الهيئة العامة للاعتماد والرقابة الصحية
GAHAR

متطلبات تسجيل المستشفيات

Version 1

الهيئة العامة للاعتماد والرقابة الصحية

نظام تسجيل المنشآت الصحية:

استناداً إلى قانون رقم (2) لسنة 2018 بشأن نظام التأمين الصحي الشامل والصادر في يناير 2018 ولائحته التنفيذية الصادرة بقرار رئيس مجلس الوزراء في مايو 2018 وقرار رئيس مجلس الوزراء رقم 2040 لسنة 2018 بتشكيل مجلس إدارة الهيئة العامة للاعتماد والرقابة الصحية.

وفي إطار الخطوات الحثيثة والمتلاحقة التي تخطوها الدولة نحو تنظيم القطاع الصحي بما يضمن سلامته واستقراره وتحسين جودته وتوكيد الثقة في جودة مخرجات الخدمات الصحية بجمهورية مصر العربية على كافة المستويات المحلية والإقليمية والدولية.

فقد قرر مجلس إدارة الهيئة العامة للاعتماد والرقابة ما يلي:

أولاً: وضع قواعد وشروط تسجيل المنشآت الصحية تمهيداً لاعتمادها من قبل الهيئة، والتي تشمل على سبيل الحصر والتحديد ما يلي:

أ- تحقق الاشتراطات الأساسية للمنشآت الصحية.

ب- تحقق المتطلبات الوطنية للسلامة بالمنشآت الصحية بما يضمن سلامة المرضى والمرافقين والزوار والعاملين بتلك المنشآت.

ج- وجود دليل تشغيل فعلي للمنشأة الصحية والالتزام به بما يحقق أداءً احترافياً مستقراً للمنشأة في كافة أقسامها وعلى كافة مستويات تقديم الخدمة بها في جميع الأوقات ومع جميع الحالات.

د- تحقق متطلبات القيادة في المنشآت الصحية بما يضمن الوصول إلى أعلى درجات الوعي والقدرة والالتزام من القيادات في المنشآت الصحية على اختلاف مستوياتهم القيادية.

هـ- تحقق المتطلبات الأساسية للموارد البشرية في المنشآت الصحية بما يضع الأسس السليمة لاختيار العاملين وتوزيعهم وتقييم أدائهم وتحسينه بشكل مستمر وتنمية قدراتهم والاحتفاظ بهم على اعتبار أن الموارد البشرية هي من الأصول المهمة للمنشأة والتي يجب الحفاظ عليها وتنميتها بشكل مستمر.

ثانياً: مع مراعاة التدرج الجغرافي في التطبيق، تحتفظ الهيئة العامة للاعتماد والرقابة الصحية في البت في تسجيل واعتماد المنشآت الصحية في كافة أنحاء الجمهورية وفي كافة القطاعات وفقاً للقانون (2) لسنة 2018.

ثالثاً: إلزام كافة المستشفيات ومراكز ووحدات الرعاية الصحية بالمحافظات بالتقدم للتسجيل في موعد أقصاه ستة أشهر من تاريخ دخول المحافظة نطاق التطبيق للقانون وفقاً لأحكام القانون (2) لسنة 2018م.

رابعاً: تلتزم المنشآت المسجلة بالهيئة بالتقدم للحصول على اعتماد الهيئة خلال موعد أقصاه سنة من تاريخ التسجيل وإلا اعتبر التسجيل لاغيا ويجب إعادته مرة أخرى.

خامساً: تلتزم الهيئة العامة للاعتماد والرقابة بتعريف وتعليم وتدريب الأطراف المعنية بإجراءات تسجيل المنشآت الصحية وفق خطة محددة ومفهوم لا يتعارض مطلقا مع أي من القواعد الحاكمة لمبدأي الشفافية وتجنب تضارب المصالح.

سادساً: تلتزم الهيئة بإتاحة ما يلي:

أ. الوثائق المرفقة (في البند سابعاً) والتي توضح تفاصيل متطلبات تسجيل المنشآت الصحية لديها.

ب. أدلة مفصلة للاسترشاد بها في تحقيق تلك المتطلبات، مع الوضع في الاعتبار عدم التقيد الحرفي بها والعمل على موائمتها بما يتناسب وطبيعة كل منشأة على حدة.

سابعاً: الوثائق المرفقة:

أ- الاشتراطات الأساسية للمنشآت الصحية كما وردت بالقانون (51) لسنة 1981 المعدل بالقانون (153) لسنة 2004 أو ما يساويها في المنشآت التي لا ينطبق عليها القانون.

ب- المتطلبات الوطنية للسلامة بالمنشآت الصحية.

ج- دليل تشغيل المنشأة الصحية.

د- دليل متطلبات القيادة في المنشأة الصحية.

هـ- دليل المتطلبات الأساسية للموارد البشرية في المنشأة الصحية.

خطوات تسجيل المنشآت الصحية لدى هيئة الاعتماد والرقابة الصحية:

1. تتقدم المنشأة بطلب التسجيل لدى الهيئة، وذلك عن طريق ملء وتقديم الاستمارة المخصصة لذلك.
2. تقوم الهيئة بدراسة الطلب المقدم من المنشأة والرد عليها ببيان بمتطلبات ورسوم التسجيل لتلك المنشأة.
3. تقوم المنشأة صاحبة الطلب بدفع رسوم التسجيل وتسليم الوثائق اللازمة لهيئة الاعتماد والرقابة الصحية وفقاً لمتطلبات التسجيل الواردة في رد الهيئة في البند السابق.
4. تقوم الهيئة بمراجعة الوثائق المستلمة من المنشأة والتأكد من اكتمالها ومخاطبة المنشأة لاستكمال وتقويم ما ترى الهيئة ضرورة استكماله وتقويمه من الوثائق اللازمة لإتمام عملية التسجيل.
5. بعد التأكد من اكتمال جميع الوثائق المطلوبة في البند (٣) تقوم الهيئة بتحديد موعد لإجراء زيارة للمنشأة للتدقيق والتحقق من البنية والعمليات المرتبطة بالوثائق المقدمة من المنشأة.
6. يتم إبلاغ المنشأة بموعد زيارة التدقيق والتحقق قبل فترة لا تقل عن 15 يوماً من التاريخ المحدد للزيارة.
7. يقوم فريق من المقيمين/ المراجعين بزيارة التدقيق والتحقق للمنشأة.
8. تلتزم الهيئة بإبلاغ المنشأة بقرار الهيئة خلال فترة لا تزيد عن ١٥ يوم عمل من تاريخ انتهاء الزيارة.
9. الحالات المختلفة لقرار الهيئة:
   أ- قبول تسجيل المنشأة وعليه تلتزم المنشأة بالتقدم للاعتماد خلال فترة لا تزيد عن سنة من تاريخ قبول تسجيل المنشأة.
   ب- رفض تسجيل المنشأة وفي هذه الحالة تقوم المنشأة بكافة الإجراءات المذكورة عاليه من البند (١) وحتى البند (٧).
   ج- القبول المشروط لتسجيل المنشأة وفي هذه الحالة يتم تحديد زيارة أخرى (زيارة الفرصة الثانية) وتلتزم المنشأة بتسديد تكاليف تلك الزيارة.
10. الحالات المختلفة لقرار الهيئة عقب زيارة الفرصة الثانية للمنشأة:
    أ- قبول تسجيل المنشأة كما في البند ٨أ.
    ب- رفض تسجيل المنشأة كما في البند ٨ب.

