master patient index, updated at least quarterly and/or upon entry of each new patient to the facility.**

**Evidence of Compliance**

MOI.10.EC.1 Availability of updated master patient index at least quarterly and/or upon entry of each new patient to the facility (interview with Medical Records leader). Interview

**MOI.11 The hospital has a policy on how confidentiality of data and information will be maintained and includes:**

MOI.11.1 Who will have access to all different types and categories of information, and describes the penalties for the staff who violate the security and confidentiality of data and information.

MOI.11.2 The Policy includes levels of access to patient information on a need to know basis.

**Evidence of Compliance**

MOI.11.EC.1 There is a written policy on maintenance of data and information confidentiality. (levels of access on need to know basis, and disciplinary actions) Document Review

**MOI.12 The hospital contributes to external databases in accordance with Saudi laws or regulations.**

**Evidence of Compliance**

MOI.12.EC.1 There is contribution to external databases in accordance with Saudi laws or regulations (Infectious diseases reports, Cancer Registry, etc.). Document Review

**MOI.13 There is Internet access for staff to obtain information which supports safe patient care.**

**Evidence of Compliance**

MOI.13.EC.1 Availability of internet access for staff to support safe patient care. Interview

**MOI.14 There is a process to obtain the necessary information for the administration and clinical staff and includes:**

MOI.14.1 The information resources addresses staff needs and support them to maintain and improve their competence.

MOI.14.2 There is a designated location(s) where appropriate information resources provided by the hospital can be accessed.

MOI.14.3 Information is accessible to clinical staff 24 hours a day, 7 days a week.

**Evidence of Compliance**

MOI.14.EC.1 The hospital provide information resources appropriate to the staff needs (e.g., library). Interview

MOI.14.EC.2 The information resources are available to clinical staff 24/7.. Observation

**MOI.15. When there is automation of data, there is a planned, documented recovery system in case of computer malfunction to include system linked and stand alone computers.**

**Evidence of Compliance**

MOI.15.EC.1 There is documented recovery system for automated data on all computers. Interview



## Medical Records Standards

**MR.1 A record is initiated for every patient assessed and/or provided care or services by the hospital.**

### Evidence of Compliance

MR.1.EC1 Availability of medical record initiated for every patient assessed and or provided care Interview or services by the hospital (medical record director interview).

**MR.2 The patient record initiated is easily identified by a unique patient identifier either by using pre-printed labels or by using an addressograph machine.**

### Evidence of Compliance

MR.2.EC1 Patient record initiated is easily identified by a unique patient identifier either by using Observation pre-printed labels or by using an addressograph machine.

MR.2.EC2 There is a numbering system for medical records (medical record director interview). Interview

**MR.3 All medical records must contain the following information at a minimum:**

MR.3.1 The patient's name, address, date of birth, and next of kin. The name must include: family name, first name, middle name.

MR.3.2 The medical history of the patient.

MR.3.2.1 Details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status.

MR.3.2.2 Relevant past, social, and family histories appropriate to the age of the patient.

MR.3.2.3 A clinical review by body systems.

MR.3.3 As appropriate to the age of the patient, a summary of the patient's psycho/social needs.

MR.3.4 Reports of relevant physical examinations.

MR.3.5 Diagnostic and therapeutic orders.

MR.3.6 Evidence of informed consent.

MR.3.7 Clinical observations, including the result of therapy.

MR.3.8 Reports of procedures, tests, and their results.

MR.3.9 Physician includes his/her assessment, diagnosis, impression, and plan of care revisions when indicated and therapeutic intervention.

MR.3.10 Conclusions at termination of hospitalization or evaluation/treatment.

### Evidence of Compliance

MR.3.EC1 Completed face sheet in the medical record.

Medical Record Review

MR.3.EC2 There is a complete and unified medical record contents (complete demographics, history and physical examination, details of the present illness, past, social, and family histories, clinical review by body systems, psycho/social needs, diagnostic and therapeutic orders, informed consent, reports of procedures, tests, and their results, assessment, clinical progress, diagnosis, impression, and plan of care revisions, discharge summary).

Medical Record Review

**MR.4 Only authorized staff members are allowed to make entries in records and:**

MR.4.1 There is a unique identifier (name and/ or number) for each staff member that he/she uses when making entries in the records.

MR.4.2 The staff dates and times each entry into the medical record.

MR.4.3 The staff signs every entry.

### Evidence of Compliance

MR.4.EC1 Policy or other mechanism to identify authorized staff to make entries in medical records (using name and ID number or stamp and signature).

Document Review

MR.4.EC2 All entries are dated, and timed and identity of staff making the entry can be verified by name or ID number.

Medical Record Review



**MR.5 The hospital uses standardized diagnosis codes (such as International Classification of Diseases 9th & 10th, Current Procedure Terminology or Diagnostic Related Groups), procedure codes, and definitions so that data can be aggregated and transformed into i**

- MR.5.1 Using standardized diagnosis codes.
- MR.5.2 Using standardized procedure codes.
- MR.5.3 Using standardized symbols and definitions.

**Evidence of Compliance**

MR.5.EC1 Availability of standardized diagnosis and procedure codes (ICD9 or ICD10, CPT, or Medical Record Review DRG), and standardized symbols and its definitions.

**MR.6 The hospital has a policy on the storage and retention of records, data and information and:**

- MR.6.1 The policy is consistent with the Ministry of Health rules and regulations.
- MR.6.2 The policy defines the length of time required to retain the records including x-rays (minimum 5 years).
- MR.6.3 The policy addresses how confidentiality, integrity, and security of the records will be maintained.

**Evidence of Compliance**

MR.6.EC1 Written policy on the storage and retention of records, data and information which is consistent with MOH rules (minimum of 5 years). Document Review

MR.6.EC2 Written policy on the confidentiality, integrity, and security of medical records. Document Review

**MR.7 There is a policy that outlines how records are protected from loss, theft and/or deliberate alterations, or tampering with any medical records that includes but is not limited to:**

- MR.7.1 Describing how records will be protected from loss, theft and/or deliberate alterations or destruction.
- MR.7.2 Describing the disciplinary action to be taken if staff make any deliberate alterations (tampering), take a record without authorization, and/or destroy any part of the record.

**Evidence of Compliance**

MR.7.EC1 Written policy on medical records protection (from loss, theft and/or deliberate alterations, destroy or tampering and disciplinary actions). Document Review

**MR.8 There is a medical records tracking system which can identify the location of any record not in the medical records department.**

**Evidence of Compliance**

MR.8.EC1 There is a medical record tracking system (interview with Medical Records Department Leader). Interview

**MR.9 Each hospitalization episode, both in-patient and out-patient records, are separated into different sections in the patients' chart for doctors orders, nursing notes, progress notes for physicians, etc.**

**Evidence of Compliance**

MR.9.EC1 Separation of medical chart contents for each hospitalization episodes. Medical Record Review

**MR.10 The hospital has a policy for the Medical Records Department, which includes the content and the forms that go in the record.**

- MR.10.1 A complete Medical Record is the one that contains the following:
  - MR.10.1.1 Identity information of patients and next of kin.
  - MR.10.1.2 History and physical examination.
  - MR.10.1.3 Typewritten operative report.
  - MR.10.1.4 Typewritten Histopathology report.



- MR.10.1.5 Typewritten Radiology report.
- MR.10.1.6 Typewritten Discharge summary.
- MR.10.1.7 Progress notes of Physicians.
- MR.10.1.8 Progress notes of Nurses.
- MR.10.1.9 All physician orders signed.

**Evidence of Compliance**

- MR.10.EC1 Written policy for medical records content. Document Review
- MR.10.EC2 The Medical Record is complete: containing history, physical, all physician orders, progress notes, typewritten Histopathology report, and typewritten Radiology report, discharge summary, physicians and nurses progress notes, all physician orders are signed (sampled medical records). Medical Record Review

**MR.11 The following issues are included in the hospital policy for the completions of medical records:**

- MR.11.1 Chart completion is a requirement within 30 days of patient discharge and before any elective vacation or period of absence of staff entering the note in the medical record and must contain:
  - MR.11.1.1 All relevant diagnoses established by the time of discharge, as well as all operative procedures performed.
  - MR.11.1.2 A discharge summary concisely restating the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, and the condition of the patient on discharge.
- MR.11.2 The attending physician is responsible for the completion of his own record.
- MR.11.3 Physicians, who do not complete their records in a timely manner, receive disciplinary actions as outlined in the Hospital's Delinquent file policy.

**Evidence of Compliance**

- MR.11.EC1 Written policy on completion of medical records (record completion within 30 days of discharge, discharge diagnosis, surgical procedures, complete discharge summary, discharge condition). Document Review
- MR.11.EC2 There is completion of medical records within 30 days of patient discharge. Medical Record Review
- MR.11.EC3 The hospital disciplinary action is considered in the policy of delinquent files. Document Review

**MR.12 The head of Medical Records works closely with the Medical Records Review Committee to check the quality of the following documentation:**

- MR.12.1 History and physical.
- MR.12.2 Admission assessments.
- MR.12.3 Operative notes.
- MR.12.4 Histopathology report.
- MR.12.5 Lab results.
- MR.12.6 Typed x-ray reports.
- MR.12.7 Discharge summaries.
- MR.12.8 Documentation of patient education activity.
- MR.12.9 Progress notes.
- MR.12.10 Plan of care.

**Evidence of Compliance**

- MR.12.EC1 The Medical Records Review Committee evaluates the quality of all medical records documents (meeting minutes, reports, etc.). Document Review

**MR.13 There is a written policy on verbal and telephone orders and includes:**

- MR.13.1 Not considering a record complete before the attending physician or his designee signs off on the entire verbal and telephone orders.

**Evidence of Compliance**

- MR.13.EC1 Written policy on verbal and telephone orders that includes physician signing off on Document Review



entire verbal and telephone orders.

MR.13.EC2 There is timely authentication of verbal and telephone orders according to the policy. Medical Record Review

**MR.14 The Medical Records Department has the following categories of staff and has clear job descriptions for the positions. (as per the scope of service and volume of discharges):**

MR.14.1 Coders

MR.14.2 Assemblers / Analysts

MR.14.3 Transcriptions / Medical Secretaries

MR.14.4 File Clerks

**Evidence of Compliance**

MR.14.EC1 Medical record department has the following staff: coders, assemblers/analysts, transcribers/medical secretaries, and file clerks (organization chat). Document Review

MR.14.EC2 Clear job descriptions for all Medical Records staff. Personnel File

**MR.15 The Director of Medical Records has:**

MR.15.1 A Bachelors degree in healthcare or related field and or/has Medical Record Certification.

MR.15.2 Attended Medical Records Management training courses.

MR.15.3 At least 3-5 years experience in managing Medical Records Department.

**Evidence of Compliance**

MR.15.EC1 Qualified, trained, and experienced medical record director. Personnel File

**MR.16 The medical records are available within 30 minutes of being requested.**

**Evidence of Compliance**

MR.16.EC1 The medical record is available within 30 minutes of request (interview of nurses in clinical areas). Interview

**MR.17 The medical records can be retrieved any time of the day.**

**Evidence of Compliance**

MR.17.EC1 Interview of medical record head regarding the after hours availability of medical records. Interview

**MR.18 The operative report is typewritten.**

**Evidence of Compliance**

MR.18.EC1 There are typewritten operative reports (in all examined medical record sample). Medical Record Review

**MR.19 The discharge summary is typewritten.**

**Evidence of Compliance**

MR.19.EC1 There is a typewritten discharge summary (in all examined medical record sample). Medical Record Review

**MR.20 Patient records are only released out of Medical Records according to a policy approved by administration which includes:**

MR.20.1 Records can be released to the nurses in the out-patient clinics.

MR.20.2 Records can be released to the Emergency Room nurses for a patient in Emergency Room.



MR.20.3 Records are released to Head of Morbidity and Mortality Committee and he signs for it.

MR.20.4 Approval by the Hospital Director or Medical Director for all other requests for release of the medical record.

**Evidence of Compliance**

MR.20.EC1 Written policy on the release of medical records from the medical record department (outpatient clinic nurse, emergency room nurse, morbidity & mortality head, or cases exceptionally approved by medical/hospital director). Document Review

**MR.21 Essential information about the patient is legible and located in the face sheet along with the information such as allergies and code status.**

**Evidence of Compliance**

MR.21.EC1 There is documentation on the face sheet of all essential patient information, allergies and code status. Medical Record Review

**MR.22 All entries in the Medical Records are clear and legible.**

MR.22.1 There are specific guidelines for correcting an error in the medical record that does not include the use of correction fluid to erase any entry.

**Evidence of Compliance**

MR.22.EC1 Written guidelines on legible and clear handwriting, and error correction of entries into the medical record (including the no use of correction fluid). Document Review

MR.22.EC2 All medical record entries are clear and legible (medical record sample review). Medical Record Review

**MR.23 All laboratory results are seen and signed by a physician before being filed in the patients' record while the patient is on the Ward.**

**Evidence of Compliance**

MR.23.EC1 All laboratory results signed by a physician before medical record filing while patient is on the ward. Medical Record Review

**MR.24 The hospital prepares a list of prohibited abbreviations not to be used (JCHAO Patient Safety Goals) and it is recommended and approved by related committee such as the Pharmaceutical & Therapeutic Committee and Medical Records Review Committee.**

**Evidence of Compliance**

MR.24.EC1 Written list of prohibited medical abbreviation approved by pharmacy & therapeutics committee and medical record committee. Document Review

MR.24.EC2 There is medical records compliance with the prohibited abbreviation List (all sampled medical records). Medical Record Review

**MR.25 The hospital prepares a list of approved abbreviations as suggested by Ministry of Health to be used in the institution (MOH) and it is recommended by the Medical Records Review Committee.**

**Evidence of Compliance**

MR.25.EC1 Written medical abbreviation list approved by the Medical Records Review Committee. Document Review

MR.25.EC2 There is medical records compliance with the approved medical abbreviation list (all sampled medical records). Medical Record Review

**MR.26 The Medical Records Director participates in the Quality Management program.**





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**Evidence of Compliance**

MR.26.EC1 There is active participation of the medical record director in the quality management Document Review program (membership in QMC, meeting minutes, reports, etc.).



## Infection Control

### Introduction

The hospital requires processes in place to support the prevention and control of infection that might be acquired or transmitted by patients, staff, and visitors while in the hospital. These processes reduce risk or spread of infection, and ensure that care is provided in a clean, sterile environment. To ensure staff and patient safety, the infection prevention and control requires an effective organization wide infection prevention and control program that identifies, reduces and eliminates infection risks.

This chapter outlines the requirements for the following processes and activities related to infection prevention and control:

- Infection control program
- Staff education
- Personal protective equipment
- Hand hygiene
- Sharps safety
- Cleaning, decontamination, disinfection, and sterilization
- Healthcare-associated infection
- Employee health
- Blood exposure
- Communicable diseases
- Waste management
- Laundry
- IPC precautions for renovations and constructions



## Standards

### IC.1 The hospital designs and implements a coordinated program to reduce the risk of healthcare-associated (HAIs) infections in patients, visitors, and workers.

IC.1.1 The program involves all patient care units, and involves staff, patients, patients' families, volunteers and visitors, and involves all support services such as laundry, kitchen, laboratory, housekeeping, and other support services.

IC.1.2 The Infection Control Service /or unit is an independent department that reports directly to the highest administrative authority to implement the program.

#### Evidence of Compliance

IC.1.EC.1 The Infection Control department/unit is independent and the organization chart shows reporting directly to highest administrative authority (hospital director). Document Review

IC.1.EC.2 There is comprehensive coordinated Infection Control program. Document Review

### IC.2 The infection control program is based on:

IC.2.1 Current scientific knowledge.

IC.2.2 Accepted practice guidelines.

IC.2.3 Applicable law and regulations.

#### Evidence of Compliance

IC.2.EC.1 Infection Control program is based on scientific knowledge, practice guidelines and on local laws and regulations. Document Review

### IC.3 Full time personnel carry out the functions of infection control.

IC.3.1 At least one full time Infection control practitioner is available, and more should be hired depending on the size and acuity of care delivered in the hospital (one practitioner for every 150-250 beds).

#### Evidence of Compliance

IC.3.EC.1 Full time infection control practitioner (one practitioner for every 150 beds or less). Personnel File

### IC.4 Qualified personnel carry out the functions of infection control.

IC.4.1 The infection control personnel are qualified in infection control practice through education, training, experience, or certification.

IC.4.2 The infection control personnel have free access to a computer system to analyze data, and to access the infection control websites on the net.

IC.4.3 There is continuous medical education program to update the knowledge and skills of infection control staff.

#### Evidence of Compliance

IC.4.EC.1 There are qualified infection control personnel by education, training, experience, or certification. Personnel File

IC.4.EC.2 There are internet and hospital database access and IC references. Interview

IC.4.EC.3 Infection Control staff attend continuous medical education activities related to Infection Control. Personnel File

### IC.5 The administration supports the infection control program.

IC.5.1 The infection control team reports directly to the highest administrative authority.

#### Evidence of Compliance

IC.5.EC.1 Administration support for the Infection Control program. Document Review

### IC.6 A designated group / committee / or process monitors and coordinates infection control activities in the organization.



IC.6.1 The membership of the committee includes representatives from medical staff, nursing and administration as well as the person directly responsible for management of the infection control program.

IC.6.2 The committee meets at least quarterly.

IC.6.3 There is input to the committee from the Operating Room, Central Sterilization Service, pharmacy, lab, dietary services, housekeeping and other departments as may be required.

IC.6.4 Functions of the committee are as follows:

IC.6.4.1 Review and revise the hospital infection control policies developed by the infection control team.

IC.6.4.2 Evaluate and revise on a continuous basis the procedures and the mechanisms developed by the infection control team to serve established standards and goals.

IC.6.4.3 Review and evaluate the reports of healthcare-associated infections surveillance submitted regularly by the infection control team, and suggest appropriate actions to be taken with concerned departments.

IC.6.4.4 Bring to the attention of the infection control team new infection control issues arising in different departments of the hospital and suggest solutions.

IC.6.4.5 Revise the yearly plan submitted by infection control service and suggest additions/ changes if necessary. Once approved, the committee chairperson and members shall give this plan the full support needed for implementation.

IC.6.4.6 Each member of the committee should act as an advocate of infection control in his/her department, trying to promote its principles and to ensure application of its rules.

IC.6.5 The infection control committee is preferably chaired by the hospital administrator or one his senior medical designees.

#### Evidence of Compliance

IC.6.EC.1	Infection Control committee terms of reference reflect its functions and membership (medical, nursing and administrative members, quarterly meeting, input from OR, CSSD, pharmacy, lab, dietary, housekeeping department, IC committee review policies, reports and evaluate procedures, discuss new infection control issues, revise yearly IC plan, disseminate information to all concerned departments).	Document Review
IC.6.EC.2	Infection Control committee meeting minutes reflect its functions and actions taken.	Document Review

#### IC.7 The leadership supports the Infection Control program by implementing recommendations made by the Infection Control committee and the Infection Control Director.

#### Evidence of Compliance

IC.7.EC.1	The leaders have taken actions based on Infection Control committee and the Infection Control Director recommendations . (i.e. communications, minuetts, reports, action plan).	Document Review
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#### IC.8 Infection control policies that are applicable to the hospital should be combined in a manual.

IC.8.1 The Infection control manual is available to all staff, and in all patient care units.

IC.8.2 The Infection control manual has clear job descriptions of infection control personnel, functions of infection control committee, and statement of authority.

IC.8.3 The Infection control manual has all the policies pertaining to infection control.

#### Evidence of Compliance

IC.8.EC.1	The Infection Control manual is relevant to the hospital scope and contains the administrative role of IC department.	Document Review
IC.8.EC.2	There is Infection Control manual in patient care areas.	Interview
IC.8.EC.3	There is clear job description of infection control personnel.	Document Review
IC.8.EC.4	There is signed job description of infection control personnel.	Personnel File

#### IC.9 Infection control policies are scientifically sound.

IC.9.1 Infection control manual contents to be revised periodically by the infection control personnel and the Infection Control committee. The content needs to be updated based on scientific recommendations.



**Evidence of Compliance**

IC.9.EC.1 Infection control policies are updated by infection control personnel based on scientific recommendations. Document Review

**IC.10 The organization provides education on infection control to staff upon Hiring.**

IC.10.1 All staff receive an orientation to the hospital's infection control policies upon contracting. Employees' records should show documentation of this.

**Evidence of Compliance**

IC.10.EC.1 All staff receive an orientation to the hospital infection control program. Personnel File

**IC.11 There is continuous education on infection control to staff.**

IC.11.1 Each unit has an accessible copy of the infection control manual.

IC.11.2 All personnel are familiar with the infection control policies.

IC.11.3 There is periodic staff education on infection control policies, especially when new policies and procedures are put in place or when there are significant trends in infection data.

**Evidence of Compliance**

IC.11.EC.1 Continuous education on infection control (Staff awareness of IC policies). Document Review

IC.11.EC.2 Updated IC manual in each unit. Observation

IC.11.EC.3 Periodic staff education on IC issues. Personnel File

**IC.12 There is continuous surveillance of healthcare-associated infections.**

IC.12.1 There are written policies and procedures, which define the types of surveillance to be carried out and how data will be analyzed and used.

IC.12.2 There are written definitions of healthcare-associated infections.

IC.12.3 Collection and analysis of surveillance data is ongoing according to policies.

IC.12.4 Monitoring includes using indicators related to infection issues that are epidemiologically important to the organization.

**Evidence of Compliance**

IC.12.EC.1 There are clearly written policies on the type and details of surveillance process including definition of healthcare associated infection, data analysis and use. Document Review

IC.12.EC.2 Data collection, analysis, trend reports and distribution of infection control indicators to concerned departments and/or higher administration for proper action. Document Review

**IC.13 Results of healthcare-associated infections surveillance are integrated into quality improvement projects.**

IC.13.1 The organization uses risk, rate, and trend information to design or modify processes to reduce healthcare-associated infections to the lowest possible level.

IC.13.2 The organization compares its healthcare-associated infections rates with other national and international organizations through comparative database.

IC.13.3 The results of infection monitoring in the organization are regularly communicated to staff, doctors and management.

IC.13.4 Data collection is achieved through hospital information system, by verbal and written communication, chart review, direct observation and clinical indicators.

**Evidence of Compliance**

IC.13.EC.1 HAI rates are integrated into Quality Improvement projects. Document Review

IC.13.EC.2 Calculated HAI rates are trended, and are communicated with concerned departmental/unit leaders and staff. Interview



**IC.14 The hospital identifies the epidemiologically important infections, processes, and devices that are associated with risk of healthcare-associated infections and address them by doing performance improvement projects.**

**Evidence of Compliance**

IC.14.EC.1 Infection Control PI projects are based on related devices and applied processes. Document Review

**IC.15 A comprehensive program for preventing sharp injuries is implemented:**

IC.15.1 There are written policies and procedures that address handling sharps.

IC.15.2 Needles are not bent, broken or recapped except in special and approved circumstances.

IC.15.3 If recapping is necessary the "scoop method" is used.

**Evidence of Compliance**

IC.15.EC.1 There are written policies and procedures on handling sharps use and disposal. Document Review

IC.15.EC.2 Hospital staff have the knowledge and skills on handling sharps (needles are not bent or broken, scoop method for necessary recapping). Interview

**IC.16 Sharps are discarded in appropriate containers.**

IC.16.1 The type of sharp box used is puncture-proof and leak-proof and presents no risk to staff or patients.

IC.16.2 There is a sufficient number of sharp boxes (ideally one per patient' room or at least one per procedure trolley), and should be appropriately located away from traffic and preferably wall mounted.

IC.16.3 Sharp boxes are properly used: not overfilled, not opened to transfer sharps into other containers, and at or below eye level.

IC.16.4 Sharp boxes are sent for incineration when their contents are 3/4 of their sizes.

**Evidence of Compliance**

IC.16.EC.1 Sharp boxes are sent for incineration when their contents are 3/4 of their sizes. Interview

IC.16.EC.2 Availability of a sufficient number of appropriate sharp containers. Interview

IC.16.EC.3 The type of sharp box used is puncture-resistant and leak-proof and presents no risk to staff or patients. Interview

IC.16.EC.4 Sharp boxes are properly located and used. Interview

**IC.17 There is a system that separates patients with communicable diseases and those who are colonized or infected with epidemiologically important organisms from other patients, staff and visitors.**

IC.17.1 There are written policies and procedures that address standard and isolation precautions.

**Evidence of Compliance**

IC.17.EC.1 There are policies on standard and isolation precautions. Document Review

**IC.18 Facility design and available supplies support isolation practices.**

IC.18.1 There is at least one negative pressure airborne isolation room in the emergency room and one in every patient care area (one negative pressure room for every 25-50 beds in general hospitals). The need for more airborne isolation rooms shall be decided upon with the Infection Control team depending on the volume of patients in need for airborne isolation that get admitted to the hospital.

IC.18.2 The ventilation system serving airborne isolation facilities provides pressure patterns that prevent airborne pathogens from being distributed to other areas of the hospital. Rooms designed for airborne isolation patients are under negative pressure. Air is exhausted to the outside and is not re-circulated unless it is filtered through HEPA Filter.

IC.18.3 Room entry is through a work area or ante-room; this will serve as a site for hand- washing, gowning and storage of protective clothing (gloves, aprons, masks).

IC.18.4 Toilet, shower or tub and hand washing facilities are provided for each isolation room.

IC.18.5 Isolation signs are consistent with the patient diagnosis and are posted in Arabic and English, and indicating the type of



precautions required.

IC.18.6 Respirator (High filtration) masks (N-95, N-99) are used by staff during direct care of patients on airborne precautions, and are available on all units likely to admit patients on airborne precautions.

