الهيئة العامة للاعتماد والرقابة الصحية
GAHAR

Mental Healthcare Accreditation Standards

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Foreword

As an essential step toward implementing comprehensive healthcare reform in Egypt, here is the GAHAR Handbook for Mental Health Hospitals Standards – Edition 2022 issued by the General Authority for Healthcare Accreditation and Regulation (GAHAR). This edition is a continuation of the efforts started in the last century for improving healthcare services in the country through standardization. The development of these standards is a valuable eventual product of collaborative efforts of representatives from the different health sectors in Egypt, including the Ministry of Health and Population, the private sector, university professors, military sectors, and professional syndicates.

This book of standards handles healthcare delivery from two main perspectives, the patient-centered perspective, and the organization-centered perspective. Each perspective is thoroughly handled in a separate section and discusses in detail the minimum requirement for accrediting organizations based on them. The first section discusses accreditation prerequisites and conditions. The second section discusses patient-centered standards and adopts Picker's model for patient-centered care to ensure the responsiveness of organizations to patients' needs. The third section discusses organization-centered standards, highlighting many aspects required for workplace suitability to provide safe and efficient healthcare. The third section also adopts the Health WISE concepts.

While these standards were carefully tailored to steer the current situation of Egyptian healthcare in the direction of Egypt’s 2030 Vision, they have been finely compared to international standards and found to meet their basic intent that applies to Egyptian laws, regulations, and culture. It is expected that the standards shall be a catalyst for applying change and improvement in both the culture and practice of healthcare in Egypt.

Introduction

Patient-centered care is healthcare that respects and responds to the preferences, needs, and values of patients and consumers. The widely accepted dimensions of patient-centered care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, family involvement, and access to care. Surveys measuring patients' experience of health care are typically based on these domains. Research demonstrates that patient-centered care improves patient care experience and creates public value for services. When healthcare administrators, providers, patients, and families work in partnership, the quality and safety of health care improve, costs decrease, provider satisfaction increases and patient care experience is successfully achieved.

Patient-centered care can also positively affect business metrics, such as finances, quality, safety, satisfaction, and market share. Patient-centered care is recognized as a dimension of high-quality healthcare and is identified in the Institute of Medicine Report *Crossing the Quality Chasm* as one of the six quality aims for improving care. In recent years, strategies used worldwide to improve overall healthcare quality, such as public reporting and financial incentives, have emerged as policy-level drivers for improving patient-centered care.

Developing mental health services of good quality requires the use of evidence-based protocols and practices, including early intervention, incorporation of human rights principles, respect for individual autonomy, and the protection of people's dignity.

Patients are not the only customers of healthcare systems. Healthcare providers and workers face risks, as well. Although debate continues regarding whether worker wellbeing should be considered as part of patient safety initiatives, many organizations think about it that way, including major players in the healthcare industry worldwide. Three major aspects may affect the worker's well-being: safety, stress, and organizational structure.

This book defines the minimum requirements for healthcare organizations to comply with patient safety and centeredness while maintaining a safe, structured, and positive work environment.

Scope of this Handbook

These standards apply to Mental Health hospitals seeking to be accredited by the General Authority for Healthcare Accreditation and Regulation (GAHAR).

Inclusions:

These standards are applicable to the STANDALONE;

- Mental health hospital
- Addiction treatment hospital
- Mental health and addiction treatment hospital
- Addiction rehabilitation center
- Detoxification center

Exclusions:

These standards are not applicable to:

- Long-term care facilities

Purpose

GAHAR standards describe the competent level of care in each phase of the patient care process. They reflect a desired and achievable level of performance against which a mental health hospital's actual performance. The main purpose of these standards is to direct and maintain safe healthcare practice through the accreditation standards.

These standards also promote and guide organization management. They assist staff, the management team, and the mental health hospital as a whole to develop safe staffing practices, delegate tasks to licensed and unlicensed staff members, ensure adequate documentation and even create policies for new technologies.

Compliance with GAHAR standards guarantees mental health hospital accountability for their decisions and actions. Many standards are patient-centered and safety-focused to promote the best possible outcome and minimize exposure to the risk of harm. These standards encourage the hospital's staff to persistently enhance their knowledge base through experience, continuing education, and the latest guidelines. These standards can be used to identify areas for improvement in clinical practice and work areas, as well as to improve patient and workplace safety.

Reading and Interpretation of the book

- The General Authority for Healthcare Accreditation and Regulations evaluates organizations' structure, processes, and/or outcomes by setting standards that address these concepts.
- This book is divided into three sections, addition to the foreword, introduction, Scope of this handbook, Purpose, Use, Acknowledgments, Acronyms, Survey activities and readiness, Glossary, and References.
- Each section is divided into chapters when applicable.
- Each chapter has:
  - An introduction that contains an overall intent.
  - Implementation guiding documents that need to be checked to achieve full compliance with the standards.
  - Purpose Which clarifiy the introduction, and each purpose has a standard or more in the chapter.
- A standard is a level of quality or achievement, especially a level that is thought to be acceptable; it is composed of a standard statement, keywords, intent, survey process guide, evidence of compliance, and related standards paragraphs.

Standard Component

- Standard Statement:
  - In this handbook, each standard is written as a standard statement preceded by a code.
  - Each standard is followed by a *non-black-scripted statement* that describes the essential quality dimension(s) addressed by the standard.
- Keywords:
  - To help organizations understand the most important element of the standard statements, as these are words or concepts of great significance. They answer the question of WHAT the standard is intended to measure.
- Intent:
  - Standard intent is meant to help organizations understand the full meaning of the standard.
  - The intent is usually divided into two parts:
    - Normative: that describes the purpose and rationale of the standard and provides an explanation of how the standard fits into the overall program. It answers the question of WHY the standard is required to be met.
    - Informative: is meant to help organizations identify the strategy to interpret and execute the standard. It answers the question of HOW the standard is going to be met.
  - Some standards require the implementation of minimum components of processes to be documented, implemented, recorded, and/or monitored. These components are usually preceded with the phrase "at least the following", followed by a numbered/lettered list of requirements. Hence, these elements are considered essential, indivisible parts of compliance with the minimum acceptable standard.
- Evidence of compliance (EOCs):
  - Evidence of compliance with a standard indicates what items will be reviewed and assigned a score during the on-site survey process.
  - The EOCs for each standard identifies the requirements for full compliance with the standard as scoring is done in relation to EOCs.

- Survey process guide:
  - Facilitates and assists the surveyors in the standard's rating for the required EOCs.

- Related standards:
  As healthcare is a complex service, each standard measures a small part of it. To understand what each standard means in the overall context of healthcare standards, other standards need to be considered as well.

- Standards are categorized and grouped into three sets of groups:
  - Chapters, where standards are grouped as per a uniform objective.
  - Quality dimensions, where each standard addresses a particular quality dimension, and strategic categorization of standards to analyze their quality characteristics.
  - Documentation requirements, where some standards require certain types of documents

Used Language and Themes

This handbook used certain themes and vocabulary to ensure uniformity and clarity; these are the most important ones that will help mental health hospital to interpret the standards:

Process, **P**olicy, **P**rocedure, **P**rogram, **P**lan, **G**uideline, **P**rotocol

Whenever 'Process' is used in a standard, it indicates a requirement that is necessary to follow.

- 'Process'
  A series of actions or steps taken to achieve a particular end.
- 'Documented Process'
  A document that describes the process, and can be in the form of policy, procedure, program, plan, guideline, or protocol.
- Policy:
  - A principle of action adopted by an organization.
  - It usually answers the question of what the process is.
  - It is stricter than guidelines or protocols.
  - It does not include objectives that need to be met in a certain timeframe.
- Procedure:
  - An established or official way of doing something.
  - It usually answers the question of how the process happens.
  - It is stricter than guidelines or protocols.
  - It does not include objectives that need to be met in a certain timeframe.
- Program:
  A plan of action aimed at accomplishing a clear business objective, with details on what work is to be performed, by whom, when, and what means, or resources shall be used.
- Plan:
  - A detailed proposal for doing or achieving something.
  - It usually answers the question of what is the goal, why, how it is going to be achieved, and when.
  - It includes objectives that need to be met in a certain timeframe.
- Guideline:
  - A general rule, principle, or piece of advice.
  - It usually answers the question of what the process is and how it should happen.
  - Usually, it is more narrative than protocol.
- Protocol:
  - A best practice protocol for managing a particular condition, which includes a treatment plan founded on evidence-based strategies and consensus statements.
  - Usually, it has graphs, flow charts, mind maps, and thinking trees.
- Document versus Record
  - Document:

  Created by planning what needs to be done.
  - Record:

  Created when something is done.
- Physician Versus Medical staff member
  - Physician:

  A professional who practices medicine
  - Medical Staff member:

  A professional who practices medicine, and other independent practitioners.

Accreditation Overview

This chapter aims to set the rules and requirements to obtain GAHAR accreditation for Mental Health Hospitals which includes, but is not limited to, the following:

1. Compliance with licensure requirements for licensing the Mental Health Hospitals as mandated by laws and regulations and regulatory ministerial decrees.
2. Compliance with the National Safety Requirements for Mental Health Hospitals (herein included), to ensure the safety of the patients, families, visitors, and staff.
3. Compliance with the requirements of the standards according to Accreditation Decision Rules in this handbook.

A) General rules:

- Determining which set of accreditation manuals is applied to the applicant's facility is done by matching the facility's scope of services provided. The Authority must be informed of any change in the field of services provided (adding a new service, canceling an existing service, or increasing the volume of an existing service by more than 15%) in writing to the e-mail **reg@gahar.gov.eg.** at least one month before the actual implementation of this change.
- Facilities that desire to obtain GAHAR's accreditation have to apply starting from the date of entering the governorate under the scope of universal health insurance law implementation, within a maximum period of three years. For facilities in the governorates that have not fall yet under the scope of the law application, they have to apply within three years from the date of application submission.
- The facility shall ensure the validity of the documents and data provided at all stages of the accreditation process. If there is evidence that the submitted documents are proven to be inaccurate, the facility is at risk of rejection of accreditation.
- The facility is not permitted to use GAHAR's certificate or logo misleadingly.
- The accreditation may be withdrawn or at risk of rejection if there is evidence that the facility has falsified or withheld or intentionally misled the information submitted to GAHAR.
- GAHAR shall inform the facility about the accreditation decision within a period not exceeding 15 working days starting from the date of completion of the survey visit.
- GAHAR has the right to publish the results of survey visits, accreditation suspension, or rejection, according to the requirements of Law No. 2 of 2018.
- The facility has to complete at least 60% of its staffing plan, and register at least 60% of each category of health professional members before the survey visit, provided that the remaining registration process has to be completed within three months starting from the date of accreditation.
- In case of a sentinel event or any serious adverse event, GAHAR shall be notified within 7 days of its occurrence, or via email notification using the following link; reg@gahar.gov.eg. The root cause analysis shall be submitted no later than 45 days starting from the date of the occurrence or its notification with the appropriate corrective plan to prevent/reduce its recurrence according to the nature of the event. (Refer to standard no. (QPI.07 Sentinal events) for more information).

B) Compliance with current relevant laws, regulations, licensures requirements, and their updates as follows.

For Governmental and Non- governmental Mental Health Hospitals:

- Hospital licensure (for non-governmental hospitals).
- Approval of the National Council of Mental Health
- Hazardous waste handling license.
- Certificate of conformity with the civil protection requirements.
- Laboratory license.

- Ionizing radiation equipment license, (If any).
- Pharmacy license. (If any)
- Elevator license (if any).
- Electric generators license (in accordance with Article 2 and Article 3 of Law No. 55 of 1977 regarding the establishment and management of thermal machines and steam boilers).
- Physical therapy license (for non-governmental hospitals).

C) Accreditation may be suspended (for a period not exceeding 6 months**) if**:

- The facility fails to pass an unannounced survey,
- The facility fails to comply with GAHAR circulars when applicable.
- The facility data in the application form does not match its status upon unannounced evaluation visits.
- Sentinel events related to the safety of patients, healthcare providers, or visitors that had not reported to GAHAR within 7 days of its occurrence.
- The GAHAR has not been notified of any changes in the scope of services provided (e.g. adding a new service, canceling an existing service, or increasing the volume of an existing service by more than 15%) within at least one month before the actual implementation of this change.
- The facility did not register at least 60% of its medical professional members.
- The facility fails to submit corrective action plans in case of the presence of one not met EOC or more,

D) Accreditation may be withdrawn or at risk of rejection if:

- The facility fails to pass follow-up surveys in case of the conditioned accreditation.
- GAHAR team discovers any falsification, withholding, or intentional misleading of the information submitted during or after the survey visit, or it is proven that the attached and submitted documents are inaccurate.
- The facility prevents the GAHAR regulatory team/inspectors from doing their duties, such as refusing or preventing them from obtaining documents and data related to the scope of their duties.
- The facility refuses to meet the auditors' team or The GAHAR surveyors in the announced / unannounced evaluation visits.
- A legal document issued by an administrative agency or Supreme Court rules against the facility either by permanent or temporary closure.
- Moving the facility from its actual place mentioned in the application form, or when the facility is demolished, reconstructed, or rebuilt without any pre-notification to GAHAR.
- Exceeding the period prescribed for suspension of accreditation without correcting the reasons for this suspension.

Applying for a GAHAR survey

Mental health hospital seeking GAHAR accreditation begins by:

- Applying to join the program via www.gahar.gov.eg or by sending an email to reg@gahar.gov.eg
- GAHAR is going to respond by sending an application template attached to the email. The hospital will complete the application and upload the required documents.
- Mental health hospital documents will be reviewed by GAHAR.
- GAHAR will determine survey financial fees, and bank account details will be shared.
- The hospital will make the payment to the Central Bank of Egypt on the bank account, and it will send the receipt back via email.
- An appointment for the survey visit will be determined for the hospital.
- GAHAR's surveyor team will evaluate the hospital according to the GAHAR Handbook for mental hospital accreditation standards.
- The survey report is submitted to the accreditation committee to review and decide based on the decision rules.
- The hospital is notified of the decision of the accreditation committee. The hospital has 15 days to submit an appeal. If no appeal is submitted, the chairman of GAHAR approves the decision, and a final certificate is issued.

Look back period

- Surveyors are required to review standards requirements and evaluate organization compliance with them over a lookback period.
- Look back period: It is the period before the survey visit during which any mental health hospital is obliged to comply with the GAHAR accreditation standards. Failure to comply with this rule affects the accreditation decision.
- Look back period varies from one mental health hospital to another, depending on the hospital's accreditation status.

- A mental health hospital seeking accreditation will:
    - Comply with the GAHAR Handbook for Mental Health Hospital Accreditation Standards as applicable for at least **four months** before the actual accreditation survey visit.

- A mental health hospital seeking re-accreditation:
    - For GAHAR-accredited mental health hospitals, compliance with the GAHAR Handbook for Mental Health Hospital Accreditation Standards from receiving the approval of the previous accreditation till the next accreditation survey visit.

Scoring Guide

During the survey visit, each standard is scored for evidence of compliance (EOC).

These are mathematical rules that depend on the summation and percentage calculation of scores of each applicable EOC as follows:

- **Met** when the Mental health hospital shows 80% or more compliance with requirements during the required lookback period with a total score of 2.
- **Partially met** when the Mental health hospital shows less than 80% but more than or equal to 50% compliance with requirements during the required lookback period with a total score of 1.
- **Not met** when the Mental health hospital shows less than 50% compliance with requirements during the required lookback period with a total score of 0.
- **Not applicable** when the surveyor determines that, the standard requirements are out of the organization's scope (the score is deleted from the numerator and denominator).
- While most EOCs are independent, stand-alone units of measurement that represent the structure, process, and/or outcome, few EOCs are dependent on each other. Dependence means that compliance with one EOC cannot be achieved (or scored) without ensuring compliance with other EOCs.

Scoring of each standard

- **Met**: when the average score of the applicable EOCs of this standard is 80% or more.
- **Partially met** when the average score of the applicable EOCs of this standard is less than 80% or not less than 50%.
- **Not met** when the average score of the applicable EOCs of this standard is less than 50%.

Scoring of each chapter

Each chapter is scored after calculating the average score of all applicable standards in this chapter

Accreditation Decision Rules

Mental health hospitals can achieve accreditation by demonstrating compliance with certain accreditation decision rules. These rules mandate achieving certain scores on a standard level, chapter level, and overall level as the accreditation decision is composed of four decisions.

1st Decision: Status of Accreditation for a mental health hospital (3 years).

- Overall compliance of 80% and more, and
- Each chapter should score not less than 70%, and
- No single whole standard is scored as not met.

2nd Decision: Status of Conditioned Accreditation for a mental health hospital (2 years).

- Overall compliance of 70% to less than 80%, or
- Each chapter should score not less than 60%, or
- Up to one standard not met per chapter, and
- No single not met NSR standard.

3rd Decision: Status of Conditioned Accreditation for a mental health hospital (1 year).

- Overall compliance of 60% to less than 70%, or
- Each chapter should score not less than 50%, or
- Up to two standards not met per chapter, and
- No single not met NSR standard.

4th Decision: Rejection of Accreditation

- Overall compliance of less than 60%, or
- One chapter scored less than 50%, or
- More than two standards not met per chapter, or
- A single not met NSR standard.

Mental health hospitals having a status of accreditation or conditioned accreditation with elements of non-compliance are requested to:

- Submit a corrective action plan for unmet EOCs and standards within 90 days for 1st decision, 60 days for 2nd decision, and 30 days for 3rd decision to the email reg@gahar.gov.eg.
- Apply and pass the accreditation survey in 2 years for the 2nd Decision and 1 year for the 3rd Decision.

Acknowledgments

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Special thanks to external experts who participated in the standards development process and facilities where field-testing were carried out.

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Acronyms

Code	Meaning
APC	Accreditation Prerequisites and Conditions
NSR	National Safety Requirements
PCC	Patient-Centeredness Culture
ACT	Access, Continuity, and Transition of Care
ICD	Integrated Care Delivery
STP	Special Behavioral Therapy and Program
DAS	Diagnostic and Ancillary Services
MHP	Mental Health Procedures
MMS	Medication Management and Safety
EFS	Environmental and Facility Safety
IPC	Infection Prevention and Control
OGM	Organization Governance and Management
WFM	Workforce Management
IMT	Information Management and Technology
QPI	Quality and Performance Improvement

SECTION 1

Accreditation Prerequisites and Conditions

Section 1: Accreditation Prerequisites and Conditions

Section Intent:

This chapter aims at providing a clear ethical framework that a hospital shall follow to comply with the GAHAR survey process. Scores of these standards shall always be met in order to continue the survey process. One partially met or not met evidence of compliance shall be dealt with on the GAHAR accreditation committee level and may result in denial or suspension of accreditation.

Compliance with GAHAR accreditation prerequisites

APC.01 The hospital provides continuous and accurate monitoring of compliance with National Safety Requirements.

Safety

Keywords:
National regulations and licensure requirements.

Intent:
Regulation and licensure requirements are considered a basic requirement to ensure minimum level of compliance for any mental health hospital or other facility providing healthcare services and aiming to be enrolled in the Universal Health Insurance system or achieving the accreditation or to be accredited by GAHAR. When the facility is applied for accreditation, it is expected to sustain or improve the same level of quality scored during the accreditation visit.
Licensure requirements shall be met by the facility according to the scope of services provided.
The goal of developing NSR is to enhance individual safety in hospitals. The General Authority for Healthcare Accreditation and Regulation (GAHAR) selected those standards which directly impact an individual's safety, or in other words, it is the main cause of killers in hospitals. To establish these standards as basic requirements for hospitals looking for enrolment in the Egyptian Universal Health Insurance System.
The hospital is expected to develop monitoring tools and frequencies for checking compliance with National Safety Requirements.
The hospital can show that these tools are used to monitor compliance based on the agreed frequencies to ensure the safety of patients, staff, and visitors all the time in the whole hospital.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital's process of frequent assessment of compliance with the national safety and regulatory requirements and may review the related corrective action plans.

Evidence of compliance:

1. The hospital has a clear process of frequent assessment of compliance with the national safety and regulatory requirements.
2. When a gap is identified, the hospital has developed a corrective action plan describing all necessary measures needed to improve performance and sustain full compliance.
3. The hospital reports to GAHAR any challenges that affect compliance with the national safety and regulatory requirements.

Related standards:
QPI.01 Quality management program, QPI.02 Performance Measures QPI.09 Sustaining Improvement. QPI.07 Sentinel events.

APC.02 The hospital ensures safe medical provision by complying with GAHAR Healthcare Professionals Registration requirements.

Safety

Keywords:
Healthcare Professionals Registration requirements.

Intent:

The healthcare professionals registration process aims at ensuring the competence of healthcare professionals by matching their qualifications and experience to registered or accredited hospital scope of medical services

In return, this process will improve the quality of healthcare services provided to the community. The hospital is expected to register 100% of all members of the following healthcare professions:

a) Physicians.
b) Dentists.
c) Pharmacists.
d) Physiotherapists.
e) Nurses.
f) Nursing technicians.
g) Health Technicians.
h) Chemists and physicists.
i) Veterinary doctors (working in the kitchen, hospital research lab, or other areas).

The hospital shall create a process to register all applicable newly hired staff members within 1-3 months.

Survey process guide:

- The GAHAR surveyors may review healthcare professional registration records including both the current and new staff.

Evidence of compliance:

1. The hospital has an approved process for registering all members of the required medical professionals.
2. The hospital assigns a task force to ensure complete registration and Identify staff who are not registered within a defined timeframe.
3. The process covers all full-time, part-time, visiting, or other types of contracts/agreements.
4. The hospital reports to GAHAR, and relevant professionals syndicates any findings that can affect patient safety such as fake, or misrepresented credentials.

Related standards:
APC.03 Accurate and complete information, OGM.02 The Mental Health Hospital director, WFM.05 Verifying credentials, WFM.03 Job Description.

Transparent and ethical relationships

APC.03 The hospital provides GAHAR with accurate and complete information through all phases of the accreditation process.

Effectiveness

Keywords:
Accurate and complete information.

Intent:
During registration and/or accreditation processes, there are many points at which GAHAR requires data and information.

When a hospital is registered, it lies under GAHAR's scope to be informed of any changes in the hospital and any reports from external evaluators.
Hospitals may provide information to GAHAR verbally, through direct observation, an interview, application, or any other type of communication with a GAHAR employee.
Relevant accreditation policies and procedures inform the hospital of what data and/or information are required and the period for submission.
The hospital is expected to provide timely, accurate, and complete information to GAHAR regarding its structure, hospital scope of work, building, governance, licenses, and evaluation reports by external evaluators.
GAHAR requires each hospital, whether registered, accredited, or just interested in engaging in the accreditation process with honesty, integrity, and transparency.

Survey process guide:

- The GAHAR surveyors may review reports of other accreditation, licensure, inspection, audits, legal affairs, reportable sentinel events, and reportable measures.
- The GAHAR surveyors may observe honesty, integrity, and transparency through the accreditation process.

Evidence of compliance:

1. The hospital reports accurate and complete information to GAHAR during the registration and/or accreditation processes.
2. The hospital reports within 30 days any structural changes in the hospital scope of work of addition or deletion of medical services by more than 15% (if beds, specialties, staff), building expansions, or demolitions.
3. The hospital provides GAHAR access to evaluation results and reports of any evaluating organization.

Related standards:

IMT.01 Document management system, APC.02 Healthcare Professionals Registration requirements, OGM.02 The Mental Health Hospital director, OGM.01 Governing body Structure and clear responsibilities.

APC.04 The hospital uses the accreditation process to improve safety and effectiveness.

Safety

Keywords:
Accreditation process value.

Intent:
GAHAR accreditation implies that a hospital is a place that maintains high safety standards.
Public, governmental bodies, staff, third- party payers, among others, will assume credibility in accredited hospital processes.
Thus, GAHAR has the right to obtain any information to confirm standards and accreditation policy compliance and/or evaluate patient safety and quality concerns at any time during all phases of accreditation.
When external bodies other than GAHAR evaluate areas related to safety and quality such as fire safety inspections, police criminal investigations, court allegations checking, staff working conditions inspections, and evaluation of safety incidents or quality complaints. These evaluations complement accreditation reviews but may have a different focus or emphasis.
Creating a safe culture is not an easy task; it requires everyone to be aware of safety issues and be able to report them.
The hospital improves hospital safety by sharing knowledge with GAHAR about any challenges identified through internal or external processes.

The hospital's website, advertising and promotion, brochures, newspapers, and other information made available to the public accurately reflect the scope of programs and services that are accredited by GAHAR.

Survey process guide:

- The GAHAR surveyors may review any reports of concerns related to safety issues.
- The GAHAR surveyors may interview responsible staff and patients to check their awareness of the mechanisms of reporting safety issues to GAHAR.

Evidence of compliance:

1. The hospital permits GAHAR to perform on-site evaluations of standards and policy compliance or verification of quality and safety concerns, reports, or any regulatory authority sanctions.
2. The hospital accurately represents its accreditation status and scope.
3. The hospital informs staff and patients on mechanisms to report safety issues to GAHAR.

Related standards:
QPI.01 Quality management program, QPI.02 Performance Measures QPI.09 Sustaining Improvement, QPI.08 Performance improvement and patient safety plan.

APC.05 The hospital maintains professional standards during the survey.

Safety

Keywords:
Professional standards during surveys.