اشتراطات التراخيص للمستشفيات

اشتراطات عامة:

1. رسم هندسي معتمد من مهندس نقابي للمبنى بقياس رسم ١/١٥٠.
2. ما يفيد ملاءمة المبنى لأداء الغرض المنشأ له فنيا وتقنيا وصحيا موضح به توزيع وتقسيمات وحدات المبنى الداخلية بالتفصيل، كل طابق على حده في حالة تعدد الطوابق.
3. أن تكون حجرات المنشأة الطبية جيدة التهوية والإضاءة.
4. أن تكون المنشأة مزودة بوسائل تغذيتها بالمياه النقية بصفة مستمرة.
5. أن تكون المنشأة مزودة بوسائل الصرف الصحي المناسبة.
6. أن تزود المنشأة بالوسائل والأدوات الصحية اللازمة للتخلص من القمامة والفضلات.
7. أن تزود المنشأة بالأجهزة اللازمة لإطفاء الحرائق.
8. شهادة من إدارة الدفاع المدني والحريق بتوفر الاشتراطات اللازمة لحماية المركز من إخطار الحريق.
9. أن تكون المنشأة مجهزة بوسائل الإسعاف الأولية.
10. شهادة تداول المواد والنفايات الخطرة.
11. ما يفيد الاشتراك أو التعاقد مع محرقة للنفايات الطبية.
12. التقدم بخطة محدد بها الأسلوب الذي سيتم اتباعه لمنع انتشار العدوى بالمنشأة.
13. التقدم بخطة محدد بها الأسلوب الذي سيتم اتباعه للتخلص الآمن من النفايات.
14. يجب أن يتوفر بكل منشأة طبية بها عشرون سريراً فأكثر عدد مناسب من الأطباء المقيمين على ألا يقل عددهم عن طبيب مقيم لكل عشرين سريراً.
15. يجب أن يتوفر بكل منشأة طبية بها أَسَرّة للعلاج العدد المناسب من الممرضات المرخص لهن بمزاولة المهنة على ألا يقل عددهن عن ممرضة للعيادة الخاصة بأَسَرّة وممرضة على الأقل لكل خمسة أَسَرّة بالعيادة المشتركة والمستشفيات وذلك خلال الـ 24 ساعة.
16. تعهد بالالتزام بتنفيذ الاشتراطات الفنية والصحية المحددة بالقانون رقم ٥١ لسنة ١٩٨١ الخاص بالمنشآت الطبية ولائحته التنفيذية والقرارات الوزارية المكملة، وتعديلاته بالقانون ١٥٣ لسنة ٢٠٠٤م.

اشتراطات للمستشفيات:

1. تزود كل غرفة من غرف المرضى بالمنشأة بأثاث سهل التنظيف لا يعوق التهوية، والإضاءة ولا تقل المساحة المخصصة لكل سرير عن 9 متر، على أن تنشأ دورة مياه وحمام لكل عشرة أسرة على الأكثر في حالة عدم تزويد الغرفة بدورة مياه مستقلة.
2. يجب على المنشأة تخصيص محطة تمريض مجهزة لكل أربعين سريراً على أن تمد هذه المحطة بأثاثات خاصة بحفظ الملفات والسجلات وأخرى لحفظ الأدوية والمهمات والآلات الطبية اللازمة للعمل التمريضي وكذلك بجهاز استدعاء.
3. يشترط توافر الاشتراطات الآتية في حجرة العمليات بالمنشأة:

أ- ألا تقل مساحة الحجرة التي تجري بها العمليات الصغرى والمتوسطة عن 12م^2 على ألا يقل طول أحد الأضلاع عن 3 متر، أما الحجرة التي تجرى بها عمليات كبيرة فلا تقل مساحتها عن 20 م^2.

ب- أن تكون الأبواب والنوافذ جيدة الصنع ومحكمة وأن يكون زجاجها سليم "دائم" وفي حالة استعمال جهاز التكييف يفضل استعمال نظام التكييف المركزي المزود بالمرشحات.

ج- أن تكون الحجرة مزودة بضوء صناعي كاف فوق منضدة العمليات، وأن تكون هناك أجهزة إضاءة احتياطية للعمل في حالة انقطاع التيار الكهربائي.

د- تزود الحجرة بالحد الأدنى على الأقل من الآلات الجراحية وأجهزة التخدير والإفاقة ووسائل الإسعاف التي تتناسب مع نوع العمليات التي تجرى بها.

هـ- يلحق بالحجرة في حالة إجراء عمليات جراحية كبرى غرفة أو مكان للإفاقة يكون مجهزاً بالتجهيزات المناسبة.

و- في حالة عدم وجود قسم للتعقيم المركزي بالمنشأة الطبية التي بها جناح للعمليات يلحق بحجرة العمليات غرفة للتعقيم تكون مزودة على الأقل بأتوكلاف يعمل بالبخار وفرن تعقيم بالهواء الساخن وعدد مناسب من علب التعقيم.

4. يلحق بالحجرة مكان لتغيير الملابس وغسل الأيدي للجراحين وهيئة التمريض.
5. يجب أن تتوافر بكل منشأة طبية بها مائة سرير فأكثر صيدلية يطبق عليها الاشتراطات الواردة بالقانون رقم 127 لسنة 1955 بشأن مزاولة مهنة الصيدلة.
6. يجب على المنشأة الطبية مراعاة أحكام قرار وزير الصحة رقم 630 لسنه 1962 بإصدار اللائحة التنفيذية للقانون رقم 59 لسنه 1960 في حالة وجود أجهزة للتشخيص أو العلاج بالإشعاعات المؤينة.

في حالة وجود عيادة خارجية بالمنشآت يجب أن تتوافر بها الاشتراطات الآتية:

1. أن يكون لها مدخل خاص.
2. أن تكون بها أماكن انتظار مناسبة ومزودة بأثاث جيد وملحق بها عدد كاف من دورات المياه.
3. أن يكون بها عدد كاف من غرف الكشف المزودة بوسائل التشخيص المناسبة.
4. يجب على المنشأة الطبية مراعاة أحكام قرار وزير الصحة رقم 291 لسنه 1980 والقرارات المعدلة له بشأن جمع وتخزين وتوزيع الدم في حالة وجود مركز بها لهذا الغرض
5. تسرى أحكام القانون رقم 367 لسنه 1954 في شأن مزاولة مهن الكيمياء الطبية والبكتريولوجيا والباثولوجيا وتنظيم معامل التشخيص الطبي ومعامل الأبحاث العلمية ومعامل المستحضرات الحيوية والقوانين المعدلة له واللوائح والقرارات المنفذة على معامل الفحوص البكتريولوجية والباثولوجية الموجودة بالمنشآت الطبية.

المطبخ:

- يجب أن يزود المطبخ بتغذية مياه نقية والوسائل المناسبة للصرف وللتخلص من الفضلات وأن تكون التهوية والإضاءة جيدة وأن تزود الأبواب والشبابيك بسلك ناموسية.

National Safety Requirements (NSR) for Hospitals

PREFACE

The goal of developing NSR is enhancing individual's safety in hospitals. The General Authority for Healthcare Accreditation & Regulation (GAHAR) selected those standards which may impact individual's safety, or in other words; the main killers in hospitals, to establish these standards as basic requirements for hospitals looking for enrollment in the new healthcare system in Egypt.

EVALUATION OF NSR:

General Authority for Healthcare Accreditation & Regulation (GAHAR) is very much focused on individual's safety. These NSR are meant to promote individual's safety in hospitals.

The NSR are selected standards from the Egyptian Hospitals Accreditation Standards (3rd Edition, 2017).

The NSR are Grouped into 4 groups (A, B, C, and D). A unit has to score 70% or more in each group separately and a total of 80% or more in all groups.

No standard should be scored Not Met (NM) for a hospital to pass the NSR evaluation.

ACKNOWLEDGEMENT:

The development of these NSR is based on the work of expert teams who developed the current and previous versions of Egyptian Accreditation Standards for Hospitals. We would like to thank in particular the (Health Governance Unit/ Medical Research Institute/ Alexandria University) and World Health Organization (WHO) for sharing with us their previous efforts to improve patient safety.

NSR STANDARDS vs PATIENT CARE PATHWAY:

Patient Pathway	NSR Standards				
Admission	Patient Identification			Medication Reconciliation	
Assessment	Fall Prevention			Pressure Ulcers Prevention	
Diagnosis	Panic Values			Critical Alarm Systems	
Medications	Injection Safety	Electrolytes Safety	Dangerous Abbreviations	Look Alike Sound Alike Medications	Medication Labeling
Surgeries & Procedures	Checklists	Timeout	Site-marking	Instrument Retention	Tube Misconnection
Discharge	Medication List			Continuity of Care	
Environment of care	Fire Safety – Utility Safety – Biomedical Safety – Safety & Security – Lab & Radiology Safety – Waste & Handling of Hazardous Material				
General	Staff Awareness of Policies & Procedures		Hand Hygiene	Verbal Orders	Handover

A. General Patient Safety Standards:

NSR.1

Standard:

The patient's safety policy defines Egyptian & WHO Patient Safety recommendations & solutions, including at least the following:

NSR.1.1 Accurate standardized patient identification in all service areas.