#### Evidence of Compliance

IC.18.EC.1	Rooms designed for airborne isolation should be provided with negative pressure, HEPA filter, dedicated toilet, evidence of air-exchange, ante-room, hand washing facility and the required Isolation signs/cards.	Interview
IC.18.EC.2	Availability of Personal Preventive Equipment including respirator masks (N-95, N-99).	Interview
IC.18.EC.3	Isolation signs are consistent with the patient diagnosis and are posted in Arabic and English, and indicating the type of precautions required.	Interview

### IC.19 Disinfectant use is supervised by infection control team and should be in accordance with current recommended practice.

IC.19.1 There is review by infection control of purchase of equipment and supplies used for sterilization and disinfection.

IC.19.2 Antiseptics and disinfectants are used in accordance with current scientific guidelines and recommended practice.

IC.19.3 Environmental safety is observed when disinfectants are used outside Central Sterilization Service.

IC.19.3.1 In the endoscopy unit, if glutaraldehydes are used, proper ventilation is in place.

#### Evidence of Compliance

IC.19.EC.1	IC staff are involved in purchasing sterilization equipment and related supplies.	Document Review
IC.19.EC.2	IC staff are involved in purchasing disinfectant and antiseptics and monitor their use and related precautions.	Interview
IC.19.EC.3	Proper ventilation in areas where toxic disinfectants such as glutaraldehyde is used (endoscopy unit).	Interview

### IC.20 Central sterilization service policies follow scientific guidelines and are reviewed by infection control.

IC.20.1 There are written policies and procedures which advise all areas how to prepare items for transport to Central Sterilization Service.

IC.20.2 There are written policies and procedures for Central Sterilization Service on cleaning, decontamination, disinfection, sterilization and storage of sterile items.

IC.20.3 There are written policies and procedures on recall of sterilized items if sterilization or disinfection processes were found later to be deficient.

#### Evidence of Compliance

IC.20.EC.1	CSSD policies are reviewed by IC as part of the approval process.	Document Review
IC.20.EC.2	There are CSSD policies that advise all staff on how to prepare items for transport to Central Sterilization Service.	Document Review
IC.20.EC.3	There are clear guidelines on cleaning, decontamination, disinfection, sterilization and storage of sterile items.	Document Review
IC.20.EC.4	There is clear policy on recall of sterilized items if sterilization or disinfection processes were found later to be deficient.	Document Review

### IC.21 Central Sterilization Service staff are qualified in the field of sterilization and disinfection.

IC.21.1 The supervisor of the Central Sterilization Service has experience, knowledge and certification in sterilization practice.

IC.21.2 The staff are able to explain sterilizer's operation and to name the main parameters to be followed: sterilization time, temperature, and pressure.

IC.21.3 Proper sterilization parameters are recorded.

IC.21.3.1 Sterilization records are kept for 1 year to allow inspection.

IC.21.3.2 Records include load list, daily function test, spore test results, lot number, and name of operator.

IC.21.4 Sterilization time and temperature cycles used follow those generally accepted as effective by the industry.



**Evidence of Compliance**

IC.21.EC.1	Supervisor of the Central Sterilization Service has experience, knowledge and certification in sterilization practice.	Personnel File
IC.21.EC.1	Central Sterilization Service staff have adequate knowledge and training.	Personnel File
IC.21.EC.1	There is a record documenting sterilization parameters that include load list, daily function test, spore test results, lot number, and name of operator and retained for one year to allow inspection.	Observation

**IC.22 Centralization of cleaning and disinfection is in place.**

IC.22.1 All decontamination, cleaning, and sterilization of medical equipments should be done in Central Sterilization Service. None in the respective departments.

IC.22.2 Transport of contaminated equipment to Central Sterilization Service is done in a way to prevent spills or aerosolization of infectious fluids.

**Evidence of Compliance**

IC.22.EC.1	All the cleaning and sterilization of medical equipment is performed in Central Sterilization Service.	Interview
IC.22.EC.2	Transportation of contaminated equipment to Central Sterilization Service is conducted in a way that prevents spills or aerosolization of infectious fluids.	Interview
IC.22.EC.3	All flexible scopes Centrally Sterilized.	Observation
IC.22.EC.4	Proper disinfectant is used according to Infection control current scientific guidelines.	Observation

**IC.23 Central Sterilization Service design supports its functions.**

IC.23.1 There is a uni-directional flow of traffic from dirty to clean areas. I.e. decontamination area > packing > sterilization > storage areas.

IC.23.2 Traffic control signs are in place.

IC.23.3 The dirty area is under negative pressure with exhaust to the outside; the clean area is under positive pressure with at least 10 air cycles / hr.

IC.23.4 There is complete physical separation between the decontamination area, the area where clean items are packaged and sterilized, and the area where sterilized items are stored.

**Evidence of Compliance**

IC.23.EC.1	CSSD construction design has complete separation between dirty (negative pressure) and clean areas (positive pressure with at least 10 air cycle/hr).	Interview
IC.23.EC.2	There is unidirectional flow of traffic.	Observation
IC.23.EC.3	Traffic control signs in place and storage area of sterilized item.	Observation

**IC.24 Central Sterilization Service has measures to ensure staff safety and proper function:**

IC.24.1 Personal protective equipment is available and used during decontamination: (heavy-duty gloves, waterproof aprons, facemask, goggles or face shield).

IC.24.2 Sterilizers are in good working order. (Instructions on sterilizers are available).

IC.24.3 Maintenance records for sterilizers are available.

IC.24.4 Chemical indicators are used in every package. Biological indicators are used at least weekly. Records of results are kept for one year.

IC.24.5 Use of flash steam sterilizer is limited to urgent situations, which preclude use of other sterilizer methods. This use is closely monitored and recorded. Policies in this regard should be written by Central Sterilization Service team and approved by Infection Control team.

IC.24.6 Each hospital wrapped and sterilized item is labeled with expiration date or a statement: "sterility preserved unless integrity broken."

IC.24.7 Storing conditions meet requirements for temperature humidity, airflow, shelving and containers are easily cleanable and are distant from floors (20 cm), ceilings (40 cm), and side wall (5 cm).

IC.24.8 Where ethylene oxide is used, safety and health hazards have been addressed.

**Evidence of Compliance**

IC.24.EC.1	Comprehensive monitoring of CSSD function to ensure staff safety.	Interview
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- IC.24.EC.2 There is a complete and comprehensive monitoring of the sterilization process that is documented and can be presented. Observation
- IC.24.EC.3 Sterilized item storing conditions meet the optimal requirements. Interview

**IC.25 Housekeeping has policies describing their functions.**

IC.25.1 Housekeeping has written policies describing areas to be cleaned, schedule for cleaning, and procedures to be used for cleaning different environmental surfaces.

IC.25.2 There is review of cleaning procedures, schedules and agents by infection control staff.

IC.25.3 All units have a cleaning / disinfection schedule which lists all environmental surfaces to be cleaned. The list has the items to be cleaned, chemicals to be used, frequency of cleaning, and persons responsible for each task.

**Evidence of Compliance**

- IC.25.EC.1 There are written housekeeping policies and procedures are reviewed by Infection Control staff. Document Review
- IC.25.EC.2 Cleaning schedules are prepared and implemented by Housekeeping department and monitored by Infection Control staff. Observation
- IC.25.EC.3 There is a list which indicates the chemicals that are used in the hospital, their concentration and way of use. Document Review

**IC.26 The hospital environment is kept clean.**

IC.26.1 Hospital environment, lockers, and cabinets are clean.

IC.26.2 Food is stored under sanitary conditions and is consumed in designated places.

IC.26.3 Food refrigerators are clean and are used only for food storage.

IC.26.4 There are separate clean and dirty utility areas on each patient care area.

IC.26.5 There is a system with written policies on pest control.

IC.26.6 Routine environmental microbiological cultures should not be done unless recommended by the Infection Control team.

**Evidence of Compliance**

- IC.26.EC.1 There is a complete Pest Control policy with a fixed schedule for different hospital areas. Document Review
- IC.26.EC.2 There is a separate dirty and clean utility room in each patient care area. Interview
- IC.26.EC.3 Hospital-wide clean environment, lockers and cabinets. Food is stored under sanitary condition. Interview

**IC.27 There is a system to handle spills and wastes**

IC.27.1 Hospital staff working in patient care areas are proficient in cleaning of blood / body fluids spills.

IC.27.2 There is a blood spill kit in every patient care unit that includes all necessary equipment. Policies on spill kit use should be written.

IC.27.3 Waste disposal differentiates between regular waste and infectious waste.

**Evidence of Compliance**

- IC.27.EC.1 There are policies on waste management and spills are clearly written. Document Review
- IC.27.EC.2 Implementation of handling of spills and disposal of medical wastes. Interview
- IC.27.EC.3 Availability of blood spill kit in every patient care unit that includes all necessary equipment. Interview

**IC.28 The mortuary and postmortem area are supervised by infection control.**

IC.28.1 There are written policies on how to handle bodies post mortem.

IC.28.2 The temperature of the morgue is kept at 2-8°C (36-46°F) and temperature is logged daily.

IC.28.3 The morgue is cleaned and disinfected regularly.

**Evidence of Compliance**



IC.28.EC.1	Comprehensive policies and procedures cover post mortem functions.	Document Review
IC.28.EC.2	Morgue temperature is kept between 2 to 8 degrees centigrade and temperature is logged daily.	Observation
IC.28.EC.3	The mortuary and postmortem area are regularly cleaned, disinfected and supervised by Infection Control.	Observation

**IC.29 Kitchen environment and functions are supervised by Infection control.**

- IC.29.1 Food containers are properly labeled and expiry dates noted.
- IC.29.2 Temperature requirements are met during:
- IC.29.2.1 Storage
  - IC.29.2.2 Preparation
  - IC.29.2.3 Transportation
- IC.29.3 Food is protected from environment during:
- IC.29.3.1 Storage
  - IC.29.3.2 Preparation
  - IC.29.3.3 Display
  - IC.29.3.4 Transportation
- IC.29.4 Fruits and vegetable are washed and disinfected thoroughly.
- IC.29.5 Garbage containers or receptacles are adequate in number, and are insect and rodent proof and are covered.
- IC.29.6 Food containers are washed immediately after being emptied from food.
- IC.29.7 Boards to cut meat, poultry, chicken, or vegetables should be separate and should be immediately washed after use.
- IC.29.8 Refrigerator temperatures are checked daily and documented on log sheets.
- IC.29.9 Kitchen environment is clean without areas of stagnant water on floors.

**Evidence of Compliance**

IC.29.EC.1	Food containers are properly labeled and expiry dates are noted.	Interview
IC.29.EC.2	Food is protected from the environment and stored properly during storage, preparation and transportation (including proper temperature, washing disinfection and cutting).	Interview
IC.29.EC.3	Comprehensive hygiene for all steps of food preparation.	Interview
IC.29.EC.4	Adequate resource that ensure clean kitchen environment (including adequate and proper garbage containers, no stagnant water on floors).	Interview

**IC.30 Kitchen staff hygiene and health is supervised by infection control:**

- IC.30.1 Hands are washed and cleaned on start of shift, and every time when non-food item is touched.
- IC.30.2 Hair covered upon handling food.
- IC.30.3 Gloves are worn while handling raw meat, or vegetables, or fruits.
- IC.30.4 There is enough hand washing facilities with liquid soap and paper towels in the kitchen.
- IC.30.5 Personnel with respiratory infections or gastroenteritis are restricted from handling food.
- IC.30.6 Stool for ova and parasites and stool cultures are done routinely upon hiring, every 3 months thereafter, and after returning back from vacation.
- IC.30.7 Results of stool analysis and cultures are reviewed by the Infection Control practitioner as soon as they become available.

**Evidence of Compliance**

IC.30.EC.1	The kitchen staff hygiene is practiced properly utilizing the required resources (hand washing, hair covering, wearing gloves, others).	Interview
IC.30.EC.2	The kitchen staff health is monitored as required with supported documents (including routine checkup upon hiring).	Document Review
IC.30.EC.3	Annual stool test for ova, cyst and parasite with stool culture.	Document Review
IC.30.EC.4	Evidence of implementation of Infection Control guide lines e.g. Restriction of staff with respiratory infections or gastroenteritis from handling food.	Observation

**IC.31 There are written policies and procedures that address all the above issues in the kitchen and that are**



reviewed by infection control.

**Evidence of Compliance**

IC.31.EC.1 There are comprehensive policies and procedures for the kitchen are available and reviewed by IC staff. Document Review

**IC.32 Laundry functions are supervised by infection control.**

IC.32.1 There are written policies and procedures on linen management that cover all steps starting from collecting linen from patients' rooms until completion of the cleaning process.

IC.32.2 Clean linen is transported, handled and stored in a way that keeps it protected from contamination and dust.

IC.32.3 There is functional separation of clean and used linen during storage and transport.

IC.32.4 Linen carts used for clean and used linen are clearly identified.

IC.32.5 Loose (un-bagged) linen is not to be put down a laundry chute.

IC.32.6 Soiled linen (contaminated with patient's blood, excreta, or other body fluids) and linen from patients under isolation precautions are contained and transported in accordance with current standards:

IC.32.6.1 linen is handled as little as possible and with minimum agitation.

IC.32.6.2 Appropriate barriers (gloves, gowns, and masks) should be used when handling such linen.

IC.32.6.3 Hand washing facilities are located in all areas where un-bagged linen is handled.

IC.32.6.4 linen is bagged at the location where it is used, and is not stored or pre-rinsed in patient's care areas.

IC.32.6.5 Linen is put into special color-coded and water-proof laundry bags.

**Evidence of Compliance**

IC.32.EC.1 There are written policies and procedures on linen management that cover all steps starting from collecting linen from patients rooms until completion of the cleaning process. Document Review

IC.32.EC.2 Proper linen handling, transportation, and storage using the required resources, in a way to protect staff and environment. Interview

IC.32.EC.3 The laundry is properly structured and adequately functions with respect to all infection control standard measures. Interview

**IC.33 Infection control practices are strictly supervised in hemodialysis unit:**

IC.33.1 There is sufficient space (1.2 -1.5 meters) between patients to prevent transmission of infection.

IC.33.2 There is a clear separation between patient care (contaminated) and office / supply areas (clean).

IC.33.3 Standard precautions are strictly implemented in the unit with special emphasis on hand hygiene and the appropriate use of barriers.

IC.33.4 An adequate supply of personal protective equipment is available and readily accessible.

IC.33.5 Hand disinfectants for waterless hand hygiene should be available at every chair/bed. Sinks are conveniently located, at least one sink for every two patients.

IC.33.6 Sinks are available in adequate number (preferably one for every 2-4 chair/beds) and are conveniently located.

IC.33.7 Staff have thorough knowledge about avoiding cross contamination.

IC.33.8 Staff practice related to cross contamination is satisfactory.

IC.33.9 Sharp disposal containers are located at each chair/bed and elsewhere as needed within the unit.

IC.33.10 Infectious wastes are disposed of according to waste disposal hospital policies.

IC.33.11 The surfaces of machines and chairs/beds are disinfected after use with an approved disinfectant.

IC.33.12 The machine manufacturer's instructions on cleaning the machine are available and adhered to.

IC.33.13 Equipment such as blood pressure cuffs, stethoscopes, clamps, scissors and thermometers are allocated to a single patient and are disinfected at the conclusion of each patient treatment.

IC.33.14 There is a system in place that ensures that multi-dose vials are adequately labeled and used for one patient only.

**Evidence of Compliance**

IC.33.EC.1 Staff awareness of all Infection Control guidelines in Hemodialysis Unit. Interview

IC.33.EC.2 The HD unit is designed appropriately emphasizing the implementation of infection prevention measures (sufficient space between patients, separation of clean from contaminated areas, adequate number of sinks and sharp containers near each bed/chair, others). Interview

IC.33.EC.3 General standards precaution are applied precisely to protect staff and patient Observation



from acquiring infection.

**IC.34 There is a system that protects patients and staff from blood borne pathogens during hemodialysis.**

- IC.34.1 All patients are screened for Hepatitis B and Hepatitis C and HIV at the beginning of dialysis.
- IC.34.2 Patients whose laboratory tests for HBsAg, anti HBs, HCV, and/or HIV is/are negative should be re-screened every 3-6 months.
- IC.34.3 All patients susceptible to hepatitis B (negative for HBsAg and anti HBs) are immunized with Hepatitis B vaccine.
- IC.34.4 All patients infected with Hepatitis B are strictly segregated in a separate room and treated on a separate machine used exclusively for Hepatitis B (not for patients with Hepatitis C or HIV).
- IC.34.5 All hemodialysis unit employees are screened for Hepatitis B and Hepatitis C upon hiring.
- IC.34.6 All HBV and HCV susceptible hemodialysis unit employees should be screened annually and as needed after any blood or body fluid exposure.
- IC.34.7 All hemodialysis unit employees susceptible to Hepatitis B are immunized with Hepatitis B vaccine.
- IC.34.8 All vaccinated personnel are tested for antibodies to evaluate response, and all non-responders are given a second series of the HBV vaccine.
- IC.34.9 Records for hepatitis screening and immunization are kept in database (cards, sheet or computerized) to allow a rapid evaluation of the information.

**Evidence of Compliance**

- |            |  |                       |
|------------|--|-----------------------|
| IC.34.EC.1 | All patients are screened for Hepatitis B, C and HIV at the beginning of dialysis. Patients with negative test for HBsAg, anti HBs, HCV, and/or HIV is/are re-screened every 3-6 months. | Medical Record Review |
| IC.34.EC.2 | Patient vaccination / immunization is applied and monitored as required.   | Medical Record Review |
| IC.34.EC.3 | Infected patient are handled with different dialysis setup.  | Interview             |
| IC.34.EC.4 | There is a comprehensive documented vaccination system that protects staff from blood borne pathogens.   | Personnel File        |

**IC.35 Hemodialysis water is periodically disinfected and cultured.**

- IC.35.1 Microbiologic monitoring of treated water and dialysate should be performed at least monthly and more frequently if a problem is identified. Water is collected from deionized water outlet before each hemodialysis machine, and from dialysate just exiting from each hemodialysis machine.
- IC.35.2 Chemical testing of water to be done yearly.
- IC.35.3 Reverse osmosis water should be decontaminated weekly and documented.

**Evidence of Compliance**

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|------------|---|-------------|
| IC.35.EC.1 | Records of hemodialysis water analysis are maintained and reflect (monthly Microbiologic monitoring, weekly decontamination of reverse osmosis water ). | Observation |
|------------|---|-------------|

**IC.36 There are written policies that address all the above issues in the hemodialysis unit.**

**Evidence of Compliance**

- |            |  |                 |
|------------|--|-----------------|
| IC.36.EC.1 | IC policies and procedures for the hemodialysis unit including water analysis. | Document Review |
|------------|--|-----------------|

**IC.37 Infection control standards are strictly implemented and supervised in the Operating Rooms.**

- IC.37.1 Operating Room environment is clean and dustless.
- IC.37.2 No closets are built inside theaters.
- IC.37.3 Minimal items are stored in Operating Room.
- IC.37.4 Traffic control in Operating Room is observed with policies in this regard written.
- IC.37.5 Operating Room is maintained at positive pressure with respect to corridors.
- IC.37.6 Maintain > 15 air changes per hour.
- IC.37.7 Air is introduced near the ceiling and exhausted near the floor.
- IC.37.8 All re-circulated or fresh air should be filtered through filters that provide 90% efficiency HEPA filters.



IC.37.9 There is clear separation between restricted and non-restricted areas of Operating Room.

IC.37.10 Only Operating Room specified clothes are allowed inside the restricted areas of Operating Room.

IC.37.11 Large scrubbing sinks are available at entry to each Operating theater.

#### Evidence of Compliance

IC.37.EC.1	IC standards are implemented in the OR (OR theater is clean and dustless).	Interview
IC.37.EC.2	IC standards are implemented in the OR (no built closets and minimal stocks).	Observation
IC.37.EC.3	IC standards are implemented in the OR (restricted and non-restricted areas are well defined with good traffic control).	Observation
IC.37.EC.4	IC standards are implemented in the OR (large scrubbing sink at entry of each theatre with the proper disinfectant).	Observation
IC.37.EC.5	IC standards are implemented in the OR (Only Operating Room specified clothes are allowed inside the restricted areas of Operating Room).	Observation
IC.37.EC.6	Records of pressure gradients and air cycles measures (15 air exchanges per hour).	Observation
IC.37.EC.7	IC standards are implemented in the OR (HEPA filters at the supply and proper exhaust grills).	Observation

#### IC.38 Infection control team reviews and supervises construction projects in the hospital.

IC.38.1 There are written policies that address infection control considerations during construction.

IC.38.2 There is a system that ensures involvement of infection control prior to any construction projects in the hospital.

IC.38.3 Environmental fungal cultures should be routinely done at the end of construction work and reviewed by the infection control team.

#### Evidence of Compliance

IC.38.EC.1	There are written policies that address infection control considerations during construction.	Document Review
IC.38.EC.2	Infection control team reviews and supervises construction projects.	Document Review
IC.38.EC.3	Environmental fungal cultures is routinely done at the end of construction work and reviewed by the infection control team.	Document Review

#### IC.39 Infection control team reviews and supervises procedures that are associated with increased risk of healthcare-associated infections:

IC.39.1 Care of indwelling urinary catheters.

IC.39.2 Care of peripheral and central venous catheters.

IC.39.3 Respiratory care.

#### Evidence of Compliance

IC.39.EC.1	Infection control guideline on handling high risk healthcare-associated infections-	Document Review
IC.39.EC.2	Infection control team reviews procedures that are associated with increased risk of healthcare-associated infections	Document Review

#### IC.40 Gloves, gowns, masks use is supervised by infection control.

IC.40.1 Written policies and procedures are available on the appropriate use of gloves, gowns, facemasks, protective eyewear and respirator (High filtration) masks (N-95, N-99...).

#### Evidence of Compliance

IC.40.EC.1	IC manual include policies for appropriate use of PPE.	Document Review
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#### IC.41 Gloves, gowns, masks are used correctly.

IC.41.1 Gloves are properly used:

IC.41.1.1 Gloves are worn when there is a potential for contact with blood/body fluid e.g. venipuncture, other vascular access procedures.

IC.41.1.2 Gloves are removed and discarded (not washed) after use.



IC.41.1.3 Gloves are removed as soon as work on the patient is done, and before leaving room.

IC.41.1.4 Contaminated gloves are not used to touch uncontaminated surfaces (telephone, pens, paper, and files).

IC.41.2 Gowns or other protective clothes are worn during all the procedures, which are likely to generate splashes or soiling from blood or other body fluids.

IC.41.2.1 Gowns are not worn outside of the patient's room or the treatment room unless the employee is escorting /transporting a patient under isolation.

IC.41.3 Masks and protective eyewear or face shields are worn during procedures which are likely to generate droplets of blood or body fluids.

**Evidence of Compliance**

IC.41.EC.1 Proper way of using PPE (Gloves, gowns, masks).

Interview

**IC.42 Protective personal equipment (gown, gloves, masks, and protective eyewear) is readily available in all patient care areas.**

**Evidence of Compliance**

IC.42.EC.1 Protective personal equipment is available in all patient care areas.

Interview

**IC.43 Hand hygiene is strictly observed in the hospital:**

IC.43.1 Written policies and procedures on appropriate hand hygiene are available.

IC.43.2 Hand hygiene is done according to policies.

**Evidence of Compliance**

IC.43.EC.1 Hand hygiene is done according to policies.

Interview

**IC.44 The hospital provides sufficient hand hygiene facilities.**

IC.44.1 Toilets, hand washing and bathing facilities meet the needs of the hospital and are clean and in good repair.

IC.44.1.1 Hand washing sinks should be available in all patients' rooms (including clinics and emergency room) and nursing stations.

IC.44.2 Hand washing sinks and bathing facilities are supplied with hot and cold water under pressure.

IC.44.3 Hand washing sinks are conveniently accessible to staff.

IC.44.4 Plain and antiseptic soap and paper towels (not cloth towels) should be available for hand washing.

IC.44.5 Hand disinfectants are available in adequate number (one dispenser per patients room in general wards and clinics, one per bed in critical areas and the emergency room, and one in every nursing station).

**Evidence of Compliance**

IC.44.EC.1 The hospital provide the necessary resources to ensure the implementation of hand hygiene practice (toilets, hand washing and bathing facilities, hot and cold water, plain and antiseptic soap and paper towels, hand disinfectant with dispenser).

Interview

**IC.45 Communicable diseases are tabulated and reported to the Ministry of Health as per written hospital policies and Ministry of Health guidelines.**

**Evidence of Compliance**

IC.45.EC.1 Reporting of communicable diseases to MOH as per the hospital policy.

Document Review

**IC.46 Employee's health is in accordance with scientific recommendations and the Ministry of Health guidelines.**

IC.46.1 There are written policies and procedures that address employees' health, their immunization, and post exposure



prophylaxis.

IC.46.2 There is a clinic to provide counseling and medical services related to screening, immunization, and post exposure management.

IC.46.3 The screening and immunization data are kept in staff medical records.

#### Evidence of Compliance

IC.46.EC.1	Policies for staff health including immunizations and blood/body fluid exposure are in place.	Document Review
IC.46.EC.2	Employees' medical records reflect required staff immunization.	Medical Record Review
IC.46.EC.3	Staff health clinic scope of services includes counseling and medical services related to screening, immunization, and post exposure management.	Document Review

#### IC.47 Employee's health and their immunization are practiced according to policies:

IC.47.1 Baseline screening of all employees for hepatitis B, C, HIV and PPD should be done.

IC.47.2 The immune status of employees against hepatitis B, measles, mumps, rubella and varicella should be determined by serological testing and the appropriate vaccine administered to those who are susceptible.

IC.47.3 Response to hepatitis B vaccination is monitored in vaccinated employees.

IC.47.4 Non-responders to hepatitis B vaccine are offered at least a second series of the vaccine.