Intent:
A surveyor aims to perform their duties and responsibilities and attain the highest levels of performance by the ethical requirements generally to meet the public interest and maintain the reputation of GAHAR.
To achieve these objectives, the survey process has to establish creditability, professionalism, quality of service, and confidence.
The hospital is expected to maintain professional standards in dealing with surveyors.
The hospital is expected to report to GAHAR if there is a conflict of interest between a surveyor and the hospital that could affect any of the following:

a) Integrity
b) Objectivity
c) Professional Competence
d) Confidentiality
e) Respect

The hospital ensures that there are no immediate risks to surveyors' safety and security.
The hospital respects the confidentiality and sensitivity of the survey process.

Survey process guide:

- The GAHAR surveyors may observe all aspects of the safety, security, confidentiality, privacy, respect, integrity, objectivity, professional competence values, and proper ethical management implementation.

Evidence of compliance:

1. Any conflict of interest is directly reported to GAHAR with evidence, (if any).
2. The hospital maintains professional standards for dealing with surveyors.

3. The hospital ensures that the environment does not pose any safety or security risks to surveyors during the survey.
4. Social media releases are not allowed without GAHAR's prior approval and notification.

Related standards:
PCC.01 Mental health hospital advertisement, OGM.12 Ethical Management, OGM.03 The Mental health hospitals' leaders

SECTION 2

Patient-Centered Standards

Section 2: Patient-Centered Standards

Patient-centered care represents a paradigm shift in how patients, healthcare professionals, and other participants think about the processes of treatment and healing. It is defined by the Institute of Medicine as the act of providing care that is respectful of, and responsive to, individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions. The rise of patient-centered care makes way for a healthcare system designed to optimize the benefit comfort of the most important and vulnerable people in the equation: patients, their families, and their communities.

Over the past two decades, patient-centered care has become internationally recognized as a dimension of the broader concept of high-quality healthcare. In 2001, the semiannual US Institute of Medicine's (IOM), *Crossing the Quality Chasm: A New Health System for the 21st century,* defined good-quality care as safe, effective, patient-centered, timely, efficient, and equitable.

The report sets out several rules to redesign and improve patient-centered care, including ensuring that care is based on continuous, healing relationships; customizing care based on patient's needs and values; ensuring the patient is the source of control; sharing knowledge and information freely, and maintaining transparency.

The IOM report defined four levels that further define quality care and the role of patient-centered care in each level:

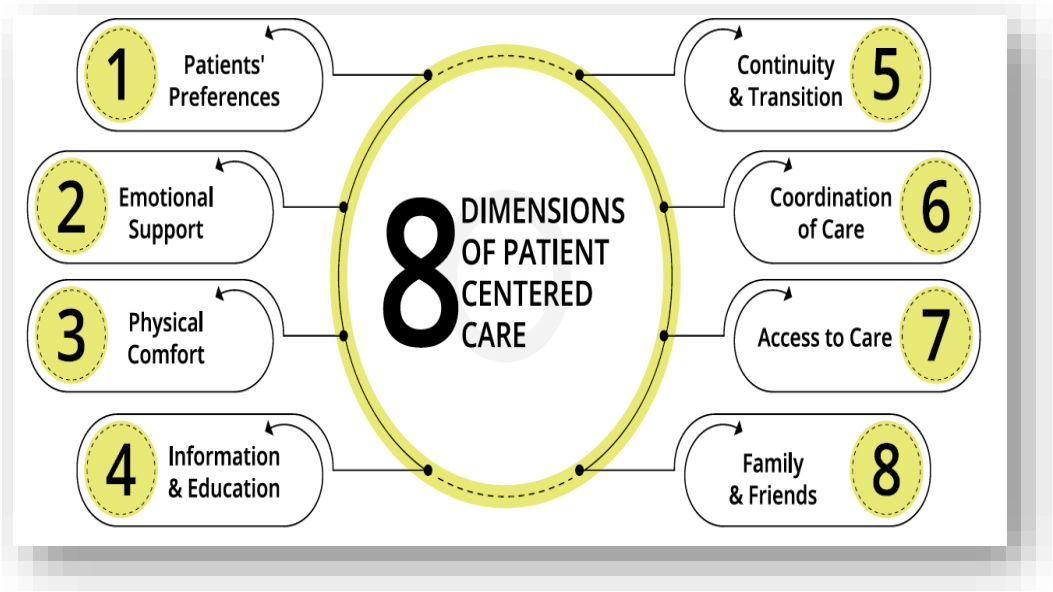
1. The experience level refers to an individual patient's experience of their care. Care should be provided in a way that is respectful, informative, and supportive for the participation of patients and families
2. The clinical microsystem level refers to the service, department, or program level of care. Patients and families should participate in the overall design of the service, department, or program.
3. The hospital level refers to the hospital as a whole. Patients and families should participate as full members of key hospital committees
4. The environment level refers to the regulatory level of the health system. Patients and families can inform local authorities.

According to Charmel and Frampton, the IOM report reinforces patient-centered care not only as a way of creating a more appealing patient experience but also as a fundamental practice for providing high-quality care in the US.

Practically, many Egyptian hospitals could readily put patients' medical records, and informed consent policies in place, but many find it hard to actively change the way care is delivered, and struggle to involve patients and learn from their experiences. Key strategies from leading patient-centered care organizations worldwide include demonstrating committed senior leadership; regular monitoring and reporting of patient feedback data; engaging patients and families as partners; resourcing improvements in care delivery and environment; building staff capacity and a supportive work environment; establishing performance accountability; and supporting a learning organization culture.

Internationally, healthcare services use a range of strategies to promote patient-centered care, including staff development, leadership, collecting and reporting patient feedback, redesigning and co-designing service delivery, implementing patient rights bills, and engaging patients and families as partners in improving care.

There are Eight Principles of Patient-Centered Care as defined by Picker's Institute:



1) Patients' Preferences

At every step, patients should be given the needed information to make thoughtful decisions about their care. Those preferences should always be considered when determining the best course of action for that patient. The expertise and authority of healthcare professionals should complement and enhance the patient perspective. Assessment and care should be in a way that maintains patients' dignity and demonstrates sensitivity to their cultural values healthcare professionals need to focus on the person's quality of life, which may be affected by their illness and treatment. Everyone involved is always on the same team, working toward the same goal.

2) Emotional Support

The challenges of treating and healing the body can also take their toll on the mind and the heart. Practicing patient-centered care means recognizing the patient as a whole person, having a multi-dimensional human experience, eager for knowledge and human connection, who may need extra, specialized help in keeping up the spirit of optimism. It helps to alleviate fear and anxiety the person may be experiencing with respect to their health statute (physical status, treatment, and prognosis), the impact of their illness on themselves and others (family, caregivers, etc.), and the financial impacts of their illness.

3) Physical Comfort

Patients shall summon the courage to face circumstances that are scary, painful, lonely, and difficult. Strong pain relief and a soft pillow can go a long way. Healthcare professionals should work to ensure that the details of patients' environments are working for them, rather than against them. Patients should remain as safe and comfortable as possible through difficult straits, surrounded by people equipped to care for them.

4) Information and Education

Providing complete information to patients regarding their clinical status, progress, and prognosis; the process of care; and information to help ensure their autonomy and their ability to self-manage and to promote their health. When patients are fully informed, and given the trust and respect that comes with sharing all relevant facts, they will feel more empowered to take responsibility for the elements of their care that are within their control.

5) Continuity and Transition

A transition from one phase of care to the next should be as seamless as possible. Patients should be well informed about what to expect. Treatment regimens, especially medication

regimens, should be clearly defined and understood. And everyone involved should be able to plan and understand what warning signs (and positive indicators) to look out for.

6) Coordination of Care

Every aspect of care depends on every other aspect working as efficiently and effectively as possible. Treatment and patient experience shall be considered as an integrated whole, with different moving parts working in concert to reduce feelings of fear and vulnerability. Healthcare professionals shall cooperate in the interest of the patient's overall well-being.

7) Access to Care

To the extent that it is possible, patients should have access to all the care they need, when they need it, in a manner that's convenient and doesn't inflict too much stress. It should be simple to schedule appointments, stick to medication regimens, and practice self-care.

8) Involvement of Family and Friends

Patient-centered care encourages keeping patients involved and integrated with their families, their communities, and their everyday lives by:

- Accommodating the individuals who support the person during care.
- Respecting the role of the person's advocate in decision making.
- Supporting family members and friends as caregivers, and recognizing their needs.

National Safety Requirements

Chapter intent:

The WHO defines patient safety as the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes. Healthcare is a complex environment where errors can lead to injury or death. Usually, the safeguards work. However, each layer of defense such as alarms, standardized procedures, and well-trained health professionals has weak spots.
Advances and commitment to patient safety worldwide have grown since the late 1990s, which leads to a remarkable transformation in the way patient safety is viewed.
When multiple system failures occur, mistakes that would usually be caught slip through, the price we pay when such situations occur is often high, on both a human and a health-system level.
Measuring patient safety initiatives and adverse events is essential when monitoring the progress of these strategies, tracking success, and helping to flag issues or identify potential areas for improvement.
As part of the GAHAR registration process, Hospitals have to show commitment to patient safety. This requires compliance with each of the National Safety Requirements (NSRs). During surveys, surveyors evaluate that safe and efficient implementation of each of the NSRs is maintained in all relevant practices. The application of the standards should be according to the applicable Egyptian laws and regulations.

Chapter purpose:

1. To address all the National Safety Requirements.
2. To ensure that the organizations provide and maintain the patient safety program effectively.

Implementation guiding documents:
(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Constitution
2) Egyptian code of medical ethics 238/2003
3) Egyptian code of nursing ethics
4) Jeddah Declaration on Patient Safety 2019
5) WHO Patient Safety Assessment Manual
6) WHO Surgical Safety Checklist
7) WHO Patient Safety Friendly Initiatives
8) Law 71/2009 psychiatric patient care

No standards are scored under this chapter; all National Safety Requirements will be scored in their corresponding chapters.

Code	NSR Keyword	Code in this book
	GENERAL PATIENT SAFETY	
NSR.01	Patient Identification	ACT.02
NSR.02	Hand Hygiene	IPC.05
NSR.03	Fall screening and Prevention	ICD.10
NSR.04	Pressure Ulcers	ICD.11
NSR.05	Venous Thromboembolism Prophylaxis	ICD.12
NSR.06	Handover Communication	ACT.08
NSR.07	Verbal and Telephone Orders	ICD.15
NSR.08	Critical Results	ICD.16
NSR.09	Recognition and Response to Clinical Deterioration	ICD.18
NSR.10	Cardiopulmonary Resuscitation and Medical Emergencies	ICD.20
NSR.11	Catheter and Tube Misconnections	ICD.17
	SPECIAL BEHAVIORAL THERAPY AND PROGRAM	
NSR.12	Behavioural Restraint and Seclusion	STP.02
NSR.13	Imminent Harm to Self or Others.	STP.03
NSR.14	Suicide prevention program	STP.04
	DIAGNOSTIC AND ANCILLARY SERVICES	
NSR.15	Radiation Safety Program	DAS.08
NSR.16	Laboratory Safety Program	DAS.16
	MENTAL HEALTH PROCEDURES	
NSR.17	Electroconvulsive Therapy (ECT).	MHP.12
NSR.18	Pre- verification Process	MHP.13
NSR.19	Time-out	MHP.14
	MEDICATION MANAGEMENT AND SAFETY	
NSR.20	Medication storage, Medication labeling	MMS.03
NSR.21	High-Risk Medications, Concentrated Electrolytes	MMS.05
NSR.22	Look-alike, Sound-alike Medication	MMS.06
	ENVIRONMENTAL AND FACILITY SAFETY	
NSR.23	Fire and Smoke Safety Plan	EFS.02
NSR.24	Fire Drills	EFS.04
NSR.25	Hazardous Materials and Waste Management	EFS.05
NSR.26	Violence Prevention Program	EFS.08
NSR.27	Medical Equipment Plan	EFS.10
NSR.28	Clinical alarms	EFS.11
NSR.29	Utility Management	EFS.12
	INFORMATION TECHNOLOGY AND MANAGEMENT	
NSR.30	Standardized Symbols and Abbreviations	IMT.03

Patient-Centeredness Culture

Chapter intent:

In patient-centered care, a patient's specific health needs and desired health outcomes are the driving force behind all healthcare decisions and quality measurements. As many patients are unable to evaluate a healthcare professional's level of technical skill or training, criteria for judging a particular service are non-technical, and personal and include aspects like comfort, friendly service, healthcare professional communication, soft skills, and on-time schedules.

This requires that healthcare professionals develop good communication skills and address patient needs effectively and timely. Patient-centered care also requires that the healthcare professional becomes a patient advocate and strives to provide care that is not only effective but also safe.

The goal of patient-centered healthcare is to involve and empower patients and their families to become active participants in their care not only from a clinical perspective, but also from an emotional, mental, spiritual, social, and financial perspective.

Globally, the universal declaration of human rights article 25 emphasized the human right to a standard of living adequate for the health and wellbeing of himself and of his family, which includes medical care and the right to security in the event of sickness or disability. In 1990, the Cairo declaration on human rights in Islam clearly stated in article 20 that no human should be a subject in clinical research without his/her consent provided that there is no harm to the subject's health or life.

Locally, Egyptian legal and ethical frameworks supported patient-centered care as well. According to the Egyptian constitution, comprehensive quality-standardized healthcare is a right for Egyptians. Egyptian codes of medical, nursing, pharmaceutical, and other healthcare professionals' ethics emphasized multiple aspects of patients' rights and healthcare professionals' obligations toward patients. Egyptian Law 71/2009 for psychiatric patient care organized patient-centered practice in mental health and addiction hospitals. Consumer Protection Agency (CPA) has identified multiple practices and instructions for patients to assume during their healthcare processes. In addition, Egyptian laws clearly describe the mechanism to obtain legal consent. During the past few years, the Egyptian parliament discussed some laws that are pertinent to the rights of some groups of Egyptian society, such as women, children, and the handicapped and elderly. Egyptian government identified multiple methods for the public to voice complaints from hospitals, including hotlines in the ministry of health and population.

Practically, Hospitals need to ensure infrastructure for uniform patient-centered care policies and procedures. Organizations shall not stop their patient-centered care processes by just printing patient rights and responsibilities brochures and handing them to patients. Policies and procedures need to identify mechanisms to establish and sustain patient-centered care culture. Education and techniques to encourage patient-centeredness behaviors are needed.

During the GAHAR Survey, Surveyors shall be able to measure how organizations define their patient-centeredness culture and work to sustain it through reviewing documents pertinent to this chapter, reviewing the implementation of direct patient management, during patient tracers, and interviewing staff. The leadership interview session may touch on this topic, as well.

Chapter purpose:

The main objective of this chapter is;

1. To describe the patient-centeredness culture needed to comply with the chapter requirements.
2. To describe basic patient rights and responsibilities.
3. To emphasize the techniques and cultural changes that organizations need to address while building patient-centred culture.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Constitution.
2) Cairo Declaration on Human Rights in Islam, 1990.
3) Egyptian law for the care of psychiatric patients, 71/2009.
4) Law no. 210/ 2020 amendment for the law of psychiatric patient care, 71/2009.
5) Regulations for the care of psychiatric patients, 128/2010.
6) Regulations for the care of psychiatric patients, 55/2021.
7) Egyptian code of medical ethics 238/2003.
8) Egyptian Children Protection Law number126/2008.
9) Rights of the Handicapped law, 10/2018.
10) Egyptian Consumer Protection law, 181/2018.
11) Law 51/1981 amended by law 153/2004, Healthcare facilities organization.
12) MOHP Ministerial decree of patient right to know expected cost of care number 186/2001.
13) Egyptian Criminal code law 58/1937.
14) Advertisement for Healthcare Services law, 206/2017.
15) Egyptian Code of Nursing Ethics (Nursing Syndicate Publications).
16) Code of Ethics and Behavior for Civil Service Staff, 2019.
17) Prime Minister decree for management of emergency cases number1063/2014.
18) Universal Declaration on Human Rights, 1964.

Planning and protecting the patient-centeredness culture

PCC.01 The mental health hospital advertisements are clear and comply with applicable laws and regulations, and ethical codes of the healthcare professionals' syndicates.

Patient-centeredness

Keywords:
Mental health hospital advertisement.

Intent:
Usually, mental health hospitals use advertisements as an important tool to improve the utilization of services. Good advertisement aims to help the community have a better understanding of the available health services. Mental health hospitals might use newspapers, TV advertisements, banners, brochures, pamphlets, websites, social media pages, call centers, SMS messaging, mass emailing, or other media to advertise provided services. According to Egyptian laws and regulations, an advertisement for healthcare services should be done honestly. Medical syndicates, nursing syndicates, pharmacists syndicates, and others addressed honesty and transparency as high values in their codes of ethics. The mental health hospital shall start complying with this standard by exploring the relevant ethical codes and finding out how they apply to the mental health hospital advertisement/communication plan Information must be accurate, updated, and communicated about types of services, healthcare professionals, cost of services, and working hours.

Survey process guide:

- The GAHAR surveyors may check mental health hospital advertisements at any time from receiving the application and assigning surveyors until sending the survey report. Advertisements may be matched with the application information and with survey visit observations.
- The GAHAR surveyors may review the hospital advertisement policy /communication plan.

Evidence of compliance:

1. The mental health hospital has an approved policy guiding the process of providing clear, updated, and accurate advertisements of services.
2. Advertisements are done in compliance with the ethical codes of healthcare professionals' syndicates.
3. Patients, families, and carers receive clear, updated, and accurate information about the hospital's services, healthcare professionals, and working hours.

Related standards:
PCC.03 Patient, family, and carer rights, ACT.01Granting access, OGM.12 Ethical Management, OGM.04 Scope of services

PCC.02 Patient-centered culture is developed and maintained by interdisciplinary collaboration.

Patient-centeredness

Keywords:
Patient-centered culture.

Intent:
Patient-centered culture development and maintenance require careful planning, agile implementation, and close monitoring. A journey of changing/improving a hospital culture requires collaborative teamwork from multiple disciplines. A site-based interdisciplinary group in the form of the Patients' Rights Protection Committee shall be established to oversee and assist the implementation and maintenance of patient-centered culture through communicating

this vision to multiple stakeholders and staff members, identifying potential obstacles and resistance, then working to remove these obstacles and ease down resistance.
The patients' rights protection committee has terms of reference that clearly define responsibilities and activities according to laws and regulations any violations of patient rights that are reported to the committee are analyzed and managed through a defined process.

Survey process guide:

- The GAHAR surveyors may review the committee matrix, and terms of reference and may review a sample of meeting minutes.
- The GAHAR surveyors may interview staff to evaluate the mechanisms taken to plan, assist, and maintain patient-centered practices.
- The GAHAR surveyors may interview staff to check their awareness of how to manage violations of patient rights.

Evidence of compliance:

1. The patients' rights protection committee has clear terms of reference.
2. The committee meets at predefined intervals according to terms of reference
3. The committee meetings are recorded.
4. The committee reports on its work are submitted to the director of the hospital to act upon.
5. Any reported violations of patient rights are analyzed and managed within a defined timeframe as per the established hospital process.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.11 Complaints and suggestions, STP.02 Behavioral Restraint and Seclusion, PCC.07 Informed consent, OGM.08 billing system, PCC.10 Patient, family, and carer feedback.

PCC.03 The mental health hospital supports and respects the patients, families, and carers' rights to participate in the care and services process

Patient-centeredness

Keywords:
Patient, family, and carer rights.

Intent:
Seeking and receiving care and treatment at mental health hospitals can be overwhelming for patients, making it difficult for them to act upon their rights and understand their responsibilities in the care process. Patients should be able to understand their rights and know how to use them.
If for any reason, a patient does not understand his/her right, the mental health hospital is committed to helping the patient to gain knowledge about his/her rights. The mental health hospital provides direction to staff regarding their role in protecting the rights of patients and families. Patient emotional, religious, spiritual needs and other preferences shall be addressed and recognized. Whenever appropriate, provide separate facilities and services for women and men according to their cultural needs.
The mental health hospital ensures implementation of the process of dealing with disoriented patients or patients lacking the capacity to understand these rights on admission and ensure their mental capacity is assessed and documented in their medical record (with respect to conditions for obtaining the patient admission consent). Patient and family rights shall be defined according to laws and regulations, and the ethical code of healthcare professionals' syndicates

The mental health hospital shall develop and implement policy and procedures to ensure that all staff members are aware of and respond to patient and family/carer rights issues when they interact with and care for patients throughout the hospital. The policy addresses at least the following:

i. The patients right to:
   a) Access care that is provided by the hospital with equality and non-discrimination.
   b) Know the name of the treating, supervising, responsible medical staff member and who to contact in an emergency.
   c) Respect the patient's values, preferences, and beliefs.
   d) Refuse care and discontinue treatment (except in compulsory admission, in accordance with the psychiatric patient care law).
   e) Have security, personal privacy, confidentiality, and dignity.
   f) Have pain assessed and managed.
   g) Seek a second opinion either internally or externally.
   h) Be engaged in the community with no fear of discrimination.
   i) Have liberty and security and have protection against restraints or limits to freedom unless there are compelling reasons that comply with the law and regulations.
   j) Have privacy and confidentiality of any information concerning his/ her medical record and not disclose any information unless they are necessary for therapeutic purposes and according to laws and regulations.
   k) Obtain a temporary, conditioned discharge according to the established plan of care.
   l) Leave the hospital without any relatives after ending the compulsory admission period treatment.
   m) Accept or refuse personal contacts, visitors, and communications unless it contradicts the hospital therapeutic plan.
   n) Be protected against torture or cruelness, exploitation, neglect, violence, abuse, and degrading treatment or punishment.

ii. Patients, families, and carers' rights to:
   o) Be informed and participate in making decisions related to patient care (with respect to the type of admission).
   p) Make a complaint or suggestion without fear of retribution or discrimination.
   q) Know the price of services and procedures in a manner and a language they understand.
   r) Take ethical approval to conduct any scientific research by Ethics Committee according to laws and regulations.

The mental health hospital shall ensure the protection of patient and family rights in special psychiatric conditions according to laws and regulations such as; Patients with compulsory admission or emergencies with imminent harm to self or others.

Survey process guide:

- The GAHAR surveyors may review patient rights policy and interview staff members to check their awareness.
- The GAHAR surveyors may observe patient rights statements availability in the mental health hospital, may also observe how patients receive information about their rights and may check conditions under which patient rights are protected.

Evidence of compliance:

1. The mental health hospital has an approved policy that defines patient, family, and carer rights, as mentioned in the intent from a) through r).
2. All staff members are aware of patients' and families' rights.

3. An approved statement on patient, family, and carer rights is available in all public areas in the hospital.
4. Patient, family, and carer rights are protected in all areas, and at all times with respect to the psychiatric patient laws and regulations.
5. Information about patient rights is provided in a written or another manner that the patients and their families, and carers understand.

Related standards:
PCC.06 Patient, family, and carer education process, PCC.10 Patient, family, and carer feedback, PCC.05 Admission consent, PCC.07 Informed consent, ICD.13 Plan of Care PCC.08 Patient comfort and dignity, ACT.01 Granting access, OGM.08 billing system, OGM.17 Research Patient Rights.

PCC.04 Patients, families, and carers are empowered to assume their responsibilities.

Equity

Keywords:
Patient, family, and carer responsibilities.

Intent:
Patients, their families, and carers shall be able to assume responsibilities related to the care process. If for any reason, patients (or their surrogates) do not understand their responsibilities, the mental health hospital is committed to helping them to gain relevant knowledge. The inability to assume these responsibilities might affect the care or the management processes of the patients themselves, their families, other patients, or staff members. The mental health hospital is responsible for making the patients' responsibilities visible to patients, individuals served, and staff members at all times. The mental health hospital shall develop and implement a policy and procedures to ensure that patients are aware of their responsibilities.
The policy shall address at least the following:

a) Patients, their families, and carer have the responsibility to provide clear and accurate information on the disease, current condition, and past medical history.
b) Patients, their families, and carer have the responsibility to comply with the regulations of the mental health hospital.
c) Patients, their families, and carer have the responsibility to comply with financial obligations according to laws and regulations and mental health hospital policy.
d) Patients, their families, and carer have the responsibility to show respect to other patients and healthcare professionals.
e) Patients, their families, and carer have the responsibility to follow the recommended treatment plan.

Survey process guide:

- The GAHAR surveyors may review patient responsibilities policy and interview staff members to check their awareness.
- The GAHAR surveyors may observe patient responsibility statements availability in the mental health hospital.
- The GAHAR surveyors may also observe how patients receive information about their responsibilities.

Evidence of compliance:

1. The mental health hospital has an approved policy that defines patient, family, and carer responsibilities as mentioned in the intent from a) through e).
2. All staff members are aware of patients', families', and carers' responsibilities.

3. An approved statement on patients', families', and carers' responsibilities is available in all public areas in the mental health hospital in a way that makes it visible to staff members, patients, families, and carers.
4. Information about patient responsibilities is provided in a written manner and in other manners that the patients and their families, and carers understand.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.06 Patient, family, and carer education process, PCC.07 Informed consent, ICD.13 Plan of Care, MMS.09 Medication Reconciliation, STP.01Family involvement.

Empowerment and involvement of patients and their families/carers

PCC.05 The mental health hospital has a defined process to obtain admission consent

Patient-centeredness

Keywords:
Admission consent.