NSR.1.2 Standardized process for dealing with verbal or telephone orders.

NSR.1.3 Handling critical values/tests.

NSR.1.4 Hand hygiene throughout the organization.

NSR.1.5 Prevention of catheter & tubing mis-connections.

NSR.1.6 Prevention of patient's risk of developing pressure ulcers.

NSR.1.7 Prevention of patient's risk of falling.

NSR.1.8 A standardized approach to hand over communications.

Rationale:

To address the most common & critical identified areas, thus preventing adverse events & to ensure full awareness of the Egyptian & WHO standards for patient safety.

Survey Process:

Review the patient safety policy & procedures & check if it includes all the standard's items. Interview hospital staff to ensure awareness of policy.

Documents	Interviews	Observations
Patient safety policy & procedures	10 Hospital staff to ensure awareness of policy	

NSR.2

Standard:

At least two (2) ways are used to identify a patient when giving medicines, blood, or blood products, taking blood samples & other specimens for clinical testing, &/or providing any other treatments or procedures.

Rationale:

Providing care or performing interventions on the wrong patient are significant errors, which may have grave consequences. Using two identifiers for each patient is the key driver in minimizing such preventable errors, which is especially important with administration of high alert medications or conducting high risk or invasive procedures.

Survey Process:

- Review relevant policy & procedures & check whether it states those two identifiers (personal) & the occasions when they should be used.
- Review an appropriate number of medical records & check each sheet for the presence of the two identifiers mentioned in the policy & procedures document.
- Interview a number of healthcare staff (at least 10) & ask them about the two identifiers & when should they be used according to what is mentioned in the standard.
- Observe patient identification wrist bands for the two identifiers.
- Observe patient identification before procedures or care.

Documents	Interviews	Observations
Patient Identification policy & procedures	At least 10 interviews with any staff providing patient care	Patients identification (10 observations at least)
Medical records		Wrist Bands

NSR.3

Standard:

A process for taking verbal or telephone orders & for the reporting of critical test results, that requires a verification by write down and "read-back" of the complete order or test result by the person receiving the information is implemented.

Rationale:

Miscommunication is the commonest root cause for adverse events. Writing down & reading back the complete order or test result, by the person receiving the information, minimizes miscommunication & reduces errors from unambiguous speech, unfamiliar terminologies or unclear pronunciation. It also provides an opportunity for verification.

Survey Process:

- Review the policy of receiving verbal or telephone orders & of the critical test results reporting & check whether it clearly describes the process of documentation & "read-back" by the recipient & also the measures to be taken in case of critical test results.
- Review documentation in dedicated registers &/or medical records.
- Interview clinicians & technicians to assess knowledge & implementation.

Documents	Interviews	Observations
Verbal, telephone orders, critical test results (VTC) reporting policy & procedures	Clinicians Technicians	
VTC Logbooks &/or Medical records		

NSR.4

Standard:

Current published & generally accepted hand hygiene guidelines, laws & regulations are implemented to prevent healthcare-associated infections.

Rationale:

Hand hygiene is the cornerstone for reducing infection transmission at all healthcare settings. It is considered the most effective & efficient strategy for hospital wide infection prevention & control.

Survey Process:

- Review relevant policy & procedures of hand hygiene.
- Review hand hygiene guidelines.
- Interview hospital staff, enquiring about hand hygiene technique & WHO five moments of hand hygiene.
- Observe hand washing facilities at each patient care area.
- Check availability of supplies (soap, tissue paper, alcohol hand rub, etc).
- Observe compliance of clinicians with hand hygiene technique & the 5 moments.

Documents	Interviews	Observations
Hand hygiene policy & procedures	At least 10 hospital staff	Hand hygiene facilities (such as hand washing sinks, alcohol dispensers.. etc)
Hand hygiene guidelines		Hand hygiene supplies
		Staff compliance (10 observations at least)

NSR.5

Standard:

Systems are implemented to prevent catheter & tubing misconnections.

Rationale:

Patients, especially within critical & specialized care areas, are connected to many tubes & catheters, each with a special function (monitoring, access, drainage). During care, these tubes & catheters may be misconnected leading to the administration of wrong material via the wrong route resulting in grave consequences.

Survey Process:

- Review the policy & procedures for catheter & tubing misconnections & check for catheter differentiation, catheter maps.. etc.
- Interview clinicians to ensure their understanding of misconnection prevention.
- Observe compliance of clinicians with misconnection prevention.

Documents	Interviews	Observations
Catheter & tubing misconnections policy & procedures	Physicians & nurses	Patients particularly at Critical Care Areas
Catheter maps in Medical Records		

NSR.6

Standard:

Each patient's risk of falling, including the potential risk associated with the patient's medication regimen, is assessed & periodically reassessed. Action is taken to decrease or eliminate any identified risks of falling.

Rationale:

All patients are liable to fall; however, some are more prone to. Identifying the more prone is usually done through a risk assessment process in order to offer them tailored preventative measures against falling. Effective preventive measures to minimize falling are those that are tailored to each patient & directed towards the risks being identified from risk assessment.

Survey Process:

- Review the policy & procedures for fall prevention & check for patient risk assessment at admission & status change; noticing that medication review is part of the assessment & also check for the presence of general measures generated to reduce risk of falling & for tailored care plans based on individual patient fall risk assessment.
- Check availability of fall risk assessment forms (including mediation care view).
- Review medical records for fall risk assessment.
- Review fall prevention care plan forms & fall risk labels.
- Review patient & family education material.
- Review medical records for general measures & tailored care plans.
- Interview nurses & physicians to ensure their understanding & implementation of fall risk assessment.

- Interview clinicians to ensure their understanding & implementation of fall prevention care plans.
- Interview patients & families to ensure their awareness & involvement.
- Check organization wide general preventive measures (Call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs & trolleys with locks).

Documents	Interviews	Observations
Fall prevention policy & procedures	Clinicians	Organization wide general measures
Fall assessment forms in Medical Record		Specific measures for patients with high risk of falling
Patient & family education forms	Patients & families	

NSR.7

Standard:

Each patient's risk of developing pressure ulcers is assessed & documented. Action is taken to decrease or eliminate any identified risks of developing pressure ulcers.

Rationale:

Identifying patients who are more prone to develop pressure ulcers is a better preventive strategy than trying to treat them, as this not only consumes lots of resources but also has a negative impact on the patients themselves. Effective preventive measures to minimize pressure ulcer development are those that are tailored to each patient & directed towards the risks identified from risk assessment.

Survey Process:

- Review the policy & procedures for pressure ulcer prevention, check for patient risk assessment at admission & at status change, & check for general measures generated to reduce risk of pressure ulcer & for tailored care plans based on individual pressure ulcer risk assessment.
- Check availability of pressure ulcer risk assessment forms.
- Review medical records for pressure ulcer risk assessment.
- Review pressure ulcer prevention care plan forms in medical records.
- Review patient & family education forms & material.
- Interview clinicians to ensure their understanding & implementation of pressure ulcer risk assessment & their preventive care plans.
- Interview patients & families to ensure their awareness & involvement.
- Check organization wide general measures (pressure relieving devices).
- Check specific patient's measures such as changing position when applicable.

Documents	Interviews	Observations
Pressure ulcer prevention policy & procedures	Nurses	Pressure relieving devices in use
Pressure ulcer prevention care plan & progress notes in Medical Records	Nurses	Periodic changing patient's position when not contraindicated
Patient & family education material & Medical Record forms	Patient & families	

NSR.8

Standard:

A standardized approach to hand over communications, including an opportunity to ask and respond to questions is implement.

Rationale:

The primary objective of a 'handover' is the direct transmission of accurate patient care information among staff to ensure the continuity of care. Moreover, it ensures adequate chance for clarifications which subsequently decreases medical errors.