IC.47.5 Employees are screened for TB upon contracting with PPD test, and the test repeated annually for those who are non-reactive.

#### Evidence of Compliance

IC.47.EC.1	Employee's health and their immunization: Baseline screening of all employees for hepatitis B, C, HIV and PPD should be done.	Document Review
IC.47.EC.2	The immune status of employees against hepatitis B, measles, mumps, rubella and varicella should be determined by serological testing.	Document Review
IC.47.EC.3	Availability of the vaccine according to staff immunization policies.	Interview
IC.47.EC.4	The susceptible employee will receive the appropriate vaccine.	Document Review
IC.47.EC.5	Response to hepatitis B vaccination is monitored in vaccinated employees.	Document Review
IC.47.EC.6	Non-responders to hepatitis B vaccine are offered at least a second series of the vaccine.	Document Review
IC.47.EC.7	Employees are screened for TB upon contracting with PPD test, and the test repeated annually for those who are non-reactive.	Document Review

#### IC.48 Infection control team monitors incidence of exposure of the staff to pathogens in the Hospital:

IC.48.1 There is a system for reporting, follow up and management of exposure to open pulmonary TB.

IC.48.2 There is a system for reporting, investigation, follow up and management of needle stick and sharp injuries. Collected data is trended and reported at the Safety committee and Infection control committee.

IC.48.3 There is a system for reporting, follow up and management of exposure vaccine-preventable viruses (chickenpox, measles, mumps, and rubella).

IC.48.4 PPD conversion rates and sharp injuries rates are calculated.

#### Evidence of Compliance

IC.48.EC.1	Policies on identification of exposures to TB, varicella and sharp injuries.	Document Review
IC.48.EC.2	Policies on post exposure management.	Document Review
IC.48.EC.3	IC team reports for (open pulmonary TB, needle prick and sharp injuries, chickenpox, measles, mumps, and rubella).	Document Review
IC.48.EC.4	Staff awareness about appropriate reporting of exposure to needle stick, sharps injuries and vaccine preventable viruses.	Interview
IC.48.EC.5	IC team monitors incidence of exposure of the staff to open pulmonary TB.	Document Review
IC.48.EC.6	There is a system for reporting, follow up and management of exposure vaccine-preventable viruses (chickenpox, measles, mumps, and rubella).	Document Review
IC.48.EC.7	Calculation of the PPD conversion rates and sharp injuries rates.	Document Review



IC.49 Staff accommodation is healthy (clean, well ventilated, not overcrowded, well maintained, and free from pests).

**Evidence of Compliance**

IC.49.EC.1 Staff accommodation is clean, well ventilated, not overcrowded, well maintained and free from pests.

Observation





## Pharmacy

### Introduction

The use of medication is an important component in the treatment of many diseases and conditions. However, the improper management or use of medications may cause great harm to patients. Therefore, the pharmaceutical services should be organized and administered to provide effective, efficient, and safe pharmacy services. In essence, a well- managed medication system promotes patient safety and quality of care.

The pharmacy standards comprise the following processes and activities:

- Ordering
- Medication security and safety
- Formulary system
- Labeling
- Dispensing
- Administration
- Storage
- Emergency medications
- Monitoring medications effects
- Medication error identification and reporting
- Adverse drug events identification, reporting, and response
- Retrieving and managing recalled medications
- Controlled drugs management



## Standards

### PH.1 The hospital has a pharmacy service department and headed by a qualified pharmacist with appropriate experiences.

- PH.1.1 The Pharmacy has a clear organization structure.
- PH.1.2 Pharmacy head holds Pharm.D, Master, or Bachelor of Science degree in Pharmacy.
- PH.1.3 Pharmacy head has signed an updated job description.
- PH.1.4 Evidence of valid Saudi Council of Health Specialties license to practice in Saudi Arabia.
- PH.1.5 The Pharmacy head has an updated curriculum vitae.
- PH.1.6 Evidence of work experience in hospital setting.

#### Evidence of Compliance

- PH.1.EC1 There is qualification (Bachelor of pharmacy or higher degree), experience and licensed by the Saudi Council of Health Specialties. Personnel File
- PH.1.EC2 Current job description of Pharmacy director. Personnel File

### PH.2 The pharmacy has a clear mission, vision, and values.

- PH.2.1 Mission is clearly written, posted, and verbalized by pharmacy staff.
- PH.2.2 Vision is clearly written, posted, and verbalized by pharmacy staff.
- PH.2.3 Values are clearly written, posted, and verbalized by pharmacy staff.

#### Evidence of Compliance

- PH.2.EC1 Pharmacy mission, vision, and values are clearly written. Document Review
- PH.2.EC2 Pharmacy mission, vision, and values are posted. Observation
- PH.2.EC3 Pharmacy mission, vision, and values are verbalized. Interview

### PH.3 The pharmacy space is adequate. Hours of operation are determined, announced and followed.

- PH.3.1 The space provided for pharmacy services allows the principal functions to be carried out in efficient and effective manner.
- PH.3.2 Hours of operation of each pharmacy section are clearly defined in the policy and procedure, announced within the hospital and posted at the pharmacy entrance.
- PH.3.3 Monthly work schedule is written and announced.

#### Evidence of Compliance

- PH.3.EC1 Pharmacy has adequate space to efficiently operate. Observation
- PH.3.EC2 Pharmacy monthly work schedule is available and posted. Observation
- PH.3.EC3 Pharmacy operation hours are known and posted. Observation

### PH.4 The pharmacy has qualified and licensed staffing.

- PH.4.1 All Pharmacy staff has valid licenses from the Saudi Council of health Specialties to practice in Saudi Arabia.
- PH.4.2. All staff have a current job description.
- PH.4.3. Each staff signed his/her job description.

#### Evidence of Compliance

- PH.4.EC1 All pharmacy staff are qualified and licensed by the Saudi Council of Health Specialties. Personnel File
- PH.4.EC2 All pharmacy staff have current and signed job description. Personnel File

### PH.5 The pharmacy actively participates in all relevant hospital committees as evidenced by meeting minutes.

- PH.5.1 The pharmacy actively participates in the Pharmacy and Therapeutics committee.
- PH.5.2 The pharmacy actively participates in the hospital QM/TQM committee.
- PH.5.3 The pharmacy actively participates in the hospital Infection Control committee.



PH.5.4 The pharmacy actively participates in the hospital Fire and Safety committee.

**Evidence of Compliance**

- PH.5.EC1 Actively participates in the Pharmacy and Therapeutics committee (as per meeting minutes). Document Review
- PH.5.EC2 Actively participates in the Hospital Quality Management committee (as per meeting minutes). Document Review
- PH.5.EC3 Actively participates in the Infection Control committee (as per meeting minutes). Document Review
- PH.5.EC4 Actively participates in the Fire and Safety committee (as per meeting minutes). Document Review

**PH.6 The pharmacy has updated internal policy and procedures for all available services (IPPs.)**

- PH.6.1 All approved IPPs are written according to standard hospital format & updated every 2 years.
- PH.6.2 All multidisciplinary IPPs are established by the combined effort of pharmacy, medical, nursing, and hospital administration.
- PH.6.3 IPPs are made accessible to all pharmacy staff all the time and staff is familiar with IPPs.

**Evidence of Compliance**

- PH.6.EC1 Pharmacy internal policy and procedures are complete, updated (every 2 years) and approved. Document Review
- PH.6.EC2 Multidisciplinary policies are established when necessary. Document Review
- PH.6.EC3 Pharmacy policies are accessible to all pharmacy staff and staff are familiar with it. Observation

**PH.7 The Pharmacy Director reports workload statistics to the appropriate committee and leadership. Number of FTE (full-time equivalent staff) and actual workload are published.**

- PH.7.1 Standard time for each function/task is determined.
- PH.7.2 Monthly workload is reported for inpatient pharmacy (Unit dose and/or IV admixture).
- PH.7.3 Monthly workload is reported for Chemotherapy.
- PH.7.4 Monthly workload is reported for pharmacy storeroom.
- PH.7.5 Monthly workload is reported for extemporaneous compounding.
- PH.7.6 Monthly workload is reported for outpatient pharmacy.
- PH.7.7 Monthly workload is reported for clinical pharmacy services.
- PH.7.8 Monthly manpower (staffing, FTE) is reported
- PH.7.9 Monthly workload is reported for other activities (e.g. meetings, in-services, floor inspections, etc.).
- PH.7.10 Workload statistics are reported monthly to the appropriate committee and the leadership for future planning and pharmacy staffing.
- PH.7.11 The pharmacy has the necessary manpower to operate the available service as evidenced by the workload statistics.

**Evidence of Compliance**

- PH.7.EC1 Monthly workload statistics of the pharmacy is reported to the appropriate committee and leadership. Document Review
- PH.7.EC2 Standard time for each pharmacy task is well defined. Document Review
- PH.7.EC3 Comprehensive workload statistic report including all available services (inpatient, outpatient, IV admixture, etc.). Document Review
- PH.7.EC4 Pharmacy has the necessary manpower to operate the available services. Document Review

**PH.8 The pharmacy has administrative rules regarding availability of medications 24-hours a day.**

- PH.8.1 The Pharmacy is open 24 hr/day for inpatient areas, EMS, and clinic prescriptions.
- PH.8.2 If the pharmacy is not open 24hr/day.
- PH.8.2.1 Availability of on-call pharmacist within 20 minutes whenever pharmacy is closed.
- PH.8.2.2 On-call service is announced to all hospital service areas (written schedule, communication numbers, etc.) for use after working hours.

**Evidence of Compliance**



- PH.8.EC1 The pharmacy provides 24 hours daily services for inpatient and emergency room customers. Interview
- PH.8.EC2 The pharmacy provides on-call services within reasonable time frame (20 minutes) after the normal working hours. Interview

**PH.9 The Hospital has an updated formulary system.**

- PH.9.1 The Hospital formulary is established in collaboration with the pharmacy and therapeutics committee.
- PH.9.2 The Hospital formulary is updated every TWO years at least.
- PH.9.3 The Hospital formulary is available to healthcare team (hardcopy or electronic).

**Evidence of Compliance**

- PH.9.EC1 Updated (within 2 years) and approved hospital formulary by the Pharmacy and Therapeutics committee. Document Review
- PH.9.EC2 Pharmacy and therapeutics committee is actively participating in establishing the hospital formulary. Interview
- PH.9.EC3 Availability of updated hospital formulary in all patient care units. Observation

**PH.10 The Hospital formulary is very well structured.**

- PH.10.1. Hospital formulary has at least generic & brand name information, formulations, strength, therapeutic classification, and prescribing information.
- PH.10.2 The Hospital formulary is properly indexed using alphabetical indexing for both generics- and brand-named available drugs.
- PH.10.3 An approved abbreviation list for prescribing is included in a separate section and there is evidence of implementation.

**Evidence of Compliance**

- PH.10.EC1 Well structured hospital formulary (including brand, generic, formulation, strength, therapeutic class, prescribing information, approved prescribing abbreviations and alphabetical index). Document Review
- PH.10.EC2 Implementation of the approved prescribing abbreviations (Check Outpatient prescriptions and open medical records during hospital tour). Observation

**PH.11 The Hospital formulary provides guidance to antibiotic use.**

- PH.11.1 Antibiotic utilization guidelines and/or restriction are included in a separate section.
- PH.11.2 Evidence of implementation by prescribers of the antibiotic utilization guidelines.
- PH.11.3 Antibiotic dispensing as per antibiotic hospital policy (dosing, duration, restriction, etc.).

**Evidence of Compliance**

- PH.11.EC1 Antibiotic use guidelines are published through the hospital formulary. Document Review
- PH.11.EC2 Antibiotics use guidelines are approved by the Pharmacy and Therapeutics committee. Interview
- PH.11.EC3 Antibiotic prescribing as per antibiotic hospital policy (restriction or prescribing privileges). Medical Record Review
- PH.11.EC4 Antibiotic dispensing as per antibiotic hospital policy (dose, duration and restrictions). Observation

**PH.12 The pharmacy has infection control guidelines that include:**

- PH.12.1 Written policies and procedures.
- PH.12.2 Guidelines verbalized by pharmacy staff.
- PH.12.3 Guidelines adhered to by pharmacy staff.
- PH.12.4 No food, drink, or smoking allowed in the pharmacy.
- PH.12.5 A sink, soap, and antiseptic hand scrub are available in the pharmacy.
- PH.12.6 Separate housekeeping materials of the IV admixture room



**Evidence of Compliance**

- PH.12.EC1 Written policy on pharmacy infection control. Document Review
- PH.12.EC2 Implementation and verbalization of infection control guidelines by staff. Interview
- PH.12.EC3 Availability of sink, soap, antiseptic hand scrub and separate housekeeping materials of the IV admixture room (if IV room is available). Observation

**PH.13 The pharmacy has a system for accepting verbal orders.**

- PH.13.1 There is a written multidisciplinary IPP for accepting and transcribing verbal orders by medical staff.
- PH.13.2 IPP clearly defines urgency/emergency situation for accepting verbal orders "code" and time frame for order authentication.
- PH.13.3 IPP clearly defines restriction on drugs that may be ordered verbally.
- PH.13.4 IPP clearly defines non-medical staff who may accept a verbal order.
- PH.13.5 IPP defines proper procedure for receiving and documenting verbal orders.
- PH.13.6 Staff (pharmacy and/or nurse) clearly understands how to handle verbal orders.

**Evidence of Compliance**

- PH.13.EC1 Comprehensive multidisciplinary verbal orders policy is clearly written and approved (define urgent situation for verbal order, who can accept, time frame for authentication, receiving and documentation). Document Review
- PH.13.EC2 Staff understanding of verbal order (Interview medical, nursing and pharmacy staff during unit tour). Interview

**PH.14 The pharmacy has a system for accepting telephone orders:**

- PH.14.1 Written multidisciplinary IPP for accepting and transcribing telephone orders by medical staff.
- PH.14.2 IPP clearly defines urgency situation for accepting telephone orders and time frame for order authentication.
- PH.14.3 IPP clearly defines restriction on drugs that may be ordered by telephone.
- PH.14.4 IPP clearly defines staff who may accept a telephone order.
- PH.14.5 IPP defines proper procedure for receiving and documenting telephone orders.
- PH.14.6 Staff (pharmacy and nurse) clearly understand how to handle telephone orders.

**Evidence of Compliance**

- PH.14.EC1 Comprehensive multidisciplinary telephone orders policy is clearly written and approved (define urgent situation for telephone order, who can accept, time frame for authentication, receiving and documentation). Document Review
- PH.14.EC2 Staff understanding of telephone order (Interview medical, nursing and pharmacy staff during unit tour). Interview

**PH.15 There is a list of Medical staff signatures who are authorized to prescribe medication.**

- PH.15.1 The list contains medical staff name, signature, ID number, specialty, and stamp or code (if available) and updated every year.
- PH.15.2 Clear copy of the signature list is available to pharmacy staff in each drug dispensing area.
- PH.15.3 Pharmacy staff is aware of the list.

**Evidence of Compliance**

- PH.15.EC1 Comprehensive and updated records of all prescribers' signatures are readily available in the pharmacy. Document Review
- PH.15.EC2 There is pharmacy staff awareness of prescribers' signature records. Interview

**PH.16 There is an updated list of prescribers and their prescribing privileges.**

- PH.16.1 The list contains medical staff specialties and their prescribing privileges.
- PH.16.2 The list clearly defines prescribing privileges especially for narcotics, controlled drugs, psychotropics, chemotherapeutics, and high risk medications, etc.
- PH.16.3 The list is updated every year and whenever a new medical staff joins.



PH.16.4 Clear copy of the privilege list is available to pharmacy staff in each drug dispensing area.

PH.16.5 Pharmacy staff is aware of the list.

PH.16.6 There is clear evidence of proper implementation.

#### Evidence of Compliance

- |  |                       |
|--|-----------------------|
| PH.16.EC1 Comprehensive, updated and approved list of medical staff prescribing privileges is readily available in the pharmacy. | Document Review       |
| PH.16.EC2 Prescribing privileges are clearly defined and approved by the pharmacy and therapeutics committee.                    | Interview             |
| PH.16.EC3 There is proper implementation of prescribing privileges (Check at least 5 medical records for compliance).            | Medical Record Review |

#### PH.17 The pharmacy has a system for handling drug recall.

PH.17.1 Clearly written IPP including identification and handling drug recalls, time frame, and procedures for informing patients who received any recalled drug.

PH.17.2 Evidence of proper recall is documented (memos, recall forms, hospital exit documents).

PH.17.3 None of the recalled drugs is available in the pharmacy or patient care areas.

#### Evidence of Compliance

- |   |                 |
|---|-----------------|
| PH.17.EC1 Written policy and procedures on handling drug recall.  | Document Review |
| PH.17.EC2 There is proper recall system (documentation of actual recalls, absence of recall drugs in the hospital). | Observation     |
| PH.17.EC3 Drug recalls are monitored on timely basis by the pharmacy and therapeutics committee.                    | Interview       |

#### PH.18 The pharmacy has a system for identifying and handling expired medications.

PH.18.1 Written policy clearly defines expiry date, expired medications, nearly expired medications, and proper procedure for handling expired drugs, and inspection form(s).

PH.18.2 All expired and/or nearly-expired medications are properly labeled and stored separate from other medications.

PH.18.3 No expired drugs are found in any patient care area.

PH.18.4 Documents of return of expired drugs to supplier or manufacturer are maintained on file or evidence of proper destruction.

#### Evidence of Compliance

- |  |                 |
|--|-----------------|
| PH.18.EC1 Written policy on identification and proper handling of expired and nearly expired drugs.                | Document Review |
| PH.18.EC2 There is proper labeling, isolation, destruction, and/or return of expired drugs to the supplier/vendor. | Observation     |

#### PH.19 The pharmacy has a system for handling pharmaceutical sales representatives and free medical samples.

PH.19.1 Written multidisciplinary IPP to outline the relationship of pharmaceutical sales representatives with healthcare professionals.

PH.19.2 Written multidisciplinary IPP for handling and dispensing free medical samples that has been approved by the Pharmacy and Therapeutic committee.

PH.19.3 All free medical samples are kept under tight inventory control in a separate and properly labeled cabinet in the pharmacy.

PH.19.4 No free medical samples are found in the inpatient areas or the outpatient clinics (OPD).

#### Evidence of Compliance

- |  |                 |
|--|-----------------|
| PH.19.EC1 Written multidisciplinary policy for handling pharmaceutical sales representatives and free medical samples. | Document Review |
| PH.19.EC2 There is tight control of free medical samples by the pharmacy (no samples in all patient care areas).       | Observation     |
| PH.19.EC3 The use of free medical samples is controlled and monitored by the pharmacy and therapeutics committee.      | Interview       |



**PH.20 The pharmacy has a system for handling non-formulary drug requests.**

- PH.20.1 Written multidisciplinary IPP for handling non-formulary drugs including clearly defined time frame for drug procurement.  
PH.20.2 Non-formulary drug request form is available.  
PH.20.3 Clear evidence of proper handling of non-formulary drug request is available.

**Evidence of Compliance**

- PH.20.EC1 Written multidisciplinary policy on handling non-formulary drug requests. Document Review  
PH.20.EC2 There is proper handling of non-formulary drug requests (actual samples on file). Document Review  
PH.20.EC3 All non-formulary drug requests are reviewed and evaluated by the pharmacy and therapeutics committee on regular basis. Interview

**PH.21 The pharmacy has a system for using formulary drugs for un-approved indications.**

- PH.21.1 Written multidisciplinary IPP for using a formulary drug for an un-approved indication and/or investigation.  
PH.21.2 Request form for using formulary drug for an un-approved indication is available.  
PH.21.3 Clear evidence of proper adherence to the IPP for using formulary drugs for an un-approved indications.

**Evidence of Compliance**

- PH.21.EC1 Written multidisciplinary policy for the use of formulary drugs for unapproved indications. Document Review  
PH.21.EC2 There is proper implementation of using drugs for unapproved indications (actual samples on file). Document Review  
PH.21.EC3 All requests for using drugs for un-approved indications are reviewed and evaluated by the pharmacy and therapeutics committee on regular basis. Interview

**PH.22 The pharmacy has a system for handling out-of-stock medications and PRN.**

- PH.22.1 Written IPP for handling out-of-stock formulary medications including clearly defined time frame for drug procurement.  
PH.22.2 Written IPP and evidence of implementation for handling PRN drugs e.g. NTG, S.L Isordil, Voltaren, etc.

**Evidence of Compliance**

- PH.22.EC1 Written policy for handling out-of-stock medications. Document Review  
PH.22.EC2 Active involvement of the pharmacy and therapeutics committee in the proper management of out-of-stock formulary medications. Interview  
PH.22.EC3 Written policy for handling PRN (as needed) drug orders. Document Review  
PH.22.EC4 There is proper implementation of PRN drug orders. Observation

**PH.23 The pharmacy has a system for handling patient's own medications (brought from home).**

- PH.23.1 Written multidisciplinary IPP for handling patient's own medications (brought from home).  
PH.23.2 Patient's own medications are properly labeled by the pharmacy before use.  
PH.23.3 Evidence of proper implementation of patient's own medication (documentation in patient's drug profile and nursing MAR).

**Evidence of Compliance**

- PH.23.EC1 Written multidisciplinary policy on handling patients own medications (brought from home). Document Review  
PH.23.EC2 There is proper implementation of patient's own medication system (observation in the patient care units and nursing MAR). Observation

**PH.24 The pharmacy has a system for ensuring preparedness of crash cart medications.**

- PH.24.1 Developing and maintaining a set of guidelines for crash cart medication (all drugs on crash carts throughout the



hospital are standardized) - multidisciplinary policy.

PH.24.2 Updating the crash cart drug list in accordance to the Saudi Heart/American Heart Association recommendation.

PH.24.3 Protecting emergency medications from loss or theft using safety plastic seal.

PH.24.4 Keeping plastic seals stocked in a safe place under supervision of pharmacy or nursing.

PH.24.5 Monitoring emergency medications and replacing them in a timely manner after use or when expired or damaged.

PH.24.6 Performing documented monthly inspection of crash cart medications and maintaining records in the pharmacy.

#### Evidence of Compliance

PH.24.EC1 Written multidisciplinary policy on standardization of crash cart medication contents (according to Saudi/American Heart recommendations) Document Review

PH.24.EC2 Emergency medications are protected from loss or theft (Properly locked and easily open, lock number is recorded, tight control on extra locks). Observation

PH.24.EC3 Regular monitoring and replacement of expired, damaged or used medication(s). Observation

PH.24.EC4 There is documented monthly inspection of crash cart medications (crash cart records of the pharmacy). Document Review

#### PH.25 The pharmacy has a system for ensuring stability of medication available in multi-dose containers.

PH.25.1 Developing and maintaining a set of guidelines for ensuring stability of multi-dose vials, multi-dose oral liquid, and other multi-dose medications (e.g., eye, ear, and nose drops, creams, ointments, nebulization solution, etc.).

PH.25.2 Ensuring that all open multi-dose containers carry open date, expiry date, initials, and time (if necessary).

PH.25.3 Ensuring that no expired open or unlabeled open multi-dose containers are available in patient care areas.

#### Evidence of Compliance

PH.25.EC1 Availability of pharmacy stability guidelines of multi-dose vials and containers in all patient care units. Observation

PH.25.EC2 There is proper labeling of vials and multi-dose containers after the first use. Observation

#### PH.26 The pharmacy has a system for managing floor stock medications

PH.26.1 An approved list of floor stock medication is allowed on each unit or clinic.

PH.26.2 Floor stock supply is available in limited quantities.

PH.26.3 Floor stock supply is not accessible to patients or visitors.

PH.26.4 Floor stock medications are stored under proper condition (temperature, light protection). Storage area is clean and organized.

PH.26.5 No expired medications are available.

PH.26.6 All floor stock medications are well separated and properly labeled.

#### Evidence of Compliance

PH.26.EC1 Well structured and approved system for floor stock medication assignment in limited quantities according to each service unit needs. Observation

PH.26.EC2 There is proper storage and maintenance of floor stock drugs (locked, inaccessible to visitor/patients, properly labeled, proper storage condition, not expired, not overstocked). Observation

#### PH.27 The pharmacy has a system for handling high-risk medications.

PH.27.1 Written guidelines for handling high-risk medications (including a defined list).

PH.27.2 Concentrated intravenous potassium, magnesium and hypertonic saline are not allowed as floor stock except as part of the crash cart medication as per Saudi Heart recommendation.

PH.27.3 Only, if necessary, critical care areas may stock limited quantities of intravenous potassium, and magnesium in a separate, locked and properly labeled cabinet.

PH.27.4 Standard drug concentrations of all intravenous drips in the hospital.

#### Evidence of Compliance

PH.27.EC1 Written guidelines for high-risk medications. Document Review

PH.27.EC2 The guidelines for handling high-risk medications are closely monitored and reviewed Interview





by the pharmacy and therapeutics committee.

- PH.27.EC3 Concentrated intravenous electrolytes are not readily available in patient care units. Observation  
PH.27.EC4 There is standardization of intravenous drip concentrations in patient care units. Observation

**PH.28 The pharmacy has a system developed for handling outpatient prescriptions which includes:**

- PH.28.1 A policy for filling, refilling prescriptions, discharge medications, and self-medication of healthcare professionals.  
PH.28.2 All prescriptions have the patient's name, hospital number, age, sex, diagnosis, prescriber's name, pager # or code & signature, clinic name and date.  
PH.28.3 Any prescription is double-checked by another pharmacist before dispensing.