Intent:
Admission consent represents a patient's or family's understanding and approval of the hospitalization process and its consequences. These consequences may include potential costs, hazards, and obligations that the patient may acquire during hospitalization. Admission consent is obtained from the patient or a legal representative before hospitalization after discussing the patient's needs and obligations according to applicable laws and regulations. The mental health hospital shall develop and implement a policy to guide the process of obtaining admission consent that addresses at least the following:

a) How to give patients and their families and carers information about potential costs, hospitalization process, and obligations in a language they understand.
b) Methods to assess the capacity of a patient to make decisions about their care starting with admission.
c) Assess the competency of the patient (or surrogate) to make a decision:

I. In case of voluntary admission:

i. Admission consent is signed by the patient, if the patient is above 18 years old and fully competent.
ii. Admission consent is signed by the parent or the legal guardian, if the patient is under 18 years old or incompetent.

II. In case of compulsory admission:

i. Admission consent is signed by first or second-degree relatives.
ii. Admission consent is signed by the legal guardian in case of legal guardianship.

Survey process guide:

- The GAHAR surveyors may review a policy guiding the patient admission consent process.
- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may check patient admission consent to assess completion.
- The GAHAR surveyors may check the distribution and availability of admission consent forms in areas where they are most needed, such as the admission office, ER desk, Nurse stations, or others.

Evidence of compliance:

1. The mental health hospital has an approved policy that guides the process of obtaining admission consent which addresses elements from a) to c) in the intent.
2. Responsible staff members are aware of the policy.
3. The admission consent forms are available in all relevant areas as per the hospital's policy.
4. Admission consent is obtained in a manner and language that the patient, the patient's guardian, and the family understand.
5. Admission consent is recorded and kept in the patient medical record.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.06 Patient, family, and carer education process, STP.01Family involvement, OGM.08 Billing System.

PCC.06 The mental health hospital ensures that patients, families, and carers' education is provided clearly.

Patient-centeredness

Keywords:
Patient, family, and carer education process.

Intent:
Patient, family, and carer education help to understand the care process and empower patients and families taking well-informed decisions. Multiple disciplines contribute to the process of educating patients and families during the course of care processes
Education materials need to be appropriate for the patient's condition, level of education, language, and culture.
The hospital shall develop and implement a policy and procedures to define the process of patient and his representative education. The policy shall address at least the following:

a) Identifying patient, family, and carer educational needs and their willingness to learn which may include
    i. Diagnosis and condition.
    ii. Plan of care expected outcome of care, and alternative to the planning of care.
    iii. Discharge instructions.

    .
b) Multidisciplinary responsibility to educate patients, families, and carers.
c) Method for education is provided according to the patient, family, and carer values and level of learning, and also in a language and format that they understand.
d) Process of recording patients' educational activities.

Hospitals may need to provide mass education to patients and families/carers on certain health topics based on the served community needs. The hospitals need to make sure that these materials are available when needed, especially during health campaigns and high-risk procedures. It is also important to ensure that these educational materials are understandable by the target audience and that they may include different languages or pictorial illustrations.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy describing the patient and family education process.
- The GAHAR surveyors may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the documentation of educational activities.
- The GAHAR surveyors may observe the availability of patients' educational materials.

Evidence of compliance:

1. The mental health hospital has an approved policy that guides the process of the patient, family, and carer education that includes at least the points mentioned in the intent from a) through d).
2. Responsible staff members are aware of patients', families', and carer's education policies.
3. Patients, families, and carers receive education relevant to the patient's condition.
4. Patient education activities such as patient education needs, the responsibility of providing education, and the method used is recorded in the patient's medical record.
5. Appropriate patient education materials are available as per the hospital's policy.

Related standards:
PCC.03 Patient, family and carer rights, PCC.04 Patient, family and carer responsibilities, PCC.05 Admission consent, PCC.07 Informed consent, STP.01Family involvement, STP.09 Tele-mental health services, ICD.13 Plan of Care, MMS.11 Medication dispensing, MHP.12 Electroconvulsive Therapy (ECT).

PCC.07 The mental health hospital has a defined process to obtain informed consent for certain processes.

Patient-centeredness

Keywords:
Informed consent.

Intent:
One of the main pillars to ensure patients' involvement in their care decisions is by obtaining informed consent. To give consent, a patient shall be informed of many factors related to the planned care. These factors are required to make an informed decision. Informed consent is a process for getting permission before performing a healthcare intervention on a person, or for disclosing personal information. The informed consent shall include the likelihood of success and the risk of not doing the procedure or intervention, benefits, and alternatives for performing that particular medical process. The mental health hospital shall develop and implement a policy and procedures to describe how and where informed consent is used. The policy shall include at least the following:

a) The list of medical processes when informed consent is needed, this list shall include:
    I. Invasive procedures, if any.
    II. Anesthesia, moderate and deep sedation.
    III. High-risk procedures or treatments such as electroconvulsive treatment (ECT) and other similar modalities.
    IV. Photographic and promotional activities, for in which the consent could be for a specific time or purpose
    V. Research, (if applicable).
    VI. Use of blood and donation of blood, (if applicable).

b) Certain situations when consent can be given by someone other than the patient, and mechanisms for obtaining and recording it according to applicable laws and regulations
c) Refusing or discontinuing a step or steps in the medical care process, the patient informed refusal consent shall be used to document the refusal process according to law; as follow;
    i. Informed refusal is signed by the patient in case of voluntary admission only, provided the patient is in a stable condition and has the mental capacity to do so.

ii. In patients under 18, a parent or legal guardian signs, the informed refusal provided the patient`s condition is stable.
iii. The psychiatrist may refuse to sign the informed refusal consent based on the assessment of the patient's current conditions and in accordance with the psychiatric patient care law and regulations.

d) Determine staff who is authorized to obtain and sign the consent.
e) Availability of the consent forms in all applicable, relevant locations.
f) The validity requirements for informed consent according to the psychiatric patient care law and regulations.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the patient consent process and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the documentation of the informed consent.
- The GAHAR surveyors may observe the availability and distribution of the informed consent forms.

Evidence of compliance:

1. The mental health hospital has an approved policy that guides the process of informed consent that includes all elements mentioned in the intent from a) through f).
2. Responsible staff members are aware of the consent process
3. The informed consent forms are available in all relevant areas as per the hospital' policy.
4. Informed consent is obtained in a manner and language that the patient and his/her representatives understand.
5. Authorized medical staff who is obtaining the informed consent signs the form with the patient.
6. Informed consent is recorded and kept in the patient's medical record.

Related standards:
PCC.03 Patient, family and carer rights, PCC.04 Patient, family and carer responsibilities, ACT.07 Patient Care Responsibility, STP.01Family involvement, MHP.09 Drug-assisted interview, MHP.12 Electroconvulsive Therapy (ECT), OGM.16 Consent for Clinical Research, IMT.03 Standardized symbols and Abbreviations, symbols, and Abbreviations.

Ensuring patient's comfort and dignity

PCC.08 The mental health hospital ensures optimum patient comfort and dignity during hospitalization.

Patient-centeredness

Keywords:
Patient comfort and dignity.

Intent:
Patient care space is defined as space within a healthcare facility wherein patients are intended to be examined or treated. More than 600 studies have linked the hospital-built environment to factors such as patient satisfaction, stress, health outcomes, and overall healthcare quality, as quoted by the American Hospital Association. Overarching factors in the healthcare hospital environment include noise levels, patient and pain management, and environmental factors inhibiting or facilitating communication; these factors all tie together.

When an environment is too noisy, patients may have a hard time getting sleep or being comfortable, inhibiting their abilities to recover. This may also limit communication.
The hospital shall ensure that the patient's stay is comfortable, preserving safety needed for the psychiatric condition nature, and suitable for the patient's and family's needs.
The mental health hospital shall provide an environment that includes at least the following:

a) A comfortable atmosphere;
b) Sufficient space with access to personal living space;
c) Proper and convenient furnishings and equipment in all areas that ensure the safety of the patient and are convenient to his mental state;
d) Proper temperature control and ventilation
e) Availability of resources that may be required to meet patients' spiritual, cultural, and gender needs.
f) Communication about room and roommate assignments or changes;
g) Respect patient, and staff comfort, and safety from acoustic noise especially during hospital codes and alarm activation.

A comfortable stay may obtain in mental health hospital through many ways and methods as accessibility to the internet and social media, accessibility to safe outdoor space every day which is subjected to risk assessment, and/ or making and receiving private telephone calls in line with the local policy, follow healthy diet and food and having a convenient visiting hour.

Staff members shall ensure their complete awareness of how to maintain and protect their patients' privacy, comfort, and dignity and know how to manage situations when this is breached.

Survey process guide:

- The GAHAR surveyors may visit multiple patient rooms of multiple economic statuses to assess their comfort.
- The GAHAR surveyors may interview patients and staff to inquire about visiting hours, healthy food availability, and comfortable stay.

Evidence of compliance:

1. The mental health hospital provides a safe, comfortable environment that covers elements from a) to g) in the intent.
2. Staff is aware of how to maintain and protect their patients' privacy, comfort, and dignity.
3. Comfortable spaces and equipment are available for patient use.
4. Healthy food is available and accessible for patients when needed.
5. Visiting hours are convenient for patients and their families.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.06 Patient, family, and carer education process, EFS.01 Mental health hospital environment and facility safety structure, EFS.07 Security Plan, EFS.06 Safety Management Plan

Protecting patient's belongings, privacy, and confidentiality

PCC.09 The mental health hospital's responsibility towards the patient's belongings is defined.

Patient-centeredness

Keywords:
Patient's belongings.

Intent:

The patient's belongings may include clothing, dentures, hearing aids, eyeglasses or contact lenses, or valuables such as jewelry, electronic devices, cash, and credit/debit cards. The hospital shall accept custody of the patient's belongings for the patient's best interests especially if the patient is not capable of being responsible for the belongings and the family is unavailable to take custody of their belongings. The mental health Hospital shall develop a policy to manage patient belongings

, that follows patients identification local policy and addresses at least the following

a. Clarify the accountability of staff who have the responsibility for managing patients' property.
b. The safe and appropriate procedures to manage patients' property.
c. Define the lost and found process, lost and found items shall be recorded, protected, and returned when possible; the hospital shall define a clear process to follow when items are not returned within a defined timeframe.

Survey process guide:

- The GAHAR surveyors may review the hospital policy that manages patients' belonging.
- The GAHAR surveyors may interview staff members to check their awareness of mental health hospital policy.
- The GAHAR surveyors may review security records, other records, and cabinets where patient belongings are kept and recorded.

Evidence of compliance:

1. The mental health hospital has an approved policy guiding hospital responsibilities for patients' belongings including elements in the intent from a) to c).
2. Responsible staff members are aware of the hospital's policy.
3. Lost and found items are recorded, protected, and returned when possible.
4. Records to manage the patient's property are available and match the cabinet's contents.

Related standards:

PCC.03 Patient, family and carer rights, PCC.04 Patient, family and carer responsibilities, PCC.11 Complaints and suggestions, EFS.07 Security Plan.

Responsiveness to patients', families' and carers' voices

PCC.10 The mental health hospital improves its provided services based on measured patients', families', and carers' feedback.

Patient-centeredness

Keywords:

Patient, family, and carer feedback.

Intent:

Patient and family feedback could include concerns, compliments, and formal complaints through surveys that may help the mental health hospital to identify ways of improving clinical and non-clinical performance. The hospital can solicit feedback from patients and their carer in a variety of ways: phone surveys, written surveys, focus groups, or personal interviews. Many hospitals shall use written surveys, which tend to be the most cost-effective and reliable approach. The mental health hospital shall develop and implement a policy and procedures to guide the process of managing patient and family /carer feedback.
The hospital shall define if the process addresses the measurement of patient experience or patient satisfaction.

For patient experience, the mental health hospital shall assess whether something that should happen in a healthcare setting (such as clear communication with a healthcare professional) actually happened or for how long it happened. While for patient satisfaction, the hospital shall measure whether a patient or his family's expectations about a health encounter were met. Two people who receive the exact, same care, but who have different expectations for how that care is supposed to be delivered, can give different satisfaction ratings because of their different expectations. Measuring alone is not enough. The hospital needs to analyze and interpret information obtained from measured feedback and identify potential improvement projects

Survey process guide:

- The GAHAR surveyors may review the policy of patient and family feedback.
- The GAHAR surveyors may assess the process of use of patient and family feedback for performance improvement.

Evidence of compliance:

1. The mental health hospital has an approved policy guiding the process of patient and family feedback measurement.
2. There is evidence that the hospital has received, analyzed, and interpreted feedback from patients and families.
3. The interpreted feedback has been communicated to concerned staff members.
4. There is evidence that patients' and families' feedback is used to improve the quality of service.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.11 Complaints and suggestions, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement.

PCC.11 Patients, families, and all individuals served by the hospital are able to make oral or written complaints or suggestions through a defined process.

Patient-centeredness

Keywords:
Complaints and suggestions.

Intent:
The mental health hospitals shall be able to proactively measure and use patients' and carer's feedback, patients and families may also want to give oral or anonymous complaints or suggestions about their care and to have those complaints or suggestions reviewed and acted upon.
The hospital shall develop and implement a policy and procedures to create a uniform system for dealing with different complaints and suggestions from different individuals served by the hospital as patients, their families, and carers to make it easy to follow up, monitor, and learn from practices.
Hospital policy shall address at least the following:

a) Mechanisms to inform patients and families of communication channels to voice their complaints and suggestions.
b) The process to manage Complaints according to the legal framework of psychiatric patient care laws and regulations.
c) Tracking processes for patients' and families' complaints and suggestions.
d) Patients' rights protection committee`s responsibility for investigating and responding to patients' complaints and suggestions.

e) The time frame for giving feedback to patients and families about voiced complaints or suggestions according to psychiatric patients' laws and regulations and the level of urgency of the complaint.

Survey process guide:

- The GAHAR surveyors may review the policy of managing patient complaints and suggestions.
- GAHRR surveyor may interview staff to check their awareness.
- The GAHAR surveyors may review the complaints logbook.

Evidence of compliance:

1. The mental health hospital has an approved policy that guides the process of managing complaints and suggestions from all served individuals as mentioned in the intent from a) through e).
2. The hospital allows the complaining and suggestion process to be publicly available.
3. Patients, families, and carers are allowed to provide suggestions and complaints.
4. Complaints are investigated, analyzed, and resolved in an approved timeframe.
5. Patients and families receive feedback about their complaints or suggestions within approved timeframes and according to the level of urgency of the complaint.

Related standards:

PCC.03 Patient, family, and carer rights, PCC.02 Patient-centered culture, PCC.09 Patient's belongings, STP.01Family involvement, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan

Access, Continuity, and Transition of Care

Chapter intent:

Access is the process by which a patient can start receiving healthcare services. Facilitating access to healthcare is concerned with helping people to command appropriate healthcare resources, in order to preserve or improve their health. Access is a complex concept, and at least four aspects require evaluation: Availability, Affordability, Acceptability, and Physical Accessibility.

Continuity of care becomes increasingly important for patients as community ages develop multiple morbidities and complex problems or include more patients who become socially or psychologically vulnerable.

Transitional care refers to the coordination and continuity of healthcare during a movement from one healthcare setting either to another one or to home, between healthcare professionals and settings as their condition and care needs change during the chronic or acute illness.

Globally, WHO presented the global framework for access to care announcing that All people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient, and acceptable; and all careers are motivated, skilled and operate in a supportive environment.

Locally, the Egyptian constitution focuses on the importance of granting access to healthcare services to all Egyptians with a special emphasis on providing emergency lifesaving care.

, Egyptian laws for establishing mental health hospitals defined the minimum requirements for licensure and access pathways. The medical code of ethics defined the framework of doctors' responsibilities toward patients. In addition, the Egyptian government has announced a major initiative to transform the healthcare Services in Egypt, where payers and healthcare professionals shall be separated, and a body of accreditation shall measure the quality of provided services. All this shall be under the umbrella of Universal Health Insurance, where eligibility criteria are set for patient access, and referral mechanisms shall be established.

Practically, Mental health hospitals need to consider all the accesses to services, even on the pre-mental health hospital level, when applicable. Building a Most Responsible Physician culture is important as well. Establishing organization policies on patient flows and studying the flow bottlenecks help organizations to better use available resources and safely handle patient journeys.

During a GAHAR survey, The GAHAR surveyors are going to assess the smooth flow of patients to/from the mental health hospital and assess the process and its implementation. In addition, they will be interviewing staff and reviewing documents related to the standards to assure that equity, effectiveness, and efficient process are in place.

Chapter purpose:
The main objectives of this chapter are:

1. To ensure that mental health hospitals provide and maintain equitable, effective access to patient care services in a safe and efficient way.
2. To describe the patient journey from start access to healthcare services through either the emergency room, outpatient department, admission office, daycare unit, or registration/admission offices.
3. To ensure assigning responsibility for the patient's plan of care all through the patient journey.
4. To develop a process to avoid risks that may arise when patients need to be physically transported from one place to another which may entail a risk of mishandling and missing some information
5. To document clear information, upon discharge, transfer, or referral to a service outside the mental health hospital

Implementation guiding documents:
(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Constitution
2) Egyptian Law for The Care of Psychiatric Patients, 71/2009
3) Law No. 210/2020 Amendment for Law of Psychiatric Patient Care, 71/2009.
4) Regulations for The Care of Psychiatric Patients,128/2010
5) Regulations for The Care of Psychiatric Patients, 55/2021
6) Universal Health Insurance Law, 2/2018
7) Prime Minister Decree for Management Of Emergency Cases Number1063/2014
8) Rights of the Handicapped Law, 10/2018
9) Egyptian Code of Building for Handicapped
10) Nursing Syndicate Publications – Nursing Guidelines
11) Law 51/1981 Amended by Law 153/2004, Healthcare Facilities Organization
12) MOH Ministerial Decree Discharge Summary Requirements, 254/2001
13) MOH Ministerial Decree for Medical Reports Regulations Number 187/2001
14) The Transition of Care, WHO, 2016

Effective and safe patient flow in the hospital

ACT.01 The Mental health hospital grants patients access to its services according to pre-set eligibility criteria.

Patient-centeredness

Keywords:
Granting access.

Intent:
Services available shall be relevant and effective for the served population to gain access to satisfactory health outcomes. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs, and material and cultural settings of diverse groups in society. Pre-set criteria need to be available for those responsible for granting access to patients. In order to improve accessibility to mental health hospital services, patients and families should be well informed about the available services.
The Mental health hospital shall develop and implement a policy and procedures to guide the process of patient granting access. The policy addresses at least the following:

a) Services availability is based on the types of patient admissions and in accordance with the psychiatric patients' laws and regulations (e.g. Compulsory – voluntary)
b) The process of general, non-specific screening of patients aims to determine whether the mental health hospital's scope of services can meet their healthcare needs.
c) How to inform patients of the accessibility methods.
d) Actions to be taken if the patient's needs do not match the mental health hospital's scope of service

Survey process guide:

- The GAHAR surveyors may review the policy guiding the patient granting access process and may interview staff to check their awareness.
- The GAHAR surveyors may observe the process for informing patients about the criteria of granting access at the point of the first contact in the mental health hospital (such as service desks, receptions, call centers, emergency rooms, and outpatient areas).

Evidence of compliance:

1. The mental health hospital has an approved policy for granting access to patients that addresses all elements mentioned in the intent from a) through d).
2. The relevant staff is aware of the mental health hospital policy for granting access.
3. Patients are referred and/or transferred to other healthcare organizations when healthcare needs are not matching the mental health hospital's scope of service.

Related standards:
PCC.01 Mental health hospital advertisement, ACT.05 Patient flow, and uniform access, PCC.03 Patient, family and carer rights, OGM.04 Scope of services, ACT.03 Physical access and comfort, ICD.04 Screening of patient's healthcare needs,

ACT.02 NSR.01 Accurate patient identification through at least two unique identifiers to identify the patient and all elements associated with his/her plan of care.'

Safety

Keywords:
Patient Identification.

Intent:
It is noteworthy that correctly identifying patients is the guarantee that treatment will be provided to the right person, as it prevents the risks of incidents and reduces the chances for errors, which can occur at any time during mental health hospitalization. However, in the context of psychiatry, there are difficulties in the practical application of what is proposed by the guidelines for patient safety programs, and it is necessary to adopt a specific, innovative method of identification and tool such as the Photographic bracelet.
Using two identifiers for each patient is the key driver in minimizing such preventable errors, which is especially important with the administration of high-alert medications or performing high-risk procedures. The mental health hospital shall develop and implement a policy and procedures to guide the process of patient identification. The policy shall address at least the following:

a. Two unique identifiers (personal).
b. Elements associated with care such as medications, clinical specimens, and providing any other treatments or procedures
c. Occasions when verification of patient identification is required.
d. Method/tool used for patient identification which is convenient to the patient current medical condition.
e. The exclusion criteria for patient identification such as the patient's bed number, patient room number, and others.
f. Special situations when patient identification may not follow the same process, such as unknown patients and agitated patient

Survey process guide:

- The GAHAR surveyors may review the patient identification policy.
- The GAHAR surveyors may review a sample of medical records and check correct patient identification on each sheet as per mental health hospital policy.
- The GAHAR surveyors may interview the healthcare professionals, to check their awareness.
- The GAHAR surveyors may observe patient identification methods/tools for the two identifiers and observe the patient identification process before any planned procedures or care.

Evidence of compliance:

1. The mental health hospital has an approved policy and procedure for patient identification that addresses all elements mentioned in the intent from a) through f).
2. All healthcare professionals are fully aware of the patient identification policy.
3. The patient's identifiers are recorded on each sheet of the patient's medical record.
4. The mental health hospital tracks, collects, analyzes, and reports data on the staff's compliance with the patient's identification process.
5. Corrective actions are taken in accordance with the findings and results of the patient identification compliance monitoring process.

Related standards:
MHP.14 Time-out, IMT.06 Patient's medical record management, MMS.08 Medication safe ordering, prescribing, transcribing, DAS.04 Medical imaging pre-examination process DAS.11 Pre-examination process, Specimen reception, tracking, and storage, ACT.11 Patient's

Transfer and referral, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement

Effective and safe patient flow within the hospital

ACT.03 The mental health hospital works in collaboration with other community stakeholders to provide physical comfort and easy physical access.

Patient-Centeredness

Keywords:
Physical access and comfort.

Intent:
Community members often encounter barriers to healthcare that limit their ability to obtain the care they need. In order to have sufficient access, necessary and appropriate healthcare services should be available and obtainable in a defined timeframe manner. Even when an adequate supply of healthcare services exists in the community, there are other factors to consider in terms of healthcare access. For instance, to have good healthcare access, a patient should also have the means to reach and use services, such as transportation to services that may be located at a distance. The mental health hospital aiming at achieving accreditation may work with external community authorities or agencies to ensure the availability of public transportation access, ramps, and paths for wheelchairs and trollies.

Survey process guide:

- The GAHAR surveyors may observe the mental health hospital access, identifying potential blockages of access such as the absence of nearby public transportation, the presence of a physical barrier like a canal, or even the absence of clear signs to direct patients in.
- The GAHAR surveyors may observe the availability of measures such as ramps, wheelchairs, and trollies.

Evidence of compliance:

1. The mental health hospital has a defined process that guides safe physical access through multiple means of transportation, either private, public, or both.
2. Mental health hospital services are accessible for patients, especially those with disabilities.
3. Measures such as ramps, wheelchairs, and trollies are available for served patients.
4. Barriers to access the hospital services are identified and proper corrective actions are taken.

Related standards:
ACT.01Granting access, ACT.05 Patient flow, and uniform access, EFS.01 Mental health hospital environment and facility safety structure.

ACT.04 Appropriate and clear wayfinding signage is used to help patients and families/ carers reach their destination inside the mental health hospital.

Safety

Keywords:
Wayfinding signage.

Intent:
Wayfinding systems aim to help the mental health hospital to reduce their patients' stress by providing easy-to-follow signage and legible directions to their destinations. Wayfinding

signage is important for prospective patients as they need to find their way and its design should be suitable for all types of patients, good lighting is very important. Signage needs to be readable in different lighting conditions and different weathers (if the signage is used outdoors). In some settings, reliance on text-based signs is minimized, and systems rely heavily on non-text signs such as colors and symbols.

Survey process guide:

- The GAHAR surveyors may observe wayfinding signs' readability, clarity, and acceptability. Wayfinding signs may include all those signs encountered by patients during their journey in the mental health hospital.

Evidence of compliance:

1. Clear, readable, illuminated wayfinding signs are used in all relevant places and areas during working hours to reduce patient and family confusion.
2. When color-coded signage is used, clear instructions on what each color means should be available.
3. The staff is fully aware of the wayfinding signage used.

Related standards:
PCC.03 Patient, family, and carer rights, ACT.05 Patient's flow and uniform access, EFS.01 Mental health hospital environment and facility safety structure.

ACT.05 Patient flow in the mental health hospital is designed to ensure providing efficient care and uniform access based on the needs of the patient.

Efficiency

Keywords:
Patient flow and uniform access.

Intent:
Patient flow is defined as the movement of patients between departments, and staff groups in the mental health hospital as part of a patient care pathway. The patient flow needs to be managed well for mental health hospitals to be efficient. For example, patients with or without an appointment, patients who are ill and possibly infectious to other patients and staff, or patients with emergency needs that require stabilization and transfer all need to be managed efficiently. If reception/registration staff are to make decisions consistently and rapidly, they need to be supported with decision criteria and other tools to manage those patients in a timely, effective way. As reception/registration staff are often the first persons whom patients encounter, simple criteria are useful to identify patients who may need immediate assistance and when the medical staff should be notified. When there is a delay in care or treatment, or there are known long waiting periods for diagnostic and/or treatment services that require the patient to be placed on a waiting list, the patient is informed of the reasons for the delay or wait and informed of available alternatives

Survey process guide:

- The GAHAR surveyors may review the process for registering patients.
- The GAHAR surveyors may interview staff to ask about how to inform patients of the reasons for the delay or wait.