Survey Process:

- Review the policy & procedures for of handover of patients in-between different shifts (in same department) as well as in-between different levels of care (different department/ services) & check for the presence of recommended framework (such as, SBAR, ISOBAR, I PASS the BATON.. etc), staff responsible, recommended environment, & documentation.
- Review medical record, Handover log book, Endorsement form, Electronic Handover tool, &/or other methods as evidence of implementation.
- Interview staff to ensure their knowledge of handover agreed framework.

Documents	Interviews	Observations
Handover policy & procedures	Clinicians	Handovers whenever possible.
Handover forms		
Medical records		

NSR.9

Standard:

Preventive maintenance and testing of critical alarm systems is implemented and documented. Alarms are tested and activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

Rationale:

Medical devices especially those related to vital functions are fitted with alarms that alert staff on conditions of device malfunction or patient's critical situation. Losing that function exposes patients to increased risk of morbidity & mortality. Alarms are intended to induce immediate appropriate action from staff to either check device malfunction or initiate action that will revert the situation. This can be ensured when all the staff becomes fully aware of alarm settings (values & volume) & their significance & are trained on the required actions to be taken when triggered.

Survey Process:

- Review policy & procedures developed for maintenance & testing of critical alarm systems, which should include staff responsible, control measures, assurance measures, & remedial action. Also check whether the procedures cover testing of alarms, appropriate settings procedures, priorities for competing alarms, staff authorization for disabling alarms or changing their settings, & monitoring of response to alarm activation.
- Review inventory of all devices with critical alarms including setting guidelines.
- Review maintenance document for evidence of responsible staff, responsible company, schedule, agreed settings, evidence of function, reporting of malfunction, & remedial action.
- Review the schedules of alarm tests & list of current active settings at difference care areas.
- Interview staff around devices with critical alarm & check their knowledge of critical alarm settings & response to their activation.
- Observe (listen) or activate critical alarms to check for suitability of alarm volume to working space.
- Interview maintenance staff & check for implementation.

Documents	Interviews	Observations
Critical alarms policy & procedures	Maintenance staff	Devices with critical alarm in areas such as Critical Care Areas
Inventory of all devices with alarm	Staff using or around devices with critical alarm	
Alarm setting guidelines		
Device /alarm maintenance registers		

NSR.10

Standard:

The hospital has systems in place to ensure hospital-wide recognition of & response to clinical deterioration.

Rationale:

Functional & long-term outcome of early detection & timely providing urgent care to deteriorating patients is more superior to resuscitation of patients with cardio-pulmonary arrest. Studies have shown that this strategy has positive impact on reducing in-hospital mortality & improving patient safety.

Survey Process:

- Review the policies, procedures &/or process to develop, implement & maintain a hospital-wide system established for recognition of & response to clinical deterioration.
- Review the process established to measure & document observations via general observation chart including; respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc.
- Review the process established to build rapid response teams & to ensure regular rehearses.

- Review minutes of meetings of the concerned committee (such as Code Blue or Medical Emergencies committee) as evidence of regular auditing & monitoring of the processes.
- Check evidence & staff training concerning recognition & communication of clinical deterioration.
- Observe compliance with policies & procedures for recognition of & response to clinical deterioration.

Documents	Interviews	Observations
Policies & procedures for early recognition of & response to clinical deterioration	Clinicians	Compliance of rapid response team to clinically deteriorating patients outside critical care areas
Staff training records	Relevant committee members	
Committee minutes of meetings to check for process evaluation & measuring compliance		
Medical Records for relevant forms		

NSR.11

The hospital implements guidelines to reduce venous thromboembolism (deep venous thrombosis & pulmonary embolism).

Rationale:
Venous thromboembolism (VTE) is considered an important silent killer in hospitals. Adopting guidelines to reduce the risk of developing this condition is important for decreasing preventable adverse events & mortalities.

Survey Process:

- Review the guidelines of identifying patients at risk of venous thromboembolism (deep venous thrombosis & pulmonary embolism) & providing appropriate thromboprophylaxis.
- Interview relevant medical staff trained on guidelines to reduce venous thromboembolism (deep venous thrombosis & pulmonary embolism) to check their full awareness.
- Interview patients/families to check whether the staff provided them with full information about the risks of venous thromboembolism & the preventive measures.
- Observe compliance with guidelines to reduce venous thromboembolism (deep venous thrombosis & pulmonary embolism).

Documents	Interviews	Observations
Guidelines for VTE prophylaxis	Physicians	Measures taken for patients who are identified to be high risk for developing deep venous thrombosis & pulmonary embolism
Staff training records	Patients/ Families	
Key performance indicators to measure compliance with VTE prophylaxis		
Medical Records for relevant documentation or pathways		

B. Medication Management Safety Standards:

NSR.12

Standard:

Policy & Procedures for medication management safety including at least the following:

NSR.12.1 Abbreviations not to be used throughout the organization.
NSR.12.2 Documentation & communication of patient's current medications discharge medication.
NSR.12.3 Labeling of medications, medication containers & other solutions.
NSR.12.4 Prevent errors from high risk medications.
NSR.12.5 Prevent errors from look-alike, sound-alike medications.

Rationale:
Policies & procedures fostering a culture that supports standardization & documentation, which helps to create consistency in patient safety practices minimizing patient harm.

Survey Process:

- Review the relevant medication management safety policy & check if it includes all the standard's items.
- Interview staff to check their full awareness of policies & procedures.

Documents	Interviews	Observations
Medication management safety policy & procedures	Physicians, Nurses & Pharmacists	

NSR.13

Standard:

Abbreviations not to be used throughout the organization are:

- U/ IU
- Q.D., QD, q.d., qd.
- Q.O.D., QOD, q.o.d., qod.
- MS, MSO4.
- MgSO4.
- Trailing zero (5.0).
- No leading zero (.5).
- Dose x frequency x duration.

Rationale:

Abbreviations avoidance prevents misunderstandings, miscommunications & administration of incorrect prescription. The abbreviations mentioned in this standard are commonly misinterpreted (such as IU could be understood IV).

Survey Process:

- Review appropriate number of medical records (not less than 10) & check for the used abbreviations with medication orders.
- Interview medical staff for awareness of the prohibited abbreviations.

Documents	Interviews	Observations
Medical records	Medical staff for awareness.	

NSR.14

Standard:

A process is implemented to obtain and document a complete list of the patient's current medications upon admission to the organization & with the involvement of the patient.

Rationale:

Medication reconciliation at every patient care transition effectively reduces medication errors such as; omissions, duplications, dosing errors, &/or drug interactions. This may result from unintended medication discrepancies.

Survey Process:

- Review appropriate number of medical records (at least 10) & check for the documentation of current medications upon admission.
- Interview with appropriate number of patients & asking them if they were asked by doctors upon admission about their current medication & if they were educated if any will interfere with the new prescribed medications.

Documents	Interviews	Observations
Medical records	Physicians & Patients	Patient's own medications to be compared with documented current medications upon admission.

NSR.15

Standard:

All medications, medication containers (e.g., syringes, medicine cups, basins), &/or other solutions on & off the sterile field in peri-operative & other procedural settings are labeled.

Rationale:

Labeling of medication containers at the point of care assists health care providers to identify the correct medicine &/or fluid at all times & reduce the risk of medication error as well.

Survey Process:

Observe at the peri-operative & other procedural settings if medication containers are labeled.

Documents	Interviews	Observations
Policy of medication labeling in Peri-operative & other procedural settings.	Operating theater & anesthesia staff for awareness.	Peri-operative & other procedural settings observe the medication syringes or other containers labeling

NSR.16

Standard:

Concentrated electrolytes; including, but not limited to, potassium chloride (2 me/L or greater concentration), potassium phosphate, sodium chloride (>0.9% concentration), magnesium sulfate (50% or greater concentration) & concentrated medications are removed from all patient care areas, whenever possible. Concentrated medications, which cannot be removed, are segregated from other medications with additional warnings to remind staff to dilute before use.

Rationale:

The availability of concentrated electrolytes in areas where there is no immediate need for them is associated with higher risk on patient safety. Accidental administration of concentrated electrolytes without dilution poses a fatal threat to patients, therefore, their separation & differentiation is an error reduction strategy.

Survey Process:

- Observe patient care areas & notice if the concentrated medications are removed whenever possible.
- Observe clinical care areas where concentrated electrolytes are stored & check for the evidence based immediate medical necessity allowing for storing these concentrated electrolytes in these areas.
- Interview with nurses at different patient care areas & check if they understand the preventive strategies for dealing with concentrated electrolytes.