**Evidence of Compliance**

- PH.28.EC1 Written policy on handling outpatient prescriptions. Document Review  
PH.28.EC2 All prescriptions have the patients name, hospital number, age, sex, diagnosis, prescriber's name, pager # or code & signature, clinic name and date (Sample of pharmacy received prescriptions). Observation  
PH.28.EC3 Double check system is implemented (sample dispensed medicine). Observation

**PH.29 The outpatient pharmacy has a system developed for proper labeling of drugs which includes:**

- PH.29.1 All outpatient drugs are labeled in Arabic and/or English according to patient preference.  
PH.29.2 Outpatient label reflects Hospital name, patient name, drug name, strength, dosage, and directions.  
PH.29.3 Colored auxiliary labels that stick out are used whenever applicable (e.g. refrigerate, do not refrigerate, shake before use, external use, etc).

**Evidence of Compliance**

- PH.29.EC1 There is appropriate labeling language (Arabic and/or English according to patient preference). Observation  
PH.29.EC2 There is complete labeling information (hospital, patient and drug name, strength, dosage, directions, colored auxiliary cautions). Observation

**PH.30 The outpatient pharmacy has a system developed for patient and family education before going home which includes:**

- PH.30.1 Patients and families are offered education for dispensed medications.  
PH.30.2 Written drug counseling materials are available in easy understandable language (Arabic and English).  
PH.30.3 There is a private area for patient counseling.

**Evidence of Compliance**

- PH.30.EC1 Availability of patient and family education system (for outpatients and going home patients, written education materials in the appropriate language, private area for counseling). Observation  
PH.30.EC2 There is appropriate education (staff awareness and skills)- observation of at least three educational cases in the outpatient pharmacy. Observation

**PH.31 The pharmacy shows evidence of continuing education and staff training by:**

- PH.31.1 Written policy and well defined pharmacy orientation and continuing education program.  
PH.31.2 Evidence of completion of pharmacy orientation by all newly hired pharmacy staff.  
PH.31.3 Evidence of continuing education activities (provision or attendance of lectures, in-services, conferences & symposia, or distant learning e.g., internet or CE articles).  
PH.31.4 Each pharmacy section has the following reference manuals and/or policies (relevant policy and procedure manual, infection control manual, safety manual, operating manual of equipments, MSDS manual).  
PH.31.5 The pharmacy staff operates equipment safely by maintaining skills in the use of equipment including trouble-shooting.  
PH.31.6 The pharmacy staff knows how to report and properly label malfunctioning equipment so that staff do not use it.



**Evidence of Compliance**

- PH.31.EC1 Written policy on pharmacy orientation and continuing education program. Document Review
- PH.31.EC2 There is completion of pharmacy orientation and continuing education program (randomly screen 10% or at least 5 personnel files). Personnel File
- PH.31.EC3 Availability of all necessary manuals (pharmacy, infection control, equipment operation, and MSDS manual). Observation
- PH.31.EC4 There is safe operation of all available pharmacy equipment (interview pharmacy staff operating equipments). Interview

**PH.32 The pharmacy has a system for drug storage (inpatient, outpatient, store, patient care areas) and includes:**

- PH.32.1 Storage of items requiring refrigeration at a temperature of 2-8 °C and those requiring freezing at -20° to -10 °C.
- PH.32.2 All medication refrigerators and freezers are equipped with appropriate thermometers (digital and non-digital) and temperature log sheet and temperature is recorded at least once daily.
- PH.32.3 Vaccine refrigerator is connected to emergency power source, (electric outlets are marked) and temperature is recorded 24-h daily.
- PH.32.4 Food, drinks, biological samples, culture media are not allowed in medication refrigerators.
- PH.32.5 Storing antiseptics, disinfectants and drugs for external use separately from internal and injectable medications.
- PH.32.6 All medications are well separated and properly labeled upon display on the shelves.

**Evidence of Compliance**

- PH.32.EC1 Written policy on drug storage across the hospital. Document Review
- PH.32.EC2 There is at least daily monitoring and recording of refrigerators (2-8 °C) and freezers (-20 to -10 °C) temperature using digital or non-digital means. Observation
- H.32.EC The vaccine refrigerator(s) are connected to emergency power supply and its temperature is recorded around the clock. Observation
- PH.32.EC4 The antiseptics/disinfectants and externally used drugs are well separated from those used internally or by injection. Observation

**PH.33 The following rules are written and implemented as to the dispensing mechanism for inpatient:**

- PH.33.1 There is a quiet, adequately illuminated and low-noise working environment that does not permit interruption of work.
- PH.33.2 A log is maintained as to the person pre-packing & the person checking all unit doses made. If Unit-dose pre-packing is not available, doses of each drug are placed in plastic bag and properly labeled.
- PH.33.3 No more than 24-h supply is dispensed at a time except for bulk (liquids, ointments, etc.)

**Evidence of Compliance**

- PH.33.EC1 Written policy on inpatient pharmacy dispensing mechanism. Document Review
- PH.33.EC2 The Pharmacy dispensing area is quiet, adequately illuminated and low noise. Observation
- PH.33.EC3 Only 24 hours drug supply is dispensed as unit-dose for inpatient and a log is maintained for pre-packing activities. Observation

**PH.34 The following rules are written and implemented as to handling inpatient drug orders.**

- PH.34.1 A copy or fax of the original physician order or electronic version is sent to the pharmacy.
- PH.34.2 Any new physician order, reorder or changing order is made in writing.
- PH.34.3 Stat orders are separated from regular and filled within 30 minutes of transmittal.

**Evidence of Compliance**

- PH.34.EC1 Clearly written rules on handling inpatient drug orders (electronic or hard copy or fax for new, reorder or change of order). Document Review
- PH.34.EC2 Stat drug orders are separated from regular and filled within 30 minutes of transmittal. Observation

**PH.35 The pharmacy maintains updated drug profiles for all admitted patients.**

- PH.35.1 Each patient has a drug profile maintained in the inpatient pharmacy (electronic or hard copy).



- PH.35.2 Drug profile reflects patient name, MRN#, age, sex, weight/height, allergies, diagnosis, and location in the hospital.
- PH.35.3 Drug profile reflects all active and inactive medication orders during current admission (drug name, strength, formulation, dosage, special instruction).
- PH.35.4 Drug profile reflects the start date, stop date, number of dispensed doses and pharmacist signature.
- PH.35.5 Drug profile reflects any stat, single dose, PRN, controlled/narcotics, and floor stock medications.
- PH.35.6 Drug profile reflects IV fluids, TPN, and chemotherapy.

**Evidence of Compliance**

- PH.35.EC1 Availability of complete drug profiles (paper or electronic) for all current inpatients. Observation
- PH.35.EC2 All patient drug profiles in the pharmacy are complete and updated (patient demographics, diagnosis, allergies, location, most responsible physician (Sample 10% or at least 10 profiles). Observation
- PH.35.EC3 All drug profiles reflect both active and inactive drug orders of current admission (Sample 10% or at least 10 profiles). Observation
- PH.35.EC4 Drug profile reflects all types of drug orders (Stat, regular, PRN, IV, TPN, chemotherapy, IV fluids, etc..) with start/stop date, number of unit-doses dispensed and pharmacist signature. (Sample 10% or at least 10 profiles). Observation

**PH.36 There is a system to monitor drug allergies and includes the following:**

- PH.36.1 There is a written mechanism to ensure allergies are identified by the attending physician and immediately communicated to the pharmacy in writing.
- PH.36.2 Allergies are documented in each patient drug profile before dispensing any medication.
- PH.36.3 There is a written mechanism in place that allows for pharmacy intervention including stop dispensing when patient is identified as being allergic to prescribed drug(s).

**Evidence of Compliance**

- PH.36.EC1 Written mechanism for monitoring drug allergies (identification, documentation and communication, and pharmacy intervention). Document Review
- PH.36.EC2 There is a pharmacy flagging patient's drug profile for drug allergies (sample 10% or at least 10 profiles). Observation

**PH.37 There is a process for monitoring, detecting, and reporting adverse drug reactions (ADRs) and includes:**

- PH.37.1 Written policy and procedure for ADR.
- PH.37.2 Definition of a significant or serious ADR and timeframe for reporting.
- PH.37.3 ADR reporting forms are available
- PH.37.4 Intensive analysis is performed for all significant or serious ADRs.
- PH.37.5 Notification of treating physician.
- PH.37.6 There is evidence that the patient receives appropriate care for the ADR.
- PH.37.7 There is evidence that the medical record has been flagged for known allergies.
- PH.37.8 Process for improving ADR reporting.
- PH.37.9 Evidence of reporting any serious or unexpected ADR to the MOH.

**Evidence of Compliance**

- PH.37.EC1 Comprehensive policy on adverse drug reaction (ADRs) reporting including definition of serious /significant ADR, time frame and reporting format. Document Review
- PH.37.EC2 There is an active reporting, analyzing, and proper medical record flagging system (sample 10% or at least 10 reports available on file). Document Review
- PH.37.EC3 The pharmacy and therapeutics committee reviews and utilizes the reported data to improve ADR reporting. Interview

**PH.38 There is a process for monitoring, identifying and reporting significant medication errors & includes:**

- PH.38.1 Written policy and procedure for medication error reporting.
- PH.38.2 Definition of a significant medication error, timeframe for reporting, and reporting format.
- PH.38.3 Evidence of active reporting exists.
- PH.38.4 Intensive root-cause analysis is performed for all significant medication errors.



PH.38.5 Evidence for using reported data to improve medication use process and reduce error rate.

PH.38.6 Mechanisms to prevent serious medication errors (e.g. removal of concentrated intravenous potassium, magnesium, hypertonic saline, other high risk stocks from nursing units).

**Evidence of Compliance**

PH.38.EC1 Comprehensive policy on medication errors reporting including definition of significant errors, time frame and reporting format. Document Review

PH.38.EC2 There is an active reporting and root-cause analysis of significant errors. (sample 10% or at least 10 medication errors reports available on file). Document Review

PH.38.EC3 The pharmacy and therapeutics committee reviews and utilizes the reported data to improve medication safety. Interview

**PH.39 The pharmacy evaluates & monitors for drug indications, correct route of administration, drug interactions, and administration time.**

PH.39.1 There is a procedure for pharmacy intervention /clarification of physician orders.

PH.39.2 The pharmacy notifies the prescribing physician if a drug prescribed is not available.

PH.39.3 Evidence of evaluation, monitoring, and documentation of drug-drug and drug-food interactions.

PH.39.4 Drugs are prescribed and dispensed for their approved indications as evidenced by the given diagnosis.

PH.39.5 Standard administration time is announced and adopted by pharmacy & nursing.

**Evidence of Compliance**

PH.39.EC1 Written procedures for pharmacy monitoring prescribed medication (including indication, dosing, administration, and interactions). Document Review

PH.39.EC2 There is pharmacy intervention and clarification of drug orders (sample 10% or at least 10 drug orders/clarification forms). Observation

PH.39.EC3 Implementation of standard drug administration time. Observation

**PH.40 The pharmacy has a system for automatic stop orders (ASO):**

PH.40.1 Written policy and procedure for handling automatic stop orders.

PH.40.2 All physician orders are valid for 7 days unless shorter period is specified.

PH.40.3 ASO for all drugs at time of surgery.

PH.40.4 ASO for antibiotics as per hospital policy.

PH.40.5 Daily orders for anticoagulants (e.g. intravenous heparin, warfarin).

PH.40.6 Daily order for any continuous intravenous drips (e.g. dopamine, dobutamine, KCL, NTG, fentanyl, midazolam, etc.)

PH.40.7 ASO for IV, IM, and oral controlled medications.

**Evidence of Compliance**

PH.40.EC1 Written policy and procedures on automatic stop orders (ASO). Document Review

PH.40.EC2 There is compliance with ASO at the time of surgery (sample medical records, MAR, and Pharmacy drug profile). Medical Record Review

PH.40.EC3 There is compliance with ASO for anticoagulants, continuous intravenous drips, narcotics and controlled medications (Sample medical records, MAR, and Pharmacy drug profile). Medical Record Review

**PH.41 There is a system for verification of prescriptions:**

PH.41.1 A qualified pharmacist initially verifies all physician orders.

PH.41.2 A pharmacist or technician fills medication trolley according to a dispensing list, patient drug profile or physician orders.

PH.41.3 All medications dispensed for inpatients are checked by another licensed pharmacist.

PH.41.4 Generic equivalent may be dispensed for brand name for the same strength or concentration and dosage form.

**Evidence of Compliance**

PH.41.EC1 Clear system for prescription verification, filling, and double checking before dispensing. Observation



- PH.41.EC2 Qualified pharmacist initially verifies all physician orders. Interview  
PH.41.EC3 There is a generic substitution system (during staff interview or by observation in the pharmacy records of dispensing). Observation

**PH.42 There is evidence for safe packaging of the medications given to patients by:**

- PH.42.1 Using unit-dose packaging system for solid dosage forms.  
PH.42.2 Using unit-dose packaging system for liquid dosage forms.  
PH.42.3 Using plastic "Ziploc" bags for tablets or capsules.  
PH.42.4 Using plastic "Ziploc" bags for ampoules, vials, or suppositories.  
PH.42.5 Using plastic or amber-colored glass for bulk liquids.  
PH.42.6 Properly labeling all unit-dose, plastic Ziploc bags or original bulk liquids.  
PH.42.7 The expiry date of repackaged unit dose should comply with the current American Society of Health-System Pharmacists (ASHP) guidelines.

**Evidence of Compliance**

- PH.42.EC1 Availability of safe unit-dose pre-packaging system. Observation  
PH.42.EC2 Availability of Ziplocs plastic bags for ampoules, vials, suppositories and non-prepackaged drugs. Observation  
PH.42.EC3 There is protection for light sensitive medications (amber colored material, aluminum foil, etc.). Observation  
PH.42.EC4 There is compliance of the pre-packaged material with the current expiry date guidelines Observation

**PH.43 There is a system to ensure safe labeling of all Inpatient medications and includes the following:**

- PH.43.1 Printed or hand written label for any dispensed medication.  
PH.43.2 Unit-dose pre-pack is labeled with drug name, strength, formulation, lot # and expiry date.  
PH.43.3 If Unit-dose pre-packing is not available, doses of each drug are placed in plastic bag & labeled with: Patient MRN #, Location (ward #, Bed #), drug name, dosage, lot # and expiry date.  
PH.43.4 Label is affixed to the immediate container after removal of outside carton.  
PH.43.5 Colored auxiliary label (stick out) is used as appropriate (e.g. refrigerate, do not refrigerate, shake before use, external use only, etc.).  
PH.43.6 Inpatient drug cassettes are labeled with patient Name, MRN#, and bed number.

**Evidence of Compliance**

- PH.43.EC1 Safe labeling of all Inpatient medications (including generic name, strength, formulation, expiry date, and lot number). Observation  
PH.43.EC2 Safe labeling of patients' medication cassettes (Patient full name, MRN, and room/bed number). Observation  
PH.43.EC3 Main label and all necessary colored auxiliary labels are affixed to the immediate container after removal of outside carton. Observation

**PH.44 The pharmacy has a safe system for Extemporaneous Preparations and:**

- PH.44.1 Written IPP for extemporaneous preps.  
PH.44.2 Only Oral and Topical preparations are extemporaneously prepared.  
PH.44.3 There are adequate equipment and glass wares (e.g., weighing scale, bottles, jars, mortar, filters, electric heater, thermometer, etc).  
PH.44.4 There is a sink with water supply and stainless steel surface.  
PH.44.5 Working bench is clean with a smooth surface.  
PH.44.6 A log is maintained as of preparation name, strength, quantity prepared, batch number, preparation and expiration date, prepared by & checked by, etc.  
PH.44.7 Printed or hand written label should reflect preparation name, strength, batch number, and expiration date.  
PH.44.8 Preparation manual (formula book) is available and properly referenced (ASHP, BP and or USP Guidelines).  
PH.44.9. If compounding is done by an outside vendor, a copy of contract, registration license, and formulation should be available.



**Evidence of Compliance**

- PH.44.EC1 Written policy for safe compounding of extemporaneous preparations or evidence of contract with recognized outside vendor. Document Review
- PH.44.EC2 Availability of equipment, chemicals and facilities (space, working surface, sink, etc.) necessary for compounding. Observation
- PH.44.EC3 Compounding manual, workbook, and log book are updated for all available extemporaneous preparations. Observation
- PH.44.EC4 Safe labeling of compounded pharmaceuticals (including product name, strength, batch number and expiry date). Observation

**PH.45 There is a system for handling Narcotics and Psychotropic Drugs (Controlled Drugs) in accordance with MOH regulations and includes but is not limited to:**

- PH.45.1 There is a written policy and procedure for handling narcotics and psychotropics.
- PH.45.2 Receiving, storing and dispensing controlled drugs by the pharmacy.
- PH.45.3 Keeping controlled drugs behind steel doors with double locks.
- PH.45.4 Keeping limited floor stock supply in a double door, double locked cabinet.

**Evidence of Compliance**

- PH.45.EC1 Written policy and procedures on handling narcotics and psychotropics. Document Review
- PH.45.EC2 There is tight security (controlled by pharmacy, stored behind steel doors, limited supplies in patient care units in double-door double-locked cabinets). Observation

**PH.46 There is a system for auditing Narcotics and Psychotropic Drugs in accordance with MOH regulations:**

- PH.46.1 Auditing every shift in the pharmacy.
- PH.46.2 Auditing every shift in each nursing unit.
- PH.46.3 Maintaining proper documentation of drug count and accountability in the pharmacy.
- PH.46.4 Maintaining proper documentation of drug count & accountability in each nursing unit.
- PH.46.5 Maintaining proper documentation of empty containers of narcotics.
- PH.46.6 Evidence of proper disposal of unused portion of an ampoule or a tablet.

**Evidence of Compliance**

- PH.46.EC1 Auditing system for narcotics and psychotropics all over the hospital (every shift, full and empty ampoule, proper written document). Observation
- PH.46.EC2 There is proper disposal and documentation of unused portion of an ampoule or a tablet (sample nursing unit records). Observation

**PH.47 There is a system for Prescribing Narcotics and Psychotropic Drugs (Controlled Drugs) in accordance with MOH regulations and includes but is not limited to:**

- PH.47.1 Using the MOH approved prescriptions.
- PH.47.2 Not allowing physicians to prescribe controlled drugs for self or family members.
- PH.47.3 Allowing only clinical privileged physicians to prescribe.
- PH.47.4 Allowing only psychiatrists and specialists to prescribe psychotropics (except during emergency).
- PH.47.5 Not allowing injectable narcotics and controlled drugs for outpatients.

**Evidence of Compliance**

- PH.47.EC1 There is full compliance with MOH prescribing guidelines (MOH approved prescriptions, prescribing privileges, dispensed quantities) (sample at least 10 different drug prescriptions). Observation

**PH.48 The pharmacy provides all Intravenous admixture services in the hospital.**

**Evidence of Compliance**

- PH.48.EC1 Pharmacy provides all intravenous admixture services (no partial score is allowed) Observation



here. It is either zero or 3).

**PH.49 The Pharmacy Intravenous admixture service is safe and:**

- PH.49.1 There is a written policy and procedure for IV admixture services.
- PH.49.2 There is a manual for proper aseptic technique & IV room cleanliness. Aseptic techniques are strictly followed.
- PH.49.3 There are written guidelines for drug stability and compatibility. Guidelines are strictly followed.
- PH.49.4 The IV pharmacy staff is well trained and certified.
- PH.49.5 There are policy and procedures for recycling of returned IV admixtures in accordance with ASHP guidelines.
- PH.49.6 There are guidelines for drugs that may be safely given IV push.

**Evidence of Compliance**

- PH.49.EC1 Written policy and procedures on safe intravenous admixture services. Document Review
- PH.49.EC2 Availability of manuals (aseptic technique, drug-stability and -compatibility) and guidelines (IV push guidelines, recycling). Observation
- PH.49.EC3 Qualification, training and experience of IV pharmacy staff (recognized training center, Personnel File recognized trainer, official certificate).

**PH.50 The Pharmacy Intravenous Admixture section is fully equipped and well maintained.**

- PH.50.1 The IV room space, design, floor cover, wall painting, air flow and pressure are in compliance with ASHP requirements for clean room.
- PH.50.2 The LAFH has HEPA filter (99.97% efficiency) and has visible pressure gauge for detecting leaks or defects.
- PH.50.3 The LAFH is tested in accordance with the manufacturer requirements and in accordance with ASHP guidelines.
- PH.50.4 The IV admixture area is separate form chemotherapy area.
- PH.50.5 All IV Products are labeled to show: patient name, MRN#, location, drug name(s) and concentration, diluents name and volume, infusion rate, date and time of preparation, prepared and checked by.
- PH.50.6 All I.V. admixtures are checked by another licensed pharmacist.

**Evidence of Compliance**

- PH.50.EC1 Availability of adequate space, design (floor cover, wall painting, air flow and pressure) and equipments (including functional and certified LAFH). Observation
- PH.50.EC2 There is proper labeling of final product (patient name, MRN, location, drug name and concentration, diluents name and volume, infusion rate, date and time of preparation, prepared and checked by). Observation

**PH.51 If no Pharmacy-based IV admixture program is in place, pharmacy provides:**

- PH.51.1 A manual for proper aseptic technique & area cleanliness.
- PH.51.2 Assurance that aseptic techniques are strictly followed.
- PH.51.3 Written guidelines for drug stability and compatibility. Guidelines are strictly followed.
- PH.51.4 That IV admixture area is completely separate from the chemotherapy area.
- PH.51.5 Guidelines for drugs that may be safely given IV push.
- PH.51.6 That dispensing area is appropriate (location, space, cleanliness, traffic, etc).

**Evidence of Compliance**

- PH.51.EC1 Availability of manuals (aseptic technique, drug-stability and -compatibility) and guidelines (IV push guidelines, recycling) in each nursing unit. Observation
- PH.51.EC2 Availability of appropriate dispensing area (location, space, cleanliness, traffic, etc) in the patient care area. Observation
- PH.51.EC3 Qualification, training and experience of IV nurse(s) (recognized training center, recognized trainer, official certificate). Personnel File

**PH.52 If no Pharmacy-based IV admixture program is in place, the pharmacy is responsible for:**

- PH.52.1 Training and monitoring performance and qualifications of non-pharmacy personnel forming parenteral products.
- PH.52.2 Monitoring IV admixture areas all over the hospital (cleanliness, proper storage, etc).



PH.52.3 All IV Products are labeled to show: (patient name, MRN#, location, drug name(s) and concentration, diluents name and volume, infusion rate, date and time of preparation, prepared and checked by).

**Evidence of Compliance**

PH.52.EC1 The pharmacy is training and regularly monitoring the performance of nursing doing IV admixture. Document Review

PH.52.EC2 There is proper labeling of final product (patient name, MRN, location, drug name and concentration, diluents name and volume, infusion rate, date and time of preparation, prepared and checked by). Interview

**PH.53 Only Pharmacy Department provides Chemotherapy admixture services.**

**Evidence of Compliance**

PH.53.EC1 Only Pharmacy provides chemotherapy admixture services (no partial score is allowed here. It is either zero or 3). Observation

**PH.54 Chemotherapy Preparation Service is provided by certified pharmacy staff in a fully equipped and properly designed place according to Occupational Safety and Health Administration (OSHA) Standards.**

PH.54.1 Written policy and procedures for handling chemotherapy.

PH.54.2 Preparation is done under a biological safety cabinet (Vertical LAFH) type B.

Exhaust is separated from air circulation to outside the building.

PH.54.3 Work is done by well-trained and certified chemotherapy pharmacist.

PH.54.4 Aseptic techniques are strictly followed.

PH.54.5 Chemotherapy area is isolated from IV admixture area.

**Evidence of Compliance**

PH.54.EC1 Written policy and procedures on chemotherapy preparation services. Document Review

PH.54.EC2 Availability of functional and certified biosafety cabinet (Vertical LAFH with proper exhaust system) isolated from regular IV admixture area. Observation

PH.54.EC3 Qualification, training and experience of chemotherapy pharmacy staff (recognized training center, recognized trainer, official certificate). Personnel File

**PH.55 There is a safe system for handling Chemotherapy Preparation and includes but is not limited to the following processes:**

PH.55.1 OSHA guidelines are adopted.

PH.55.2 All preparations are double checked by a certified pharmacy staff and records of dispensed prescription are kept for at least 30 days.

PH.55.3 All preparations are placed inside a Ziploc plastic bag and labeled "Cytotoxic".

PH.55.4 All wastage and spillage are handled separately according to OSHA.

PH.55.5 Special chemotherapy protective gloves, masks and gowns are in use.

PH.55.6 Chemotherapy spill kit is available and staff is trained on how to use it.

**Evidence of Compliance**

PH.55.EC1 Availability of personal protective equipment, chemotherapy spill kits, Ziploc cytotoxic plastic bags, chemotherapy waste disposal bags). Observation

PH.55.EC2 Staff are fully trained on using chemotherapy spill kit. Interview

**PH.56 Only the pharmacy provides Total Parenteral Nutrition (TPN) services.**

**Evidence of Compliance**

PH.56.EC1 Only Pharmacy provides Total Parenteral Nutrition (TPN) services (no partial score is allowed here. It is either zero or 3).. Observation





**PH.57 There is a safe system for Total Parenteral Nutrition (TPN) Services which includes but is not limited to the following:**

- PH.57.1 Written IPP for handling TPN
- PH.57.2 Work is done under LAFH-type A.
- PH.57.3 Aseptic techniques are strictly followed.
- PH.57.4 Work is done by well-trained & certified TPN pharmacy staff.
- PH.57.5 Availability of macro- & micro-nutrients and TPN filters.
- PH.57.6 Stability / compatibility references are available.
- PH.57.7 Double check policy at each stage of admixture is implemented.
- PH.57.8 Final product passes visual inspection for particles.
- PH.57.9 Proper labeling to reflect ingredients and their quantities, volume, infusion rate, expiry date, patient demographics, etc.
- PH.57.10 All TPN orders are monitored by qualified pharmacist.