Evidence of compliance:

1. There is a standardized process in place for registering patients based on the scope of services provided.
2. The registration process is managed to give priority to patients with urgent needs.

3. When there will be a delay in care and/or treatment, the patient is informed of the reasons for the delay or wait.
4. Patients are provided with information on available alternatives consistent with their clinical needs.

Related standards:
PCC.03 Patient, family, and carer rights, ACT.01Granting access, ACT.03 Physical access and comfort, ACT.04 Wayfinding signage, ACT.06 Coordination and continuity of care, ACT.09 Patient Transportation, EFS.01 Mental health hospital environment and facility safety structure.

ACT.06 The mental health hospital designs and carries out processes to ensure the continuity of patient care services.

Patient-Centeredness

Keywords:
Coordination and continuity of care.

Intent:
Throughout all phases of access to care and continuity of care, patient needs are matched with the required resources within the mental health hospital or outside when necessary. Continuity is enhanced when healthcare professionals get the required information from patients about the current situation and past history that will help in patient diagnosis and decision-making. For patient care to appear seamless, the mental health hospital needs to design and implement processes for continuity and coordination of care, prioritize patient clinical needs, setting criteria for the patient end of care or transfer/referral process.
The responsible staff works together to design and implement the processes of care coordination and continuity. These processes may be supported with the use of tools such as guidelines, clinical pathways, care plans, referral forms, and checklists.
Mental health hospitals shall offer care to patients whose needs can be met within the capabilities of the hospital' staff and scope of services. Appropriateness of care shall be based upon patient assessments, re-assessments, and desired outcomes. Provided care shall be uniform for all ages regardless of national or ethnic origin, economic status, lifestyle, or beliefs.
The mental health hospital shall develop a policy that addresses all the above-mentioned components of continuity of care, including patients' referrals when their needs do not match the hospital's scope of services.

Survey process guide:
- The GAHAR surveyors may review the coordination and continuity of care policy that describes the components of continuity of care, including patients' referrals when their needs do not match the hospital's scope of services.
- The GAHAR surveyors may interview healthcare professionals to check their awareness.
- The GAHAR surveyors may review patients' medical records to evaluate the documentation of all phases of patient care.

Evidence of compliance:
1. The mental health hospital has an approved policy that addresses all components of coordination and continuity of care.
2. Continuity and coordination of care are evidenced and documented throughout all phases of patient care.

3. The patient's medical record(s) is available and categorized to involve and document all phases of patient care.

Related standards:
ACT.01Granting access, ACT.05 Patient's flow, and uniform access, ACT.08 Handover communication, ACT.11 Patient's Transfer and referral, ACT.07 Patient Care Responsibility ACT.10 Patient's Discharge, ICD.01 Uniform care provision, STP.01 Family involvement, ICD.13 Plan of Care.

ACT.07 The mental health hospital ensures safe, effective, and clear responsibilities for patient care.

Safety

Keywords:
Patient Care Responsibility.

Intent:
Patients often require concurrent care from more than one healthcare professional in mental health hospitals and healthcare institutions. The term *most responsible physician* (MRP) in mental health hospitals refers to the licensed psychiatrist who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time. Misunderstandings about who among the healthcare team is responsible for a patient's care may compromise that care and may result in an adverse event and increased medico-legal risk

The mental health hospital shall identify the most responsible physician who shall properly manage handovers of care to reduce the possible medico-legal risks that arise and prevent potential breakdowns in the chain of communication between both patients and healthcare providers. The identity of who will act as an MRP for a patient should be determined early and based on the particular circumstances of each case. It should be clear in the patient's medical record, that the physician is designated as the MRP.

The mental health hospital shall develop and implement a policy and procedures to guide the process of assigning patient care responsibility. The policy shall address at least the following:

a) Each mental health hospitalized patient is assigned to one Most Responsible Physician (MRP) as relevant to a patient's clinical condition and with respect to the patient's preferences.
b) Conditions to request and grant transfer of care responsibility.
c) How information about assessment and care plan, including pending steps, shall be transferred from the first most responsible physician to the next one(handover).
d) The process to ensure clear identification of responsibility between the transfer of responsible parties.

Survey process guide:
- The GAHAR surveyors may review the policy for assigning patient care responsibility.
- The GAHAR surveyors may observe the process of transfer of care responsibility.
- The GAHAR surveyors may review a sample of medical records to verify that the process of assigning patient care responsibility met the hospital's policy.

Evidence of compliance:
1. The mental health hospital has an approved policy and procedure for assigning care responsibility that covers all components mentioned in the intent from a) through d).
2. The patient's medical record identifies the most responsible physician who has overall responsibility for directing and coordinating patient care and management.

3. In cases of transfer of care responsibility, clear handover is signed by the most responsible physician and documented in the patient medical record.

Related standards:
PCC.03 Patient, family, and carer rights, ACT.06 Coordination and continuity of care, ACT.08 Handover communication, ACT.11 Patient's Transfer and referral, WFM.03 Job Description, IMT.01 Document management system.

ACT.08 NSR.06 the mental health hospital ensures standardized accurate and complete handover of the communication process

Safety

Keywords:
Handover communication.

Intent:
The primary objective of a 'handover' is the direct transmission of accurate patient care information among staff members to ensure the continuity of care. Moreover, it provides a chance for clarification, which subsequently decreases medical errors. Handovers of patient care within the mental health hospital occur in:

I. Between healthcare professionals (for example, physician to physician, and so forth);
II. Between different levels of care (for example, when transferring a patient from the mental health hospital to the general hospital)
III. From one department to another

The mental health hospital shall develop and implement policy and procedures to guide the process of handover communication. The policy shall address at least the following:

a) Use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care; such as SBAR, ISOBAR, I PASS the BATON, and others.
b) Situations that require implementing a handover process and tools
c) Assigning Staff responsibilities.
d) Tools used for documenting and recording the handover process, such as handover logbook, endorsement form, electronic Handover tool, and/or other methods.

Survey process guide:

- The GAHAR surveyors may review the policy of handover communication and check the process implementation.
- The GAHAR surveyors may review medical records, handover logbooks, endorsement forms, and/or other methods as evidence of implementation.
- The GAHAR surveyors may interview staff to check their awareness of handover policy and procedures.

Evidence of compliance:

1. The mental health hospital has an approved policy that addresses all elements mentioned in the intent from a) through d).
2. All healthcare professionals are aware of how to apply the handover policy.
3. Handover communications records are available as per the hospital's policy.
4. The mental health hospital tracks, collect, analyzes, and reports data on the handover communication process.

5. The mental health hospital acts on the findings and results identified in the handover communication process and uses it in improvement opportunities

Related standards:
ACT.06 Coordination and continuity of care, ACT.11 Patient's Transfer and referral, ICD.01 Uniform care provision, ICD.15 verbal and telephone orders, ICD.16 critical results.

ACT.09 The mental health hospital ensures that the transportation services provided meet requirements for quality and safe transport.

Safety

Keywords:
Patient Transportation.

Intent:
Transportation means safe patient handling either intra-facility or inter-facility. It may involve the transfer of patients within the same facility for any diagnostic procedure or transfer to another facility with more advanced care. The mental health hospital shall coordinate patient transportation between mental health hospital departments and services and between it and other facilities. Patient transportation shall be facilitated and coordinated within the available services and resources to meet patient needs within an approved time frame.
The mental health hospital shall develop and implement a policy and procedures for managing patient transportation. The policy shall address at least the following:

a) Safe patient handling process, especially the agitated patients and patients after ECT sessions.
b) Measures to maintain staff safety while handling patients, especially agitated patients.
c) Coordination mechanism to ensure safe transportation within the approved timeframe, especially in critical conditions.
d) Competency of responsible staff members during the transportation of patients.
e) Defined criteria to determine the appropriateness of transportation means within or outside the mental health hospital.
f) In situations when accompanying persons/ family members, the carer is needed during the transport of the patient.

Survey process guide:

- The GAHAR surveyors may review the policy that manages patients' transportation process and may interview responsible staff to check their awareness.
- The GAHAR surveyors may observe the different means of transportation and the used mechanisms for patient lifting.

Evidence of compliance:

1. The mental health hospital has an approved policy of patient transfer that addresses all elements mentioned in the intent from a) through f).
2. All staff members involved in the transportation of patients are aware of how to apply the policy.
3. Staff responsible for monitoring the patient during transportation are qualified according to the type of patient being transferred.
4. The means of transportation are determined based on the patient's needs, preferences, and current conditions.
5. All documents used during transporting patients (especially in critical conditions) are timely recorded in the patient's medical records.

Related standards:
ACT.06 Coordination and continuity of care, ACT.11 Patient's Transfer and referral, ACT.05 Patient's flow and uniform access, EFS.01 Mental health hospital environment and facility safety structure, ACT.03 Physical access and comfort.

Effective and safe patients flow out of the hospital

ACT.10 The mental health hospital ensures that the discharge of the patients is safe and appropriate to their current conditions.

Safety

Keywords:
Patient's Discharge.

Intent:
Discharge from the mental health hospital is the point at which the patient leaves the mental health hospital and returns home. Types of discharge shall apply to all types of psychiatric patients, either restricted or unrestricted patients. Complete or full discharge is a discharge of the unrestricted patients completely, with no conditions or liability to be recalled while the conditioned discharge starts when a mental healthcare provider decides that a patient can be discharged from the mental healthcare facility subjected to conditions that must be adhered to according to the psychiatric patient care law.
Some patients may require a brief time off and community involvement during their care (especially if under the compulsory admission rules) hence, mental health hospitals may grant a temporary conditioned discharge to patients to the extent reasonably possible and without compromising the quality of healthcare delivered and the desired outcome. A conditioned discharge is not time limited. This means the conditions will stay in place unless the person is successful in being absolutely discharged.
The mental health hospital shall develop and implement policies and procedures for managing patient discharge. The policy shall address at least the following:

a. Obligations that determine the type of patient discharge in compliance with national psychiatric patient care law.
b. Situations when patient discharge is preferred and do not pose a threat to the others
c. The need to present an accompanying person /carer before requesting the discharge.
d. Situations when a Discharge Consent from the accompanying person is a required or a must by the national mental health act.
e. Documentation required for an accurate, valid discharge order includes at least the following:
    i. A signature of the qualified staff individual who is authorized to order the discharge.
    ii. Reasons and type of discharge
    iii. Date, time of beginning, and period of discharge
    iv. Name and contact details of the accompanying person (family member, carer. etc.) who is responsible for the patient after discharge.
    v. Destination on temporary, conditioned discharge
    vi. Instructions and precautions to be taken during temporary discharge
    vii. Patient's community involvement plan and follow-up visits.
f. Effective, complete patient and family/ carer education prior to the patient discharge and consequences of not returning.
g. Actions to be taken if the patient misses a follow-up appointment visit or doesn't return to the hospital after the temporary, conditioned discharge with consideration given to the relevant laws and regulations and individual patient risks and needs.

Survey process guide:

- The GAHAR surveyors may review the discharge policy and may interview staff to check their awareness.
- The GAHAR surveyors may review a sample of patients' medical records to assess the completion of documentation of discharge orders.
- The GAHAR surveyors may assess the taken process to ensure patient safe return and compliance with the follow-up appointment.

Evidence of compliance:

1. The mental health hospital has an approved policy that addresses all elements mentioned in the intent from a) through g).
2. All relevant staff members are aware of how to apply the policy.
3. All documentation requirements of discharge orders are recorded in the patient medical record.
4. The mental health hospital has a defined process to ensure the patient safe return and full compliance with the follow-up appointments.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.06 Patient, family and carer education process, ACT.07 Patient Care Responsibility, ACT.09 Patient Transportation, STP.01 Family involvement, , IMT.01 Document management system, ICD.13 Plan of Care.

ACT.11 The mental health hospital ensures that the transfer and referral of patients meet their needs and ensures the continuity of care provided.

Safety

Keywords:
Patient's Transfer and referral.

Intent:
A referral is when the patient leaves the mental health hospital to seek additional medical care temporarily in another organization. A transfer is when the patient leaves the mental health hospital and gets transferred to another organization, such as a tertiary care organization, rehabilitation center, or nursing home.
Referral and transfer involve the medical instructions that the patient will need to fully recover. For mental health hospitals, an effective patient referral system is an integral way of ensuring that patients receive optimal care at the right time and the appropriate level, as well as cementing professional relationships throughout the healthcare community.
Recording and responding to referral feedback ensures continuity of care and completes the cycle of referral.
The mental health hospital shall develop and implement policy and procedures to guarantee the appropriate patient referral and transfer within an approved timeframe, which is based on the identified patient's needs and guided by clinical guidelines/protocols.
The referral, and/or transfer policy addresses at least the following:

a. Situations when transfer and/or referral are permitted or indicated, based on the hospital-approved scope of service and the patient's needs for continuing care.
b. Determine who is responsible for the patient during transfer and/or refer
c. Actions to be taken when transferring and/or referring is not possible
d. The referral/transfer process documentation requirements include at least the following:
    I. Reason for referral/transfer.
    II. Collected information through assessments and care.
    III. Medications and provided treatments.

IV. Transportation means and required monitoring.
V. Condition on referral/transfer.
VI. Destination on referral/transfer.
VII. Name and signature of the medical staff member who decided the patient referral/transfer and medical staff member who is responsible to monitor the patient during transfer and/or refer.
VIII. Any special instructions for the patient.
IX. Contact details of the patient and his accompanying person
X. Referral/transfer' date and time.
XI. Any special conditions happened during the patient's referral and/or transfer.

e. Qualification of individuals responsible for ordering, executing, and monitoring the referral, and/or transfer out of patients.
f. Coordination with transfer/ referral agencies, if applicable, other levels of health service, and other organizations.

Survey process guide:

- The GAHAR surveyors may review the transfer/ referral policy and may interview staff to check their awareness.
- The GAHAR surveyors may review a sample of patients' medical records to assess the completion of documentation of the transfer/ referral process.

Evidence of compliance:

1. Mental health hospital has an approved policy that addresses all elements mentioned in the intent from a) through f).
2. Relevant staff members are aware of how to apply the policy.
3. There is documented evidence of an arrangement with the receiving organization is in place, prior to the patient's transfer or/and referral.
4. The referral, and/or transfer out order is clearly recorded in the patient's medical record using all the required elements from I) through XI).
5. The referral and/or transfer feedback is reviewed, signed, and recorded in the patient's medical record.

Related standards:
ACT.06 Coordination and continuity of care, PCC.03 Patient, family, and carer rights, IMT.01 Document management system, ACT.05 Patient's flow and uniform access, ACT.07 Patient Care Responsibility, ACT.09 Patient Transportation, ICD.03 Clinical practice guidelines

ACT.12 The mental health hospital provides a written summary of patients' clinical and non-clinical conditions and the care provided.

Effectiveness

Keywords:
Discharge summary.

Intent:
To ensure continuity of care and services, patient information is transferred with the patient when possible. When the mental health hospital arranges for the transfer, a copy of a written clinical and nonclinical summary is provided to the receiving organization with the patient or his designee, and a second copy of the discharge summary shall be kept in the patient's medical record. This summary is prepared by a healthcare professional at the conclusion of a stay in the mental health hospital or series of treatments. It is often the primary mode of communication between the mental health hospital care team and aftercare healthcare

professionals. It is considered a legal document, and it has the potential to jeopardize the patient's care if errors are made. The discharge summary shall include at least the following:

a) The reason for mental health hospitalization.
b) Provisional and/or final diagnosis.
c) Investigations.
d) Significant findings.
e) Procedures performed.
f) Medications (before/during and after mental health hospitalization) and allergies.
g) Patient's condition and disposition at transfer, refer or discharge.
h) Personnel instructions, including diet, medications, and follow-up instructions.
i) Name of the medical staff member who transfer, refer, or discharged the patient.

Survey process guide:

- The GAHAR surveyors may perform a closed medical records review for patients who were discharged to assess the completeness of the discharge summary.
- The GAHAR surveyors may also interview healthcare professionals to check their awareness.

Evidence of compliance:

1. The discharge summary includes all elements mentioned in the intent from a) through i).
2. Relevant staff members are aware of how to obtain a discharge summary.
3. A copy of the discharge summary is kept in the patient's medical record.

Related standards:

PCC.03 Patient, family, and carer rights, IMT.03 Standardized symbols and Abbreviations, ACT.11 Patient's Transfer and referral, IMT.01 Document management system, ACT.06 Coordination and continuity of care.

Integrated Care Delivery

Chapter intent:

Screening is a strategy used in a population to identify the possible presence of an as-yet-undiagnosed disease in patients without signs or symptoms by performing a high-level evaluation of patients to determine whether a further deeper assessment is required. It is a crucial step to save resources and time.

Assessment is a structured deeper process when a patient is checked holistically by listening to the patient's complaint, obtaining further information about illness history, and performance of observation. Clinical judgment should be used to decide on the extent of the assessment required. Mental health hospitals define the minimum contents of initial and subsequent assessments. This process starts with collecting enough relevant information to allow healthcare professionals to draw pertinent conclusions about the patient's strengths, deficits, risks, and problems. In addition to understanding the meaning of signs and symptoms, Healthcare professionals are distinguishing real problems from normal variations, identifying the need for additional analysis and intervention, distinguishing, and linking physical, functional, and psychosocial causes and consequences of illness and dysfunction, and identifying a patient's values, goals, wishes, and prognosis. Taken together, this information enables pertinent, individualized care plans and interventions.

Individualized care plans are developed by multiple disciplines after the collection of patients' needs. Literature shows that this concept helps to coordinate care, to improve healthcare service utilization, and to reduce costs at hospitals. It also improves patient, family, and carer satisfaction and engagement.

The assessment and management of certain categories of patients may differ in their content and scope from the regular processes. Mental health hospitals shall clearly identify, assess, and manage these categories of patients accordingly. To fight drug abuse and addiction, specific assessment is required to ensure a proper plan of care is in place that individually assists patients in their journey to social and psychological well-being.

The Egyptian government has announced a major initiative to transform the healthcare industry in Egypt, where payers and providers shall be separated, and a body of accreditation shall measure the quality of provided services. All this shall be under the umbrella of Universal Health Insurance, where defined eligibility criteria are set for patients, and access and referral mechanisms shall be developed.

Mental health hospitals need to comply with national laws and regulations that maintain and organize the new healthcare initiative

Chapter purpose:

1. To emphasize, the uniformity of care through the description of simple screening, assessment, and care provided to the patient at the first point of contact with the mental health hospital.
2. To describe the basic screening, assessment, reassessment, and care processes.
3. To highlight the need for special forms of assessments and care processes based on the patient's needs or patient risks.
4. To describe situations that need care plan changes or request further consultation and the clear process needed to be followed.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Constitution
2) Egyptian code of medical ethics 238/2003 (Medical Syndicate Publications)
3) Egyptian code of nursing ethics (Nursing Syndicate Publications)
4) Egyptian law for the care of psychiatric patients, 71/2009
5) Law no. 210/2020 amendment for the law of psychiatric patient care, 71/2009.
6) Regulations for the care of psychiatric patients,128/2010
7) Regulations for the care of psychiatric patients, 55/2021
8) Law 51/1981 amended by law 153/2004, Healthcare facilities organization
9) Egyptian Children Protection Law number126/2008
10) Rights of the Handicapped law, 10/2018
11) Prime Minister decree for management of emergency cases number1063/2014
12) Emergency Department unified protocol, Egyptian ministry of health and population curative and critical sector
13) Managing victims of social abuse guidelines – ministry of health, UNFPA 2014
14) Core Standards for Intensive Care Units 2013
15) ASAM Standards of Care: For The Addiction Specialist Physician, 2014
16) International Standards for the Treatment of Drug Use Disorders2017/2020 UNODC.
17) Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)2018
18) Standards for Inpatient Mental Health Services Third edition, 2019. Royal College of Psychiatrists

Sustaining uniform care

ICD.01 The mental health hospital has a uniform process for care provision and treatment.

Equity

Keywords:
Uniform care provision.

Intent:
The mental health hospital similarly treats similar patients regardless of their different backgrounds (such as religion, economic class, literacy level, race, language, etc.), and regardless of the location or the time, the patients receive their care. Mental health hospitals are expected not to discriminate between patients and provide them with uniform medical care per their clinical requirements. Mental health hospitals can demonstrate a similar level of compliance across all departments and services.
The mental health hospitals shall demonstrate a uniform process when a service is provided in a department under the supervision of another department (such as complying with anesthesia protocols even if anesthesia services are provided outside the specific units).
To carry out the principle of uniform care requires that the hospital's leaders plan and coordinate the provision of care and standardize care processes. To ensure this, the mental health hospital shall develop a policy that specifies what constitutes uniform care and what practices can be followed to ensure that patients are not discriminated based on their background or category of their accommodation. Describe a clear process for addressing and reporting discrimination and harassment, if any.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for uniform care provision.
- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may observe and assess the uniformity of similar care in the different places in the mental health hospital.

Evidence of compliance:

1. The mental health hospital has an approved policy for the uniform care provision process.
2. When similar care is provided in more than one place in the organization or more than one site, care delivery is uniform.
3. There is a clear process that explains options for addressing discrimination and\or harassment and describes methods of investigations and reporting, if any.
4. All staff members involved in patient care are aware of the hospital policy.

Related standards:
PCC.03 Patient, family and carer rights, PCC.09 Patient's belongings, ACT.01 Granting access, PCC.11 Complaints and suggestions, ACT.06 Coordination and continuity of care, ICD.03 Clinical practice guidelines,

Ensuring safe pre-hospitalization services

ICD.02 The mental health hospital ensures that pre-hospitalization services are safe, and comply with laws and regulations

Safety

Keywords:
Pre-hospitalization services.

Intent:
A psychiatric emergency refers to any disturbances in a patient's thinking, emotions, or behavior that requires immediate intervention such as suicidality, psychotic episodes, major depressive disorder, alcohol and substance abuse disorders, bipolar mood disorder, and homicidal or aggressive patients. This disruption usually puts patients in critical conditions, which can put them, their families, and the people around them in danger. There is a noticeable increase in the need to provide a service that is safe and available to transport patients to mental health hospitals.

Pre-hospital care shall be safe and delivered according to the applicable laws and regulations. During pre-hospital care, the patient's vital signs and evidence of life-threatening disorders shall be examined. Impairment of the judgment and lack of co-operation in psychiatric patients can worsen the situation. Pre-hospital care is provided by emergency medical responders, who are the initial healthcare professionals who contact the patient before transferring to the hospital. The mental health hospitals might owe ambulances or contract another organization for the sourcing of ambulance services. This does not apply to the national ambulance system. The mental health hospital shall develop and implement a policy and procedures for pre-hospital care. The policy shall address at least the following:

a) Provision, operation, or sourcing of ambulance services.
b) Continuous readiness.
c) The time frame for receiving calls, dispatching vehicles, and reaching patients.
d) Screening, assessment, and reassessment of patients.
e) Care protocols for patients at the scene and during transfer.
f) Parsons responsible for the completeness of request forms
g) Drill and its frequency.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for pre-hospital care.
- The GAHAR surveyors may interview staff members to check their awareness of the policy.
- The GAHAR surveyors may review a patient's medical record and logbook to evaluate their completeness.

Evidence of compliance:

1. The mental health hospital has an approved policy that covers all elements mentioned in the intent from a) through g).
2. Emergency staff members are aware of how to apply policy.
3. Drills are performed on regular basis to ensure continuous readiness, the drill frequency is determined in the hospital policy.
4. Pre-hospital care records are completed and kept in the patient's medical record.
5. The response time is recorded and monitored, related findings are immediately acted upon.

Related standards:
ICD.03 Clinical practice guidelines, ICD.04 Screening of patient's healthcare needs, ACT.06 Coordination and continuity of care, ICD.21 Emergency Services, EFS.13 Emergency preparedness plan, ICD.20 Cardiopulmonary resuscitation and medical emergencies.

Clinical guidelines selection, development, and use

ICD.03 The mental health hospital ensures that the process of clinical practice guidelines' selection, development, and consistent use is strictly followed and implemented.

Effectiveness

Keywords:
Clinical practice guidelines.

Intent:
Clinical practice guidelines are statements that include recommendations intended to optimize patient care and reduce process variations. Promoting the uptake and use of clinical guidelines at the point of care delivery represents a final translation hurdle to move scientific findings into practice. The mental health hospital shall select guidelines from among those applicable to the services and patient population; it should formally be approved or adopted from an authoritative source. Any mandatory national guidelines shall be included in this process, if present the mental health hospital's leaders shall periodically measure the consistent use and effectiveness of the implemented guidelines. The mental health hospital shall develop a policy and procedure for clinical guidelines adaptation and adoption.
The policy addresses at least the following:

a) Selection criteria of clinical practice guidelines.
b) How clinical practice guidelines/protocols implementation is monitored and evaluated
c) Staff training is required to apply the selected guidelines, pathways, or protocols
d) Periodic update of clinical practice guidelines based on changes in the evidence and evaluation of processes and outcomes.

A clinical care standard is a small number of quality statements that describe how the care of patients should be offered by healthcare professionals for a specific clinical condition or defined clinical pathway in line with current best evidence. The mental healthcare hospital shall ensure that clinical care standards are used when indicated and identify the list of the applicable clinical care standards and set certain criteria to monitor its implementation.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyors may review medical records to check the implementation of clinical practice guidelines.
- The GAHAR surveyors may review a sample of staff files to check for the training records.