- Observe clinical care areas & notice if there are concentrated medications for clinical use & check whether they are separated in secure areas & labeled individually, such as, with a visible florescent warning label that states MUST BE DILUTED or other effective methods.

Documents	Interviews	Observations
Policy & procedures	Nurses & Pharmacists	Clinical care areas: observe removal of concentrated electrolytes when there is no immediate need for their use
		Clinical care areas when concentrated electrolytes are available for clinical necessity; observe its segregation & labeling

NSR.17

Standard:

Look-alike & sound-alike medications are identified, stored & dispensed in a way which assures that risk is minimized.

Rationale:

Identification & differentiation is an error reduction strategy. Using look alike & sound alike (LASA) medications could lead to wrong dispensing & administration.

Survey Process:

- Review the updated list of look -alike & sound -alike medications.
- Interview pharmacists & nurses & check if they understand how to minimize the risk associated with using look- alike sound - alike medications.
- Observe at the pharmacy & the medication carts the labeling of LASA medications.
- Review the medical records to check if doctors write the purpose of drug usage, to avoid confusion due to LASA medication during dispensing by the pharmacist.

Documents	Interviews	Observations
List of look -alike & sound -alike medications policy & procedures	Pharmacists & nurses	LASA medication storage at pharmacy & medication carts

C. Operative and Invasive Procedure Safety Standards:

NSR.18

Standard:

Policy & Procedures for operative & invasive procedures safety including at least the following:

NSR.18.1 Preoperative marking of site of surgery.

NSR.18.2 Process for preoperative verification of all documents & equipment needed for surgery &/or invasive procedures.

NSR.18.3 Accurate documented patient identification preoperatively, and just before surgery (time out).

NSR.18.4 Process for verification of accurate counting of sponges, needles & instruments pre & post procedure.

Rationale:

Performing the right surgery on the right patient & on the right side without any retained instrument is the mainstay objective of surgical safety. Establishing related policies & procedures, otherwise known as the universal protocol, is the initial step for offering safe surgery.

Survey Process:

- Review the operative & invasive procedures safety policy & procedures & check if it includes all the standard's items.
- Interview staff to check their awareness.

Documents	Interviews	Observations
Operative & invasive procedures safety policy & procedures	Operating theater staff & surgeons	

NSR.19

Standard:

The precise site where the surgery or invasive procedure will be performed is clearly marked by the physician with the involvement of the patient.

Rationale:

Visible & clear site marking is an error reduction strategy that should be performed by the operating surgeon while the patient is awake.

Survey Process:

- Review surgery/invasive site marking policy & procedure & check that it specifies situations for site marking (laterality, multiple structures or levels), states that organization wide site marking is done with a recognizable & consistent mark, which should resist disinfection procedures, should be visible after draping, should be made by the authorized person performing the procedure & should be done when the patient is awake & fully aware.
- Review the checklist & observe whether it is dedicated to this standard or it is a part of a wider checklist (surgical safety checklist, universal protocol checklist).
- Review relevant post- operative patients' medical records & check for documentation evidence.
- Interview surgeons/interventionists & check their understanding of this process.
- Interview relevant post-operative patients & check their involvement in site marking.
- Observe implementation of this process at the intervention room if possible.

Documents	Interviews	Observations
Surgery/invasive site marking policy & procedures	Surgical departments staff	Pre-procedure verification (if possible)
Surgical safety checklist	Invasive procedures staff	Site markers at patient care areas

NSR.20

Standard:

A process or checklist is developed & used to verify that all documents & equipment needed for surgery or invasive procedures are on hand, correct & functioning properly before the start of the surgical or invasive procedure.

Rationale:

Ensuring availability of patient data & the necessary functioning equipment minimizes the risk of errors. Implementing regular checkup is a quality improvement process that should be guided by well-designed checklists performed by well-trained staff.

Survey Process:

- Review document & equipment verification policy & procedures & ensure that it supports a documented verification process for: patient documents (consent, physical examination, medical assessment, nursing assessment, pre-anesthetic assessment), as well as patient laboratory & radiologic test results, procedure devices &/or blood products.
- Review the checklist & observe whether it is dedicated to this standard or it is a part of a wider checklist (surgical safety checklist, universal protocol checklist).
- Review medical records of post-operative patients & check for checklist utilization.
- Interview relevant staff checking their full understanding of this process
- Observe implementation of this process at the intervention room if possible.

Documents	Interviews	Observations
Documents & equipment verification policy & procedures	Surgical team staff	Pre-surgery & invasive procedure verification including sign in process.
Documents & equipment verification checklist	Invasive procedures staff	

NSR.21

Standard:

There is a documented process of accurate patient identification preoperatively & just before starting a surgical or invasive procedure (time out), to ensure the correct patient, procedure, & body part.

Rationale:

Double checking that is verified by others, declared & documented is a quality improvement process that minimizes errors.

Survey Process:

- Review preoperative/pre-intervention policy & procedure for preventing wrong patient, wrong site/side, & wrong surgery/invasive procedure & ensure that it supports patient, procedure, as well as part of body verification just before start of the procedure, regardless whether the patient is anesthetized, sedated or awake (Time Out).
- Review the checklist & observe whether it is dedicated to this standard or it is a part of a wider checklist (such as surgical safety checklist, universal protocol checklist).
- Ensure that the policy states clearly the responsibilities of each of the operative/intervention team members in implementing this standard.
- Review medical records of post-operative patients & check for checklist utilization.
- Interview relevant staff to check their understanding of this process.
- Observe implementation of this process at the surgery or intervention room if possible.

Documents	Interviews	Observations
Preoperative/ pre-intervention patient identification policy & procedure	Surgical team staff	Time out process
Time out/surgical safety checklist in Medical Record	Invasive procedures staff	

NSR.22

Standard:

There is a documented process to verify an accurate counting of sponges, needles & instruments pre & post procedure.

Rationale:

Equipment retention causes serious morbidity in the form of pain, organ injury & sepsis. Such situations require a second surgery to remove the retained equipment which is also associated with high risk of new complications. Every effort should be done by the surgical team to prevent such an event.

Survey Process:

- Review retention prevention policy & procedure & ensure that it covers the role of nurses & surgeons, pre & postoperative count double verification, documentation, as well as steps to be taken in case of discrepancy between pre & postoperative counts.
- Review the checklist & observe whether it is dedicated to this standard or it is a part of a wider checklist (surgical safety checklist, universal protocol checklist).
- Review post-operative patient medical records checking for pre & postoperative counts documentation of this process.
- Interview surgical team & check their understanding of this process.
- Observe implementation of this process at the operating room if possible.

Documents	Interviews	Observations
Sponge, needles & instruments retention prevention policy & procedures	Surgical team staff	Pre& post-operative verification process for sponge, needles & instruments count including the sign out process
Surgical sponge & instruments count forms or surgical safety checklist	Invasive procedures staff	

D. Environmental Safety Standards:

NSR.23

Standard:

There is a well-structured & implemented fire & smoke safety plan that addresses prevention, early detection, response, & safe exit when required by fire or other emergencies & including at least the following:

NSR.23.1 Frequency of inspecting fire detection & suppression systems, including documentation of the inspections.

NSR.23.2 Maintenance & testing of fire protection & abatement systems in all areas.

NSR.23.3 Documentation requirements for staff training on fire response & evacuation.

NSR.23.4 Assessment of fire risks when construction is present in or adjacent to the facility.

Rationale:

The facility must be vigilant about fire safety as fire is an ever present risk in a hospital.

Survey Process:

Review the fire safety plan, facility fire safety inspections, & fire system maintenance. Fire alarm should be effectively working. Firefighting & smoke containment should comply with civil defense requirements. Review plan of testing (drills) & staff training (all staff should be trained on fire safety).

Documents	Interviews	Observations
Fire Safety Plan.	All hospital staff.	Functioning fire alarm, firefighting equipment, smoke containment facilities, emergency exit signs, emergency exit doors, & assembly points.
Documents showing staff participation in evacuation drills & Fire safety training.		Staff response in case of fire & evacuation.
Fire Safety Inspection Reports & risk assessment.		Safe storage, smoking outside safe areas, using kettles, unsafe electric cords, & other high-risk devices.
Fire & alarm system maintenance records & contracts.	Maintenance Staff.	