**Evidence of Compliance**

- PH.57.EC1 Written policy and procedures on TPN preparation. Document Review
- PH.57.EC2 Availability of equipment (functional and certified LAFH), micro- and macro-nutrients, TPN filter, bags, and volume transfer system), and manuals (stability and compatibility, etc.) Observation
- PH.57.EC3 All TPN orders are monitored by qualified, trained and experienced TPN pharmacist (recognized training center, recognized trainer, official certificate). Personnel File
- PH.57.EC4 There is proper labeling of TPN (ingredients, quantities, volume, infusion rate, expiry date, patient demographics, etc.) Observation

**PH.58 Drug Information Service is available and includes:**

- PH.58.1 Written policies and procedures.
- PH.58.2 Drug information center is staffed by qualified pharmacist with special training in drug information.
- PH.58.3 A good collection of up-to-date information resources: Micromedex, IOWA drug information system, local and international pharmacy and therapeutics journals, pharmacy textbooks and manuals, Saudi national formulary, specialty references as needed
- PH.58.4 Being equipped with: Microfiche reader/ printer, photocopier machine, computer with printer, reading table with chairs, storage shelves & cabinets, telephone line with internet connection, quiet and well illuminated reading area.
- PH.58.5 All questions being logged in with date and time of arrival. All answers are documented and filed in order.
- PH.58.6 Giving priority to poisoning and critical care patients.
- PH.58.7 Posting and making available telephone number for the nearest poison control center and poison antidote information.

**Evidence of Compliance**

- PH.58.EC1 Written policies and procedures on Drug Information Services. Document Review
- PH.58.EC2 Qualification, training and experience of the drug information pharmacist(s) (recognized training center, recognized trainer, official certificate). Personnel File
- PH.58.EC3 Availability of appropriate space, design, environment, equipments, and updated information resources. Observation
- PH.58.EC4 There is appropriate documentation (of all answered questions) and posting of necessary information (poisoning antidotes, poison center telephone numbers) . Observation

**PH.59 If drug information service is not available, pharmacy areas should have adequate drug information resources and includes but is not limited to:**

- PH.59.1 Saudi National Formulary (SNF).
- PH.59.2 British National Formulary (BNF).
- PH.59.3 Middle East Medical Index.
- PH.59.4 Martindale the extra pharmacopoeia.
- PH.59.5 Specialty drug references according to available services.
- PH.59.6 Posting and making available telephone number for the nearest poison control center and poison antidote information.



**Evidence of Compliance**

- PH.59.EC1 Availability of updated drug information references (including Saudi National Formulary, British National Formulary, Martindale the extra pharmacopoeia, Middle East Medical Index, and other Specialty drug references). Observation
- PH.59.EC2 Posting all necessary information (poisoning antidotes, poison center telephone numbers). Observation

**PH.60 The pharmacy shows evidence of Quality Improvement by:**

- PH.60.1 Appointing a Quality Management Coordinator who reports to the pharmacy head.
- PH.60.2 Having standards for all the pharmaceutical care processes.
- PH.60.3 Subjecting current standards to evaluation.
- PH.60.4 Having a Pharmacist who is actively involved with drug utilization committee process/function.
- PH.60.5 Developing and maintaining a plan and documented performance improvement program.
- PH.60.6 Continually determining areas for improvement.
- PH.60.7 Immediately reporting life threatening issues to the pharmacy head and hospital TQM department (e.g. morbidity, mortality, teratogenicity), drugs required immediate surgical intervention, any new ADR or toxic events of a new drug(s).
- PH.60.8 Reporting any questionable drug quality to pharmacy head (e.g. ineffective medication, inconvenient size, shape, volume or color, package or label, etc.).

**Evidence of Compliance**

- PH.60.EC1 Availability of quality management coordinator who reports directly to pharmacy director/head. Personnel File
- PH.60.EC2 There is continuous performance improvement program. Interview
- PH.60.EC3 There is reporting of any questionable drug quality issues (both locally and to MOH authorities). Interview
- PH.60.EC4 There is an active drug utilization evaluation (DUE) program. Interview

**PH.61 Security measures are in place and include:**

- PH.61.1 Limited access to pharmacy.
- PH.61.2 Visible name tags for all personnel.
- PH.61.3 Proper locking procedures for any pharmacy not open 24h a day.
- PH.61.4 The pharmacy doors and windows being locked during operation.
- PH.61.5 Identification of which pharmacy personnel have keys to pharmacy.
- PH.61.6 Having an IPP for non-pharmacy staff accessing pharmacy after hours in case of emergency (fire, flood, etc.)

**Evidence of Compliance**

- PH.61.EC1 Appropriate pharmacy security (visible name tags, limited access, doors and windows are closed during operation, key holding, etc.) Observation
- PH.61.EC2 Written policy and procedures on emergency opening pharmacy after working hours. Document Review

**PH.62 Safety measures are in place and include but is not limited to:**

- PH.62.1 Having an IPP for safe handling of dangerous substances and changing the HEPA filter of biological safety cabinets.
- PH.62.2 Keeping a list of hazardous materials readily available in areas where they are stored or used.
- PH.62.3 Storing all chemicals in a separate place on low shelves, & in the original labeled container.
- PH.62.4 Keeping material safety data sheets (MSDS) available in areas where hazardous materials are stored or used.
- PH.62.5 Keeping all flammables in a well-ventilated area where no smoke is allowed.
- PH.62.6 Keeping spill kits available in areas where hazardous materials are stored or used.
- PH.62.7 Keeping personnel protective equipment (gowns, gloves, eye & face protection) readily available.
- PH.62.8 Storing Cancer chemotherapy drugs separately.
- PH.62.9 Not allowing pregnant and lactating mother to work with chemotherapy. Regular medical checks for chemo worker (Family Medicine).
- PH.62.10 Having eye wash stations and shower rooms available in appropriate area.
- PH.62.11 Collecting all chemotherapy wastes in orange plastic bags to be incinerated.
- PH.62.12 Training all staff on how to handle spills.



**Evidence of Compliance**

PH.62.EC1	Written policy and procedures on identification, safe handling, stocking, and transportation of hazardous materials (chemicals, chemotherapy, flammables, etc.)	Document Review
PH.62.EC2	There is safe storage of hazardous materials (Hazardous list, safety cabinets, good ventilation, low shelves, original labeled container).	Observation
PH.62.EC3	Availability of personnel protective equipments, eye wash station, MSDS, and spill kits.	Observation
PH.62.EC4	There is staff training on handling spills and waste disposal (may ask few staff to demonstrate spill handling using spill kit).	Interview



## Laboratory

### Introduction

The assessment/reassessment of patients to determine the proper diagnosis, the course of treatment, and evaluation of treatment plan for future decisions may require laboratory services. To meet the patient needs, the organization should provide appropriate laboratory services required by its patient population, clinical services offered, and healthcare provider needs.

This chapter addresses the following:

- Physical structure
- Staffing
- Safety program
- Specimen collection
- Equipment management program
- Labeling
- Results reporting
- Quality management program
- Point of care testing



## Standards

**LB.1 The space available does not compromise the quality and the flow of work, safety of personnel, or limit quality control activities (according to College of American Pathologists Standards -CAP, Joint Commission International - JCI Standards, and Clinical**

- LB.1.1 Adequate water taps, sinks and drains.
- LB.1.2 Adequate emergency power.
- LB.1.3 Adequate electrical outlets.
- LB.1.4 Adequate ventilation.
- LB.1.5 Adequate lighting.
- LB.1.6 Adequate temperature /humidity control adequate.
- LB.1.7 Conveniently located telephones and calls easily transferred.

### Evidence of Compliance

LB.1.EC1 The physical structure of the lab should not affect the flow of work, quality control activity and safety of personnel (adequate water source, emergency power, electrical outlets, ventilation, lighting, temperature climate control with telephones that transfer calls easily). Observation

**LB.2 The lab services and capacities match the patient needs and includes:**

- LB.2.1 Emergency lab service available 24 hours/day.
- LB.2.2 Basic lab work (e.g. Hematology, Blood Bank and Biochemistry) available 24 hrs/day.

### Evidence of Compliance

LB.2.EC1 Basic lab work and emergency lab services are available 24 hrs/day according to patient's need. Document Review

**LB.3 All lab services are known and available to all medical staff.**

- LB.3.1 A list of all available lab services should be distributed to all departments.
- LB.3.2 Turn-around times are included.
- LB.3.3 Collection methods and collection medium is included for the various laboratory tests.

### Evidence of Compliance

LB.3.EC1 A lab service guide explaining specimen requirement and TAT, distributed to all departments. Document Review

**LB.4 The lab organization structure is defined and available.**

- LB.4.1 The director in-charge of the laboratory is a qualified pathologist or a qualified clinical scientist.
- LB.4.2 All lab sections are identified and they are under the directors' supervision.
- LB.4.3 All staff categories are included.
- LB.4.4 Chain of command is clear.

### Evidence of Compliance

LB.4.EC1 Current, approved and posted lab organizational chart with lab sections and staff categories identified under the director supervision. Document Review

LB.4.EC2 Lab Director is a qualified pathologist or a qualified clinical scientist. Personnel File

**LB.5 All staff have clear documented information on what is expected from them towards their work which includes:**

- LB.5.1 Job descriptions
- LB.5.2 Orientation and training programs.

### Evidence of Compliance



LB.5.EC1 Job descriptions for all lab staff.

Personnel File

LB.5.EC2 Documented lab staff orientation and training program.

Personnel File

**LB.6 The lab has a staff competency program that ensures the staff awareness of the Internal Policies & Procedures (IPPs) and the work essentials:**

LB.6.1 Written evaluation and documented direct observation of test procedures should be done at least once a year.

**Evidence of Compliance**

LB.6.EC1 An annually documented competency assessment program (includes written evaluation of direct observation of test procedures) that ensures staff awareness of internal policies and procedures.

Document Review

**LB.7 The lab staff are qualified to do the tests and includes:**

LB.7.1 Identification of staff who can perform the tests.

LB.7.2 Identification of staff who supervises the tests.

LB.7.3 Identification of staff who interpret the tests results.

**Evidence of Compliance**

LB.7.EC1 The test procedure records should contain a heading related to accountability of test performance, supervision and interpretation.

Document Review

**LB.8 The lab has a documented procedure defining how pipets are checked for accuracy of calibration using certified balance and this includes the following:**

LB.8.1 Pipets are checked for accuracy before being placed in service initially, and results are documented.

LB.8.2 Pipets are checked every six months and results are documented.

LB.8.3 Pipets are checked for reproducibility and the results are recorded.

**Evidence of Compliance**

LB.8.EC1 Documented quality control procedure and results of the process for pipets check.

Document Review

**LB.9 Thermometers in use are checked against an appropriate thermometric standard device before being placed in service.**

**Evidence of Compliance**

LB.9.EC1 Documented quality control procedure and results of the process for thermometers check.

Document Review

**LB.10 Temperatures are checked and recorded, and acceptable ranges are defined for all temperature dependant equipment (water baths, dry baths, heating blocks, incubators and ovens, refrigerators and freezers).**

**Evidence of Compliance**

LB.10.EC1 Temperature record for all temperature dependent equipment with defined acceptable ranges.

Document Review

**LB.11 The lab has evidence of corrective action taken if temperature exceeds the acceptable ranges for temperature dependant equipment, including evaluation of contents for adverse effects.**

LB. 11.1 An IPP in place for corrective action.

LB. 11.2 Evidence of corrective action.

**Evidence of Compliance**



- LB.11.EC1 Corrective action IPP when temp exceeds acceptable targets for temperature dependent equipment. Document Review
- LB.11.EC2 Corrective action taken for fridge temperature changes. Document Review
- LB.11.EC3 Evaluation of contents for adverse effects on refrigerated materials when temperature exceeds acceptable range. Document Review

**LB.12 All balances are properly maintained by:**

- LB.12.1 Periodically checking against a certified standard weight.
- LB.12.2 Cleaning, servicing and mounting them such that vibrations do not interfere with readings.

**Evidence of Compliance**

- LB.12.EC1 Documented quality control procedure and results of the process for balances check and maintenance. Document Review
- LB.12.EC2 Balances are placed on a vibration resistant surface. Observation

**LB.13 The lab has a schedule or system for the regular checking of all instruments including periodically checking the operating speeds of all centrifuges or as needed for the intended use, in a safe manner.**

**Evidence of Compliance**

- LB.13.EC1 Documented and scheduled quality control procedure and results of the process for Centrifuges check and maintenance. Document Review
- LB.13.EC2 Documented quality control procedure and results of the process for all instrument check and maintenance. Document Review

**LB.14 The lab has a system for unscheduled maintenance that includes:**

- LB.14.1 Utilizing the QC run charts to detect trends or malfunctions.
- LB.14.2 Documenting the linearity limits for specific instruments.
- LB.14.3 Providing instructions for minor troubleshooting and repairs of instruments (such as manufacturer's service manual).
- LB.14.4 Maintaining records AT or NEAR each instrument to document all repairs and service procedures.

**Evidence of Compliance**

- LB.14.EC1 Unscheduled maintenance system IPP. Document Review
- LB.14.EC2 An accessible maintenance records near each instrument documenting the utilization of QC chart, linearity limits and repairs. Observation

**LB.15 Reagents and solutions are properly labeled, as applicable and appropriate, with the following elements:**

- LB.15.1 Content, quantity, concentration and / or titer.
- LB.15.2 Storage requirements.
- LB.15.3 Date prepared or reconstituted by laboratory.
- LB.15.4 Expiration date.
- LB.15.5 All reagents are used and stored as recommended by the manufacturer.
- LB.15.6 All reagents used must be within their indicated expiration date.
- LB.15.7 If there are multiple components of a reagent kit, the laboratory uses components of reagent kits only within the kit lot unless otherwise specified by the manufacturer.
- LB.15.8 New reagent lots are checked against old reagent lots or with suitable QC material before or concurrently with being placed in service.

**Evidence of Compliance**

- LB.15.EC1 Lab Reagents/solutions control system (including checking, labeling with contents, quantity, concentration, storage condition, reconstitution and expiration date, and storing, etc.). Observation



**LB.16 The lab has an accepted system and clear method for results reporting:**

LB.16.1 Age and sex specific reference intervals (normal values) are verified or established by the laboratory. If a formal reference interval study is not possible or practical, then the laboratory carefully evaluates the use of published data for use

LB.16.2 Defining upper and lower limits of the analytical measurement range (AMR) for all analyses (results that fall outside these limits must be appropriately reviewed and re-assayed if necessary before reporting).

**Evidence of Compliance**

LB.16.EC1 Result reporting system is clear, acceptable and well defined utilizing the approved Document Review normal values with appropriate revision of out of range results. Handling use of published data for use when formal reference interval study is not possible or practical.

**LB.17 The lab has an established Turn Around Time (TAT) to report results for all different kinds of tests and:**

LB.17.1 All STAT tests are be defined and reported within 1 hour.

LB.17.2 The lab has a policy for Turn Around Time (TAT) for routine test in agreement with medical staff.

**Evidence of Compliance**

LB.17.EC1 Approved (in agreement with medical staff) and monitored mean TAT of routine test Document Review and All STAT tests are reported within 1 hour.

**LB.18 The lab has a specimen collection manual that covers:**

LB.18.1 Methods for patient identification (2 unique patients' identifier).

LB.18.2 Methods for patient preparation.

LB.18.3 Specimen collection and labeling.

LB.18.4 Specimen preservation.

LB.18.5 Specimen storage.

LB.18.6 Condition for transportation.

**Evidence of Compliance**

LB.18.EC1 Written manual on specimen collection and transportation (methods for patient identification, patient preparation, specimen collection/labeling, preservation, storage, and condition for transportation). Document Review

**LB.19 Specimen identifications and labeling are checked periodically to prevent errors in mixing the specimens or labeling them.**

**Evidence of Compliance**

LB.19.EC1 Periodic monitoring system for specimen identification and labeling. Document Review

**LB.20 There are clear instructions to be distributed to the physicians and paramedical personnel for proper collection, handling, transportation, and preparation for all samples including cytology and histology specimens.**

**Evidence of Compliance**

LB.20.EC1 Written guidelines on specimen collection, transportation and sample preparation is distributed to physicians and paramedical staff/ includes cytology histology specimens. Document Review

**LB.21 Services not available are out sourced to an accredited lab and:**

LB.21.1 There is documentation of selection process and certificates of accreditation are available.

LB.21.2 A list of tests to be sent out is available.





LB.21.3 There is an IPP for specimen transportation and result reporting.

**Evidence of Compliance**

- LB.21.EC1 Written policy and procedures on send out specimen transportation and result reporting. Document Review
- LB.21.EC2 Documentation of selection process and certification of selected out sourced lab. Document Review
- LB.21.EC3 List of tests to be outsourced is available. Document Review

**LB.22 The lab procedure manual that includes policy & procedure is available and approved by the lab director. This manual includes:**

- LB.22.1 A sectional policies and procedure that is readily available for all staff.
- LB.22.2 A documented review every 2 years by the lab section head and / or designee.
- LB.22.3 It is mandatory that all lab personnel are knowledgeable with the relevant policies and procedure.

**Evidence of Compliance**

- LB.22.EC1 Accessible and approved, current or reviewed (every 2 year) lab procedure manual. Document Review
- LB.22.EC2 Laboratory personnel are knowledgeable with the procedure manual. Observation

**LB.23 The lab has a policy that defines the test to be reported as “panic values”.**

- LB.23.1 Name of the person providing the results.
- LB.23.2 Name of the person receiving the results.
- LB.23.3 Time of the call.

**Evidence of Compliance**

- LB.23.EC1 Written policy on panic value reporting (name of persons providing and receiving the panic value results and time of the call). Document Review

**LB.24 Policies and procedures are written and enforced for all aspects of work related to blood and blood products and:**

- LB.24.1 Blood and blood products are maintained and available according to the size of the Hospital and its scope of service.

**Evidence of Compliance**

- LB.24.EC1 Strictly followed Blood Bank (transfusion service) IPP according to scope of service. Document Review

**LB.25 There are policies on how to collect, handle, and store blood which includes:**

- LB.25.1 Donor selection criteria for blood collection.
- LB.25.2 Donor consent shall be obtained before donation.
- LB.25.3 Aseptic collection method shall be clearly written and strictly followed by staff.

**Evidence of Compliance**

- LB.25.EC1 IPP that controls the system of donated blood from donor arrival to storage of blood and blood products. Document Review

**LB.26 Care of donor is addressed in the policies and procedures and includes:**

- LB.26.1 Treating donor adverse reactions.
- LB.26.2 The necessary equipment and supplies for immediate assistance and care.
- LB.26.3 Donor selection criteria is done in private and confidentiality is maintained.

**Evidence of Compliance**



LB.26.EC1 Care of donor related policies and procedures (includes treating donor adverse reactions, necessary equipment for immediate care, confidentiality and privacy of donor selection criteria). Document Review

LB.26.EC2 First aid skills and equipment necessary for immediate assistance and care of donor. Observation

**LB.27 The following blood bank procedures are available, performed and documented according to blood bank policy:**

LB.27.1 Blood type/ Rh.

LB.27.2 Cross matches.

LB.27.3 Antibody screening and identification.

**Evidence of Compliance**

LB.27.EC1 IPP for blood type/ Rh, cross match, antibody screening and Ab identification. Document Review

**LB.28 A tracing record for all blood units is available and includes:**

LB.28.1 Following strict policy and procedure for screen donated blood.

LB.28.2 Following strict policy and procedure for donor notification of abnormal test results.

LB.28.3 Keeping a record to ensure easy tracing of a unit of blood from drawing until final disposition.

**Evidence of Compliance**

LB.28.EC1 Tracking methods and records for (screened donated blood, donor notification) from drawing to disposition. Document Review

**LB.29 There is a clear hospital policy when blood is ordered.**

LB.29.1 A positive identification for blood and blood products according to policy and procedure.

LB.29.2 A policy on how to handle a blood shortage.

**Evidence of Compliance**

LB.29.EC1 Clear hospital policy for blood ordering, handling of shortage, and positive identification. Document Review

**LB.30 Blood is ordered only by authorized physician.**

**Evidence of Compliance**

LB.30.EC1 Blood is ordered only by authorized physician. Medical Record Review

**LB.31 The hospital has a policy for reporting all adverse transfusion reactions. The report is reviewed by the lab director and submitted to Blood Utilization Committee.**

**Evidence of Compliance**

LB.31.EC1 Adverse transfusion reactions records and policy. Document Review

LB.31.EC2 Adverse transfusion reactions records revision by lab director and submission to Blood Utilization committee. Document Review

**LB.32 There is an IPP for reporting blood utilization and blood product wastage.**

**Evidence of Compliance**

LB.32.EC1 Blood utilization and wastage reporting policy. Document Review

**LB.33 All equipment, refrigerators, and freezers are monitored and:**



LB.33.1 Equipment used to regulate the temperature of blood, blood components and reagents have the required thermometers, recorders, alarms and other monitoring devices. (This includes heating blocks, water baths, and devices of blood components).

LB.33.2 An approved blood-warming device is used appropriately as indicated, and monitored so that blood is not warmed above 42 C.

LB.33.3 Donor's blood not intended for preparation of platelets is refrigerated at a temperature of 1 - 6 C. If platelets are to be harvested, donated blood are kept at 22-24 C.

LB.33.4 Refrigerators and freezers for blood storage have central electronic monitors or twenty-four (24) hours chart recorders to ensure all blood and components are continuously stored at acceptable temperatures.

LB.33.5 If there is no continuous automated recording; temperatures are manually recorded at least every four (4) hours. The recorded temperature on all systems is checked at least once daily.

LB.33.6 The temperature recording sensor is stored in a volume of liquid, equal to a unit of blood, (e.g. water).

#### Evidence of Compliance

LB.33.EC1 Blood bank temperature dependent instrument/equipment continuously and strictly monitored utilizing the best method to ensure safe storage environment. Observation

#### LB.34 The alarm system has a separate power source in order to ensure proper monitoring of power and:

LB.34.1 The alarm system is maintained periodically.

#### Evidence of Compliance

LB.34.EC1 Blood bank temperature dependent instrument/equipment alarm system has a separate power source and is maintained periodically. Observation

#### LB.35 A complete procedure manual for Histopathology and Cytopathology is available with approved policies and procedures signed by the lab director. All lab personnel are knowledgeable about the contents of the procedure manual.

#### Evidence of Compliance

LB.35.EC1 Comprehensive, accessible and approved (by lab director) Histopathology and Cytopathology IPP. Document Review

LB.35.EC2 Histopathology staff are aware of the content. Interview

#### LB.36 All specimens removed from patients should be sent to the pathology. Any specimen that is not submitted to pathology or exempted from microscopic examination is approved by the lab director in agreement with the medical staff.

#### Evidence of Compliance

LB.36.EC1 All specimens removed from patients are sent to pathology. A lab director in agreement with the medical staff approved policy and records of exempted pathology specimens. Document Review

#### LB.37 The pertinent previous cytological and /or histological material from the patient are reviewed with current material being examined.

#### Evidence of Compliance

LB.37.EC1 Records of reviewing the current cytological/histological material with the pertinent previous one. Document Review

#### LB.38 When significant disparities exist between frozen section, cytology, or gross evaluation and final pathology diagnosis, this is reconciled and documented either in the pathology report or in the departmental quality management file.

#### Evidence of Compliance



LB.38.EC1 Reconciled disparities between the frozen section, cytology, or gross evaluation and final pathology diagnosis. Document Review

**LB.39 All gross specimens are examined by a pathologist. The specimens must be retained at least 1 month after the final pathology reports are signed and results reported to referring physicians.**

**Evidence of Compliance**

LB.39.EC1 Pathologist examination of all gross specimen and retention of specimen not less than 1 month. Document Review

**LB.40 The pathologist has direct supervision on all stages of specimen processing and staining. There also documented evidence of daily review of the technical quality of histological preparations by the pathologist. All special stains and immunohistochemist**

**Evidence of Compliance**

LB.40.EC1 Daily supervision of all stages of specimen processing and quality monitoring. Document Review

**LB.41 The pathology report includes all the relevant information for proper patient management, and is signed by a qualified histopathologist and / or cytopathologist. (Presence of IPPs in pathology reporting is highly recommended to provide consistency in rep**

**Evidence of Compliance**

LB.41.EC1 Adequate, proper and approved pathology report (by histopathologist). Medical Record Review

LB.41.EC2 Reporting system IPP in place. Document Review

**LB.42 The pathology reports Turn Around Time for frozen section and routine specimen (Histology & Cytology Specimen) is defined and monitored.**

**Evidence of Compliance**

LB.42.EC1 Defined and monitored TAT for frozen section and routine histology and cytology specimen reports. Document Review

**LB.43 All intra-departmental and extra-departmental cases submitted for consultation are documented and sent to be included with the original pathology report.**

**Evidence of Compliance**

LB.43.EC1 Inclusion of the submitted case with the original pathology report for all intra-departmental and extra-departmental consultation. Document Review

**LB.44 Pathology records and materials are retained at least for an appropriate period:**

LB44.1 Accession log records 2 years.

LB44.2 Paraffin blocks 10 years.

LB44.3 Glass slides and reports 10 years.

LB44.4 Cytopathology and Histopathology Reports 10 years.

LB44.5 Gynecologic and non-gynecologic glass slides 5 years.

LB44.6 Fine needle aspiration glass slides 10 years.

**Evidence of Compliance**

LB.44.EC1 Pathology records and materials retention policy (2-years for accession log records, 10-years for Paraffin blocks, Glass slides and reports, cytopathology and Histopathology Reports, and Fine needle aspiration glass slides, 5-years for Gynecologic and non-gynecologic glass slides). Document Review



**LB.45 There is a documented criterion for categorizing a gynecologic specimen as unsatisfactory. The unsatisfactory rate is monitored by lab director. Also, the statistical records are maintained of the number of cases of the following Cytopathology results:**

LB45.1 Diagnostic category (including unsatisfactory cases).