Evidence of compliance:

1 The mental health hospital has an approved policy of the clinical practice guidelines that guides all the elements mentioned in the intent from a) through d).
2 Responsible staff is trained on the implementation of the relevant approved clinical guidelines.
3 The approved list of clinical care standards is available, and easily accessible when needed.
4 Compliance with clinical guidelines is linked to staff performance evaluation and appraisal processes.

Related standards:
ICD.01 Uniform care provision, ACT.06 Coordination and continuity of care, WFM.08 Staff Performance Evaluation, WFM.07 continuous education and training program, QPI.08 Performance improvement and patient safety plan, WFM.07 Continuous education, and training program.

Effective patient screening, assessment, and care

ICD.04 Patients' healthcare needs are identified according to defined screening processes.

Effectiveness

Keywords:
Screening of patient's healthcare needs.

Intent:
Screening in general is performing a very simple, quick, high-level evaluation of a patient to determine if the patient exhibits a risk that might indicate the need for a more in-depth assessment. The screening criteria are developed by qualified individuals able to refer for further assessment. Initial medical and/or nursing screening helps to determine the need for further in-depth assessment or not such as nutritional, functional, and special needs assessments.
A Qualified individual shall perform the screenings, and when the need for additional specialized assessments is identified, patients shall be referred within the hospital or to outside services in the community with referral feedback for appropriate follow-up.
In addition, psychological and socioeconomic screening may help to early identify any behavioral issues and social determinants of health, the mental health hospital shall consider the main, critical types of the screening process as recommended by best practice, which shall include at least the following:

i. Mental capacity status
ii. Suicide risks
iii. Signs of substance abuse
iv. Signs of abuse and neglect
v. Special needs population
vi. Nutritional status
vii. Functional status
viii. Socioeconomic status

Moreover, the mental health hospital shall develop a policy to guide the screening process; the screening policy addresses at least the following:

a) Define screening criteria for assessing the patient's needs.
b) Determine who is responsible to perform the screenings and the related further assessments, when needed.
c) Timeframe to complete the patient screening.
d) Identifying the process when further assessment by a specific specialty or sub-specialty is needed.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy of Screening healthcare needs and may interview staff members to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the completeness of screening documentation.

Evidence of compliance:

1. The mental health hospital has an approved screening policy that guides screening for patients' needs including elements in the intent from a) through d).
2. All staff who perform the screening process are qualified and trained to do so.
3. All screening records are completed and documented within an approved timeframe as per hospital policy.
4. Patients' referrals for further assessment by the specific specialty or sub-specialty are completed and documented in the patient's medical record.

Related standards:
ACT.01 granting access, ICD.05 Patient medical assessments, ICD.08 Special patient populations, STP.01 Family involvement, WFM.03 Job Description, ICD.10 Fall screening and prevention, ICD.07 Pain screening and assessment, ICD.09Victim of abuse and neglect, ICD.11 Pressure Ulcers, ICD.12 Venous Thromboembolism Prophylaxis.

ICD.05 The mental health hospital ensures that a comprehensive, effective patient assessment process is implemented

Effectiveness

Keywords:
Patient medical assessments.

Intent:
The initial medical and nursing assessments are considered the basis of all medical care decisions, it aids in the determination of the severity of a condition of mental illness, and it helps in prioritizing the initial clinical interventions. The goal of initial medical and nursing assessments is to:

I. Collecting information and data on the patient's physical, psychological, and socioeconomic status, and health history from the screening tools and procedures
II. Analyzing the data and information, including the results of diagnostic investigations, to identify the current patient's health care needs
III. Establishing a plan of care to meet the patient's identified need and assess the patient's needs for discharge, referral, or transfer

Initial medical and nursing assessments and any other specialty or subspeciality assessments shall be standardized, comprehensive, detailed, and completed within a specific time span that doesn't exceed 24 hours in elective cases and less time is needed in urgent or emergent cases to achieve high-quality care that fulfills patient needs.
The mental health hospital shall develop and implement a policy and procedures to define the acceptance criteria and the minimum contents of the initial medical and nursing assessments. the initial medical and nursing assessments and reassessments shall include at least the following:

a) Define the minimum content of the initial medical and nursing assessment forms that are consistent and developed by different specialties and in different locations.
b) Determine the need for discharge planning in the initial assessments
c) Define measures to be followed if specific further assessments are needed. (When the initial screening labels the patient "at risk" for the screening elements).
d) Determine the timeframe for completing the initial assessments and situations when to consider the initial assessments not valid.
e) Frequency of re-assessments based on the severity of the patient's condition with respect to the validity period of the initial assessments as determined by hospital policy.
f) Determine who is responsible to develop and perform the assessments and reassessments. Each discipline within its scope of practice, licensure, and certification in accordance with the applicable laws and regulations shall participate in the assessment and reassessment process.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the initial medical and nursing assessment and reassessment process and may interview staff members to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the completeness of initial patients' assessment and re-assessment documentation.

Evidence of compliance:

1. The mental health hospital has an approved assessment and re-assessment policy that contains at least from a) to f) in the intent.
2. All staff, who participates in the patient assessment process, is aware, and well-trained in the components of the policy.
3. Only qualified and well-trained individuals conduct the patient' medical assessments and reassessment.
4. Patient assessments are timely documented in the patient medical record according to the hospital's policy.
5. The assessment process for special patient groups and populations is modified to reflect their needs.
6. Patient reassessments are performed and timely documented in the patient's medical record according to the hospital's policy.

Related standards:

ICD.04 Screening of patient's healthcare needs, ICD.06 Medical assessments conducted outside the hospital, ICD.13Plan of Care, ICD.08 Special patient populations, IMT.01 Document management system, STP.01 Family involvement, MMS.09 Medication Reconciliation, MHP.03 Pre- anesthesia assessment_ Pre- induction assessment, MHP.12 Electroconvulsive Therapy (ECT).

ICD.06 There is a process for accepting the initial medical assessments conducted outside the mental health hospital or in the outpatient settings prior to admission or provision of care.

Effectiveness

Keywords:

Medical assessments conducted outside the hospital.

Intent:

When the initial medical assessment is conducted in a private clinic or other outpatient settings prior to care in the hospital, the validity period of the medical assessment must be determined by the mental health hospital, and it shall not exceed the one-month period of the days. Otherwise, the medical history must be updated and the physical examination repeated. However, any significant changes in the patient's condition that occurred during this period shall be reevaluated/reexamined and documented at admission. This re-evaluation of patient health status aims to determine the appropriateness of the current care plan and the need for any mandatory changes.

Mental health Hospitals shall develop and implement a policy and procedures to highlight the main criteria of accepting patients with outside hospital medical assessment, the policy shall address at least the following:

a) Scope and content of the initial assessment to be considered valid and accepted.
b) The time frame for accepting the initial assessment was conducted outside the hospital.
c) Measures to be taken in case of non-compliance
d) Situations that require re-examination and updating of the assessment within 30 days or within the validity period that is determined by hospital policy.

e) Recording any changes and modifications in the patient's care plan.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the acceptance of outside hospital medical assessment and may interview staff members to check their awareness .
- The GAHAR surveyors may review patients' medical records to evaluate the performed outside the hospital medical assessment .

Evidence of compliance:

1. The mental health hospital has an approved policy that guides patients outside hospital medical assessment; it addresses all the elements mentioned in the intent from a) through e).
2. Responsible staff members are aware of the outside hospital medical assessment' policy.
3. Any significant changes in the patient's condition since the initial assessment (and within the 30 days) are documented in the patient's medical record, prior to the care provision
4. All medical assessments performed outside the hospital are reviewed and/or verified, prior to the care provision

Related standards:
ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, ACT.01 granting access, STP.01 Family involvement, ICD.13Plan of Care, IMT.01 Document management system, MMS.09 Medication Reconciliation.

Patient-tailored screening, assessment, and care processes

ICD.07 patients are screened for pain, assessed, and managed accordingly.

Patient-Centeredness

Keywords:
Pain screening and assessment.

Intent:
Each patient has the right to a pain-free life. Pain, when managed properly, leads to patient comfort, proper role function, and satisfaction. The mental health hospital shall develop and implement a policy and procedures for screening, assessment, and management of pain processes. The policy addresses at least the following:

a) Pain screening tool consistent with the patient's age.
b) Complete pain assessment elements that include nature, site, and severity .
c) The need and frequency of pain reassessments .
d) Pain management protocols .
e) Assign responsibility for managing the pain .
f) Process of recording pain management plan in the patient's medical record .

Survey process guide:

- The GAHAR surveyors may review the policy for screening, assessment, and management of pain
- The GAHAR surveyors may interview relevant staff members to check their awareness of the policy.
- The GAHAR surveyors may review a patient's medical record to check for evidence of pain assessment, re-assessment, and management.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide pain screening, assessment, and management processes that address all elements mentioned in the intent from a) through f).
2. Relevant staff members are aware of how to apply the policy.
3. All patients are screened for pain using a valid, approved tool.
4. Pain assessment, re-assessment, and management plans are recorded in the patient's medical record.

Related standards:
ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, PCC.06 Patient, family, and carer education process, IMT.01 Document management system, PCC.03 Patient, family, and carer rights.

ICD.08 Special screening, assessment, reassessment, and care components for special patient populations are defined.

Effectiveness

Keywords:
Special patient populations.

Intent:
The initial assessment of special needs groups and populations shall be modified from the usual assessment process used in the mental health hospital as they have unique and specific needs. The mental health hospital shall identify those special populations and consider them high-risk patients. The mental health hospital shall develop and implement a policy and procedures for the assessment, reassessment, and management of special-needs populations. The policy shall address at least the following:

a) Identification of special-needs populations that visit the hospital which shall include at least the following:
   I. Very young Patients
   II. Adolescent Patients
   III. Chronically ill Patients
   IV. Frail elderly Patients
   V. Terminally ill Patients and patients in pain.
   VI. Patients with suspected infectious diseases or communicable diseases
   VII. Patients receiving chemo or radiation therapy.
   VIII. Patients whose immune systems are compromised.

b) Describe the special assessments tool and components of each tool to match each type of the special patient population's needs.
c) Determine staff who is authorized and permitted to perform each type of assessment.
d) The timeframe needed to complete and document the assessment
e) Determine the validity and frequency of reassessment
f) Management and care for special patient populations need an individualized plan of care based on the findings of the assessment.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding assessment, reassessment, and management of the special-needs patient population and may interview staff to check their awareness.

- The GAHAR surveyors may review patients' medical records to check the completeness of documentation of special patient populations' needs assessment, reassessment, and management.

Evidence of compliance:

1. The mental health hospital has an approved policy for assessment, reassessment, and management of special-needs patient populations that addresses all the elements mentioned in the intent from a) through f).
2. Responsible staff is aware of how to apply the policy.
3. Special-needs populations are assessed by valid tools that match each type of special patient population's needs.
4. Special patient populations' needs assessment, reassessment and management processes are recorded in the patient's medical record as per hospital policy.

Related standards:

ACT.03 Physical access and comfort, ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, ICD.10 Fall screening and prevention, ICD.13Plan of Care, IMT.01 Document management system, STP.01 Family involvement.

ICD.09 The mental health hospital has a clear process to early identify, report, and manage suspected or pretended victims of abuse or neglect, according to law and regulation.

Patient-centeredness

Keywords:

Victim of abuse and neglect.

Intent:

The mental health hospital shall develop a process for identifying and reporting victims of pretended or suspected abuse or neglect, according to law and regulation. Whether the signs of abuse and neglect have been identified at the point of the first contact or at some point during the patient care inside the hospital. The mental health hospital shall identify which agencies or authorities shall be contacted to support and report victims of suspected or pretended abuse or neglect. Coordination between the mental health hospital and the referral hospital shall be ensured to provide the appropriate care to those patients. The mental health hospital shall develop a policy and procedures for identification of the victims of abuse or neglect that addressed at least the following:

a) The referral criteria and process.
b) Determine staff who is authorized and permitted to manage a process for victims of abuse or neglect.
c) The timeframe needed to complete and document the process.
d) The documentation process of information in the patient's record.
e) Modifications are required to the individualized plan of care based on the findings.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the identification of victims of abuse and neglect and may interview the responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the documentation of information and referral forms when used.

Evidence of compliance:

1. The mental health hospital has an approved policy for the identification of the victims of abuse or neglect that addresses all the elements mentioned in the intent from a) through e).
2. Responsible staff members are aware of how to apply the policy.
3. Suspected or pretended victims of abuse and neglect are referred, when needed, according to law and regulations.
4. Any abuse and neglect-related information is documented in the patient's record.

Related standards:
PCC.03 Patient, family and carer rights, ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, ICD.13Plan of Care, IMT.01 Document management system, ACT.01 granting access, ACT.11 Patient's Transfer and referral, STP.08 Promotion of mental health and wellbeing.

ICD.10 NSR.03 Patient's risk of falling is screened, assessed and managed safely.

Safety

Keywords:
Fall screening and prevention.

Intent:
All patients are liable to fall; however, some are more prone. Identifying the more prone is usually done through a screening process in order to offer tailored preventative measures against falling.
Screening tools are commonly used and include questions or items that are used to identify fall-risk patients. For example, the questions may require a simple yes/no answer, or the tool may involve assigning a score to each item based on the patient's responses. When fall risk is identified from the screening process, the fall risk assessment shall be implemented to reduce fall risk for those patients identified to be at risk, preventive measures to minimize falling are those that are tailored to each patient and directed toward the risks being identified from risk assessment. The mental health hospital shall develop and implement a policy and procedures to guide the fall screening and prevention process. The policy addresses at least the following:

a) Patient fall risk screening at the first point of care.
b) Timeframe to complete the fall risk screening.
c) The need and frequency of fall re-assessment.
d) General measures required to reduce the risk of falling such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.
e) Tailored care plans based on individual patient fall risk assessment.

Survey process guide:

- The GAHAR surveyors may review the policy describing screening and prevention of patient falls.
- The GAHAR surveyors may review a sample of medical records to check the completeness of the patient fall screening/ assessment forms.
- The GAHAR surveyors may interview healthcare providers, to assess their knowledge about the patient fall screening/ assessment process.
- The GAHAR surveyors may observe patient fall prevention' general measures.

Evidence of compliance:

1. The mental health hospital has an approved policy and procedures for fall screening and prevention that addresses items from a) to e) of the intent.
2. The staff is aware of the fall screening and prevention policy.

3. Patients at high risk of falls are identified and educated on fall prevention measures.
4. All fall risk screenings are completed and timely documented in the patient's medical record according to the hospital policy.

Related standards:
ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, IMT.01 Document management system, ICD.13Plan of Care, STP.01 Family involvement, PCC.06 Patient, family and carer education process, EFS.06 Safety Management Plan.

ICD.11 NSR.04 Patient's risk of developing pressure ulcers is screened, assessed and managed safely.

Safety

Keywords:
Pressure Ulcers.

Intent:
The use of pressure ulcer screening tools or scales is a component of the assessment process used to identify patients at risk of developing a pressure ulcer.
The use of pressure ulcer screening tools is recommended by many international pressure ulcer prevention guidelines, identifying patients who are more prone to develop pressure ulcers is a better preventive strategy than trying to treat them.
Tailoring pressure ulcer prevention measures to each patient is proven to be effective.
The mental health hospital shall develop and implement a policy and procedures to guide the Pressure Ulcer screening and prevention process. The policy shall address at least the following:

a) Patient risk assessment at the first point of care including skin assessment.
b) Timeframe to complete pressure ulcer screening.
c) The need and frequency of reassessment of risk of pressure ulcer development.
d) General measures are required to reduce the risk of developing pressure ulcers such as pressure relieving devices and mattresses.
e) Tailored care plans based on individual patient pressure ulcer assessment.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding pressure ulcer prevention and may interview staff to check their awareness about pressure ulcer screening and assessment and prevention measures.
- The GAHAR surveyors may review a sample of patients' medical records to check the completeness of pressure ulcer screening and assessment forms.
- The GAHAR surveyors may observe the available measures to reduce the risk of pressure ulcers.

Evidence of compliance:

1. The mental health hospital has an approved policy that guides screening for patients' pressure ulcer risk. The policy addresses all elements mentioned in the intent from a) through e).
2. The staff is aware of the elements of the pressure ulcer screening policy.
3. Patients at high risk of pressure ulceration are identified and educated on prevention measures.
4. All pressure ulcer risk screenings are completed and timely documented in the patient's medical record according to the hospital's policy.

Related standards:
ICD.04 Screening of patient's healthcare needs**,** ICD.05 Patient medical assessments, IMT.01 Document management system, ICD.13Plan of Care, STP.01 Family involvement, PCC.06 Patient, family, and carer education process.

ICD.12 NSR.05 Patient's risk of developing venous thromboembolism (deep venous thrombosis and pulmonary embolism) is screened, assessed and managed safely.

Safety

Keywords:
Venous Thromboembolism Prophylaxis.

Intent:
Venous thromboembolism (VTE) is considered an important silent killer in hospitals
Patients in mental health hospitals may be at risk of developing venous thromboembolism, this may be due to the presence of risk factors such as reduced mobility due to psychiatric illness or sedation, dehydration due to poor oral intake, or comorbid physical illness. The use of antipsychotic medication also increases thrombotic risk. Parity of esteem for mental health is a priority for healthcare and should include equity of provision for the management of physical health problems in those people presenting primarily with mental illness. Adopting guidelines to reduce the risk of developing this condition is important for decreasing preventable adverse events and mortalities.
The mental health hospital shall develop and implement a policy of screening patients at risk of venous thromboembolism that has been developed according to the approved guideline for VTE prophylaxis. The policy shall address at least the following:

a) Patient risk assessment at the first point of care.
b) Timeframe to complete VTE screening.
c) The need and frequency of VTE reassessment.
d) General measures are required to reduce the risk of VTE such as mobilization and medication.
e) Changing in care plans based on individual patient VTE risk assessment.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the management of patients at risk of venous thromboembolism (deep venous thrombosis and pulmonary embolism) and may interview staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the documented VTE prophylaxis measures and to assess compliance with guidelines.

Evidence of compliance:

1. The mental health hospital has an approved policy of screening patients for the risk of venous thromboembolism which addresses all elements mentioned in the intent from a) through e).
2. The staff is aware of the elements of the VTE screening policy and prevention measures.
3. Patients at high risk of developing VTE are identified and educated on VTE prophylaxis measures.
4. All VTE risk screenings are completed and timely documented in the patient's medical record.
5. The staff's compliance with VTE prophylaxis guidelines is monitored.
6. VTE prophylaxis measures are recorded in the patient's medical record.

Related standards:
ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, IMT.01 Document management system, ICD.13Plan of Care, STP.01 Family involvement, PCC.06 Patient, family and carer education process, ICD.03 Clinical practice guidelines, MMS.12 Medication Monitoring, Medication errors, adverse drug events, and near misses.

ICD.13 An individualized plan of care is developed for every patient.

Effectiveness

Keywords:
Plan of Care.

Intent:
A plan of care provides direction on the type of healthcare the patient may need.
The focus of a plan is to facilitate standardized, evidence-based, and holistic care.
Recording a plan of care shall ensure medical staff members, nurses, and other healthcare professionals integrate their findings and work together with a common understanding of the best approach to the patient's condition. The plan of care is:

a) Developed by all relevant disciplines providing care under the supervision of the most responsible physician (MRP).
b) Developed and updated according to evidence-based guidelines and patient needs and preferences
c) Based on assessments of the patient performed by the various healthcare disciplines and healthcare professionals including the investigations' results, if any.
d) Developed with the involvement of the patient and/or family/carer through shared decision making, with the discussion of benefits and risks that may involve decision aids.
e) Includes identified needs, and interventions, to obtain the desired outcomes and goals within the determined timeframe for each intervention.
f) Updated as appropriate based on the patient reassessment's findings, needs, preferences, and the resources available.
g) The progress of the patient/service user in achieving the goals or desired outcomes is monitored.

Survey process guide:

- The GAHAR surveyors may review a patient's medical record to review the recorded plan of care .
- The GAHAR surveyors may interview healthcare professionals to check their awareness of the process .

Evidence of compliance:

1 The patient's plan of care is performed and followed by all relevant disciplines based on their assessments and addresses all the elements mentioned in the intent from a) through g).
2 The individualized plan of care is recorded in each patient's medical record.
3 Healthcare professionals are aware of the plan of care components.
4 The plan of care is revised/updated based on a re-assessment finding or any significant changes in patient condition.

Related standards:
ICD.05 Patient medical assessments, STP.01 Family involvement, IMT.01 Document management system, ICD.03 Clinical practice guidelines, PCC.03 Patient, family and carer rights, ACT.07 Patient Care Responsibility,

ICD.14 The medical consultation process is available, safe, and effective.

Safety

Keywords:
Consultation process.

Intent:
Medical consultation is a deliberation between physicians on a case or its management. It is the process of seeking an assessment by a medical staff member of a different discipline to suggest a diagnostic or treatment plan. Often, consultation leads to professional communication where clinicians share their opinions and knowledge to improve their ability to provide the best care to their patients. Such dialogue may be part of a clinician's overall efforts to maintain current scientific and professional knowledge or may arise in response to the needs of a particular patient. Although consultation usually is requested in an efficient manner that expedites patient care. The mental health hospital shall develop and implement a policy for a safe and appropriate consultation process. The policy addresses at least the following:

a. Defined criteria for patient consultation.
b. Type and urgency of consultation.
c. A clear process of communicating consultation requests to a concerned medical staff member.
d. Timeframe to respond to consultation requests.
e. Consultation feedback' documentation process to ensure safe and appropriate care planning, especially in case of urgency.

Survey process guide:

- The GAHAR surveyors may review the policy for consultation.
- The GAHAR surveyors may interview medical staff members to check their awareness of the policy.
- The GAHAR surveyors may review patients' medical records to check the documentation process of consultations.

Evidence of compliance:

1. The mental health hospital has an approved policy of consultation that addresses all elements mentioned in the intent from a) through e).
2. Medical staff members who are involved in the consultation process are aware of how to apply the policy.
3. Consultations are performed and timely documented in the patient's medical record according to the hospital policy.

Related standards:
ICD.05 Patient medical assessments, ACT.06 Coordination, and continuity of care, IMT.01 Document management system.

ICD.15 NSR.07 Verbal or telephone orders are communicated safely and effectively throughout the mental health hospital.

Safety

Keywords:
Verbal and Telephone Orders.

Intent:
Miscommunication is the most common root cause of adverse events. Writing down and reading back the complete order, by the person receiving the information, minimizes miscommunication and reduces errors resulting from ambiguous speech, unfamiliar

terminologies, or unclear pronunciation. This also provides an opportunity for verification. Limiting verbal communication to urgent situations in which immediate written or electronic communication is not feasible. For example, verbal orders can be disallowed when the prescriber is present. Verbal orders shall be restricted to situations in which it is difficult or impossible for hard copy or electronic order transmission. Mental health hospitals shall develop and implement a policy and procedures for verbal and telephone communication. The policy addresses at least the following:

a. Process of recording verbal orders.
b. Process of recording telephone orders.
c. Read-back by the recipient.
d. verification by the individual giving the order.
e. The time frame for documentation of verbal order.
f. The situation when verbal orders are restricted.

Survey process guide:

- The GAHAR surveyors may review the policy of verbal or telephone orders to check whether it clearly describes the process of recording, read-back by the recipient, and confirmation by the individual giving the order .
- The GAHAR surveyors may review documents of recording as dedicated registers and patient medical records .
- The GAHAR surveyors may interview healthcare professionals to check their awareness of the hospital policy.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide verbal communications and to define its content that addresses at least all elements mentioned in the intent from a) through f).
2. Healthcare professionals are aware of how to apply the policy .
3. All verbal orders and telephone orders are recorded in the patient's medical record within a pre-defined timeframe. according to the policy.
4. The mental health hospital tracks, collects, analyzes, and reports data on compliance with the verbal and telephone order process.
5. The hospital plans for corrective actions, whenever indicated by findings.

Related standards:
ACT.08 Handover communication, IMT.01 Document management system, ICD.16 Critical Results, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement.

Safe Critical and Special diagnostic and care procedures.

ICD.16 NSR.08 Critical results are communicated timely, accurately, and safely throughout the mental health hospital

Safety

Keywords:
Critical Results.

Intent:
Patient safety and quality of care can be compromised when there are delays in the completion of critical tests or in communicating the critical tests or critical results to the requestor. Miscommunication is the most common root cause of adverse events. Writing down and reading back the results, by the person receiving the information, minimizes

miscommunication and reduces errors resulting from ambiguous speech, unfamiliar terminologies, or unclear pronunciation. This also provides an opportunity for verification. The process includes instructions for immediate notification of the authorized individual responsible for the patient with results that exceed the critical intervals. Any difficulties encountered in notifications shall be reported in the incident reporting system. The mental health hospital shall develop and implement a policy and procedures to guide the process of identifying and reporting critical results. The policy addresses at least the following:

a) Lists of critical results and values.
b) Critical test results reporting process including timeframe and read-back by the recipient.
c) Process of recording.
    i. Date and time of notification.
    ii. Identification of the notifying responsible staff member.
    iii. Identification of the notified person.
    iv. Examination results conveyed.
    v. Identification of what information needs to be documented in the patient medical record.
d) Measures to be taken in case of non-compliance with the critical results reporting process.