NSR.24

Standard:

Fire drills are conducted at least quarterly in different clinical areas & during different shifts, including at least one unannounced fire drill annually.

Rationale:

The facility staff should be well trained on firefighting & safe evacuation through practical simulations & regular drills.

Survey Process:

- Review the documents of fire & evacuation drills with dates, timings, staff that participated & the involved areas in the facility.
- Review corrective action plan based on the drill evaluation.
- Interviewing staff to check the awareness of fire safety plan & basic procedures in such cases like (Rescue, Alarm, Confine, Extinguish/Evacuate & Pull, Aim, Squeeze, and Sweep).

Documents	Interviews	Observations
Drill evaluation & corrective actions	All facility staff	Staff response as regard patient evacuation according to the type of patient
Documents showing staff participation in fire & evacuation drills		Staff response in case of fire (such as using fire extinguisher).
Discussion of the drill results in the environmental safety committee meeting	Firefighting plan responsible staff	

NSR 25

There is a well-structured & implemented plan for hazardous materials (Hazmat) & waste management for the use, handling, storage, & disposal of hazardous materials & waste addressing at least the following:

NSR25.1 Safety & security requirements for handling & storage.

NSR25.2 Requirements for personal protective equipment.

NSR25.3 Procedures & interventions to implement following spills & accidental contact or exposures.

NSR25.4 Disposal in accordance with applicable laws & regulation.

NSR25.5 Labeling of hazardous materials & waste.

NSR25.6 Monitoring data on incidents to allow corrective action.

Rationale:

The facility should have a hazmat & waste management program that addresses different requirements. The facility environment, staff, patients, relatives & vendors should be safe from hazardous material exposure & waste all over the time.

Survey process:

- Review the hazardous material & waste management program to make sure that it covers all safety requirements of hazardous materials, safe storage, handling, spills, required protective equipment & waste disposal in accordance to local laws & regulations.
- Review the hazardous material & waste disposal plan, hazardous material & waste inventories, as well as Material Safety Data Sheet (MSDS), & inspect hazardous material labeling & storage in addition to waste collection, segregation storage & final disposal.

Documents	Interviews	Observations
Hazardous material & waste disposal plan	All facility staff	Storage & labeling of hazardous materials
Hazmat & waste inventories		Waste collection bags Storage place as regard: proper ventilation, cleaning & appropriate labeling & signage.
MSDS		
Relevant contracts		
Hazardous material & waste risk assessment		

NSR 26

Standard:

There is a well-structured & implemented safety & security plan/s.

Rationale:

The facility should have safety & security plan/s that cover all requirements. The facility should ensure a safe & secure physical environment all the time.

Survey process:

- Review safety & security plan/s, & make sure of including suitable risk assessment surveillance, security high-risk areas & security requirements, as well as access control areas.
- Review surveillance rounds plan, checklist, different observations & check for proper corrective actions when applicable.
- Inspect workers in different areas like workshops & waste to make sure of using suitable personnel protective equipment (PPE).
- Check for security plan, cameras monitors, staff ID & access controlled areas.

Documents	Interviews	Observations
Safety & security plan	Safety officer /responsible	- Surveillance rounds are conducted in patient care areas not less than twice yearly & not less than once yearly in no-clinical areas. - Suitable tool is used with clear corrective actions for survey observations. - Interior space meets the needs for staff, patients, visitors & vendors safety. - Furnishing & equipment are safe & maintained.
Surveillance checklist		- Appropriate PPE for staff - Appropriate warning signage - There are measures to protect against infant/child abduction & to protect patients, visitors, & staff against harm, including assault, violence & aggression.

NSR 27

Standard:

The hospital has well-structured & implemented radiation safety program.

Rationale:

The facility should have documented radiation safety program according to local laws & regulations. The facility environment, staff, patients, relatives & vendors should be safe from radiation hazards.

Survey process:

- Review the radiation safety program & make sure of presence of level of exposure according to local laws & regulations, shielding methods & safety requirements for staff & patients.
- Review environmental radiation measures, thermo luminescent dosimeter (TLD) &/or badge films of the staff results, CBC results, & lead aprons inspection & check for staff awareness.

Documents	Interviews	Observations
Radiation safety program/ license	Radiology staff	Radiology department/equipment maintained & calibrated
- TLD/badge films monitoring results. - Environmental monitoring results.		Staff have self-monitoring tool like; badge film, dosimeter or Thermo-luminescent dosimeter (TLD)
Regular CBC of exposed staff		Appropriate & safe waste disposal for radioactive materials
Log book of lead aprons or other PPE inspection		
Lab safety program	Lab staff	- Lab ventilation. - Safety of medical equipment.

Documents	Interviews	Observations
MSDS include hazardous material inventory		- Safe storage of hazardous material. - Staff using suitable PPE & safety precautions. - Proper waste disposal. - Availability of Spill kits.
Safety reports at least semiannual		

NSR.28

Standard

There is a well-structured & implemented Laboratory & pathology safety program.

Rational:

The facility should have a documented laboratory safety program that covers all safety requirements specific for the laboratory. The facility Environment, staff, patients, relatives and venders should be safe from laboratory hazards.

Survey process:

- Review laboratory safety program which should include at least: list of chemicals & hazardous materials, dealing with spills, safety requirements, suitable PPE, maintenance & calibration of medical equipment, & staff orientation, & proper waste disposal.
- Review laboratory safety reports, lab equipment safety, storage of chemicals, labeling & waste disposal process.

Documents	Interviews	Observations
Lab safety program.	Lab staff	- Lab ventilation - Safety of medical equipment.
MSDS include hazardous material inventory.		- Safe storage of hazardous material. - Staff using suitable PPE and safety precautions - Proper waste disposal. - Availability of Spill kits.
Safety reports at least semiannual.		

NSR29.

Standard

There is a well-structured & implemented plan for selecting, inspecting, maintaining, testing, & safe usage of medical equipment that addresses at least the following:

NSR29.1 Inventory of all medical equipment.

NSR29.2 Schedule for inspection and preventive maintenance according to manufacturer's recommendations and frequency of repair and breakdown.

NSR29.3 Testing of all new equipment before use and repeat testing, as part of the preventive maintenance.

NSR29.4 Testing of alarm systems including clinical alarm.

NSR29.5 Qualified individuals who can provide these services.

NSR29.6 Data monitoring for frequency of repair or equipment failure.

NSR29.7 Ensure only trained and competent people handle specialized equipment.

Rationale:

The facility should have a documented program for medical equipment that covers all required standers. The facility should ensure that all diagnostic medical equipment are maintained and calibrated to minimize diagnostic errors.

Survey process:

Review the medical equipment maintenance program, & ensure availability of all required documents, inventory of medical equipment, schedule of preventive maintenance & calibration & documents of staff training.

Documents	Interviews	Observations
- Medical equipment program. - Inventory of medical equipment.	Biomedical engineer	Preventive maintenance & calibration cards on the medical equipment
- Staff training - Defibrillator log of testing per shift. - Dialysis water testing results.	Nurses & ask about how to use critical devices as defibrillator	- Work instructions are available for critical equipment. - Dialysis water treatment unit inspection.

NSR 30.

Standard:

There is a well-structured & implemented plan for regular inspection, maintenance, testing & repair of essential utilities addressing at least the following:

NSR30.1 Electricity; including stand-by generators.

NSR30.2 Water.

NSR30.3 Heating, ventilation, & air conditioning including; air flow in negative & positive pressure rooms, appropriate temperature, humidity, & odors eliminates.

NSR30.4 Medical gases.

NSR30.5 Communications systems.

NSR30.6 Waste disposal.

NSR30.7 Regular inspections.

NSR30.8 Regular testing.

NSR30.9 Regularly scheduled maintenance.

NSR30.10 Correction of identified risks & deficiencies.

Rationale:

The facility should have a documented program for utility management that covers all required standards. The facility should keep safe & effective key utility system 24 hour 7 days per week.