LB45.2 Significant cytologic / histologic discrepancies (as defined by laboratory policy).

LB45.3 Where re-screen resulted in re-classification of a result as pre-malignant or high malignant.

LB45.4 Where histopathology results are available to compare with malignant or high-grade squamous intra-epithelial lesion (HSIL) cytopathology results.

**Evidence of Compliance**

LB.45.EC1 Unsatisfactory gynecologic specimen and other gynecologic cytopathology results rate is documented and monitored by lab director. Document Review

**LB.46. For lab safety, there is evidence that the chief of the lab cooperates with the safety officer of the hospital and is following the general safety guidelines of the hospital and includes:**

LB.46.1 A lab safety officer appointed.

LB.46.2 A written job description for the Safety Officer.

LB.46.3 The safety officer is a member of the safety committee (preferred).

**Evidence of Compliance**

LB.46.EC1 A lab safety officer appointed.

Personnel File

LB.46.EC2 A written job description for the Safety Officer.

Document Review

LB.46.EC3 Lab safety officer is a member of the Safety Committee.

Document Review

**LB.47 The lab safety officer ensures the lab compliance with the FMS standards.**

**Evidence of Compliance**

LB.47.EC1 The lab safety officer ensures the lab compliance with the FMS standards.

Document Review

**LB.48 The lab has a safety manual that is approved by the laboratory director and available to all laboratory staff that includes the following:**

LB.48.1 Handling chemical spills and how to use the spill kits, with posted instructions.

LB.48.2 How to handle chemical hazards, and reduce their risk.

LB.48.3 A list of all the chemical hazards, and their manufacturers, (e.g. mercury and ethylene oxide).

LB.48.4 The documentation of all laboratory accidents resulting in property damage or involving spillage of hazardous substances.

LB.48.5 The reporting of all occupational injuries or illness that require medical treatment (more than first aid).

LB.48.6 Fire prevention and control.

LB.48.7 The safe handling of electrical equipment.

LB.48.8 Hazardous waste handling, storage, and disposal.

**Evidence of Compliance**

LB.48.EC1 Comprehensive lab safety manual approved by the laboratory director (include handling chemical hazards, chemical spills, chemicals list with manufacturer, lab accident documentation, reporting injuries, fire prevention and control safe handling of electrical equipment and wastage handling and disposal).

Document Review

**LB.49 Fire safety is implemented according to the Facility Management Safety (FMS) chapter and includes but is not limited to:**



- LB.49.1 Training all staffs how to use fire extinguishers.
- LB.49.2 Being able to state what action to take in the event of fire.
- LB.49.3 Posting maps to show the evacuation routes.
- LB.49.4 Fire alarms, fire extinguishers are checked periodically by the hospital safety officer.

**Evidence of Compliance**

- LB.49.EC1 Training on how to use fire extinguishers, checking of fire alarms, fire extinguishers is document review. Document Review
- LB.49.EC2 Staff are able to state what actions to take in the event of fire. Interview
- LB.49.EC3 Posting evacuation maps. Observation

**LB.50 Annual electrical checks are conducted which include:**

- LB.50.1 Grounding checks conducted on all outlets.
- LB.50.2 Electrical equipment grounded or doubly insulated.

**Evidence of Compliance**

- LB.50.EC1 Annual electrical checks (equipment are grounded and the outlets are checked for grounding). Document Review

**LB.51 All compressed gas cylinders are marked and clearly identified the type of gas contained and they are:**

- LB.51.1 Marked (full not in use/full in use/empty).
- LB.51.2 Placed in an upright position and mounted against the wall or a stand.

**Evidence of Compliance**

- LB.51.EC1 Comprehensive control system for compressed gas cylinder (marked as full not in use/ full in use/ empty and placed in upright position and mounted properly against wall or stand). Observation

**LB.52 The following safety signs and phone numbers are posted:**

- LB.52.1 All doors leading to the lab are marked to indicate hazard.
- LB.52.2 No smoking signs.
- LB.52.3 Caution signs of potential hazards.
- LB.52.4 Emergency telephone numbers.
- LB.52.5 Danger signs in areas where special precautions are required.

**Evidence of Compliance**

- LB.52.EC1 Safety signs and phone numbers are posted as appropriate (doors leading to the lab marked to indicate hazard, no smoking signs, caution signs, emergency phone numbers, danger danger signs). Observation

**LB.53 All sharp wastes (needle, syringes, blades, lancets) are discarded in a puncture proof rigid labeled container and all containers are:**

- LB.53.1 Discarded when 2/3 full.
- LB.53.2 Discarded in a safe and sanitary manner.

**Evidence of Compliance**

- LB.53.EC1 Sharp waste disposal requirement is implemented (discarded in safe and sanitary manner when 2/3 full). Observation

**LB.54 Eye wash stations and emergency showers are located within 30 meters where acids, caustics, corrosives and oxidizers are located.**



**Evidence of Compliance**

LB.54.EC1 Eye wash stations and emergency showers are located within 30 meters of risk material. Observation

**LB.55 There are no obstructions to exits, fire extinguishers, fire alarm boxes, emergency blankets, safety showers and eye wash stations, and:**

LB.55.1 Emergency lighting is adequate for safe evacuation of the laboratory.

LB.55.2 All exits are maintained free of obstructions. All exits are free of locks or fastening devices that could prevent free escape.

LB.55.3 All rooms in the laboratory have direct and unimpeded access to the outside corridor or a second exit.

LB.55.4 All doors leading to laboratories are marked to indicate the fire hazards of materials used within this area

**Evidence of Compliance**

LB.55.EC1 Clear, guided and an unimpeded access for safe evacuation and unobstructed accessibility to the required safety materials. Observation

**LB.56 All liquid materials are stored in a way to secure them against spills.**

**Evidence of Compliance**

LB.56.EC1 Adequate and safe storage of All liquid materials. Observation

**LB.57 Formaldehyde and Xylene vapor concentrations are monitored at least once a year.**

**Evidence of Compliance**

LB.57.EC1 Monitoring Formaldehyde and Xylene vapor concentrations at least once a year. Document Review

**LB.58 Special containers are available for broken glass.**

**Evidence of Compliance**

LB.58.EC1 Availability of special containers for broken glass. Observation

**LB.59 All containers of hazardous materials are labeled with precautionary labels e.g. flammables, corrosives, oxidizers etc.**

**Evidence of Compliance**

LB.59.EC1 Labeling of all hazardous materials containers. Observation

**LB.60 Flammable gas (acetylene, hydrogen, hydrocarbons, propane) cylinders are stored in a separate room or enclosure reserved exclusively for that purpose and with a fire-resistance classification. The area must be well ventilated and:**

LB.60.1 Flammable gases are not stored within 6 meters (20 feet) of oxidizing gases unless separated by a firewall.

LB.60.2 Flammable liquid storage cabinets are labeled and vented.

LB.60.3 Highly flammable and toxic procedures are performed in a fume hood.

LB.60.4 A specially constructed storage room is provided for large amounts of flammable or combustible liquids. This includes a floor seal across the door to contain liquids, explosion-proof fixtures and venting of vapors to the outside.

LB.60.5 Refrigerators and freezers approved for storage of flammable liquids are identified with a sign or label.

**Evidence of Compliance**

LB.60.EC1 Flammable gases and liquids are stored in a well ventilated, separate room or enclosure with fire-resistance classification and appropriate labeling. Observation



**LB.61** The section of the lab dealing with Radioactive material is marked with a Radiation sign, and staff training in handling and disposing of RA material is documented.

**Evidence of Compliance**

LB.61.EC1 Staff training on handling and disposing of Radioactive materials. Personnel File

LB.61.EC2 Precautionary signs are posted in the Lab section dealing with radioactive materials. Observation

**LB.62** If the mercury is used in the lab, a written plan is in place to reduce or eliminate the usage of mercury.

**Evidence of Compliance**

LB.62.EC1 Plan to reduce or eliminate the usage of mercury in the lab if it is still in use. Document Review

**LB.63** Exhaust air from biological safety cabinets is filtered through high efficiency particulate air (HEPA) filters.

LB.63.1 Inspection for condition and fit of the HEPA filters for air flow velocity and smoke patterns, and for output of UV lights.

**Evidence of Compliance**

LB.63.EC1 Monitoring the condition and fit of the HEPA filters for air flow velocity and smoke patterns, and for output of UV lights. Document Review

**LB.64** Fume hoods are inspected and certified at least once a year and this includes:

LB.64.1 Inspection for air flow velocity and smoke patterns, and for output of UV lights.

**Evidence of Compliance**

LB.64.EC1 Monitoring fume hoods for the air flow velocity and smoke patterns at least once a year. Document Review

**LB.65** The lab must have quality management program. This is approved by the lab director and available for all lab personnel.

**Evidence of Compliance**

LB.65.EC1 Available and approved (by lab director) a lab quality management program. Document Review

**LB.66** The lab director designates a qualified person to coordinate the quality management program with other medical departments. Also, this person is in-charge of implementing the quality management program in the department.

**Evidence of Compliance**

LB.66.EC1 Assignment of Lab quality management officer to coordinate and implement the QM program. Personnel File

**LB.67.** The lab develops the quality indicators to evaluate and detect problems. These following quality indicators are monitored:

LB.67.1 Incident reports.

LB.67.2 Turn around time for lab test.

LB.67.3 Specimen identification errors.

LB.67.4 Corrected Pathology and lab result reports.

**Evidence of Compliance**





LB.67. EC1 Lab Quality indicators development and evaluation, incident reports, TAT, Document Review  
specimen identification errors, corrected pathology and lab result reports.

**LB.68 The incident and accident reports are incorporated into the laboratory's quality improvement program and include:**

LB.68.1 An evaluation of the incident and accident reports to avoid re-occurrence.

**Evidence of Compliance**

LB.68.EC1 Lab incident and accident are part of QI program. Document Review

LB.68.EC2 Evaluation of the lab incident and accident report to avoid recurrence. Document Review

**LB.69 There is a system for proficiency testing in the laboratory. This can be either by participating in external PT or performing split sample analysis. The split sample can be with a reference lab, national or international accredited lab or established in h**

LB.69.1 All the problems identified by PT have been recognized and corrected.

**Evidence of Compliance**

LB.69.EC1 Availability of external quality assessment program (or split sample analysis with all Document Review  
problems identified by PT recognized and corrected).

LB.69.EC2 Problems identification recognition and correction. Document Review

**LB.70 Documented quality control program is available to clarify the following:**

LB.70.1 Results of the control.

LB.70.2 Instruments function.

LB.70.3 Temperature limits for procedures.

LB.70.4 Expiration date on reagents.

LB.70.5 Periodic maintenance program for equipment.

LB.70.6 Checking of tolerance limits.

LB.70.7 Checking pipettes and dilutors for accuracy.

LB.70.8 Checking media for quality.

LB.70.9 The results of QC assays are reviewed before reporting the results.

LB.70.10 The lab has a system to detect and correct analytic errors or uncertainty from each test and instrument.

**Evidence of Compliance**

LB.70.EC1 Documentation of all QC results (control results, Instruments function, temperature Document Review  
limits for procedures, reagents Expiry date, Periodic maintenance program for  
equipment, Checking of tolerance limits, pipettes and dilutors accuracy, quality  
media, results of QC assays are reviewed before reporting the results, detection and  
correction of analytic errors).

**LB.71 For Infection Control: there is evidence that the lab is following and cooperating with the Infection Control Department of the hospital and implementing all the rules and guidelines and:**

LB.71.1 Gloves, masks, and eye, face shield, gowns, and aprons and lab coats are available and are worn as appropriate on lab sections.

LB.71.2 Eating and drinking is prohibited.

**Evidence of Compliance**

LB.71.EC1 Standard precautions are strictly followed (PPE is available and being used Observation  
appropriately at lab sections. No eating or drinking)

LB.71.EC2 Cooperation with IC department. Document Review



**LB.72 Employees receive information on the potential risk of infections from materials that they work with and they are:**

- LB.72.1 Trained on how to clean up the leaks or the spills according to policy.
- LB.72.2 Trained on how to dispose of infectious material according to policy.
- LB.72.3 Trained on how to clean and disinfect work surface areas and equipment according to policy.
- LB.72.4 Trained on how to handle infections specimens e.g. T.B and how to dispose them according to policy.

**Evidence of Compliance**

LB.72.EC1 Lab staff are educated and trained on handling of infectious specimen, disinfection of work area, disposal of infectious material and clean up of leak or spill. Document Review

**LB.73 Universal precautions are implemented to protect lab employees from exposure to pathogens by:**

- LB.73.1 Implementing universal precautions for handling blood and body fluids.

**Evidence of Compliance**

LB.73.EC1 Implementation of universal precaution for handling blood and body fluids. Observation

**LB.74 All specimens of blood and body fluids are transported in leak-proof containers.**

**Evidence of Compliance**

LB.74.EC1 All specimens of blood and body fluids are transported in leak-proof containers. Observation

**LB.75 Clean and contaminated working areas are marked and:**

- LB.75.1 There is evidence of proper cleaning by housekeeping.

**Evidence of Compliance**

LB.75.EC1 Marked Clean and contaminated working areas ,and evidence of proper cleaning by housekeeping. Observation

**LB.76 All employees are vaccinated with (HBV) Hepatitis B Vaccine.**

**Evidence of Compliance**

LB.76.EC1 All employees are vaccinated with (HBV) Hepatitis B Vaccine. Document Review  
LB.76.EC2 Document Review Employee health records selected personnel or staff health record. Personnel File

**LB.77 The lab has a policy for safely handling of reagents.**

**Evidence of Compliance**

LB.77.EC1 Policy for safe handling of reagents. Document Review

**LB.78 A Class II safety cabinet is required when working with high infectious material and:**

- LB.78.1 Hoods used in the lab are tested periodically.

**Evidence of Compliance**

LB.78.EC1 Class II safety cabinet periodic testing. Observation

**LB.79 Negative pressure is maintained in laboratory dealing with high infectious material.**



**Evidence of Compliance**

LB.79.EC1 Maintenance of negative pressure in high infectious areas. Observation

**LB.80 The lab has a policy on how to deal with suspected TB specimens, and:**

- LB.80.1 Samples for TB testing are dealt with as high risk specimens.
- LB.80.2 Staff handling TB samples receives special training and this is documented.
- LB.80.3 The TB room is separate from the main lab and negative pressure monitored.
- LB.80.4 Gowns, aprons, gloves and face shield are used when handling TB specimens.
- LB.80.5 Hoods and safety cabinets are monitored for efficiency and work is stopped when hoods or safety cabinets are not properly working.

**Evidence of Compliance**

LB.80.EC1 Written policy on dealing with tuberculosis specimens (dealt with as high risk specimens, Staff training, TB room is separate from the main lab and negative pressure monitored, PPM are used, Hoods and safety cabinets are monitored for efficiency). Document Review

LB.80.EC2 Implementation of the policy and procedure. Observation

**LB.81 There is documented evidence of ongoing evaluation by the laboratory director or designee of point of care testing and ;**

- LB.81.1 A point of care testing has a written QC/QM program.
- LB.81.2 A list of all point of care testing equipment in the hospital is available in the laboratory.
- LB.81.3 A documented procedure manual for POCT available in the lab and in the areas where POCT is performed.

**Evidence of Compliance**

LB.81.EC1 Point of care testing P&P available in the lab and in the areas where POCT is performed. Document Review

LB.81.EC2 POCT list all over the hospital. Document Review

LB.81.EC3 Point of care QC/QM program and documented evaluation. Document Review

**LB.82 A documented policy is in operation to detect and correct significant clerical and analytical errors and unusual or unexpected test results.**

- LB.82.1 The lab has an appropriate person available on all shifts to assist with trouble shooting or other unusual POCT situations
- LB.82.2 There is a documented orientation, training, and competency for POCT users.

**Evidence of Compliance**

LB.82.EC1 POCT detection system for clerical and analytical error and correction (an appropriate person 24 hours/day for POCT concerns). Document Review

LB.82.EC2 Lab staff orientation, training, and competency testing. Document Review



## Facility Management and Safety

### Introduction

A safe, functional and effective environment for patients, staff, and other individuals is crucial to prevent or minimize risks in the environment of care. The organization leadership has to provide all necessary support and resources to improve safety in the work place in alignment with regulatory requirements.

The organization must have plans for managing the safety of the environment and must implement these plans. The organization must collect and analyze data to determine the effectiveness of the plans and facilitate continuous quality improvement.

Staff must also be educated on their responsibilities. Education must commence at orientation and continues on a regular basis thereafter.

Important aspects of the facility management and safety addressed in this chapter include the following:

- Safety
- Security
- Fire safety
- Emergency
- Hazardous materials
- Medical equipment
- Utilities



## Standards

**FMS.1 The Hospital administration supports and establishes a safety management program that covers the following seven important plans:**

FMS.1.1 Safety of the Building.

FMS.1.2 Security.

FMS.1.3 Hazardous materials and waste disposals.

FMS.1.4 Emergencies

FMS.1.4.1 Internal Plan

FMS.1.4.2 External Plan

FMS.1.5 Fire Safety

FMS.1.6 Medical Equipment

FMS.1.7 Utility System.

FMS.1.8 The program includes regular inspection, testing, and maintenance of all the operating components of the program.

### Evidence of Compliance

FMS.1.EC.1	Approved Safety Management Program that covers safety of the building, hazardous materials and waste disposals, internal and external emergencies plan, fire safety, medical equipment, utility system, and security.	Document Review
FMS.1.EC.2	There is evidence of regular inspection, testing, and maintenance of all the operating components of the safety program.	Document Review

**FMS.2 The hospital administration ensures that the building and its services comply with national standards, laws, and regulations and recommendations of professional organizations that relate to management of the physical environment.**

FMS.2.1 The hospital administration ensures compliance with applicable environmental protection standards, laws, and regulations (for example, discharges to drainage systems, safe disposal of waste and the like).

### Evidence of Compliance

FMS.2.EC.1	There is evidence of facility awareness and implementation of standards, laws, and regulations related to safety of the building and environmental protection.	Interview
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**FMS.3 The hospital administration establishes a budget to support the safety management programs.**

### Evidence of Compliance

FMS.3.EC.1	Review records availability of budget and invoices to support the safety management programs.	Document Review
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**FMS.4 There is an orientation on the Facility Management and Safety Plans conducted for new hires.**

### Evidence of Compliance

FMS.4.EC.1	Facility Management and Safety Plans orientation attendance records in employee file.	Personnel File
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**FMS.5 There is a No Smoking policy and it is enforced.**

### Evidence of Compliance

FMS.5.EC.1	No Smoking policy.	Document Review
FMS.5.EC.2	Enforcement of No Smoking policy (i.e. signs, compliance).	Observation



**FMS.6 The Hospital Director and/or his designee oversees implementation of the “No Smoking” policy by:**

FMS.6.1 Monitoring all areas within the hospital for compliance to the no-smoking rule.

FMS.6.2 Disciplining staff who do not adhere to the policy.

**Evidence of Compliance**

FMS.6.EC.1 No Smoking policy implementation including (disciplinary actions for non compliance). Document Review

**SAFETY OF THE BUILDING (FMS.7 – FMS.24):** The Safety of the Building Plan covers the following and is implemented as appropriate:

**FMS.7 The hospital establishes a safety committee consisting of the following representatives -head of safety, head of security, head of housekeeping, head of ER, head of Biomedical, head of maintenance department, Representative from lab, infection control, Nursing, TQM and Radiation Safety Officer**

FMS.7.1 Meets at least 10 times/year on a monthly schedule, minutes documented.

FMS.7.2 Discusses and analyzes all safety issues.

FMS.7.3 Reviews summary of the incidents/ OVR reports and errors with high level of occurrence and suggests the appropriate solution.

FMS.7.4 Reports Safety committee minutes to the hospital Director.

FMS.7.5 Communicates in writing with all Heads of Departments about the risk issues in their areas.

**Evidence of Compliance**

FMS.7.EC.1 Safety Committee terms of reference and heads of Security, Housekeeping, ER, Biomedical, Maintenance, representatives from Lab, Infection Control, Nursing and TQM are members in the Safety Committee. Document Review

FMS.7.EC.2 Safety Committee meets 10 times/year and minutes are reported to Hospital Director. Document Review

**FMS.8 The Safety committee schedules and conducts the following interdisciplinary rounds to ensure safety:**

FMS.8.1 Environmental rounds to check staff knowledge and implementation regarding the FMS plans (quarterly).

FMS.8.2 Facility tours to check the facility/ physical plant (quarterly).

FMS.8.3 The resulting information is used for corrective actions and planning and budgeting long-term upgrading and replacement.

**Evidence of Compliance**

FMS.8.EC.1 There are documented environmental rounds describing findings and actions taken. Document Review

**FMS.9 The hospital appoints a full time trained safety officer with a minimum of 5 years experience**

FMS.9.1 Communicates in writing with all Department Heads and Chiefs of units to assign safety liaison officers, to liaise the safety issues with the safety officer.

**Evidence of Compliance**

FMS.9.EC.1 Full time, trained Safety Officer with a minimum of 5 years experience. Personnel File

FMS.9.EC.2 Safety Officer communicates in writing with all Department Heads/safety representatives. Document Review

FMS.9.EC.3 Assignment of departmental Safety Liaison Officers/representative. Document Review

**FMS.10 The leadership supports the hospital wide safety plan by providing the necessary resources as identified by the safety officer and the safety committee in order to minimize risk to patients and staff.**

**Evidence of Compliance**

FMS.10.EC.1 The leaders have taken actions to support hospital wide safety plan and the Document Review



safety committee (i.e. communications, minuets, reports, action plan).

**FMS.11 Hospitals greater than 150 beds required additional staff trained in safety that work with the Safety Officer to implement the safety plan.**

**Evidence of Compliance**

FMS.11.EC.1 Assignment of staff trained in safety per 150 beds.

Personnel File

**FMS.12 The hospital has Civil Defense Gulf Countries Council (GCC) guidelines for the General Safety in the building and the guidelines are in Part 1 Chapter#7. (www.998.gov.sa) or the equivalent guidelines.**

**Evidence of Compliance**

FMS.12.EC.1 There are Civil Defense Gulf Countries Council (GCC) guidelines.

Document Review

**FMS.13 The hospital has essential signs in the hospital that are clearly marked and in appropriate designated places.**

FMS.13.1 Handicap access signs.

FMS.13.2 All fire exits (at least (1) one emergency exit sign is visible from any point in the facility).

FMS.13.3 Fire hydrants/fire extinguisher locations.

FMS.13.4 No entry signs where needed.

FMS.13.5 Hazardous material areas.

FMS.13.6 Directional signs to assist customers and staff find designated locations.

**Evidence of Compliance**

FMS.13.EC.1 The essential signs are clearly marked and in appropriate designated places. (i.e. Handicap access signs, All fire exits, Fire hydrants/fire extinguisher locations, No entry signs, Hazardous material areas, Directional signs).

Observation

**FMS.14 Warning signs are posted inside the hospital as appropriate and includes but not limited to:**

FMS.14.1 Hazardous signs.

FMS.14.2 Signs of the radioactive material as dangerous.

FMS.14.3 Signs of Wet floors during Cleaning.

FMS.14.4 Signs for x-ray.

FMS.14.5 No smoking signs.

FMS.14.6 Signs to restrict cellular phones in sensitive areas, e.g. MRI or Critical Care Units as appropriate.

**Evidence of Compliance**

FMS.14.EC.1 Warning signs are posted in the hospital as appropriate (i.e. Hazardous, radioactive material, Wet floors, x-ray, No smoking, restrict cellular phones in sensitive areas).

Observation

**FMS.15 Directive signs are posted as appropriate:**

FMS.15.1 Fire exit signs.

FMS.15.2 Directional exit signs.

FMS.15.3 Signs to direct staff and patients to the different services in the hospital.

FMS.15.4 Signs to direct patients and visitors to the Emergency Room.

FMS.15.5 Signs to identify floor level at staircases, and in front of elevators.

FMS.15.6 Signs to instruct staff, patients and visitors in restricted areas.

**Evidence of Compliance**



FMS.15.EC.1 Directive signs are posted as appropriate (i.e. Fire exit, Directional exit, services, Emergency Room, floor level, in front of elevators and restricted areas). Observation

**FMS.16 Patients bathrooms and showers are provided with the following safety measures:**

FMS.16.1 Non-slipping floors surfaces.

FMS.16.2 Bars to support patients.

FMS.16.3 Bell or a system to call for help.

FMS.16.4 Lock system to allow for opening from outside.

**Evidence of Compliance**

FMS.16.EC.1 Patients' bathrooms and showers are provided with non-slipping floors surfaces. Observation

FMS.16.EC.2 Patients' bathrooms and showers are provided with bars to support patients. Observation

FMS.16.EC.3 Patients' bathrooms and showers are provided with bell or a system to call for help. Observation

FMS.16.EC.4 Patients' bathrooms and showers are provided with lock system to allow for opening from outside. Observation

**FMS.17 Fire Safety is implemented in the lab and includes, but not limited to:**

FMS.17.1 Eye wash stations.

FMS.17.2 Emergency Shower

FMS.17.3 Fire blankets.

FMS.17.4 First aid kit.

FMS.17.5 Fire Extinguishers

FMS.17.6 Fire resistant storage safety cabinet.

**Evidence of Compliance**

FMS.17.EC.1 Fire Safety is implemented in the lab and includes eye wash stations. Document Review

FMS.17.EC.2 Fire Safety is implemented in the lab and includes emergency shower. Document Review

FMS.17.EC.3 Fire Safety is implemented in the lab and includes fire blankets. Document Review

FMS.17.EC.4 Fire Safety is implemented in the lab and includes first aid kit. Document Review

FMS.17.EC.5 Fire Safety is implemented in the lab and includes fire extinguishers. Document Review

FMS.17.EC.6 Fire Safety is implemented in the lab and includes fire resistant storage safety cabinet. Document Review

**FMS.18 The kitchen has safety equipment that includes:**

FMS.18.1 Eye wash stations.