Survey process guide:

- The GAHAR surveyors may review the policy of critical results to check whether it clearly describes the process of recording, and read-back by the recipient.
- The GAHAR surveyors may review the recording in the dedicated registers and the patient's medical record.
- The GAHAR surveyors may interview healthcare professionals to check their awareness of the policy.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide critical results communications and to define its content that addresses at least all elements mentioned in the intent from a) through d).
2. Healthcare professionals are aware of how to apply the policy.
3. All critical results are recorded in the patient's medical record within a pre-defined timeframe.
4. The mental health hospital tracks, collects, analyzes, and reports data on compliance with the critical results reporting process.
5. The hospital plans for corrective actions, whenever indicated by findings.

Related standards:
ICD.15 verbal and telephone orders, ACT.08 Handover communication, DAS.07 Medical imaging reports, DAS.15 Post examination process, Laboratory TAT, STAT, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement

ICD.17 NSR.11 Systems are implemented to prevent catheter and tubing misconnections.

Safety

Keyword:
Catheter and tube misconnections.

Intent:
Tubing and catheters are important steps of daily healthcare provision for the delivery of medications and fluids to patients. Especially within critical and specialized care areas. Patients are connected to many tubes and catheters, each with a special function

(monitoring, access, drainage). During care, these tubes and catheters may be misconnected leading to the administration of the wrong material via the wrong route resulting in grave consequences. The mental health hospital develops a policy and procedures for catheter and tubing misconnections. The policy addresses at least the following:

a) Responsibility for connection and disconnection of tubes should not be left to non-medical staff members, families, or visitors.
b) Labeling of high-risk catheters (e.g. arterial, epidural, intrathecal).
c) Avoid the use of catheters with injection ports for these applications.
d) Tracing of all lines from their origin to the connection port to verify attachments before making any connections or reconnections, or administering medications, solutions, or other products.
e) Standardized line reconciliation, rechecking process, and catheter maps as part of handover communications.
f) Acceptance testing and risk assessment (failure mode and effects analysis, etc.) to identify the potential for misconnections when purchasing new catheters and tubing.

Survey process guide:

- The GAHAR surveyors may review the policy for catheter and tubing misconnections and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review the patient's medical record to check the recording of the used catheters and tubes.

Evidence of compliance:

1. The mental health hospital has approved policy of catheter and tubing misconnections that address all the elements mentioned in the intent from a) through f).
2. All staff members using tubes and catheters are competent and aware of the mental health hospital policy.
3. Documents of tubes and catheters used are recorded in the patient's medical record.

Related standards

ACT.02 Patient identification, ACT.08 Handover communication, QPI.03 Risk Management Program, IMT.06 Patient's medical record management, MHP.13 Pre- verification process, IPC.05 Hand Hygiene, IPC.02 Infection prevention and control (IPC) program.

ICD.18 NSR.09 The mental health hospital ensures providing a hospital-wide recognition of and early response to patients' clinical deterioration.

Safety

Keywords:

Recognition and response to clinical deterioration.

Intent:

Early detection of warning signs and provision of urgent care at the right time leads to better functional and long-term outcomes than the resuscitation of patients with cardiopulmonary arrest.

Studies have shown that this strategy has a positive impact on reducing in-hospital mortality and improving patient safety.

The mental health hospital shall develop and implement policy and procedures to ensure a safe and standardized process of recognition of and response to clinical deterioration.

The policy shall address at least the following:

a) Defined criteria of recognition of clinical deterioration. The criteria shall be consistent and matched to the individual patient population (age-specific criteria).
b) Education of responsible staff members on the defined criteria (i.e. all staff who provide direct patient care).
c) Identification of involved staff members to respond.
d) Mechanisms to call staff members to respond; including code(s) that may be used for calling emergency or for further assistance.
e) The time frame of response.
f) The response is uniform 24 hours a day and seven days a week.
g) Recording of response and management.
h) Methods to inform patient, family, and carer about how to invoke or call for help when they have concerns about a patient's condition.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the response and management of clinical deterioration and may interview responsible staff to check their awareness.
- The GAHAR surveyors may assess the response of responsible staff to clinical deterioration calls.
- The GAHAR surveyors may interview the patient and family to check their awareness of how to call for help when they have a concern about the patient's condition.

Evidence of compliance:

1. The mental health hospital has an approved policy of recognition of and response to clinical deterioration that addresses all the elements mentioned in the intent from a) through h).
2. All staff members involved in direct patient care are aware of the hospital policy.
3. The mental health hospital implements and documents the age-specific criteria for early recognition of any change or deterioration in a patient's condition.
4. The hospital has a defined process to inform the patient and family of how to call for help when they have concerns about a patient's condition.
5. Recognition of and response to clinical deterioration are recorded in the patient's medical record.

Related standards:
ICD.01 Uniform care provision, ICD.19 Critical Care, ICD.20 Cardiopulmonary resuscitation and medical emergencies, EFS.11 clinical alarms, IMT.06 Patient's medical record management, PCC.06 Patient, family, and carer education process.

ICD.19 Critical Care services are provided according to laws, regulations, and clinical guidelines.

Safety

Keywords:
Critical Care.

Intent:
Psychiatric critical care is for patients who are in an acutely disturbed phase of a serious mental disorder. There is an associated loss of capacity for self-control, with a corresponding increase in risk, which does not allow their safe, therapeutic management and treatment in a less acute or less secure mental health ward. Care and treatment of the patient in the critical care unit

shall be patient-centered, multidisciplinary, intensive, and have an immediacy of response to critical clinical and risk situations. Patients shall be detained compulsorily under the appropriate mental health law and regulation framework, and the clinical and risk profile of the patient. it usually requires an associated level of security.
Critical care interventions shall be multidisciplinary, evidence-based addressing physical health and recovery from acute mental illness using the recent evidence-based intervention to improve the patient's condition and regain self-control
the mental health hospital shall provide all health care professionals with appropriate training and education for the safe provision of critical care throughout the mental health hospital
The mental health hospital shall develop and implement a policy and procedures for the safe process of the management of critical care service
The policy shall address at least the following

a. Clear admission and discharge criteria for critical care units
b. Initial assessment requirements
c. Reassessment requirements.
d. Availability of required resources medication supplies and equipment for the provision of care and monitoring
e. The use of restraining during critical care
f. Availability of competent staff for care provision
g. Documentation requirement

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the management of critical care services and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check for the documentation of the provided critical services.
- The GAHAR surveyors may review staff files for those responsible for the assessment and management of patients' needs to check competence assessment.

Evidence of compliance:

1. The mental health hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. All staff members involved in critical care services are aware of the hospital policy.
3. Competent, trained individuals are responsible for the management and provision of critical care services.
4. Management and use of critical care are recorded in the patient's medical record.

Related standards:
ICD.05 Patient medical assessments, ACT.01 granting access, PCC.03 Patient, family, and carer rights, ICD.03 Clinical practice guidelines, WFM.07 Continuous education, and training program, STP.02 Behavioral Restraint and Seclusion, IMT.01 Document management system

Safe, effective emergency and urgency services

ICD.20 NSR.10 Response to medical emergencies and cardio-pulmonary arrest throughout the mental health hospital is managed safely for both adult and pediatric patients.

Safety

Keywords:
Cardiopulmonary resuscitation and medical emergencies.

Intent:

Any patient receiving care within the mental health hospital is liable to suffer from a medical emergency requiring a rapid response. A medical emergency is simply defined as the sudden onset of a medical condition with the manifestations of acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in a serious outcome. Skills are essential elements for an emergency service to ensure satisfactory outcomes. Therefore, trained staff members, at least on basic life support, should be available during working hours ready to respond to any emergency. All staff who provide patient care, including contracted physicians and independent healthcare practitioners, are trained to provide basic life support services.
The mental health hospital shall develop and implement a policy and procedures to ensure the safe management of medical emergencies and cardio-pulmonary arrests. The policy addresses at least the following:

a) Defined criteria of recognition of emergencies and cardio-pulmonary arrest including adults, children, and youth.
b) Education and training of staff members on the defined criteria. (at least BLS)
c) Identification of involved staff members to respond according to the appropriate training provided and age of population served.
d) Mechanisms to call staff members; including code(s) that may be used for calling emergency.
e) The time- frame for response.
f) Recording of response and management process.

Survey process guide:

- The GAHAR surveyors may review the policy for medical emergencies and cardiopulmonary arrest and may interview healthcare professionals to check their awareness of the policy.
- The GAHAR surveyors may check evidence of staff training on recognition and communication of medical emergencies or cardio-pulmonary arrest.
- The GAHAR surveyors may observe the compliance with policies for medical emergencies and cardio-pulmonary arrest

Evidence of compliance:

1. The mental health hospital has an approved policy for the management of medical emergencies and cardio-pulmonary arrests that addresses all the elements mentioned in the intent from a) through f)
2. All staff members involved in medical emergencies and cardiopulmonary resuscitation are aware of the hospital policy .
3. All staff who provide patient care, including independent healthcare practitioners, are trained to provide basic life support services .
4. Qualified individuals are responsible for the management of medical emergencies and cardio-pulmonary arrests .
5. Management of medical emergencies and cardio-pulmonary arrests are timely recorded in the patient's medical record .

Related standards:
ICD.01 Uniform care provision, WFM.07 Continuous education, and training program, EFS.11 clinical alarms, IMT.01 Document management system, ICD.21 Emergency Services, WFM.08 Staff Performance Evaluation.

ICD.21 Urgent and emergency services are delivered according to applicable laws and regulations.

Safety

Keywords:
Emergency Services.

Intent:
A psychiatric emergency is one type of clinical emergency that shall be managed in the mental health hospital. It is an acute disturbance of behavior, or mood of a patient which if untreated may lead to harm, either to the individual or to others in the environment.
To ensure consistency and coordination of services with higher levels of care, emergency services offered to the community should be provided within the capabilities of the mental health hospital as defined by law and regulations. The mental health hospital shall develop and implement a policy and procedures for triage and emergency services. The policy addresses at least the following:

a) Qualified staff members are available 24 hours all over a week.
b) Defined criteria that determine the priority of care according to a recognized triage process.
c) Assessment, reassessment, and emergency care management follow approved clinical guidelines and protocols.
d) Availability of medical equipment and medications required for resuscitation. management of the psychiatric emergency.
e) Situations when reporting to patients' rights protection committee are mandatory.

Survey process guide:

- The GAHAR surveyors may review the policy of triage and emergency services.
- The GAHAR surveyors may review a patient's medical records to review the recorded emergency triage and plan of care.
- The GAHAR surveyors may review emergency room records to check the registration process of emergency patients.
- The GAHAR surveyors may observe the availability of equipment and medications for resuscitation.

Evidence of compliance:

1. The mental health hospital has an approved policy for triage and psychiatric emergency services as mentioned in the intent from a) to e).
2. Qualified staff members offer emergency services according to the policy of triage and emergency services.
3. Patients and families are informed of their priority level and expected time to wait before being assessed by a medical staff member.
4. Medical equipment and medications for resuscitation are standardized and available for use based on the needs of the population served.
5. Records of triage and emergency plan of care are recorded in the patient's medical record.

Related standards:
ICD.20 Cardiopulmonary resuscitation and medical emergencies, ICD.01 Uniform care provision, ICD.05 Patient medical assessments, PCC.02 Patient-centered culture, ACT.06 Coordination and continuity of care, ICD.22 Emergency care uniform recording process, EFS.10 Medical Equipment Plan, STP.02 Behavioral Restraint and Seclusion.

ICD.22 The mental health hospital has a uniform recording process for emergency care services.

Effectiveness

Keywords:
Emergency care uniform recording process.

Intent:
Due to the nature of emergency care areas, multiple staff members from emergency care areas and outside emergency care areas need to exchange information. This information has to be captured and recorded to ensure consistency and coordination of services with higher levels of care. When a mental health hospital provides emergency care, the emergency room registers usually include all patients receiving care, their arrival and departure times, conclusions at the termination of treatment, the patient's condition at disposition, the patient's destination at disposition, and any follow-up care instructions. Reading and recording time might seem to be an easy process, yet, in some instances, emergency care staff members may rely on various sources to know the time. These sources might be their watches, computer clocks, digital watches, or even mobile phones. If these sources are not calibrated, it might lead to a difference in reading and recording times. This is of special importance in healthcare and definitely in emergency care areas. Mental health hospitals have a uniform recording process for emergency care services. The record includes at least the following:

a. Time of arrival and time of departure.
b. Conclusions at the termination of treatment.
c. Patient's condition at departure.
d. Patient's disposition at departure.
e. Follow-up care instructions.
f. Departure order by the treating medical staff members.

The mental health hospital shall keep the emergency record in the patient medical record and send a copy to the patient's rights protection committee according to laws and regulations

Survey process guide:

- The GAHAR surveyors may review a patient's medical record to check the uniformity of the emergency recording process.
- The GAHAR surveyors may perform an audit on the time of patient registration in the emergency room and compare between times from other sources (such as medical records) to check compliance.

Evidence of compliance:

1. The medical records of emergency patients include arrival and departure times.
2. The medical records of emergency patients include the patient's condition at the time of discharge or transfer.
3. Departure orders and follow-up instructions are signed by the treating physician and recorded in time, inpatient medical records.
4. Equipment and devices used for time recordings such as watches, clocks, digital clocks, and timers are functionally available in all emergency care areas.
5. Emergency record is documented in the patient medical record and patients' rights protection committee record.

Related standards:
ICD.20 Cardiopulmonary resuscitation and medical emergencies, IMT.06 Patient's medical record management, ICD.21 Emergency Services, PCC.02 Patient-centered culture, ACT.11 Patient's Transfer and referral, ACT.10 Patient's Discharge, EFS.10 Medical Equipment Plan.

Special Behavioral Therapy And Program

As mentioned in the World Health Organization's constitution, which defines health as "a state of complete physical, mental and social well-being and not only the absence of sickness or infirmity," mental health is a significant aspect of health and well-being. Like other aspects of health, mental health can be affected by a variety of socioeconomic statuses. As such, comprehensive strategies for promotion, prevention, treatment, and healing must be implemented across the entire health system.
putting into practice specific measures to create better environments for mental health, such as intensifying efforts, developing effective programs to combat intimate partner violence, abuse, and neglect of children and the elderly; enabling nurturing care for early childhood development; providing livelihood support for those with mental health conditions; introducing social and public educational programs and strengthening rights in mental health care,

In addition, by promoting accessibility, acceptability, affordability, and scalability of services, the availability and integration of mental health services within communities can also encourage treatment adherence and raise the likelihood of successful clinical outcomes.

Community services can also be extremely helpful in raising public awareness of mental health issues, minimizing stigma and prejudice, fostering recovery and social inclusion, and preventing mental diseases. The provision of comprehensive, integrated mental health and social care is mandated by the World Health Organization's (WHO) Mental Health Action Plan for 2013-2020. This plan also calls for the inclusion of promotion and prevention programs in communities that incorporate the perspectives and involvement of service users.

Locally, the ministry of health and population (MOH) has launched a national electronic platform in Egypt for mental health services and addiction treatment aiming to expand the provision of mental health services and make them available, and easy to access for users. This comes as the result of the rapid spread of the Coronavirus disease 2019 (COVID-19) that forced most countries to take drastic public health measures. This has suddenly created the need to adapt and expand Tele-healthcare across the country

The scope of this chapter is to cover the behavioural therapies, prevention programs, and well-being promotion programs across the mental health hospital

Chapter purpose:
The main objective of this chapter is to ensure:

1. Engaging the families and carers in the care of patients with mental illness.
2. The respect for patient’s rights, dignity, and well-being prior to and during restraint or seclusion.
3. Identifying patients at risk of imminent harm to themselves or others.
4. Establishing an effective prevention program as the suicide prevention program.
5. Correct management of patients with substance use disorders.
6. Safe transitioning to tele-mental health services and identifying the potential barriers to use.

The Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) The Egyptian Constitution
2) Egyptian Law for The Care of Psychiatric Patients, 71/2009
3) Law No. 210/2020 Amendment for Law of Psychiatric Patient Care, 71/2009.
4) Regulations for The Care of Psychiatric Patients,128/2010
5) Regulations for The Care of Psychiatric Patients, 55/2021
6) Cairo Declaration on Human Rights in Islam, 1990
7) Egyptian Children Protection Law Number126/2008
8) Rights of the Handicapped Law, 10/2018
9) Egyptian Consumer Protection Law, 181/2018
10) Egyptian Code of Medical Ethics 238/2003
11) Egyptian Code of Nursing Ethics (Nursing Syndicate Publications)
12) Code of Ethics and Behavior for Civil Service Staff,2019
13) MOH Ministerial Decree for Design Standards of Healthcare Facilities Number 402/2015
14) Law 51/1981 Amended by Law 153/2004, Healthcare Facilities Organization
15) Standards for Licensing Mental Health Facilities for the National Council of Mental Health
16) Egyptian Criminal Code 58/1937
17) The Universal Declaration on Human Rights, 1964
18) ASAM Standards of Care: for The Addiction Specialist Physician, 2014
19) International Standards for the Treatment of Drug Use Disorders2017/2020 UNODC.
20) Comprehensive Accreditation Manual For Behavioral Health Care (CAMBHC)2018

Engaging the families and carers in the care of patients with mental illness

STP.01 The mental health hospital facilitates and coordinates family, and carer involvement throughout the patient's care provision

Patient-centeredness

Keywords:
Family involvement.

Intent:
There are many short- and long-term benefits of engaging families in the care of patients with mental illness. The mental health hospital shall clarify the advantage of successfully engaging the families of patients with mental illness, such as better accessibility, better rapport, being associated with less stigma, and improved compliance to medication and treatment plans. In general, issues of confidentiality, vulnerability, stigma, and poor rapport are commonly faced by patients and families during a family engagement. The mental health hospital may engage the family in various ways, such as providing psychoeducation, supporting the family's physical, emotional and social needs, and conducting family assessments or family therapy. The hospital shall clearly explain the family or carer's role in achieving care, treatment, or service goals and obtain consent from the patient.

There are instances in which family participation may be inappropriate or contraindicated because it could have a harmful effect on the patient and contradict one or more of her or his rights. In these instances, the MRP shall document this judgment in the patient medical record.

Survey process guide:

- The GAHAR surveyors may interview patients' family members to check their involvement and participation.
- The GAHAR surveyors may review a sample of the patient's medical records to check the completeness of family involvement consent and the documentation of the family involvement process.

Evidence of Compliance:

1. The mental health hospital has a defined process to facilitate and coordinate family involvement throughout the assessment process.
2. The family is involved in developing the plan for care upon consent from the patient (if an adult with mental capacity) or in accordance with law and regulation (if a minor).
3. The mental health hospital documents family participation during patient care in the patient's medical records.
4. When family participation is not preferred based on the patient's condition and MRP judgment, it is documented in the patient's medical records.
5. Staff is aware of how to respond to family/ carers when the patient does not consent to their involvement.

Related standards:
PCC.03 Patient, family and carer rights, PCC.06 Patient, family, and carer education process, PCC.05 admission consent, ICD.04 Screening of patient's healthcare needs, ICD.05 Patient medical assessments, ACT.07 Patient Care Responsibility, ICD.13Plan of Care.

Safe use of Restraint and Seclusion

STP.02 NSR.12 **Behavioral restraint and seclusion are safely and appropriately used, in a manner that respects patients' rights, according to the psychiatric patients' care law and regulations.**

Safety

Keywords:
Behavioral Restraint and Seclusion.

Intent:
Coercion is defined as the use of an intervention against a person's will. Coercive measures limit several fundamental human rights, such as liberty of choice or movement, autonomy, and physical integrity, and therefore shall be subjected to national laws and regulations.

Restraint and seclusion shall be used only in an emergency when there is an imminent risk of a patient physically harming himself or others, including staff. Appropriate alternatives shall be considered to avoid the need for restraint. These interventions shall be used with caution and as a last choice. Physical or pharmacologic/chemical restraints are used only in limited situations with adequate, appropriate clinical justification. And all restraints require documented physical assessment based on an examination of the patient by a physician
Seclusion is the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving. The seclusion room shall be designed and equipped according to the applicable psychiatric patients care laws and regulations.
Restraint and Seclusion must never be used as a means of coercion, discipline, or staff convenience or as a means to control a patient's behavior without clinical justification to do so.
A physician's order is required for the application, change, continuation, and discontinuation of restraint or seclusion. The order should stop automatically after 24 hours. If the physician wants to continue the restraint, according to the patient's condition, he/she should re-order.
The physician/provider shall evaluate the patient prior to, during, and immediately after initiation of restraint or seclusion. Regular observation, monitoring, and frequent reassessment during and after the restraint shall be timely documented in the patient medical record. Patients need to be checked at least every 2 hours. PRN orders are not allowed in case of restraint or seclusion as it may expose psychiatric inpatients to unnecessary psychotropic medications.

The mental health hospital shall preserve and respect the patient's rights, dignity, and well-being before, during restraint, or seclusion. The patient and family shall be informed regarding the care being provided and the type, and reason for the use of restraint.

The mental health hospital shall develop and implement policy and procedures for appropriate and safe use of restraint and seclusion. The policy shall address at least the following:

a) Determine the method and type of restraints and seclusions used. The least restrictive safe methods are to be used as appropriate to the patient's condition.
b) Staff members who are permitted to execute the physician's order. Qualifications and competencies of staff who are permitted to do so.
c) Documentation requirements for physician order in patient's medical record. the order should stop automatically after 24 hours.
d) Renewal of the restraint order is based on the continuing need and according to laws and regulations, a new physician order is required.
e) Regular observation, monitoring, and frequent reassessments with timed documentation.
f) Methods used to inform patient and family regarding the care being provided and the type, and reason for the use of restraint.

g) Reporting process to patients' rights protection committee

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for restraint and seclusion and may interview involved staff to check their awareness.
- The GAHAR surveyors may observe the implemented measures for restraint and seclusion.
- The GAHAR surveyors may review patients' medical records to assess the documentation requirements of restraint/seclusion orders.

Evidence of compliance:

1. The mental health hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. All staff members involved in restraint and seclusion are aware of the hospital policy.
3. Competent individuals are responsible for the use of restraint and seclusion.
4. A physician's order is documented in the patient medical record before the application, change, continuation, and discontinuation of restraint or seclusion.
5. The mental health hospital has a defined process to inform the patient, family, and carer about the care being provided and the type, and reason for the use of restraint.
6. Patient under restraint or seclusion is monitored, and reassessed with timed documentation as per the hospital's policy.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.08 Patient comfort and dignity, ICD.19 Critical Care, IMT.01 Document management system, ICD.09 Victim of abuse and neglect, EFS.06 Safety Management Plan, ACT.07 Patient Care Responsibility.

Early detection and prevention program for patients at risk of harm to self or others.

STP.03 NSR.13 Patient's risk of imminent harm to self and others is screened, assessed and managed safely

Safety

Keywords:
Imminent harm to self or others.

Intent:
Self-harm is behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Also referred to as self-directed violence, encompasses both suicidal and non-suicidal self-injury The Centers for Disease Control (CDC) defines self-directed violence as anything a person does intentionally that can cause injury to himself, For example cutting and, suicide head banging, self-biting, and self-scratching
Screening and initial assessment of patients at risk of imminent harm to self or others play a vital role in determining the severity of a condition and in prioritizing initial clinical interventions.
It shall be standardized, completed, and documented within a specific time-span to achieve high-quality care that fulfills patient needs. The mental health hospital shall develop a policy and procedures for screening, assessment, and management of the patient at risk of imminent harm to self or others that address at least:

a) Tools used for screening and assessment of patients at risk of imminent harm to themself or others.
b) Timeframe to complete the assessment is guided by evidence of the best

practice and guidelines, if any.

c) The Methodology applied to control the risk and determine the need for immediate interventions to protect the patient or others. It may include referring the individual to another organization.
d) Documentation requirements of screening, assessment, and management of the patient at risk of imminent harm to self or others.
e) Staff training on risk assessment.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for screening, assessment, and management of the patient at risk of imminent harm to self or others and may interview responsible staff to check their awareness
- The GAHAR surveyors may review patients' medical records to check the completeness of documentation of screenings, assessments, and management of the patient at risk of imminent harm to themself or others.
- The GAHAR surveyors may review competency files for staff who are authorized to give training on risk assessment.

Evidence of compliance:

1. The mental health hospital has an approved policy for screening, assessment, and management of the patient at risk of imminent harm to self or others that addresses all elements in the intent from a) to e)
2. Responsible staff is qualified and aware of how to apply the policy.
3. Immediate intervention performed on patients at immediate risk of harm to self or others is documented in the patient medical record.
4. Screening and assessments are completed and timely documented in the patient's medical record according to the hospital's policy.

Related standards

ICD.04 Screening of patient's healthcare needs, EFS.08 Violence prevention program. ICD.05 Patient medical assessments, ACT.07 Patient Care Responsibility, ICD.13Plan of Care, ICD.09 Victim of abuse and neglect, EFS.06 Safety Management Plan.

STP.04 NSR.14 Suicide prevention program is developed, implemented, and monitored.

Safety

Keywords:

Suicide prevention program.

Intent:

Identification of patients at risk for suicide is an important step in protecting these patients. It aims to improve the quality and safety of care for those treated for psychiatric conditions and those who are identified as high risk for suicide.