Survey process:

- Review utility management plan & confirm availability of all required systems, regular inspection, maintenance & backup utilities.
- Review inspection documents & preventive maintenance schedule, contracts & equipment, as well as testing results of generators, tanks &/or other key system to make sure of facility coverage 24/7.

Documents	Interviews	Observations
- Utility management plan. - Utility inventory. - Preventive maintenance schedule. - Contracts.	Utility manger & workers	- Preventive maintenance documents are present on the machines or easily accessible to the end user. - Safe & labeled electric boards & connections. - Safe & suitable fuel tanks. - Water tanks are suitable to the facility needs with disinfection & cleaning evidence. - Temperature monitoring of all fridges is in place.
Utility inspection & testing documents		- Medical gases system with safe backup system. - Appropriate sewage disposal. - Suitable temperature & humidity monitoring of critical areas.

Operating manual Outlines

1. **Hospital overview:**
    a. A brief general description of the hospital.
    b. Scope of services.
    c. Organizational charts.
    d. Visiting times.
    e. NO Smoking policy.
    f. Parking policy (Accessibility of emergency vehicle to the facility).
    g. Internal and external communication processes.
    h. Contract oversight/ monitoring process.
2. **Management of information system:**
    a. Data management plan.
    b. List of approved & prohibited abbreviations.
    c. Data retention process.
    d. Data backup process.
3. **Medical record:**
    a. Initiation (unified medical record number).
    b. Contents and organization.
    c. Medical record release.
    d. Tracking.
    e. Retention/storing.
    f. Standardized coding system.
    g. Management of voluminous medical record.
    h. Medical record destruction.
    i. Standardized forms.
    j. Monitoring of medical record completion.

4. Provision of Care and Services:

a. Consistent process of registration and admission.
b. Assessment and Reassessment processes.
c. Patient identification policy.
d. Uniform care process.
e. VTE screening & prophylaxis processes.
f. Discharge planning.
g. Blood and blood products handling and administration.
h. Communication with patient having special communication needs.
i. Care of psychiatric patients.
j. Care of patients on restraints.
k. Care of terminally ill and dying patients.
l. Effective system to provide cardiopulmonary resuscitation across all hospital areas.
m. Effective system responding to deteriorating patients.
n. Departmental mortality and morbidity review.
o. Pain management.
p. Most responsible physician policy.
q. Plan of care development.
r. Integrated ,continued &coordinated care including not limited to:
    i. Standardized handover.
    ii. Consultancy.
    iii. Transfer between hospital units.
    iv. Efficient discharge process.
    v. Transfer (and transport) to other organization.

5. **Quality management & Patient safety:**
    a. Quality improvement, Patient safety & risk management plans.
    b. OVR management system.
    c. Sentinel events management system.
    d. Initiation of a new process or changing of existing one.
    e. Process to prevent wrong patient , wrong site ,wrong surgery /procedure, including not limited to:
        i. Site marking.
        ii. Verification.
        iii. Surgical check list.
        iv. Time out.
    f. Pressure ulcer:
        i. Identification of patient at risk.
        ii. Assessment.
        iii. Intervention.
    g. Patient fall:
        i. Identification of patient at risk.
        ii. Assessment.
        iii. Intervention.
    h. Verbal and telephone communication.
        i. Reporting panic values.
        ii. Verbal and telephone orders.

6. **Infection prevention and control:**
    a. Infection prevention and control structure.
    b. Infection prevention and control plan.
    c. Investigation and control of outbreaks of infectious diseases.
    d. Handling sharps.
    e. Standard and transmission based precautions.
    f. Disinfectants usage outside the CSSD (bronchoscopy /endoscopy).
    g. Staff safety within CSSD.
    h. Reprocessing of single use items.

i. Housekeeping P&P:
    i. A list of all environmental services to be cleaned.
    ii. Schedule of cleaning.
    iii. Procedures to be used.
    iv. Agents to be used.

j. Handling blood /body fluids spills.

k. Safe disposal of medical waste.

l. Handling bodies postmortem (especially bodies with multiple open wounds).

m. Laundry:
    i. Linen management starting from collecting linen from patients' rooms until completion of the cleaning process.
    ii. Handling, transfer and storage of clean linen.

n. Kitchen staff hygiene and health policies.

o. Handling construction projects.

p. Personnel protective equipment use.

q. Proper hand hygiene practices.

r. Reporting of communicable diseases to relevant authorities.

s. Employees' immunization & post exposure management.

t. Annual antiprogram.

u. Safe injection practices.

v. VAP prevention care bundle.

w. Surgical site infection care bundle.

x. Catheter associated infection care bundle.

y. Central intravascular catheter blood stream infection care bundle.

z. Multidrug resistant organisms(MDROs) care bundle.

7. Effective patient & family education process

8. **Patient & family rights:**
    a. Patient & family rights and responsibility statement.
    b. Patient privacy throughout the care process.
    c. Protection of Patient belongings.
    d. Patient protection against abuse, unauthorized access.
    e. Informed consent policy.
    f. Dealing with patient who refuses treatment.
    g. Patient complaints policy.

9. **Social care:**
    a. Psychosocial screening.
    b. Psychosocial comprehensive assessment.
    c. Psychosocial plan of care (when required).

10. **Anesthesia:**
    a. Anesthesia planning.
    b. Paranesthesia assessment.
    c. Safe handling and storage of anesthetic medications/agents.
    d. Intraoperative monitoring of anesthetized patients.
    e. Documentation of anesthesia care.
    f. Post-operative transfer to recovery room.
    g. Patient care within the recovery room.
    h. Discharge from recovery room.

11. **Moderate and deep sedation management system**

12. **Operative care:**
    a. Patient acceptance in OR.
    b. Assessment prior to surgery (including emergency operations).
    c. Handover process between unit/ward nurse and operating room nurse.
    d. Prevention of wrong patient, wrong surgery/procedure, or wrong site.

e. Infection control measures in operating room and recovery room including isolation Precautions including Handling patients with infectious diseases (e.g. Tuberculosis, AIDS, and Hepatitis).

f. Safe labeling, handling, storage and transportation of laboratory specimens in operating and recovery rooms.

g. Safe handling, storage and transportation of commonly used chemicals in operating and recovery rooms.

h. Safe handling, transportation and storage of blood in operating and recovery rooms.

i. Prevention of inadvertent retention of instruments/sponges in surgical wounds.

j. Day surgery management.

k. Operative report.

l. Post-operative plan of care.

m. Equipment checks and periodic maintenance.

n. Environmental controls in operating room and recovery room.

o. Fire safety plan in OR.

13. Critical care units:(ICU,CCU,PICU &NICU)

a. Admission and discharge criteria.

b. Standardized handover/ hand off processes.

c. Infection control of (ICU,CCU,PICU &NICU).

d. Proper equipment management process.

14. Labor and delivery:

a. Admission and discharge criteria.

b. Assessment and re-assessment of women in labor.

c. Immediate postpartum care.

d. Management of Ante-partum and post-partum hemorrhage.

e. Augmentation of labor and the use of oxytocin.

f. Caesarian section, repeated caesarian section, and emergency hysterectomy.

g. Management of fetal distress.

h. The use of episiotomy.

i. Pain relief and regional anesthesia.
j. Management of hypertensive disorders of pregnancy.
k. Management of the diabetic patient in labor and postpartum.
l. Management of multiple births.
m. Management of abnormal positions and presentations.
n. Instrumental vaginal delivery.
o. Management of premature rupture of membranes.
p. Management of un-booked deliveries.
q. Neonatal identification and the immediate assessment and resuscitation of the newborn.
r. Infection control measures in labor and postpartum.
s. Breast feeding encouragement.
t. Completing medical record of obstetric cases.

15. Dialysis:

a. Admission and discharge criteria.
b. Infection control in dialysis service.
c. Water quality check.
d. Assessment and reassessment of patients.
e. Care and monitoring of patients.
f. Management of clotted access.
g. Preparation of hemodialysis machines.
h. Peritoneal dialysis policy.
i. Anticoagulation usage.
j. Management of dialysis-induced complications.
k. Management of cardiopulmonary collapse and urgent medical conditions.
l. Emergency transfer of patients.