FMS.18.2 Fire blankets.

FMS.18.3 First aid kit.

FMS.18.4 Fire Extinguishers

**Evidence of Compliance**

FMS.18.EC.1 The kitchen has safety equipment that includes eye wash stations. Observation

FMS.18.EC.2 The kitchen has safety equipment that includes fire blankets. Observation

FMS.18.EC.3 The kitchen has safety equipment that includes first aid kit. Observation

FMS.18.EC.4 The kitchen has safety equipment that includes fire extinguishers. Observation

**FMS.19 There are no obstructions to exits, fire extinguishers, fire alarm boxes, emergency blankets, safety showers and eye wash stations, and:**





FMS.19.1 Emergency lighting is adequate for safe evacuation of the laboratory.

FMS.19.2 All exits are maintained free of obstructions. All exits are free of locks or fastening devices that could prevent free escape.

FMS.19.3 All rooms in the laboratory have direct and unimpeded access to the outside corridor or a second exit.

FMS.19.4 All doors leading to laboratories are marked to indicate the fire hazards of materials used within this area.

**Evidence of Compliance**

FMS.19.EC.1	No obstructions to safety equipment, exits, fire extinguishers, fire alarm boxes, emergency blankets, and safety showers.	Observation
FMS.19.EC.2	Emergency lighting is adequate for safe evacuation.	Observation
FMS.19.EC.3	All exits are free of locks or fastening devices that could prevent free escape.	Observation
FMS.19.EC.4	All rooms in the units have direct and unimpeded access to the outside corridor or a second exit.	Observation
FMS.19.EC.5	All doors leading to the units are marked to indicate the fire hazards of materials used within this area.	Observation

**FMS.20 The Laundry has safety equipment that includes:**

FMS.20.1 Eye wash stations.

FMS.20.2 Fire blankets.

FMS.20.3 First aid kit.

FMS.20.4 Fire Extinguishers

**Evidence of Compliance**

FMS.20.EC.1	The laundry has safety equipment that includes eye wash stations.	Observation
FMS.20.EC.2	The laundry has safety equipment that includes fire blankets.	Observation
FMS.20.EC.3	The laundry has safety equipment that includes first aid kit.	Observation
FMS.20.EC.4	The laundry has safety equipment that includes fire extinguishers.	Observation

**FMS.21 The Reverse Osmosis (RO) plant has safety equipment that includes:**

FMS.21.1 Eye wash stations.

FMS.21.2 Fire blankets.

FMS.21.3 First aid kit.

FMS.21.4 Fire Extinguishers

**Evidence of Compliance**

FMS.21.EC.1	Reverse Osmosis (RO) plant has safety equipment includes eye wash stations.	Observation
FMS.21.EC.2	Reverse Osmosis (RO) plant has safety equipment includes fire blankets.	Observation
FMS.21.EC.3	Reverse Osmosis (RO) plant has safety equipment includes first aid kit.	Observation
FMS.21.EC.4	Reverse Osmosis (RO) plant has safety equipment includes fire extinguishers.	Observation

**FMS.22 All units or services using lasers have written laser safety policies and procedures, and they are implemented.**

**Evidence of Compliance**

FMS.22.EC.1	There are laser safety policies and procedures.	Document Review
FMS.22.EC.2	Implementation of laser safety measures.	Interview

**FMS.23 Flammable liquids are stored according to the Materials Safety Data Sheet (MSDS) guidelines.**



**Evidence of Compliance**

FMS.23.EC.1 Adherence to MSDS guidelines in the storage of flammable liquids. Observation

**FMS.24 Occurrence, Variance Report (incident reports) is used to report safety of the building related incidents, and corrective actions taken.**

**Evidence of Compliance**

FMS.24.EC.1 Completed OVR form regarding safety of the building incidents with corrective actions. Document Review

**SECURITY (FMS.25 – FMS.34)** The Security Plan covers the following aspects and is implemented as appropriate:

**FMS.25 The following categories of employees are identified by an I.D. Badge:**

- FMS.25.1 Hospital Staff
- FMS.25.2 Temporary Employees
- FMS.25.3 Contractor Staff

**Evidence of Compliance**

FMS.25.EC.1 All ID badges are issued by the hospital (not the contracted company) for all hospital staff, temporary employees, and contractor staff. Observation

**FMS.26 Access to sensitive areas is restricted by Security Personnel / Security System, like:**

- FMS.26.1 Delivery
- FMS.26.2 NICU
- FMS.26.3 Nursery
- FMS.26.4 Female Floors
- FMS.26.5 Operating Room
- FMS.26.6 CSSD

**Evidence of Compliance**

FMS.26.EC.1 There is restricting access to sensitive areas (i.e. Delivery room, NICU, Nursery, Female Floors, Operating Room, CSSD). Observation

**FMS.27 There are written policies on preventing abduction of children, and neonates.**

**Evidence of Compliance**

FMS.27.EC.1 Policies on preventing abduction of children, and neonates/security policy. Document Review

**FMS.28 There are written policies on the following that includes but not limited to:**

- FMS.28.1 Lost and Found items
- FMS.28.2 Safe keeping of patient belongings
- FMS.28.3 How to contact the local police, in case of need.

**Evidence of Compliance**

FMS.28.EC.1 There is lost and Found policy. Document Review  
FMS.28.EC.2 There is a written policy on Safe keeping of patient belongings policy. Document Review  
FMS.28.EC.3 There is a written policy on How to contact the local police policy. Document Review



**FMS.29 There is a written policy on how to handle the following:**

FMS.29.1 Involvement of police in Trauma, Motor vehicle accidents and similar Incident

FMS.29.2 Drug addicts cases

FMS.29.3 Manslaughter cases

FMS.29.4 Violent patient (MR. STRONG)

**Evidence of Compliance**

FMS.29.EC.1 There is a security policy on police reportable case addressing: Involvement of police in Trauma, Motor vehicle accidents and similar incident, drug addicts cases, manslaughter cases, and violent patient (MR. STRONG). Document Review

**FMS.30 There is a written policy on how to deal with a bomb threat (code white) in the hospital and the policy includes:**

FMS.30.1 Defining the role of person receiving threat.

FMS.30.2 Defining the response team.

FMS.30.3 Defining the duties and the responsibilities of all staff involve and their action cards.

FMS.30.4 Defining the responsible person who announces the emergency status and calls the local authorities.

FMS.30.5 How to contact the local police.

FMS.30.6 The command centre location.

FMS.30.7 Defining the steps to be taken during the bomb threat.

**Evidence of Compliance**

FMS.30.EC.1 Bomb threat (Code White) policy which includes defining the role of person receiving threat, the response team, the duties and the responsibilities of all staff involved and their action cards, the responsible person who announces the emergency status and calls the local authorities and how to contact the local police, the command center location, and state the steps to be taken during the bomb threat. Document Review

**FMS.31 The security rules are clearly defined in the following:**

FMS.31.1 External Plan.

FMS.31.2 Internal Plan.

FMS.31.3 No smoking policy.

**Evidence of Compliance**

FMS.31.EC.1 Defined security roles in internal disaster plan, no smoking policy, and external disaster plan. Document Review

**FMS.32 There are specific personnel assigned to take care of security, as appropriate to the size of the hospital and:**

FMS.32.1 Security personnel have a written job description.

FMS.32.2 Security personnel are oriented on their scope of work and location of job description

FMS.32.3 Security personnel are oriented on the emergency codes.

FMS.32.4 Security personnel are oriented on fire safety.

FMS.32.5 Security staff are trained on how to extinguish fires

FMS.32.6 Security personnel are properly dressed.

**Evidence of Compliance**

FMS.32.EC.1 Assigned qualified security officers according to the size of the hospital. Personnel File

FMS.32.EC.2 Security Officer job description. Personnel File

FMS.32.EC.3 Security personnel are oriented and trained on their scope of work, location of job description, emergency codes, fire safety and how to extinguish fires. Interview



FMS.32.EC.4 Security personnel are properly dressed (uniform). Observation

**FMS.33 Security conducts security rounds hospital-wide 3 times/day and rounds are documented.**

**Evidence of Compliance**

FMS.33.EC.1 Hospital-wide security rounds policy and security rounds reports for each shift. Document Review

**FMS.34 OVRs are used to report security related incidents, and corrective actions taken.**

**Evidence of Compliance**

FMS.34.EC.1 Completed OVR form regarding Security incidents with corrective actions. Document Review

**HAZARDOUS MATERIALS AND WASTE DISPOSAL (FMS.35– FMS.41):** The Hazardous materials plan covers the following and are implemented as appropriate:

**FMS.35 Handling, storing, transporting and disposing of HazMat.**

FMS.35.1 Education / training on signs / symptoms of exposure to HazMat and the appropriate treatment as per MSDS.

FMS.35.2 Each department / section has a current list of HazMat used in their area, the list covers:

FMS.35.2.1 Purpose of use.

FMS.35.2.2 The responsible person.

FMS.35.2.3 Permitted Quantity.

**Evidence of Compliance**

FMS.35.EC.1 There is a HazMat management plan. Document Review

FMS.35.EC.2 There is evidence on staff training on HazMat (attendance sheet). Personnel File

FMS.35.EC.3 Each department / section has a current list of HazMat used in their area that covers purpose of use, responsible person, and permitted quantity. Document Review

**FMS.36 Each department/ section dealing with HazMat has Material Safety Data Sheets (MSDS) relevant to their current list of HazMat.**

FMS.36.1 The above list of HazMat used in each dept./ section is available at the following departments:

FMS.36.1.1 Safety

FMS.36.1.2 Senior Nurse on call

FMS.36.1.3 Logistics

FMS.36.1.4 Lab.

**Evidence of Compliance**

FMS.36.EC.1 Each dept./ section dealing with HazMat has Material Safety Data Sheet (MSDS) relevant to their current list of HazMat. Document Review

FMS.36.EC.2 A compiled list of HazMat used in all dept./ section is available at the Safety department. Document Review

**FMS.37 All HazMat are labeled clearly, this includes:**

FMS.37.1 Anti-neoplastic Drugs.

FMS.37.2 Radioactive material.

FMS.37.3 All corrosives, acids, and toxic material used.

FMS.37.4 Hazardous gases and vapors.

FMS.37.5 Anesthetic gases.



**Evidence of Compliance**

FMS.37.EC.1 All HazMat are labeled. Observation

**FMS.38 Any radioactive leak, spill or exposure to any hazmat is reported.**

**Evidence of Compliance**

FMS.38.EC.1 Reporting radioactive leak, spill or exposure to any hazmat. Document Review

**FMS.39 All departments/sections dealing with HazMat have protective clothes or equipment as required.**

**Evidence of Compliance**

FMS.39.EC.1 Protective clothes or equipment are available. Observation  
FMS.39.EC.2 Staff are trained in the use of protective equipment. Document Review

**FMS.40 All requirements for radioactive materials from King Abdulaziz City for Science and Technology are implemented.**

**Evidence of Compliance**

FMS.40.EC.1 There is a license for radioactive material from King Abdulaziz City for Science and Technology. Document Review

**FMS.41 Handling, storing, transporting, and disposing all kinds of waste such as:**

- FMS.41.1 Clinical waste
- FMS.41.2 Chemotherapeutic waste.
- FMS.41.3 Radioactive waste.
- FMS.41.4 Hazardous gases
- FMS.41.5 Anesthetic gases

**Evidence of Compliance**

FMS.41.EC.1 Waste Management plan. Document Review  
FMS.41.EC.2 Proper handling of clinical, chemotherapeutic and radioactive wastes, hazardous gases, and anesthetic gases. Observation  
FMS.41.EC.3 Proper storage of clinical, chemotherapeutic and radioactive wastes, hazardous gases, and anesthetic gases. Observation  
FMS.41.EC.4 Proper transportation of clinical, chemotherapeutic and radioactive wastes, hazardous gases, and anesthetic gases. Observation

**EMERGENCY (FMS.42 – FMS.55) The written disaster plans cover:**

**FMS.42 Dealing with external disasters emergencies (Code Yellow) in the community, the plan includes:**

- FMS.42.1 Names of all staff called, including their contact numbers and action cards.
- FMS.42.2 The duties and responsibilities of each hospital leader, department heads, and chief of units.
- FMS.42.3 The Triage areas, their locations, and triage action cards.
- FMS.42.4 Identifying the responsible person who announces the emergency state and calls the local authority.
- FMS.42.5 The control room location and the person in charge.
- FMS.42.6 The total number of beds that can be evacuated.
- FMS.42.7 Defining the role of security.

**Evidence of Compliance**

FMS.42.EC.1 Code Yellow plan includes names of all staff called, including their contact numbers and action cards. Document Review



FMS.42.EC.2	Code Yellow plan includes the duties and responsibilities of each hospital leader, department heads, and chief of units.	Document Review
FMS.42.EC.3	Code Yellow plan includes the triage areas, their locations, and triage action cards.	Document Review
FMS.42.EC.4	Code Yellow plan includes identifying the responsible person who announces the emergency state and calls the local authority.	Document Review
FMS.42.EC.5	Code Yellow plan includes the control room location and the person in charge.	Document Review
FMS.42.EC.6	Code Yellow plan includes the total number of beds that can be evacuated.	Document Review
FMS.42.EC.7	Code Yellow plan includes defining the role of security.	Document Review

**FMS.43 The hospital conducts an external plan drill minimum once a year to test the following:**

- FMS.43.1 The timely response of staff to the emergency call.  
FMS.43.2 The efficiency of the communication system, e.g. bleeps, mobile phone and over head paging system.  
FMS.43.3 If all staff can perform their expected roles.  
FMS.43.4 The time taken to evacuate patients and beds.  
FMS.43.5 How effective the management of crowds was handled.

**Evidence of Compliance**

FMS.43.EC.1	There are annual external plan drill reports.	Document Review
FMS.43.EC.2	External plan drill tests the timely response of staff to the emergency call.	Document Review
FMS.43.EC.3	External plan drill tests the efficiency of the communication system, e.g. bleeps, mobile phone and over head paging system, skillful staff of their role, the time taken to evacuate patients and beds, effectiveness of the management of crowds was handled.	Document Review

**FMS.44 The hospital administration ensures the availability of the needed supplies and equipment in case of external disaster, e.g. Medical Bags, drugs, and mobile monitors.**

- FMS.44.1 The hospital ensures that the Ambulances are always ready and supplied with the necessary equipment and medical bags to be used in case of the disaster.  
FMS.44.2 There is an orientation on the External Disaster plan for the new hires, and annual updating for all staff.

**Evidence of Compliance**

FMS.44.EC.1	Annual staff orientation to emergency preparedness.	Document Review
FMS.44.EC.2	Availability of adequate resources in Emergency Room and ambulances.	Observation

**FMS.45 Dealing with the Internal Disasters emergencies (Code Red), the Plan includes:**

- FMS.45.1 Names of all the staff called in case of disaster, their contact numbers, and action cards.  
FMS.45.2 The control room's location and the position of the person in charge.  
FMS.45.3 The duties and responsibilities of each hospital leader, Department heads, and chiefs of units.  
FMS.45.4 The procedure for relocation of patients.  
FMS.45.5 Identifying the responsible person who should announce the emergency state and call local authority.  
FMS.45.6 Defining the role of the safety officer to deal with the electricity supply and medical gas system, to shut them off as needed in case of fire or explosions in the hospital.  
FMS.45.7 Defining the meeting point for the staff incase of horizontal evacuations (Assembly points) inside the building.  
FMS.45.8 Defining the meeting point for the full evacuation (Holding Area) outside the building.

**Evidence of Compliance**

FMS.45.EC.1	There is a comprehensive Internal Emergency plan (personnel, action cards, control room location, assembly points, and holding areas).	Document Review
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**FMS.46 Evacuation procedure of the organization employees, visitors or patients is included in the plan.**

**Evidence of Compliance**



FMS.46.EC.1

There is a comprehensive evacuation procedure.

Document Review

**FMS.47 There are evacuation maps posted hospital-wide indicating locations of:**

FMS.47.1 You are here

FMS.47.2 Fire extinguishers

FMS.47.3 Fire hose reel/cabinets

FMS.47.4 Fire blankets

FMS.47.5 Escape routes

FMS.47.6 Assembly points

FMS.47.7 Fire exits

FMS.47.8 Call points break glass / pull station

**Evidence of Compliance**

FMS.47.EC.1

There is a comprehensive posted evacuation maps (location, fire extinguishers, fire hoses, fire blankets, escape routes, assembly points, fire exits, and pull stations).

Observation

**FMS.48 Fire drills are scheduled and conducted as follows:**

FMS.48.1 Four times a year for inpatient areas

FMS.48.2 Two times a year for out patient areas

FMS.48.3 Once a year for non clinical areas

**Evidence of Compliance**

FMS.48.EC.1

There is proper scheduling of annual fire drills (4 for inpatient, 2 for outpatient, 1 for non-clinical).

Document Review

FMS.48.EC.2

Fire drills are conducted as scheduled (reports and evaluation).

Document Review

**FMS.49 Fire Drills are conducted on each shift to test:**

FMS.49.1 Using RACE procedure

FMS.49.2 Using PASS procedure

FMS.49.3 The ability to contain the fire when it starts.

FMS.49.4 Staff performance in his/her role in the event of fire.

FMS.49.5 Evacuation procedures.

FMS.49.6 If the oxygen supply and electricity supply were closed off in the right time, and as needed.

**Evidence of Compliance**

FMS.49.EC.1

There is a comprehensive fire drill evaluation of all staff on each shift (RACE, PASS, Fire containment, staff performance, evacuation, oxygen and electricity supply shut off).

Document Review

**FMS.50 All staff participate in fire drills.**

**Evidence of Compliance**

FMS.50.EC.1

There is evidence of staff attendance in fire drill.

Document Review

**FMS.51 All fire drill results and corrective actions are documented and integrated into the Quality Improvement program.**

**Evidence of Compliance**



FMS.51.EC.1 There is quality improvement initiatives based on fire drill results. Document Review

**FMS.52 Full fire drill is conducted for the Internal Plan once a year and this drill is evaluated.**

**Evidence of Compliance**

FMS.52.EC.1 There is an annual documentation and evaluation of full fire drill. Document Review

**FMS.53 The hospital has a Hospital-wide disaster plan that includes.**

FMS.53.1 Response to both internal and external disaster.

FMS.53.2 A description of the roles of every employee in the organization.

**Evidence of Compliance**

FMS.53.EC.1 There is an approved hospital-wide disaster plan clarifying the roles and responsibilities of every employee and response to both internal and external disaster. Document Review

**FMS.54 The leadership supports the implementation of the disaster plan by:**

FMS.54.1 Planning, implementing evaluating disaster drills. (no less than annually)

FMS.54.2 Making improvements in disaster readiness based on results of disaster drills.

**Evidence of Compliance**

FMS.54.EC.1 Leadership supports the implementation of the disaster plan by planning, implementing and evaluating disaster drills (no less than annually). Document Review

FMS.54.EC.2 The leaders have taken improvement actions in disaster readiness based on evaluation of disaster drills. Document Review

**FMS.55 The hospital has the following effective communication systems for contacting essential personnel in emergencies:**

FMS.55.1 An overall paging system that is fully functional and is used for calling for help in case of emergencies.

FMS.55.2 Bleeps for all physicians and other staff as necessary.

FMS.55.3 Mobile telephones on the ambulances.

**Evidence of Compliance**

FMS.55.EC.1 There are communication systems for contacting essential personnel in emergencies" are available in the hospital as appropriate (i.e. an Overall paging system, Bleeps for all physicians and other staff as necessary, Mobile telephones on the ambulances). Document Review

**LIFE/ FIRE SAFETY (FMS.56 FMS.64)** The Life/ Fire Safety plan covers the inspection and tests of the following and is implemented as appropriate:

**FMS.56 Fire extinguishers:**

FMS.56.1 They are adequate in number.

FMS.56.2 Appropriately distributed throughout the institution.

FMS.56.3 Appropriately positioned.

FMS.56.4 Inspected regularly to assess functionality.

**Evidence of Compliance**

FMS.56.EC.1 Proper distribution, location of adequate number of fire extinguishers. Observation

FMS.56.EC.2 Regular functionality assessment (Inspection Reports). Document Review





**FMS.57 Fire alarm system:**

- FMS.57.1 Regularly inspected.
- FMS.57.2 Results are documented.
- FMS.57.3 The system has preventive maintenance.

**Evidence of Compliance**

- FMS.57.EC.1 There is documented regular maintenance of fire alarm system. Document Review

**FMS.58 Fire Suppression System:**

- FMS.58.1 Sprinkler System
- FMS.58.2 CO<sub>2</sub> System
- FMS.58.3 Wet Chemical System

**Evidence of Compliance**

- FMS.58.EC.1 Fire Suppression System inspection reports. Document Review

**FMS.59 Fire Exits:**

- FMS.59.1 Not locked
- FMS.59.2 Not obstructed
- FMS.59.3 Having panic hardware
- FMS.59.4 Fire resistant
- FMS.59.5 Clearly marked with illuminated exit sign

**Evidence of Compliance**

- FMS.59.EC.1 All fire exits are accessible (fire resistant, clearly marked, and has panic hardware). Observation

**FMS.60 Fire/ smoke barrier doors.**

**Evidence of Compliance**

- FMS.60.EC.1 There are Fire/smoke barriers that fulfill requirements. Observation

**FMS.61 Elevators are connected to the fire alarm system.**

**Evidence of Compliance**

- FMS.61.EC.1 Elevators are connected to the fire alarm system. Observation

**FMS.62 Emergency Lights.**

**Evidence of Compliance**

- FMS.62.EC.1 There are functional emergency lights. Observation  
FMS.62.EC.2 There are emergency lights check reports. Document Review

**FMS.63 The hospital makes efforts to prevent fire in the institution and this includes:**

- FMS.56.1 Buying all materials, like curtains, drapes, that are fire resistant.
- FMS.56.2 Separating all dangerous materials, or flammables from heat generating areas.
- FMS.56.3 Installing fire resistant walls as appropriate, especially in risky areas like the lab.
- FMS.56.3 Installing fire stop materials to seal penetration as appropriate (especially: Technical Rooms, Electrical rooms, and



Escape Routes)

**Evidence of Compliance**

FMS.63.EC.1	All resources are available for prevention of fire.	Observation
FMS.63.EC.2	Fire hazardous materials are isolated.	Observation
FMS.63.EC.3	There are fire-resistant walls in high risk areas.	Observation

**FMS.64 The hospital develops the necessary scheduled training program of hospital employees on how to use the fire extinguishers.**

**Evidence of Compliance**

FMS.64.EC.1	There is scheduled staff training program.	Document Review
FMS.64.EC.2	Staff know how to use the fire extinguishers.	Interview

**MEDICAL EQUIPMENT (FMS.65 – FMS.73)** The Medical Equipment plan covers the following and are implemented as appropriate:

**FMS.65 An inventory of all hospital equipment and their location.**

**Evidence of Compliance**

FMS.65.EC.1	There is Medical Equipment plan.	Document Review
FMS.65.EC.2	There is Medical Equipment inventory.	Document Review

**FMS.66 The effective Preventive Maintenance (PM) as per the manufacturer recommendations (at least 95% receive PM)**

FMS.66.1 Electrical safety testing for patient related equipment.

FMS.66.2 Each piece of equipment has a checklist for its maintenance schedule, failure incidence, repairs done.

FMS.66.3 There is a written policy to perform inspection on all new equipment before put into operation.

**Evidence of Compliance**

FMS.66.EC.1	Effective PPM plan for medical equipment in use.	Document Review
FMS.66.EC.2	There is a written policy to perform inspection on all new equipment before put into operation.	Document Review

**FMS.67 Availability of the following:**

FMS.67.1 Safety manuals at biomed workshops.

FMS.67.2 Operator manual for each equipment at each dept./section using the equipment.

**Evidence of Compliance**

FMS.67.EC.1	Safety manuals are available at the biomed workshops.	Observation
FMS.67.EC.2	Operator manual for each equipment is available at each dept./section using the equipment.	Observation

**FMS.68 There is a written policy for tagging medical equipment as follows:**

FMS.68.1 PM with testing date and due date.

FMS.68.2 Inventory number

FMS.68.3 Removal from service.

FMS.68.4 Safety check



**Evidence of Compliance**

FMS.68.EC.1	There is a comprehensive policy on proper tagging of medical equipment.	Document Review
FMS.68.EC.2	There is proper tagging of medical equipments (PM testing and due date, inventory number, out of service, and safety check).	Observation

**FMS.69 There is a written policy on removal of equipment from service.**

**Evidence of Compliance**

FMS.69.EC.1	There is a written policy on removal of equipment from service	Document Review
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**FMS.70 The hospital staff, physicians, and nurses, and paramedics, are trained to operate the medical equipment assigned to them and the hazards attached to it, training includes the following:**

- FMS.70.1 New equipment
- FMS.70.2 Staff transferred from section to another.
- FMS.70.3 New staff hired.
- FMS.70.4 Reoccurrence misuse of equipment.