The mental health hospital shall develop a program for suicide prevention that addresses at least the following elements:

a) Suicide risk assessment and reassessment of patients who have screened positive for risk of suicide using a valid screening tool.
b) Tools used for suicide assessment
c) Staff competency required for the assessment of suicide
d) Address the immediate safety needs and most appropriate ways for treatment

e) Monitoring patients who are at high risk for suicide and under the care of the hospital**.**
f) Identify environmental features that may increase the risk of suicide
g) Provide suicide prevention information to the patient and his/her family
h) Methods applied to inform patients and their families about suicide prevention when he leaves the hospital.
i) Documentation requirements for the suicide prevention program
j) Performance measures to monitor, assess, and improve the suicide prevention program

Survey process guide:

- The GAHAR surveyors may review the mental health hospital program for suicide prevention and may interview responsible staff to check their awareness.
- The GAHAR surveyors may observe the environmental safety measures that are implemented to mitigate the risk of suicide
- The GAHAR surveyors may review the suicide prevention information provided to the patient and family before his/her discharge.

Evidence of compliance:

1. The mental health hospital has a program for suicide prevention that includes all elements in the intent from a) to j)
2. Relevant staff are educated and trained on the suicide prevention program
3. The immediate safety needs and most appropriate interventions for patients at risk of suicide are timely documented.
4. When a patient with a history of risk for suicide leaves the hospital (or planned to), the suicide prevention information is provided to the patient and his or her family

Related standards:
EFS.06 Safety Management Plan, IMT.01 Document management system, QPI.02 Performance Measures, STP.08 Promotion of mental health and wellbeing, PCC.03 Patient, family and carer rights, ICD.09 Victim of abuse and neglect, PCC.06 Patient, family, and carer education process, ICD.13Plan of Care.

Screening, assessment, and care of the patient with substance use disorder

STP.05 The mental health hospital has an effective process for screening, assessment, and management of patients who are suffering from substance use disorders.

Effectiveness

Keywords:
Substance use disorders (SUD).

Intent:
The purpose of substance use disorder (SUD) screening is to determine the presence of substance use and identify the need for a further clinical SUD assessment. Gather information from a variety of sources, including the patient history of medication use, signs and symptoms, and drug testing. The mental health hospital shall use nationally accepted, standardized screening tools, such as the AUDIT, AUDIT-C, ASSIST, or UNCOPE.

The goal of the initial substance use assessment is to evaluate the patient's substance use, the patient's level of functioning, and the appropriate entrance into a substance use treatment program. A face-to-face clinical interview shall take place with each patient. The MRP shall be able to complete the initial assessment early as determined in the hospital policy. The mental health hospital shall identify a plan to work with non-cooperative patients including those who believe they have no problems to be addressed.

Appropriate assessment includes data from clinical interviews, substance use history, physical examination, and diagnostic procedures, to assure optimal clinical outcomes. The individual's readiness to change can influence his or her treatment outcomes positively, and lead to treatment retention. The withdrawal potential of the patient shall be fully assessed by looking at the individual's current and past experiences with substance use, including levels of intoxication and risk of severe withdrawal symptoms (such as seizures). Properly assessing withdrawal potential is vital to keeping individuals safe and providing quality care. Care and management of patients based on the results of the assessment, identified needs, and patient preference.

The mental health hospital shall develop and implement a policy and procedures for the assessment and management of patients suffering from substance use disorder according to the evidence of the best practice and the psychiatric patients' laws and regulations and address at least the following:

a) The scope and content of the substance use disorder assessment shall include at least the following:

    I. A physical assessment
    II. A mental status assessment
    III. Detailed past substance use history
    IV. levels of intoxication and risk of severe withdrawal symptoms
    V. Types of previous treatment and responses to the treatment, if any.
    VI. Identification of facilitators and barriers to treatment engagement, as patient motivational level and recovery environment.
    VII. Family medical, psychiatric, substance use, addictive behavior, and addiction treatment history

b) Using approved, standardized, nationally accepted assessment tools
c) The timeframe for completion and documentation of the initial assessment and reassessment
d) Situations when the hospital considers the initial assessment not valid.
e) Assessments are performed by a qualified healthcare professional.
f) Need for family participation in the patient's care
g) Relapse prevention and continued follow-up

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for the assessment and management of patients with substance use disorder and may interview staff members to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the documentation and completeness of the assessment
- The GAHAR surveyors may review staff files to assess the qualifications of health care professionals responsible for patients' assessment

Evidence of compliance:

1. The mental health hospital has an approved policy and procedures for the assessment and management of patients with substance use disorder that address all elements in the intent from a) to g).
2. The staff is fully aware of the mental health hospital policy.
3. All assessment is a timely documented in the patient medical record according to the hospital policy.

Related standards:

ICD.04 Screening of patient's healthcare needs, ACT.07 Patient Care Responsibility, STP.01 Family involvement, STP.08 Promotion of mental health and wellbeing, STP.07 Addiction

prevention and treatment program STP.06 Supplementary laboratory tests, ICD.05 Patient medical assessments, ICD.13Plan of Care.

STP.06 The mental health hospital provides supplementary laboratory tests to patients who are suffering from substance use disorder to promote the safety and quality of their care and outcome.

safety

Keywords:
Supplementary laboratory tests.

Intent:
It is important when performing tests, such as urine drug screens, that all individuals are treated with respect and dignity. The stigma surrounding substance use disorder treatment has been a barrier to pursuing care. Although several laboratory tests can detect substance abuse or misuse in urine and blood, these tests measure recent substance use rather than chronic use or dependence. Until now, there is no specific test to identify substance use disorders. However, laboratory tests may be useful during the assessment process to confirm a diagnosis, establish a baseline, and monitor progress. The mental health hospital shall use drug screening as an aid to monitor and evaluate a patient's progress in treatment.

Clinicians shall determine the frequency of ongoing toxicological testing by evaluating the need for testing at the patient's stage in treatment. The ongoing drug-testing regime shall be determined by analyzing individual circumstances and community drug use patterns. Staff shall discuss the results of toxicology testing with patients, and document both the results of toxicology tests and the follow-up therapeutic interventions in the patient record. The mental health hospital shall consider when drug testing is appropriate based on the individual's diagnosis, progress in treatment, history of use, and the provider's clinical judgment

Survey process guide:

- The GAHAR surveyors may review the mental health hospital process for requesting and implementing supplementary laboratory tests for patients who are suffering from substance use disorder.
- The GAHAR surveyors may review the list of the available laboratory tests used for drug screening.
- The GAHAR surveyors may review patients' medical records to check the documentation of drug screening results and measures taken for follow-up therapeutic interventions.

Evidence of compliance:

1. The mental health hospital has a defined process of requesting and implementing Supplementary laboratory tests for patients who are suffering from substance use disorder.
2. There is a list of all available laboratory tests that are used for drug screening in the hospital, referral is documented in case of unavailability.
3. Results of drug screening and toxicology are documented in the patient medical record.
4. The follow-up therapeutic interventions are discussed with the patient and documented in the patient record.

Related standards:
PCC.03 Patient, family, and carer rights, STP.05 Substance use disorders (SUD), PCC.06 Patient, family, and carer education process, IMT.04 Confidentiality and Security of data and

information, DAS.09 Laboratory services planning and management, IPC.12 Virology screening process.

Effective addiction prevention program.

STP.07 The mental health hospital develops an effective program for addiction prevention and treatment with defined goals and the scope of the services provided.

Effectiveness

Keywords:
Addiction prevention and treatment program.

Intent:
The risk of addiction can be decreased. While there is no single way to prevent addiction, the mental health hospital shall develop and implement a program to prevent addiction the program shall include Public and concerned parties' education, Support and rehabilitation methodology, and general awareness of the factors that affect substance misuse, Treating people with drug dependency with dignity and respect. Stigma, or negative attitudes, toward drug use and addiction can prevent those who need help from seeking it. Too often, addiction is seen as a choice rather than the disease that it is. To assure the full treatment that those people experiencing substance use disorders and addiction need, the stigma surrounding addiction must be addressed and reduced. The addiction prevention and treatment program shall be periodically revised and updated including the mechanisms of continuous feedback, monitoring, and evaluation.

The addiction prevention program shall include at least the following:

a) Treatment protocols, and evidence-based treatment interventions that match the needs of the people affected.
b) An evidence-based assessment tool such as the Addiction Severity Index (ASI), evaluates the severity of drug use problems and associated problems (medical, psychiatric, family, etc.) Can be administered by a trained staff member
c) Multidisciplinary team and responsible staff who shall integrate different interventions tailored to each patient.
d) Determine situations when referral and consultation with other agencies and providers are needed.
e) For hospitals that make referrals, the hospital maintains a list of private and public community agencies that provide or arrange for the assessment and care of individuals who may have experienced substance abuse
f) General education includes education of all women of childbearing age about the potential effect on their infants and the need for treatment
g) Relapse prevention and continuing care strategies for a reasonable period after treatment.
h) Follow-up treatment plan that includes strategies for patients to successfully transition to the next level of care.
i) Recovery support services according to patients' needs. Examples include follow-up phone calls and face-to-face meetings.
j) Adequate record systems shall be in place to ensure accountability and continuity of treatment and care.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital program for addiction prevention and treatment and may interview responsible staff to check their awareness.

- The GAHAR surveyors may review the program's monitoring records to assess the continuity of care.
- The GAHAR surveyors may review a sample of staff files to ensure the availability of training records.

Evidence of compliance:

1. The mental health hospital has a program for addiction prevention and treatment that addresses all the elements mentioned in the intent from a) through j).
2. All relevant staff is aware and well trained on the program's applicability and components.
3. The addiction prevention and treatment program is periodically revised and updated
4. The addiction prevention and treatment program includes the mechanisms of continuous feedback, monitoring, and evaluation

Related standards:
STP.05 Substance use disorders (SUD), STP.08 Promotion of mental health and wellbeing, PCC.06 Patient, family, and carer education process, IMT.04 Confidentiality and Security of data and information, OGM.14 Community Initiatives.
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Mental Health Promotion and community wellbeing

STP.08 The mental health hospital has an effective program for the promotion of mental health and well-being throughout the community

Effectiveness

Keyword:
Promotion of mental health and wellbeing.

Intent:
The promotion of mental health and well-being is aiming to increase individuals' social and emotional well-being and quality of life. These Initiatives can target entire populations, groups of people, or individuals, and can occur in any setting. It applies to all people, including those currently experiencing or recovering from a diagnosed mental illness. The mental health hospitals shall highlight or target the areas to promote and the goals to be attained, develop and implement a multi-sectoral mental health promotion program based on the current community needs assessment to maximize impact, mental health promotion activities must be linked closely with mental health services, and engage a variety of health and non-health sectors. The program shall be designed to assist individuals in coping with the stresses of life, establishing, and maintaining healthy lifestyles. The mental health promotion program shall address the main related topics for example:

a) Creating healthy public activities:
   I. Including reducing stigmatization and discrimination
   II. Avoid human rights violations
   III. Increase public knowledge and understanding of mental health
   IV. How to access mental health services present in the community through media awareness campaigns and other initiatives.
   V. Awareness program on how to protect children and adults from abuse
   VI. Early identifications of the patient at risk of suicide, substance use disorders, and imminent harm to self or others.
   VII. Depression screening
b) Creating supportive environments:
   I. Anti-bullying programs especially toward specific vulnerable groups across the community,

II. Strengthening and involving the families
III. Mentoring and peer support for children and young people
IV. Supporting people with mental illness to return to work or the workforce.
V. Anti-domestic violence program, including attention to violence associated with alcohol and substance abuse.

c) Encourage the development of personal skills:
   I. Life skills training, mental health and illness literacy, parenting skills, and workplace training.
   II. The mental health hospital shall ensure the availability of well-trained staff to perform the program activities and shall collect data regarding the activity it provides as demographics of the population served. It shall monitor, evaluate and update the program activities regularly

Survey process guide:

- The GAHAR surveyors may review mental health community well-being and promotion program
- The GAHAR surveyors may review the implemented tools that support program activities such as media awareness campaigns, school-based program
- The GAHAR surveyors may interview staff to check their awareness of the program activities

Evidence of compliance

1. The mental health hospital has an approved program for the promotion of mental health and well-being throughout the community.
2. Relevant staff is aware of how to implement the program.
3. The mental health hospital identifies the required resources that are utilized to support the provision of community well-being and promotion services.

Related standards:
STP.04 Suicide prevention program, STP.07 Addiction prevention and treatment program, OGM.14 Community Initiatives, APC.04 Accreditation process value.

Effective, safe tele-mental health services.

STP.09 When indicated, the tele-mental health services are provided in a secure, safe, and effective manner.

Effectiveness

Keyword:
Tele-mental health services.

Intent:
The tele-mental health services implementation ensures the continuity of care provided to the patients regardless of the real location of patients or obstacles they may face and it facilitates the accessibility to the services for individuals served. The tele-mental health services may be conducted via an interactive audio and video telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site. Another major benefit of transitioning to tele-mental health services is that it would reduce person-to-person contact between health service providers and patients and reduce the risk of the spread of infection.
Different telehealth modalities could be used according to the hospital's available resources. It is considered a useful communication method for the delivery of mental health services.

For Examples; videoconferencing, online forums, smartphone apps, text messaging, and e-mails.
The mental health hospital shall support the transitioning and use of telehealth as a valuable way of supporting both the physical and psychosocial needs of all patients irrespective of their geographical location.
There are many concerns regarding the transitioning to tele-mental health services and potential barriers to use as the patients' psychopathology, cognitive impairment, and limited familiarity. The mental health hospital shall develop a defined process to address these issues. Users shall receive verbal and written instructions to orient them on how to use and apply the modality. An expansion of access to tele-mental health services with a focused public education campaign to promote these services shall be strengthened and begin to address this need. The mental health hospital shall develop a clear program of tele mental health and evaluate the effectiveness of the services provided, collect data on its usage and use it in improvement opportunities. The program of telemedicine services does not expand the scope of practice of health care providers or permit their practice in the location of the patient (outside the hospital).
The program of tele-mental health shall address at least the following:

a) Allocating resources and determining hospital readiness to provide telehealth services.
b) Determine staff competency required prior the providing telehealth services
c) Determine situations when using telehealth services are indicated or restricted
d) The modality used for example videoconferences or web-based applications, etc.
e) Public education with identification of the selected targeted population.
f) Measures to maintain security and confidentiality of the services and measures to manage situations when this is breached.
g) How to maintain the patient's right to withdraw from teleconsultations at any time.
h) Situations when the agreement is required by healthcare providers to request the contact information of a family or carer who could be called upon for support in the case of an emergency.

Survey process guide:

- The GAHAR surveyors may review the process for transitioning to tele-mental health service through the hospital.
- The GAHAR surveyors may observe the modalities used in the delivery of tele-mental health service
- The GAHAR surveyors may review staff files to check their training records on the use of telehealth modalities provided

Evidence of compliance:

1. The mental health hospital has an approved program of tele-mental health that addresses all elements in the intent from a) to h)
2. All users are educated and trained on how to implement the program.
3. Tele-mental health services are used to describe and administer medication only when a provider is physically located with the patient.
4. In an emergency, there is a defined process to request the contact information of a family member or carer who can be called for support.

Related standards:
PCC.03 Patient, family, and carer rights, ACT.01Granting access, OGM.12 Ethical Management, OGM.04 Scope of services, PCC.06 Patient, family, and carer education process, IMT.04 Confidentiality and Security of data and information., WFM.10 Clinical Privileges, IMT.01 Document management system, IMT.02 Information management plan.

Diagnostic and Ancillary Services

Chapter intent:

- Patients seek medical help for the determination and treatment of various health problems. Sometimes a combination of the patient's history and a clinical examination by a physician is enough to decide whether medical treatment is needed, and what treatment should be given. However, often laboratory investigations or diagnostic imaging procedures are required to confirm a clinically suspected diagnosis or to obtain more accurate information.
- The scope of this chapter covers the following diagnostic and ancillary services
  - Diagnostic Imaging
    - Radiological Imaging
    - Ultrasound.
    - Quantitative EEG.
  - Laboratory Medicine
    - Sample collection
    - Chemistry and Immunology
    - Microbiology
    - Hematology
    - Point-of-care testing
- There are generally three phases in the process of diagnostic investigation:
  - Before doing the investigation: comprises the time and all processes for the preparation of a patient for a diagnostic investigation to the moment when the investigation is performed.
  - During doing the investigation: comprises the time and all processes of a diagnostic investigation.
  - After doing the investigation: The post-analytical phase comprises the time and all processes for reporting the results of the diagnostic investigation to the person who then provides care to the patient.
- Making errors during each phase influence the clinical relevance of a diagnostic report, and precautions should be taken to avoid results that are misleading or provide false information.
- The diagnostic service shall familiarize the clinician with the value of the information obtained from an investigation, including its diagnostic specificity. This requires constant communication between clinical staff and the diagnostic service. Diagnostic reports are valuable only when the information can be used for patient management. It is, therefore, an obligation for the diagnostic service to provide the results to the clinician on time so that the results can be interpreted together with the clinical findings for the patient.
- The GAHAR surveyors shall be focusing on the communication of patient information to ensure correct and effective patient management plans. The accuracy and precision of the results reported to clinicians are one of the main targets of the survey together with the safety of the patients, staff, and facility since significant organizational hazards are present in these areas, whether biological, chemical, radiological or others.

Chapter purpose:

The main objective is to ensure that the hospital provides diagnostic services safely and effectively, the main objective of this chapter:

1. To ensure safe and effective medical imaging services.
2. To ensure safe and effective clinical laboratory and pathology services.
3. To ensure safe and effective referral services when needed

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) National Law for Laboratories, 367/ 1954
2) Regulation of Medical Imaging Work Law, 59/1960
3) Egyptian Law for the Care of Psychiatric Patients, 71/2009
4) Law No. 210/2020 Amendment for Law of Psychiatric Patient Care, 71/2009.
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Medical Imaging

Efficient planning and management of radiological services

DAS.01 Medical Imaging services are planned, operated, and provided uniformly according to applicable laws, regulations, and clinical guidelines /protocol.

Effectiveness

Keywords:
Planning and provision of Medical imaging services.

Intent:
Medical Imaging is a cornerstone of any hospital. An efficient, high-quality, well-run medical imaging service increases patient satisfaction as a result of its ability to improve patient care.
The location of medical imaging is important for easy access by emergency patients, ambulant patients, and inpatients, different functional areas need to be identified.
Special attention is given to the design of a medical imaging unit such as structural support for equipment, equipment positioning and safe patient movement, provision for cable support trays, ducts or conduits may be made from floors, walls, and ceilings, Equipment ventilation, required space and required special human expertise.
The hospital should plan and design a system for providing medical imaging services required by its patient population, clinical services offered, and healthcare practitioner needs.
The mental health hospital can provide some or all of the services on-site or can refer to/ contract with other healthcare professionals for some or all of the services, quality expectations, and professional standards.
When a medical imaging service is provided outside the designated radiology service area, it should follow the same protocols, guidelines, and safety procedures as the hospital's main radiology service area.
Medical imaging services should meet national laws, regulations, and applicable guidelines.

Survey process guide:

- The GAHAR surveyors may review the provision of medical imaging services, licenses, and permits.
- The GAHAR surveyors may observe the provided medical imaging services to check uniformity and standardization.
- The GAHAR surveyors may review contractual agreements and related reports.

Evidence of compliance:

1. Medical Imaging services provided either onsite or through outside sources meet laws, regulations, and applicable guidelines.
2. All related licenses, permits, and guidelines are available.
3. The list of Medical Imaging services meets the scope of clinical services of the mental health hospital.
4. The mental health hospital demonstrates evidence of monitoring the quality and safety of outsourced medical imaging services.
5. There is evidence of annual evaluation of the medical imaging services provided in a report discussed by the hospital leaders and presented to the governing body.

Related standards:
DAS.02 Medical imaging services healthcare professionals, DAS.03 Technical medical imaging standards (Practice Parameters), EFS.01 Mental health hospital environment and facility safety structure, OGM.03 The Mental health hospitals' leaders.

DAS.02 Medical Imaging services are performed by licensed competent healthcare professionals and specific duties are assigned according to applicable laws and regulations and assessed competencies.

Efficiency

Keywords:
Medical imaging services healthcare professionals**.**

Intent:
Medical imaging professionals are vital members of a multidisciplinary team that forms a core of highly trained healthcare professionals.
They also play a critical role in the delivery of health services as new modalities emerge and the need for medical imaging procedures increases within the laws and regulations.
Medical imaging professionals integrate scientific knowledge, technical competence, and patient interaction skills to provide safe and accurate procedures with the highest regard to all aspects of patient care.
Medical imaging professionals are sensitive to the needs of the patient through good communication, patient assessment, patient monitoring, and patient care skills.
As members of the healthcare team, medical imaging professionals participate in quality improvement processes and continually assess their professional performance.
When Medical Imaging services are provided on-site at the hospital, they are managed by a healthcare professional who is qualified by education and training consistent with applicable laws and regulations.
The mental health hospital shall define the responsibilities of the medical imaging manager/leader which address at least the following:

a) Direct observation of routine work processes and procedures, including all applicable safety practices.
b) Direct observation of equipment maintenance, function checks; and monitoring recording and reporting of examination results.
c) Review of imaging professionals' human resources records.
d) Training on special modalities, equipment, and studies.

The competence of medical imaging services staff can be assessed annually according to the assigned job.
Privileges for performing each medical imaging service function are determined based on documented evidence of competency (experience- qualifications – certifications-skills) that is reviewed and renewed as needed.

Survey process guide:

- The GAHAR surveyors may interview medical imaging services staff members to inquire about competence assessment methods, frequency, and granting privileges.
- The GAHAR surveyors may review medical imaging services staff members' files to verify the competence assessment process.

Evidence of compliance:

1. The mental health medical imaging manager/leader has defined responsibilities that address all the mentioned elements from a) through d) in the intent.
2. Competency assessment is performed annually and recorded in the medical imaging staff file.
3. Privileges are granted for performing each medical imaging service function based on assessed competencies.
4. There is a mechanism to grant privileges temporarily in emergencies.

Related standards:

DAS.01 Planning and provision of Medical imaging services, WFM.03 Job Description, WFM.10 Clinical Privileges, WFM.08 Staff Performance Evaluation, WFM.05 Verifying credentials, WFM.07 Continuous education and training program.

DAS.03 Performance of medical imaging studies and procedures is standardized and effective.

Effectiveness

Keywords:

Technical medical imaging standards (Practice Parameters).

Intent:

Medical imaging service encompasses different techniques, modalities, and processes to analyze services, and therefore plays an important role in initiatives to improve public health for all population groups.

Furthermore, Medical imaging service is frequently justified in the follow-up of a disease already diagnosed and/or treated.

A procedure manual provides a foundation for the medical imaging service's quality assurance program. Its purpose is to ensure consistency while striving for quality.

The procedure manual may be used to document how studies are performed, Train new staff members, remind staff members of how to perform infrequently ordered studies, troubleshoot technical problems, and measure acceptable performance when evaluating staff.

The medical imaging service develops technical procedures for all study types.

The technical medical imaging procedures should be written in a language commonly understood by the working staff and available in an appropriate location. It could be in a paper-based, electronic, or web-based format.

The mental health hospital shall develop and implement procedures for medical imaging to ensure the safety and usability of modalities. For each modality, Procedure manuals shall address at least the following:

a) Scope and general overview
b) Equipment description
c) Maintenance procedures
d) Quality control
e) Safety procedures
f) Critical findings

Survey process guide:

- The GAHAR surveyors may review a sample of medical imaging procedure manuals and check for their availability.
- The GAHAR surveyors may interview staff to check their awareness of the procedure manual

Evidence of compliance:

1. The mental health hospital medical imaging unit has a written procedure for each study type.
2. Procedure manuals are readily available and include all the required elements from a) through f) in the intent.
3. Medical imaging unit staff members are trained and knowledgeable of the contents of procedure manuals.
4. The procedures manual is reviewed at predefined intervals by authorized staff members.

Related standards:
DAS.01 Planning and provision of Medical imaging services, DAS.02 Medical imaging services healthcare professionals, PCC.03 Patient, family, and carer rights, WFM.07 Continuous education and training program.

Effective, safe operational processes of medical imaging

DAS.04 Medical imaging pre-examination process is effective.

Effectiveness

Keywords:
Medical imaging Pre-examination process.

Intent:
Pre-examination processes in the path of workflow for medical imaging include all activities from the time the medical imaging services are ordered through the time that the patient is present in the medical imaging service area.
Medical imaging services shall provide referrers and patients with information regarding the merits of the various diagnostic imaging techniques so that referrers can make informed decisions about the diagnostic information and relative value of the range of studies provided. Also, information about patient preparation requirements is important to ensure effectiveness.
The medical imaging service shall develop and implement a pre-examination policy that can be in the form of medical imaging service manual and communicate it to all service users.
The policy shall include at least the following:

a) Proper completion of the request form to include: patient identification (Full patient name, medical record number, date of birth, gender, and patient contact,), name of the ordering physician, studies requested, date and time the of study, clinical information, special marking for urgent tests request.
b) Patient preparations include specific risks.
c) Description of study techniques.
d) Pre-study review of requests to ensure that the requested examination is appropriate to the needs of the referrer and the patient.
e) Actions to be taken when a request is incomplete, illegible, or not clinically relevant, or when the patient is not prepared.
f) A recording of informed approvals from patients and referrers when an additional or substituted examination is called for.

Survey process guide:

- The GAHAR surveyors may review the medical imaging pre-examination policy.
- The GAHAR surveyors may observe a patient receiving a medical imaging service.
- The GAHAR surveyors may review service requests, patient preparation, and service manual.
- The GAHAR surveyors may interview responsible staff to check their awareness of preparation requirements.
- The GAHAR surveyors may observe the implementation of the medical imaging pre-examination process.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide the medical imaging pre-examination process that includes elements from a) through f) in the intent.
2. Medical imaging service provides referrers and patients with information regarding the merits of the various diagnostic imaging techniques, manual is distributed to all users and available in all technical areas.
3. Medical imaging service staff members review the patient requests and verify patient identity.