16. Emergency room:

a. Effective triage process.
b. Emergency consultation.
c. Medical record documentation.
d. Management of medico-legal cases.
e. Management of suspected victims of abuse, neglect, and domestic violence.
f. Care of trauma patients.
g. Care of patients not competent to care for themselves.
h. Care of minors.
i. Patient transfer from emergency department to inpatient areas or to another organization.
j. Boarded cases.
k. Patients who leave against medical advice.
l. Patients who leave without being seen.
m. Ambulance service management.

17. Radiology service:

a. Radiation safety plan.
b. Reporting critical results.
c. Interventional radiology.
d. Proper staffing.

18. Burn unit:

a. Admission and discharge criteria.
b. Inhalation injury management.
c. Management of varying degrees/types of burns.
d. Infection prevention and control within burn unit.
e. Use of skin or synthetic grafts.

19. Oncology and radiotherapy:

a. Proper staffing.

b. Chemotherapy administration, side effects, and safety precautions.

c. Radiation therapy administration, side effects, and safety. precautions.

d. Targeted therapy, immunotherapy and contrast media administration and education.

e. Spill management.

f. Special radiation techniques (brachytherapy, stereotactic radiotherapy, unsealed sources, other techniques), including preparation and delivery guidelines.

g. Extravasations and anaphylaxis management guidelines.

h. Radioactive iodine management.

i. Bone marrow and stem cell transplant management.

j. Management of neutropenia and other related complications of chemo/radiation therapy.

20. Medication management:

a. Medication management plan including:
   i. Procurement.
   ii. Storage of regular, refrigerated, frozen, biologicals & vaccines in stores, pharmacies and patient care areas.
   iii. Prescribing.
   iv. Preparing.
   v. Dispensing.
   vi. Administration.
   vii. Monitoring.

b. Handling high alert medications.

c. Handling look-alike & sound-alike (LASA) medications.

d. Hospital Drug formulary development.

e. Selection ,approval and procurement of non-formulary medications.

f. Prescribing non-formulary medications.

g. Handling out of stock, shortage and disaster needs of medications.

h. Storage & safe management of hazardous medications and pharmaceutical chemicals.
i. Using multi dose containers.
j. Accessibility, availability, monitoring & security of emergency medications.
k. Handling medications brought into the hospital by patients or their family (patient's own medications).
l. Handling narcotics, psychotropic and controlled medications.
m. Prescribing antibiotics.
n. Verbal and telephone orders of medications.
o. Safe preparation of sterile, non- sterile compounded preparations, chemotherapy and parenteral nutrition.
p. Labeling of medications.
q. Infection prevention and control in pharmacy.
r. Handling recalled, discontinued and damaged medications.
s. Pharmaceutical outpatient education and counseling.
t. Handling adverse drug reactions.
u. Handling medication errors.

21. Dietary services:

a. Nutritional screening.
b. Comprehensive assessment.
c. Nutritional plan development.
d. Food safety program (handling ,storage and distribution).

22. Dental services:

a. Comprehensive assessment.
b. Informed consent.
c. General , moderate & deep sedation.
d. Infection control in dental services.

23. Laboratory services:

a. Clear scope of services.
b. Staffing plan and qualifications.
c. Comprehensive training and competency assessment program.
d. Laboratory safety program.
e. Safety and infection control training program.
f. Requests for laboratory tests.
g. Contract oversight.
h. Inventory management and tracking the use of critical materials, supplies, and reagents.
i. Specimen collection, handling and management.
j. Correct specimen labeling.
k. Establishing, verifying and reevaluation of reference ranges.
l. Reagents and solutions management system.
m. Quality control of test methods.
n. Results reporting including:
    i. Contents of its reports.
    ii. Critical results reporting.
    iii. Amending reported laboratory results.
o. Laboratory records retention.
p. Sample retention.
q. Reference laboratory services.
r. Point of care testing.
s. Proficiency Testing (PT) .

24. Blood bank services:

a. Acceptance criteria for blood donors.
b. Consenting blood donors.
c. Initial immune-hematological testing of blood donor samples.
d. Preventing disease transmission by blood/platelet transfusion.
e. Care for blood donors before, during, and after the procedure.
f. Managing adverse donation events.
g. Collection of donor blood specimen.

h. Donor notification of significant findings.
i. Preparation, storage,transportation, and quality control of Red Blood Cells (RBC) components.
j. Preparation, storage, transportation,and quality control of Platelet Concentrates (PC) components.
k. Preparation, storage, transportation, and quality control of Fresh Frozen Plasma (FFP).
l. Preparation, storage, transportation, and quality control of Cryoprecipitate (CRYO).
m. Identification and discarding unacceptable blood/blood product.
n. Labeling of blood and blood components.
o. Release of incompletely tested blood/blood components.
p. Process for request, approval, and execution of therapeutic procedures.
q. Reagents quality control.
r. Receiving or sending blood and blood products to outside facilities.
s. Pre-transfusion testing of the recipient.
t. Selection of blood/blood product for transfusion.
u. Compatibility testing.
v. Emergency release of uncross-matched blood.
w. Management of adverse or suspected transfusion events.
x. Handling suspected cases of post-transfusion infection.

25. Facility Management and Safety

a. The facility management and safety program including the following written and approved plans:
    i. Safety of the Building.
    ii. Security.
    iii. Hazardous materials and waste disposal.
    iv. External emergency.
    v. Internal emergency.
    vi. Fire Safety.
    vii. Medical equipment.
    viii. Utility System.

Leadership Related Requirements

1. **Leadership manual including:**
    a. Administrative:
        i. Hospital –Mission, Vision and Values Statement.
        ii. Hospital Organizational Chart.
        iii. Leadership Structure.
        iv. Leadership Responsibilities.
        v. Standards of Patient Service.
        vi. Plan for the provision of Patient Care and Services.
        vii. Culture of Safety and Quality.
        viii. Leadership Support of Quality Initiative Monitoring and Improvement Activities.
        ix. Administrative Call.
        x. Budget Process.
        xi. Orientation of Top Management and Senior Medical Staff.
        xii. Confidentiality of Information –General Rules.
        xiii. Community Needs Assessment.
        xiv. Information management plan.
        xv. Release of Patient Information to News Media.
        xvi. Financial Incentives and Clinical Decision Making.
        xvii. Dress code.
        xviii. Disruptive and Inappropriate Behavior.
    b. Ethics:
        i. Research Conduction Guidelines.
        ii. Conduction of Clinical Research.
        iii. End of Life Issues and Care for Dying Patient.
        iv. Sexual Harassment.
        v. Conflict of Interest.
2. **Code of conduct.**
3. **Organizational ethics.**

4. **Departmental leadership policy**.
5. **Requirements, responsibilities and appointment of all hospital leaders.**
6. **Governance Policy**.
7. **Strategic and operational plans.**
8. **Contract monitoring policy.**
9. **Quality, Patient safety and risk management plan/s)** .
10. **Key performance indicators:**
    a. Policy.
    b. Indicators.
11. **Hospital wide committees Structures and functions**.
12. **Training program of hospital leaders including not limited to:**
    a. Quality concepts, skills and tools.
    b. Problem solving.
    c. Conflict resolution.
    d. Team management.
    e. Communication skills.
    f. Data management (as related).
    g. Change management.

Workforce Related Requirements

1. **Staffing plans (Departmental & hospital wide)**.
2. **Process of Recruitment.**
3. **Credentialing process.**
4. **Competency assessments:**
    a. Initial and ongoing.
    b. Specialized services competency assessments.
5. **Privileging process.**
6. **Employee Manual including not limited to the following processes:**
    a. Assignment and reassignment.
    b. Staff appraisal.
    c. Staff complaints
    d. Staff satisfaction (staff retention) .
    e. Code of conduct.
    f. Disciplinary actions.
    g. Termination.
7. **Medical Staff Bylaws.**
8. **Nursing Staff Bylaws.**
9. **Staff health program.**
10. **Job descriptions:**
    a. Policy.
    b. Forms.
11. **New employee orientation program:**
    a. General orientation program.
    b. Specific orientation programs.

12. **Personnel file:**
    a. Initiation.
    b. Management.
    c. Contents.
    d. Update.
    e. Retention time.
    f. Disposal.
13. **Identification of staff training & educational needs.**
14. **Ongoing scheduled educational program.**
15. **Basic and advanced life support certification (as related).**