**Evidence of Compliance**

FMS.70.EC.1	There is appropriate training of healthcare professionals on operating the assigned medical equipment and handling possible hazards.	Document Review
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**FMS.71 OVRs are used to report medical equipment related incidents, and corrective actions taken.**

**Evidence of Compliance**

FMS.71.EC.1	OVRs are used to report medical equipment related incidents.	Document Review
FMS.71.EC.2	Corrective actions are taken.	Document Review

**FMS.72 There is statistical Preventative Maintenance (PM) data for upgrading/ replacing of equipment.**

**Evidence of Compliance**

FMS.72.EC.1	Equipment upgrading/replacement according to PM data.	Document Review
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**FMS.73 There are written policies to:**

- FMS.73.1 Cover agent/ sub-contractor repairs.
- FMS.73.2 Eliminate the use of extension cords.
- FMS.73.3 Restrict the use of cellular phones in the following critical areas:
  - FMS.73.3.1 ICU
  - FMS.73.3.2 OR
  - FMS.73.3.3 Cardiology

**Evidence of Compliance**

FMS.73.EC.1	There is a written policy on equipment repair through agents/subcontractors, safe electrical wiring, and prevention of cell phone use.	Document Review
FMS.73.EC.	Restricting cell phone use in high risk areas (ICU, OR, Cardiology) and elimination of extension cords.	Observation

**UTILITY SYSTEM (FMS.74 – FMS.96)** The Utility System plan covers the following and is implemented as appropriate:



**FMS.74 The Periodic Preventive Maintenance Program (PPM) of:**

- FMS.74.1 Electrical system.
- FMS.74.2 Elevators
- FMS.74.3 Generator(s)
- FMS.74.4 Refrigerators/ Freezers
- FMS.74.5 Air conditioning system
- FMS.74.6 Medical gas system.
- FMS.74.7 Medical suction.
- FMS.74.8 Domestic water system, including water pumps.
- FMS.74.9 Fire water system, including fire pumps.
- FMS.74.10 Boilers.
- FMS.74.11 Plumbing.
- FMS.74.12 Low current and communication system.
- FMS.74.13 Pavement and Ground
- FMS.74.14 Hospital building and Ancillaries.

**Evidence of Compliance**

FMS.74.EC.1	There is PPM of electrical system, generator(s), and low current/communication system.	Document Review
FMS.74.EC.2	There is PPM for elevators.	Document Review
FMS.74.EC.3	There is PPM for refrigerators, freezers, air conditioning system.	Document Review
FMS.74.EC.4	There is PPM for medical gas and medical suction.	Document Review
FMS.74.EC.5	There is PPM of domestic water system, fire water system.	Document Review
FMS.74.EC.6	There is PPM for boilers and plumbing system.	Document Review
FMS.74.EC.7	There is PPM of hospital building, pavement and ground.	Document Review

**FMS.75 The administration supports the necessary programs to:**

- FMS.75.1 Acquire necessary equipment
- FMS.75.2 Upgrade equipment
- FMS.75.3 Upgrade physical condition of the building

**Evidence of Compliance**

FMS.75.EC.1	There is adequate administrative support for equipment procurement and upgrading.	Document Review
FMS.75.EC.2	There is adequate administrative support for building renovation.	Document Review

**FMS.76 There is a plan on what to do in case of failure, or interruption of the following utilities:**

- FMS.76.1 Normal Power
- FMS.76.2 Emergency Power, Cases of: No Power at Socket at Critical Areas, and Lamp Failure at Critical Area
- FMS.76.3 Elevator
- FMS.76.4 Water Supply
- FMS.76.5 Reverse Osmosis Plant
- FMS.76.6 Air-conditioning Fan Coil Unit (FCU) at Patient Room
- FMS.76.7 Air-conditioning Air Handling Unit (AHU) at OR's
- FMS.76.8 Medical Gas System
- FMS.76.9 Sewer Lines
- FMS.76.10 Boiler
- FMS.76.11 Telephone Service (Public Address Exchange - PABX)
- FMS.76.12 Intercom, Nurse Call on Overhead Paging



FMS.76.13 Fire Alarm

**Evidence of Compliance**

FMS.76.EC.1	There is a written comprehensive plan for handling failure of utility, equipment, alarm system, and essential services.	Document Review
FMS.76.EC.2	There is proper implementation of the utility failure plan.	Document Review

**FMS.77 Emergency plans are tested in simulation at least once a year, and test results are evaluated.**

**Evidence of Compliance**

FMS.77.EC.1	There is annual testing and evaluation of the emergency plan.	Document Review
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**FMS.78 The Periodic Preventive Maintenance (PPM) program for the electrical system is supported by trained/ specialized staff / contractor, and maintenance records are documented.**

**Evidence of Compliance**

FMS.78.EC.1	Qualified and trained staff are handling the PPM of electrical System.	Personnel File
FMS.78.EC.2	There are updated electrical system maintenance records.	Document Review

**FMS.79 The electrical outlets are identified for:**

FMS.79.1 Voltage 110/ 220

FMS.79.2 Source (essential/ prime)

**Evidence of Compliance**

FMS.79.EC.1	All electrical outlets are identified for voltage.	Observation
FMS.79.EC.2	All electrical outlets are identified for source (essential/ prime).	Observation

**FMS.80 Thermographic inspection of circuit breakers is conducted annually at least for the following:**

FMS.80.1 Operating Room

FMS.80.2 Lab

FMS.80.3 Critical care unit

FMS.80.4 Alarm system

FMS.80.5 Blood storage

FMS.80.6 Medical gas system

**Evidence of Compliance**

FMS.80.EC.1	There is annual inspection of circuit breakers for critical care areas (Operating room, ICU).	Document Review
FMS.80.EC.2	There is annual inspection of circuit breakers for the blood storage are and laboratory.	Document Review
FMS.80.EC.3	There is annual inspection of circuit breakers for alarm system and medical gas system.	Document Review

**FMS.81 The Periodic Preventive Maintenance (PPM) program for generator(s) is supported by trained/ specialized staff / contractor, and maintenance records are documented.**

**Evidence of Compliance**

FMS.81.EC.1	Qualified and trained staff are handling the PPM of electric generator(s).	Personnel File
FMS.81.EC.2	There are updated generator maintenance (PPM) records.	Document Review



**FMS.82 The hospital's emergency power (in case of main power interruption) is tested on station load for thirty minutes monthly and the test results are documented. The emergency power covers at least the following essential areas:**

- FMS.82.1 Operating Room.
- FMS.82.2 Labor and Delivery.
- FMS.82.3 Critical Care Units.
- FMS.82.4 Alarm system.
- FMS.82.5 Fire Pumps
- FMS.82.6 Blood storage.
- FMS.82.7 Medical gas system.
- FMS.82.8 Kitchen refrigerators/ freezers
- FMS.82.9 Elevators
- FMS.82.10 Escape Rotes/corridors

**Evidence of Compliance**

- |             |  |                 |
|-------------|--|-----------------|
| FMS.82.EC.1 | There is monthly documentation of emergency power testing results on station load for thirty minutes.  | Document Review |
| FMS.82.EC.2 | All essential hospital areas are covered by the emergency power testing (OR, ICU, L & D, blood storage, refrigerators, elevators, alarm and medical gas systems, fire pumps, and escape routes). | Document Review |

**FMS.83 The hospital emergency power generator is tested without load on weekly basis for ten minutes, and test results are documented.**

**Evidence of Compliance**

- |             |   |                 |
|-------------|---|-----------------|
| FMS.83.EC.1 | There is weekly emergency power generator testing without load for ten minutes. | Document Review |
|-------------|---|-----------------|

**FMS.84 The hospital emergency power generator is tested annually on load bank for 4 hours at 100% load, results are documented.**

**Evidence of Compliance**

- |             |  |                 |
|-------------|--|-----------------|
| FMS.84.EC.1 | There is annual emergency power generator testing on load bank for 4 hours at 100% load, results are documented. | Document Review |
|-------------|--|-----------------|

**FMS.85 The Periodic Preventive Maintenance (PPM) program for Medical Gas is supported by trained/ specialized staff / contractor, and maintenance records are documented.**

**Evidence of Compliance**

- |             |   |                 |
|-------------|---|-----------------|
| FMS.85.EC.1 | Qualified and trained staff are handling the PPM of the medical gas system. | Personnel File  |
| FMS.85.EC.2 | There are updated medical gas system maintenance records.                   | Document Review |

**FMS.86 Medical gas system is regularly tested for:**

- FMS.86.1 Pressure
- FMS.86.2 Leaks
- FMS.86.3 Functionality of valves, alarms, pressure gauge, switches, etc.
- FMS.86.4 Emergency shut off valves at nurse station/ corridor are identified to indicate departments supplied.
- FMS.86.5 Labels to identify medical gas lines and directions are clearly marked.

**Evidence of Compliance**

- |             |  |                 |
|-------------|--|-----------------|
| FMS.86.EC.1 | There is periodic testing of medical gas for pressure, leaks, functions, emergency | Document Review |
|-------------|--|-----------------|



shut off, and labeling.

**FMS.87 There is a written policy on how to handle various types of compressed gasses, which includes:**

- FMS.87.1 Storing them in a well ventilated area.
- FMS.87.2 Positioning them upright the wall or a stand and secured by a chain.
- FMS.87.3 Separating any flammables from oxidizing gases.
- FMS.87.4 Delivering Liquid Oxygen (LOX) by trucks.

**Evidence of Compliance**

- FMS.87.EC.1 There is a written comprehensive policy for storage, safe handling and delivery of all types of available compressed. Document Review
- FMS.87.EC.2 There is proper storage, safe handling and delivery of compressed gasses. Observation

**FMS.88 Exhausts of the following gases are extended to the roof and identified:**

- FMS.88.1 Lab safety cabinet gases of a certain class
- FMS.88.2 Central vacuum gases
- FMS.88.3 Scavenger gases of certain type
- FMS.88.4 Bone marrow transplantation (BMT) lab gases

**Evidence of Compliance**

- FMS.88.EC.1 There is proper labeling of the gas exhausts to the hospital roof (lab safety gas, central vacuum gas, scavenger gases, and BMT lab gas). Observation

**FMS.89 The Periodic Preventive Maintenance (PPM) program for Heating, Ventilating and Air-conditioning (HVAC) is supported by trained/ specialized staff / contractor, and maintenance records are documented.**

- FMS.89.1 The HVAC adopts ASHRAE (American Society of Heating, Refrigeration, and Air conditioning Engineering) standards/ equivalent standards for:
  - FMS.89.1.1 Control of Air quality by doing the following:
  - FMS.89.1.2 Cleaning / replacement of filters
  - FMS.89.1.3 Cleaning of diffuser
  - FMS.89.1.4 Cleaning ducts

**Evidence of Compliance**

- FMS.89.EC.1 Qualified and trained staff are handling the PPM of heating, ventilating and air conditioning (HVAC) System. Personnel File
- FMS.89.EC.2 There are updated HVAC system maintenance records. Document Review

**FMS.90 Control of Positive, Negative and equal pressure and air flow every 3 months, at least in the following areas:**

- FMS.90.1 OR
- FMS.90.2 Labor and Delivery
- FMS.90.3 Isolation Room(s)
- FMS.90.4 Critical Care Unit(s)
- FMS.90.5 Clean Utility
- FMS.90.6 Dirty Utility
- FMS.90.7 Janitorial Closet
- FMS.90.8 Lab

**Evidence of Compliance**

- FMS.90.EC.1 There is periodic testing and controlling air flow and pressure in all critical areas is adequately documented (OR, critical care units, L&D, isolation rooms, clean and dirty utility, janitorial closets, and lab). Document Review



FMS.90.EC.2 There is compliance with air flow and pressure requirements for all critical areas. Observation

**FMS.91 Control of temperature and humidity regularly at least in the following areas:**

- FMS.91.1 OR
- FMS.91.2 Recovery Room
- FMS.91.3 Nursery
- FMS.91.4 ICU
- FMS.91.5 Sterilize storage supply
- FMS.91.6 Patient Room

**Evidence of Compliance**

- FMS.91.EC.1 Regular Control of temperature and humidity in all critical areas is adequately documented (OR, ICU, recovery room, nursery, patient room, and sterile storage supply). Document Review
- FMS.91.EC.2 There is compliance with required temperature and humidity in all critical areas. Observation

**FMS.92 The Periodic Preventive Maintenance (PPM) program for Water System is supported by trained/ specialized staff / contractor, and maintenance records are documented for:**

- FMS. 92.1 Water is available 24hrs/day, every day of the year, by checking the water level daily.
- FMS. 92.2 The incoming water supply is checked regularly for at least the following, and results are monitored:
  - FMS. 92.2.1 Chemicals (once every six months)
  - FMS. 92.2.2 Bacteria (monthly)

**Evidence of Compliance**

- FMS.92.EC.1 Qualified and trained staff are handling the PPM of water System. Personnel File
- FMS.92.EC.2 There are updated water system maintenance records for water availability, chemical testing every 6 month and monthly bacterial testing. Observation
- FMS.92.EC.3 There is water tanker provider contract. Document Review

**FMS.93 Sewage handling and disposal is done in an efficient and sanitary manner, according to professional codes of practice.**

**Evidence of Compliance**

- FMS.93.EC.1 There is a professional code for sewage handling. Document Review
- FMS.93.EC.2 There is proper handling and disposal of sewage (Sewage disposal contract). Document Review

**FMS.94 The Utility System Plan ensures the availability of:**

- FMS. 94.1 Necessary technical utility drawings that show the distribution lines for all utilities and how to control them centrally and peripherally so that lines can be controlled as requires in case of emergency.
- FMS. 94.2 Statistical data produced by the maintenance management system as an indicator to evaluate performance of the systems, and suggest improvement/ upgrade as required.

**Evidence of Compliance**

- FMS.94.EC.1 There are comprehensive utility drawings for utility line control during emergency. Document Review
- FMS.94.EC.2 There is performance evaluation of the utility system and improvement plan. Document Review

**FMS.95 Kitchen equipment is inspected, tested and results are documented as follows:**

- FMS.95.1 Hoods fans are in good operating condition, and free from grease.
- FMS.95.2 Hood filters are cleaned weekly, and no cooking done with missing filters.
- FMS.95.3 Refrigerators are connected to emergency power.





FMS.95.4 Cold room temperature is monitored.

**Evidence of Compliance**

FMS.95.EC.1	There is regular inspection of all kitchen equipments.	Document Review
FMS.95.EC.2	Hoods fans are in good operating condition, and free from grease.	Observation
FMS.95.EC.3	Hood filters are cleaned weekly, and no cooking done with missing filters.	Observation
FMS.95.EC.4	Refrigerators are connected to emergency power.	Observation
FMS.95.EC.5	There is regular temperature monitoring of the cold room.	Document Review

**FMS.96 Laundry equipment/ systems are inspected, tested and results are documented.**

**Evidence of Compliance**

FMS.96.EC.1	Qualified and trained staff are handling the PPM of laundry equipments.	Personnel File
FMS.96.EC.2	There are updated laundry equipment maintenance records.	Document Review



## Glossary

**Access** A person's ability to get necessary medical care and services when needed. The ease of access is determined by components such as the availability of medical services and their acceptability to the individual and community, the locale of health care facilities, transportation, and hours of operation.

**Accountability** The ability of a system to track an individual's actions.

**Accreditation** A formal process by which a recognized body ("accrediting body") assesses and recognizes that a healthcare organization meets applicable, pre-determined standards.

**Aggregate** To combine standardized data/information.

**Appropriateness** Extent to which a particular procedure, treatment, test or service is effective, clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to the client needs.

**Availability** The degree to which appropriate care is available to meet the individual patient needs.

**Benchmarking** A continuous process of measuring products, services, and/or practices against the competition in order to find and implement best practices.

**Clinical Practice Guidelines** Statements that help practitioners and patients choose appropriate health care for specific clinical conditions.

**Code of Conduct** A set of principles and expected behaviors that are expectations of employee performance within a health care setting or as defined by the leadership group.

**Collaborative** An organizational culture characterized by a shared vision, shared leadership, empowered workers, and cooperation among organizational units as they work to improve process.

**Competence** Job knowledge, skills, and attitude required to perform the job. Knowledge is the understanding of facts and procedures. Skill is the ability to perform specific actions.

**Committee** A multidisciplinary body of persons officially delegated to consider, investigate, take action on, or report on some matter or perform a specified function.

**Confidentiality** The restricted access to data and information to individuals who have a need, a reason, and permission for such access. An individual's



right to personal and informational privacy, including his or her health care records.

**Continuity of Care** A performance dimension addressing the degree to which the care for a patient is coordinated among practitioners and organizations and over time, without interruption, cessation, or unnecessary repetition of diagnosis or treatment.

**Continuous Quality Improvement (CQI)** The culture, strategies and methods necessary for continual improvement in meeting and exceeding customer expectations.

**Continuous Quality Improvement Tools** CQI tools focus on process rather than the individual, and promote the need to analyze and improve process.

**Credentialing** The process of obtaining, verifying and assessing the qualifications of a health care professional to determine if an individual can provide patient care services in or for a health care organization.

**Criteria** Expected level(s) of achievement or specifications against which performance can be assessed.

**Data** Raw facts and figures from which information can be generated.

**Database** An organized, comprehensive collection of stored data.

**Dosimeter** Is any device used to measure an individual's exposure to a hazardous environment, particularly when the hazard is cumulative over long intervals of time, or one's lifetime.

**Effectiveness** The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome for the patient.

**Efficacy** The power to produce an effect, for example: Clinical trials in medicine provide evidence or efficacy.

**Evidence based Medicine** The practice of medicine or the use of healthcare interventions guided by or based on supportive scientific evidence.

**Facilitate** To make easier.

**Family or Responsible Person** The person(s) with a significant role in the patient's life. This may include a person(s) not legally related to the patient. This person(s) is often referred to as a surrogate decision maker if authorized to make care decisions for a patient if the patient loses decision-making ability.



**Functional Status** The ability of individuals to take care of themselves physically and psychologically.

**Formulary** An approved list of medications and associated information related to medication use. The list is subject to periodic review and modification.

**Goal** A broadly stated or long-term outcome written as an overall statement relating to a philosophy, purpose, or desired outcome.

**Governance** The function of determining the organization's direction, setting objectives, and developing policy to guide the organization in achieving its mission.

**Governing Body** Collectively the individual(s), group, or agency that has ultimate authority, responsibility, and accountability for the overall strategic direction, methods of operations (management and planning), establishment of policies, maintenance of safety and quality of care of the hospital.

**Guidelines** Principles guiding or directing action.

**Hazardous Materials** Substances, such as chemicals, that are dangerous to humans and other living organisms.

**Hazardous Waste** Waste materials dangerous to humans and other living organisms. Such materials require special precautions for disposal.

**Healthcare-Associated Infections (HAIs)** Infections that patients acquire during the course of receiving treatment for other conditions or that healthcare workers acquire while performing their duties within a healthcare setting. Specific criteria must be met in order to define an infection as healthcare-associated.

**Health Care Organization** A generic term used to describe many types of organizations that provide health care services.

**Health Care Professional** Any person who has completed a course of study and is skilled in a field of health. This includes a physician, dentist, nurse, or other healthcare professionals. Healthcare professionals are often licensed by a government agency or certified by a professional organization.

**Health Record** A record that contains patient health information generated by one or encounters. Included in this information are patient demographics, assessment findings, problems, medications, immunizations, diagnostic reports, provided education, and any other relevant patient-specific information.

**High Risk** High probability that severe injury will occur.



**Incident** Events that are unusual, unexpected, may have an element of risk, or that may have a negative effect on patients, staff, or the hospital.

**Indicator** Performance measurement tool which is used as a guide to monitor, evaluate and improve the quality of patient care and service.

**Information** An interpreted set of data; organized data that provides a basis for decision-making.

**Information Management** The creation, use, sharing, and disposal of data or information across an organization. This practice is critical to the effective and efficient operation of organization activities.

**Informed Consent** Person's voluntary agreement of one who has sufficient mental capacity with full knowledge of the risks involved, probable consequences, and the alternatives to make an informed decision. It allows a patient to balance the probable risks against the probable benefits of any potential care.

**Job Description** A written statements that describe the duties, responsibilities, required qualifications of candidates, and reporting relationship and coworkers of a particular job.

**Leaders** The identified and designated individuals who have the responsibility to oversee effective functioning of processes within a defined scope of services.

**Management** Setting targets or goals for the future through planning and budgeting, establishing processes for achieving those targets, and allocating resources to accomplish those plans.

**Mission** The reason or purpose for the existence of an organization or one of its components.

**Mission statement** A written expression that states the purpose of an organization or one of its components.

**Monitoring** A planned, systemic, ongoing process to gather, organize, and review data/information on a regular basis with the purpose of identifying changes in a situation.

**MSDS (Material Safety Data Sheet)** A form containing data regarding the hazardous properties of chemicals and other hazardous agents.

**Objectives** Concrete, measurable steps taken to achieve goals. Tampering

**Organizational Chart** A diagram representing the structure of the hospital and reporting relationship. It shows employee positions, reporting relationship, and lines of authority.



**Orientation** The act of being oriented. The introductory process by which staff become familiar with all aspects of the work environment and their responsibilities.

**Outcome** A broad term that is used to describe the end result of a service, practice, procedure, or intervention.

**Patient** A patient is a person for whom a hospital accepts responsibility for treatment, care and/or service. For CBAHI standards, a patient includes such designations as client, resident, and individual served.

**Patient Assessment** The gathering of information in order to evaluate a person's health and health-care needs.

**Patient Satisfaction** A measurement that obtains reports or ratings from patients about services received from an organization, hospital, physician, or healthcare provider.

**PDCA** It is a scientific method utilized to improve processes. Acronym meaning: PLAN the improvement, DO the improvement, collect data and analyze data, CHECK and study the results, ACT to improve the process and hold gains. Also known as the Shewart cycle, Deming cycle, or learning cycle of change.

**Personnel File** Collection of information about a staff member covering personnel issues such as licensure, certifications, leaves, appraisal reviews, and job description.

**Plan** To formulate or describe the approach to achieving the goals related to improving the performance of the organization.

**Plan of care (Care Plan)** A treatment plan especially designed for each patient, based on individual strengths and needs. The caregiver(s) develop(s) the plan with input from the family and communication with each others. The plan establishes goals and details appropriate treatment and services to meet the special needs of the patient. The planning is an interdisciplinary process.

**Policy** A policy is a written document which outlines the rules and expected performance of staff within the organization. Policies are dynamic and reflect current knowledge and practice and need to be reviewed on a regular basis.

**Privileging** The process of reviewing an individual's credentials through credentials body to determine the authority and responsibility to be granted to a practitioner for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care. Privileging determines the physician's scope of practice in the organization determined by his/her competencies.



**Procedure** A written set of instructions that describe the approved and recommended steps for a particular act or sequence of acts.

**Process** A set of interrelated steps directed at one particular outcome.

**Process Improvement** Mechanisms utilized to make improvements to a process through the use of continuous quality improvement methods.

**Probationary period** The time period identified by the organization for determining if the employee is competent to perform his/her duties and continue employment with the organization. Generally, the time period of probation is 3 months.

**Protocols** A plan, or set of steps, to be followed in a study, an investigation, or an intervention.

**Psychosocial** Refers to one's psychological development in the context of a social environment. It is simply the individual's interaction with the environment which he finds himself and the dynamics or factors which influence the individual's "psyche".

**Quality** The degree to which health services for individuals and population increases the likelihood of desired outcome and are consistent with current professional knowledge.

**Quality Control** A management process through which performance is measured against expectations and corrective actions are taken.

**Quality Improvement Team** Individuals (cross-department functions/services) knowledgeable about a particular aspect of care or service and commissioned to improve a process that has been identified as requiring attention.

**Referral** The process by which a patient is sent (1) from one clinician to another clinician or specialist; or (2) from one setting or service to another or other resource, either for consultation or care that the referring source is not prepared or qualified to provide.

**Rehabilitation** Programs and activities designed to help individuals maximize their independence.

**Risk** The combination of the assessment of magnitude of injury, or potential injury, with the probability that certain actions/events will occur.

**Root Cause** The underlying reason for the occurrence of a problem.



**Safe Care** The degree to which the risk of an intervention and the risk in the care environment are reduced for a patient and others, including the health care practitioners.

**Scope of Service** The range of activities provided to the patients and/or other customers by the leadership, clinical, and support personnel. This describes the full range of services, the demographics (age groups, types of patients) diagnostics provided, therapeutic interventions provided, and the number of patients who are provided each service annually. All of the resource and competency requirements flow from the organization's scope of service.

**Screening** A system for examining and separating into different groups.

**Screening Criteria** A set of standardized rules or tests applied to patient groups on which to use a preliminary judgment that further evaluation is warranted.

**Sentinel Event** An event that, when noted, requires intensive assessment.

**Standard** Statement of structure and process expectations necessary to enhance quality care.

**Standardization** To confirm with a predetermined set of expectations.

**Strategic Planning** A management tool to help an organization do a better job. It is disciplined effort to produce fundamental decisions and actions that shape what an organization is, what it does, and why it does it, with a focus on the future.

**Structure** Environmental features which shape process and outcome: resources, money, equipment, supplies, staff, policies.

**System** A group of related processes.

**Team** A group of five to eight people consisting of a leader, facilitator, and members who are addressing an issue that impacts the operations of a process.

**Terms of reference** A formal document approved by the leadership that outlines the roles/responsibilities of a committee. This document describes the expected performance of the committee, how often the committee is expected to meet, and also includes a list of the membership and alternates if needed.

**Timely** The degree to which care is provided to the patient at the most beneficial or necessary time.

**Transfer** The formal shifting of responsibility for the care of a patient from one care unit to another, one clinical service to another, one qualified practitioner to another, or one organization to another organization.





**Trending** The evaluation of data collected over a period of time for the purpose of identifying patterns or changes.

**Triage** A system of establishing the order in which acts are to be carried out in an emergency, prioritize patients by their problems, symptoms determining the order of being managed.

**Turn Around Time** Initial time from the starting point to the end point. For example: For a stat order, the time the doctor's order was written, or stated, to the time it is carried out.

**Utilization** The use, patterns of use, or rates of use of a specified health care service.

**Values** The beliefs and philosophy within an organization that establish the basis for the operation and provides guidelines for daily behavior.

**Vision** Description of what the organization would like to be.



**Further modifications will be communicated to the Hospitals through later editions and amendments. If you have any comments or queries about the Accreditation Survey Package please contact:**

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