4. A medical imaging service staff member ensures that a patient has complied with any preparation requirements (e.g. fasting) for the procedure that is being performed.
5. Actions are taken when a request is incomplete, illegible, or not clinically relevant, or when the patient is not prepared, to ensure patient safety.
6. When an additional or substituted examination is called for, a medical imaging service staff member informs patients and referrers and records in the patient's medical record.

Related standards:
PCC.06 Patient, family, and carer education process, IMT.06 Patient's medical record management, ACT.02 Patient Identification, ICD.03 Clinical practice guidelines.

DAS.05 A medical imaging quality control program is developed.

Effectiveness

Keywords:
Medical imaging quality control program.

Intent:
Management of the routine quality control (QC) of medical imaging equipment is a major responsibility of medical imaging professionals.
Quality control measures are performed to monitor and ensure the reliability of study results produced by the medical imaging service.
Quality controls can identify performance problems and helps the medical imaging service to determine the accuracy of images.
Management of routine quality control includes developing the QC protocols, implementing the program, oversight the program, and being responsible for determining the need for corrective action.
Quality control data is reviewed at regular intervals and recorded.
Outliers or trends in examination performance, that may indicate problems in the examination system, are analyzed, followed up and preventive actions are taken and recorded before major problems arise.
The mental health hospital shall develop and implement a policy and procedure for quality control which shall include at least the following:

a) Elements of internal quality control are performed according to risk assessment for each study/modality.
b) The frequency of quality control testing is determined by the mental health hospital according to guidelines and manufacturer instructions whichever is more stringent.
c) Quality control methods to be used. It can be handled and tested in the same manner and by the same medical imaging staff member.
d) Quality control performance expectations and acceptable results shall be defined and readily available to staff so that they will recognize unacceptable results in order to respond appropriately.
e) The quality control program is approved by the designee prior to implementation.
f) Responsible authorized staff member reviews quality control data at regular intervals (at least monthly).
g) Remedial actions are taken for deficiencies identified through quality control measures and corrective actions are taken accordingly.

Survey process guide:

- The GAHAR surveyors may observe areas where medical imaging services are provided to check the quality control procedures and records.
- The GAHAR surveyors may interview medical imaging service staff members and

other healthcare professionals to check their awareness of quality control performance.

Evidence of compliance:

1. The mental health hospital has an approved policy that describes the quality control process of all medical imaging tests addressing all elements in the intent from a) through g).
2. Medical imaging service staff members involved in quality control are competent in quality control performance.
3. All quality control processes are performed according to the quality control policy.
4. All quality control processes are recorded.
5. A responsible authorized staff member reviews the quality control process and checks data at least monthly.

Related standards:
QPI.02 Performance Measures, EFS.10 Medical Equipment plan, WFM.03 Job Description, IMT.01 Document management system, IMT.02 Information management plan.

DAS.06 Medical imaging examination is consistent and safe.

Safety

Keywords:
Medical imaging examination protocols.

Intent:
Medical imaging service protocols ensure that where it is known the clinical radiologist is not available to provide appropriate additional input for particular modalities or examinations, as detailed in the protocols, the medical imaging team members do not proceed with an examination.
Medical imaging service develops documented professional supervision protocols for the performance of imaging examinations under the professional supervision of the clinical radiologist.
Documented imaging protocols are available and include all necessary information for the proper conduct of the examination, considering any specifications for the required qualifications, experience, and specialization of the healthcare professionals.
The mental health hospital shall ensure that examinations requiring sedation of the patient are not undertaken unless an appropriately trained medical staff member is available to immediately personally attend to the patient, and the safety requirements are met.
These protocols cover radiographic factors, positioning, sterile tray set-up, and aftercare according to the relevant examinations and/or modalities performed at the service. These protocols also address medical emergencies.
Imaging protocols are optimized to obtain the required imaging data while delivering the lowest radiation dose possible and with minimal use of sedation and anaesthesia.

Survey process guide:

- The GAHAR surveyors may review medical imaging examination protocols.
- The GAHAR surveyors may observe a patient receiving a medical imaging service and review positioning, radiographic factors, sterile tray set-up, or aftercare processes.
- The GAHAR surveyors may interview medical imaging staff members to check their awareness of examination protocols.
- The GAHAR surveyors may visit areas where medical imaging services are provided including the radiology department or other departments where portable medical imaging services are provided to observe medical imaging equipment, setup, and modalities.

Evidence of compliance:

1. Medical imaging protocols are documented and address radiographic factors, positioning, sterile tray set-up, and aftercare according to the relevant examinations and/or modalities performed at the service.
2. Where specific tasks are delegated to members of the medical imaging team, the protocols indicate any specific circumstances under which healthcare professionals shall seek further guidance from the supervising clinical radiologist.
3. Medical imaging staff members are aware of examination protocols.
4. Examinations requiring sedation of the patient are not undertaken unless an appropriately trained medical staff member is available to immediately attend to the patient, and the safety requirements are met.
5. Radiographic factors, positioning, sterile tray set-up, and aftercare processes are performed based on approved protocol.
6. Imaging protocols are optimized to obtain the required imaging data while delivering the lowest radiation dose possible and with minimal use of sedation and anesthesia.

Related standards:
DAS.03 Technical medical imaging standards (Practice Parameters), WFM.03 Job Description, WFM.07 Continuous education, and training program.

DAS.07 Medical Imaging investigations are reported within the approved timeframe.

Timeliness

Keywords:
Medical imaging reports.

Intent:
Reporting medical imaging investigations within the planned and targeted time frame is crucial for proper decision-making and an essential function of the service, whenever emergency conditions occur.
Turnaround time (TAT) is the time interval from the time of submission of a process to the time of the completion of the process.
The process is initiated when a request is made. A medical imaging service staff member identifies the patient and performs the study. the Next stage is to record the study result and write a report for it and finally, the result is sent back to the referring medical staff member.
The mental health hospital shall develop and implement a policy and procedures to guide the process of reporting medical imaging investigations that addresses at least the following:

a) Time frames for reporting various types of images to healthcare professionals and patients.
b) Emergency and routine reports.
c) Accountabilities for the medical Imaging services across the hospital
d) A qualified licensed medical staff member is responsible for interpretation and reporting.

The written medical Imaging report is the most important means of communication between the radiologist and the referring medical staff member.
It is part of the patient's medical record and interprets the investigation in the clinical context.
Appropriate construction, clarity, and clinical focus of a radiological report are essential to high-quality patient care that addresses at least the following:

I. The mental health hospital name.
II. Patient identifiers on each page.
III. Type of the investigation.
IV. Results of the investigations.
V. Time of reporting.
VI. Name and signature of the reporting medical staff member.

Survey process guide:

- The GAHAR surveyors may observe a patient receiving a medical imaging service and review service requests, patient access to the service, study time, and reporting time.
- The GAHAR surveyors may review the patient's medical record to assess the completion of medical imaging service reports.
- The GAHAR surveyors may interview nurses, medical imaging service staff members, and other healthcare professionals to inquire about their experience regarding medical imaging service reporting time.

Evidence of compliance:

1. The mental health hospital has an approved policy that addresses all elements mentioned in the intent from a) through d).
2. Staff members involved in interpreting and reporting results are qualified to do so.
3. Results are reported within the approved timeframe.
4. The mental health hospital tracks, collects, analyzes, and reports data on its reporting times for medical imaging services.
5. Complete medical imaging reports including elements from (I) to (VI) are recorded in the patient's medical record.

Related standards:
QPI.09 Sustaining improvement, IMT.6 patients medical record management, WFM.03 Job Description, QPI.02 Performance Measures.

Safe Medical Imaging Studies.

DAS.08 NSR.15 Radiation safety program is developed and implemented.

Safety

Keywords:
Radiation Safety Program.

Intent:
Radiation safety program provides information and training on the theory, hazards, biological effects, protective measures, monitoring, and radiological equipment; mental health hospital develops policies by which radiological equipment are used safely; ensures compliance with regulations; and provides emergency response assistance. The mental health hospital environment, staff, patients, relatives, and vendors should be safe from radiation hazards, as medical Imaging services are provided on-site, the mental health hospital has a radiation safety program that shall address all components of the mental health hospital medical Imaging services.
The mental health hospital monitors staff health by performing regular biannual CBC analysis and collecting their thermos-luminescent dosimeter (TLD) and/or badge film reports. When CBC results exceed the borderline further investigations are ordered.
The mental health hospital shall develop and implement a program to guide the process of a radiation safety program to ensure the mental health hospital environment, staff, patients, families, and vendors are safe from radiation hazards that address at least the following:

a) Compliance with the applicable laws and regulations.
b) All ionizing and non-ionizing radiation equipment is maintained and calibrated.
c) Availability of the staff self-monitoring tools.
d) Availability of suitable personal protective equipment.
e) Patients' radiation safety precautions.
f) Radiation equipment protective maintenance and calibration.

g) MRI safety program (if present) which includes pre-exposure screening for metals, metallic implants, devices, and use of MRI-compatible devices

Survey process guide:

- The GAHAR surveyors may review the radiation safety program to check the approved level of exposure according to local laws and regulations, shielding methods, and safety requirements for both staff members and patients.
- The GAHAR surveyors may review environmental radiation measures, thermo-luminescent dosimeter (TLD), and/or badge films of the staff results, CBC results, and lead aprons inspection.
- The GAHAR surveyors may interview staff to check their awareness.
- The GAHAR surveyors may observe the implemented radiation safety measures.

Evidence of compliance:

1. The mental health hospital has an approved radiation safety program that addresses all elements mentioned in the intent from a) through g).
2. Staff members involved in medical imaging are aware of the radiation safety program and receive ongoing education and training for new procedures and equipment.
3. Staff members involved in medical imaging wear personal protective equipment and personal monitoring equipment.
4. Environmental radiation safety measures, personal monitoring devices' staff results, and regular CBC results are available and documented.

Related standards:
ICD.03 Clinical practice guidelines, EFS.01 Mental health hospital environment and facility safety structure, EFS.06 Safety Management Plan, EFS.10 Medical Equipment plan, WFM.07 Continuous education, and training program.

Appropriate planning and management of clinical laboratory services

DAS.09 Laboratory services are planned, provided, and operated according to applicable laws, regulations, and applicable guidelines.

Effectiveness

Keywords:
Laboratory services planning and management.

Intent:
Planned laboratory services are critical to ensuring that communities receive good clinical care. There is a major need to develop effective laboratory plans, provisions, and operations to strengthen clinical care systems, as an integral part of strengthening overall mental health hospital systems.
The mental health hospital shall plan for laboratory services and modify this plan regularly as the requirements for services evolve and change.
The mental health hospital develops and implements a technical system for providing laboratory services required by its patient population, offered clinical services, and the mental health hospital mission.
A Laboratory scope of services is required to be available for patients, mental health hospital staff, and healthcare professionals.
The designated area shall fulfill the following:

a) Is physically separate from other activities in the mental health hospital
b) According to the governance's requirements.

c) Accommodate all laboratory activities.

Survey process guide:

- The GAHAR surveyors may check the laboratory scope of services and match it with related laws and regulations.
- The GAHAR surveyors may visit the laboratory area to determine that is separate and presence of dedicated area for sample collection

Evidence of compliance:

1. Laboratory services meet applicable guidelines, standards of practice, laws, and regulations.
2. Laboratory services are available to meet the needs related to the mental health hospital mission and patient population.
3. The laboratory scope of services is defined and documented.
4. The plan for services is periodically reviewed and modified as the requirements for services evolve and change.
5. The designated laboratory area is available and separate from any other activities and includes the items from a) to c).
6. Presence of dedicated area for sample collection.

Related standards:

EFS.01 Mental health hospital environment and facility safety structure, ICD.03Clinical practice guidelines, QPI.03 Risk Management Program, EFS.06 Safety Management Plan, EFS.10 Medical Equipment Plan, IMT.01 Document management system.

DAS.10 Licensed, competent healthcare professionals are assigned to operate laboratory services and duties.

Effectiveness

Keywords:
Laboratory Staff.

Intent:
Laboratory competent staff have an influential role in the creation of a safe, healthy, productive working environment.
Staff competency assessment is an ongoing process for managers to evaluate an employee's work performance, identify strengths and weaknesses, offer feedback, and set goals for future performance.
The laboratory develops a policy and procedures describing the performance and documentation of personnel competency assessment that includes at least the following:

a) Direct observation of routine work processes and procedures, including all applicable safety practices.
b) Direct observation of equipment maintenance, the function checks; and monitoring recording and reporting of examination results.
c) Assessment of problem-solving skills.
d) Examination of specially provided samples, such as previously examined samples, inter-laboratory comparison materials, or split samples.

The competence of laboratory staff can be assessed annually using any combination, of all of the approaches mentioned above or following the guidelines according to the assigned job.
Privileges for performing each laboratory function are determined based on documented evidence of competency (experience- qualifications – certifications-skills) that is reviewed and renewed as needed.

Survey process guide:

- The GAHAR surveyors may interview laboratory staff members to inquire about competence assessment methods, frequency, and granting privileges.
- The GAHAR surveyors may review laboratory staff file members to verify the competence assessment process.

Evidence of compliance:

1. The mental health hospital has an approved policy and procedure that address all the mentioned elements from a) through d) in the intent.
2. Competency assessment is performed annually and recorded in the laboratory staff file.
3. Privileges are granted for performing each laboratory function based on assessed competencies.

Related standards:
DAS.01 Planning and provision of medical imaging services, EFS.01 Mental health hospital environment and facility safety structure, WFM.03Job Description, WFM.05 Verifying credentials, WFM.08 Staff Performance Evaluation, WFM.02 Staffing Plan, QPI.02 Performance Measures.

Effective operational processes in the laboratory

DAS.11 Laboratory pre-examination process, Specimen reception, tracking, and storage are effective.

Effectiveness

Keywords:
Pre-examination process, Specimen reception, tracking, and storage.

Intent:
Pre-examination processes are the path of workflow for clinical laboratories including all activities from the time the laboratory tests are ordered through the time that the specimens are processed and delivered to the laboratory testing location.

The laboratory shall develop a pre-examination policy that includes all needed information about the Pre-examination process, Specimen reception, tracking, and storage including at least the following:

a) Proper completion of the request form to include: patient identification (Full patient name, medical record number, date of birth, gender, patient contact, and location), name of the ordering physician, tests requested, date and time of specimen collection, identification of the person who collected the specimen, clinical information, type of specimen (source of specimens), special marking for urgent tests request.
b) Patient preparations include instructions for dietary requirements (e.g., fasting and special diets).
c) Description of specimen type collection techniques
d) Proper specimen labelling.
e) Special procedure for drug testing sample collection
f) Proper handling and transportation of specimens
g) Criteria for safe disposal of materials used in the collection
h) Turnaround time of tests.
i) Minimal Retesting Interval (defined as the minimum time before a test should be repeated, based on the properties of the test and the clinical situation in which it is used).
j) Acceptance or rejection criteria of specimens according to hospital policy

k) Evaluation of received specimens by the authorized staff member to ensure that they meet the acceptance criteria relevant for the requested examination(s).
    i. Acceptable specimen: Specimen recording process in an accession book, worksheet, computer, or another comparable system, Recording includes the date and time of specimen's reception/registration and the identity of the person receiving the specimen.
    ii. Unacceptable specimen: Records of rejection are maintained, including the cause of rejection, time and date, name of rejecting person, and name of the notified individual.
    iii. Suboptimal specimen: Recording includes the date and time of specimen's reception/registration and the identity of the person, Indications of acceptance of suboptimal specimens, and measures taken accordingly.
l) Traceability of all portions of the primary specimen to the original primary sample.
m) Process of recording all specimens referred to other laboratories for testing.
n) Instructions for proper sample storage in the pre-examination phase.

Survey process guide:

- The GAHAR surveyors may review the laboratory pre-examination policy
- The GAHAR surveyors may observe a patient receiving a laboratory service and review the service request, patient identification process, patient preparation, and service manual.
- The GAHAR surveyors may interview the staff to check their awareness of preparation requirements.
- The GAHAR surveyors may review records of received specimens and match reasons for rejection with approved criteria and review the laboratory specimen identification and traceability process.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide the pre-examination Specimen reception, tracking, and storage process that includes elements from a) through n) in the intent.
2. All staff is aware of the pre-examination Specimen reception, tracking, and storage policy.
3. Preparation of specimen, collection, labelling, and storage requirements are implemented.
4. Specimens are handled, transported, and disposed of safely.
5. All received specimens including accepted, rejected, or referred specimens, are recorded as per policy.
6. Evidence of traceability of all portions of the primary sample to the original primary sample.

Related standards:

ICD.05 Patient medical assessments, ACT.02 Patient identification, WFM.03Job Description, IMT.02 Information management plan, EFS.06 Safety Management Plan, IPC.02 Infection prevention and control (IPC) program

DAS.12 Verified/validated analytical test methods are selected and performed.

Effectiveness

Keywords:
Verified / Validated test methods.

Intent:
Analytical laboratory techniques and testing provide the data required to make critical decisions during clinical care, drive test improvement or meet regulatory compliance requirements.
In-depth knowledge of analytical laboratory technologies and how to apply them to a specific sample is critical to driving understanding of a test during analysis.
These technologies are often highly specialized analytical instruments that can only be operated by competent professionals.
In order to ensure accurate and relevant test results, the laboratory uses accurate and reproducible analytical methods for both detection or confirmation using qualitative and /or quantitative. This can be confirmed when the specified requirements for each examination procedure relate to the intended use of that examination.
Mental health hospitals shall assign competent staff members for different activities of the selected methods.
The validated examination procedures, used without modification shall be subject to verification by the laboratory before being in routine use.
The laboratory shall develop a policy for verification of examination procedure following reliable guidelines.
Once the manufacturer's claim is confirmed, the laboratory documents the procedures used for verification records the results obtained, and the staff with the appropriate authority.
Verification of performance characteristics of the process shall include at least the following:

a) Measurement of trueness.
b) Measurement of precision.
c) Measurement of linearity (detection and quantification limits).

The laboratory shall validate the examination procedures when:

i. Using a non-standard method.
ii. The standard method is used outside its intended scope.
iii. The validated method with modification.

The laboratory shall follow verification/validation methods endorsed by reliable and updated guidelines.
When changes are made to a verified/ validated examination procedure, a new verification/validation shall be carried out and documented.

Survey process guide:

- The GAHAR surveyors may review the policy for verification of the examination procedure and check the references used.
- The GAHAR surveyors may interview staff members to inquire about their awareness of the policy, their competence, and their knowledge of the introduced or changed tests.
- The GAHAR surveyors may review verification/ validation and revalidation records.

Evidence of compliance:

1. The laboratory has an approved policy to guide the verification of the examination procedure
2. The laboratory follows verification/validation methods endorsed by reliable and updated guidelines.
3. The responsible authorized staff member demonstrates competence and in-depth knowledge of the introduced or changed test.
4. Records of verification and /or validation results fulfilling acceptable criteria based on predetermined guidelines.

5. There is recorded evidence of re-verification/re-validation whenever indicated.

Related standards:
DAS.13 Laboratory examination procedures' instructions, DAS.14 Laboratory control programs, WFM.03 Job Description, WFM.07 Continuous education, and training program.

DAS.13 Instructions for performing test methods and procedures are consistently and effectively followed.

Effectiveness

Keywords:
Laboratory examination procedures' instructions.

Intent:
Laboratory service encompasses different techniques, and processes to analyze services, and therefore plays an important role in initiatives to improve public health for all population groups. Furthermore, laboratory service is frequently justified in the follow-up of a disease already diagnosed and/or treated.
A procedure manual provides a foundation for the laboratory's quality assurance program.
The laboratory shall provide carefully documented instructions—in the form of procedures—for all activities that support the performance of analytic testing. These instructions provide essential information for both new and experienced employees on how to perform all examination procedures.
Its purpose is to ensure consistency while striving for quality.
The laboratory shall develop technical procedures for all analytical test methods.
The technical laboratory procedures should be written in a language commonly understood by the working staff and available in an appropriate location.
It could be in a paper-based, electronic, or web-based format.
The Laboratory technical procedures are consistently followed and regularly reviewed. They include at least the following:

a) Principle and clinical significance of the test.
b) Requirements for patient preparation and specimen type, collection, and storage.
c) Criteria for acceptability and rejection of the sample.
d) Reagents and equipment used.
e) Verification/validation of examination procedures.
f) The test procedure, including test calculations and interpretation of results.
g) Calibration and control procedures and corrective actions to take when calibration or control results fail to meet the laboratory's criteria for acceptability.
h) Verified/Validated biological reference intervals/clinical decision values.
i) Critical test results.
j) Analytical measurement range and instructions for determining results when it is not within the measurement interval.
k) Limitations in methodologies include interfering substances.
l) References.

Survey process guide:

- The GAHAR surveyors may review laboratory procedures.
- The GAHAR surveyors may observe a patient undergoing a laboratory service and review preparation processes.
- The GAHAR surveyors may interview laboratory staff members to check their awareness of analytic procedures.
- The GAHAR surveyors may observe medical calibration, reagent use, ranges, and results.

Evidence of compliance:

1. The laboratory has a written procedure for each analytical test method.
2. The technical laboratory procedures are readily available when needed.
3. Each procedure includes all the required elements from a) through l) in the intent.
4. Staff is trained and knowledgeable of the contents of procedure manuals.
5. The procedures are consistently followed.
6. Authorized staff member reviews the procedures at predefined intervals.

Related standards:

DAS.12 Verified / Validated test methods, DAS.14 Laboratory control programs, WFM.07 Continuous education, and training program, WFM.03Job Description.

DAS.14 Quality control programs are developed and implemented for all tests.

Effectiveness

Keywords:

Laboratory control programs.

Intent:

Quality control programs include internal and external quality control or alternatives.

Internal quality control testing is performed within a laboratory to monitor and ensure the reliability of test results produced by the laboratory.

Control materials are used to monitor the test system and verify that quality patient test results have been attained.

A control is a stabilized sample with a predetermined range of result values that simulates a patient sample.

Quality control data shall be reviewed at regular intervals (at least monthly) and shall be recorded.

Outliers or trends in examination performance, that may indicate problems in the examination system, shall be analyzed, followed up, and preventive actions shall be taken and recorded before major problems arise.

The laboratory develops and implements a procedure for internal quality control which shall include at least the following:

a) The frequency for quality control testing is determined by the mental hospital laboratory according to guidelines and manufacturer instructions whichever is more stringent
   a) Quality control materials to be used shall be handled and tested in the same manner and by the same laboratory staff member testing patient samples.
   b) Quality control performance expectations and acceptable ranges should be defined and readily available to staff so that they will recognize unacceptable results and trends in order to respond appropriately.
   c) Acceptance-rejection rules for internal quality control results.
   d) The IQCP (internal quality control procedure) is approved by the designee prior to implementation.
   e) Quality Control data is reviewed at a regular interval (at least monthly) by a responsible authorized staff member.
   f) Remedial actions are taken for deficiencies identified through quality control measures and corrective actions are taken accordingly.

The external quality control program is a system designed to objectively assess the quality of results obtained by laboratories, by means of an external body.

The laboratory shall participate in an external quality assessment program that covers the whole number of analytes performed by the laboratory and available from the provider, as well as the complexity of the testing processes used by the laboratory.

The laboratory shall subscribe to proficiency testing according to the laboratory scope.

When there is no proficiency testing available, the laboratory performs interlaboratory comparison or proficiency test alternatives according to guidelines. This system is used, and

its results are recorded at least semiannually. Records of all processes of external quality control including testing, reporting, review, conclusions, and actions, are available and retained for at least one year.

Survey process guide:

- The GAHAR surveyors may review internal and external quality control procedures and records.
- The GAHAR surveyors may interview laboratory staff members to check their awareness of internal and external quality control performance.

Evidence of compliance:

1. The laboratory has an approved procedure describing the internal quality control process of all laboratory tests addressing all elements in the intent from a) through f).
2. Laboratory staff members involved in internal quality control are competent, responsible, and authorized staff member reviews quality control data at least monthly.
3. All internal quality control processes are performed and recorded according to the internal quality control procedure and the Corrective actions are taken when indicated.
4. The laboratory subscribes to an external proficiency-testing program that covers the whole number of analytes performed by the laboratory and available from the provider, as well as the complexity of the testing processes used by the laboratory.
5. Records of all processes of external quality control including testing, reporting, review, conclusions, and actions, are present and retained for at least one year.
6. Evidence of proficiency testing alternative procedures used according to guidelines whenever no proficiency testing is available.

Related standards:

DAS.13 Laboratory examination procedures' instructions, DAS.12 Verified / Validated test methods, WFM.03Job Description.

DAS.15 Laboratory post-examination process is developed and implemented effectively to ensure accurate, timely reporting and release of verified laboratory tests.

Timeliness

Keywords:

The post-examination process, Laboratory TAT, STAT.

Intent:

Laboratory post-examination key processes in the path of workflow include activities related to reporting results and archiving results and specimen material.

The overall purpose of all post-examination activities is to ensure that the results of examinations are presented accurately, timely, and clearly.

Turnaround time (TAT) is a period of time required for completing a particular process.

TAT is commonly measured in clinical analyses in the lab, but nowadays, TAT includes all the phases from the request of the samples to the reporting of test results.

STAT testing is defined as laboratory testing urgently needed for the diagnosis or treatment of a patient when any delay can be life-threatening.

The laboratory shall define the tests that can be ordered on a STAT basis and the interval of time between sample collection, reception, and reporting results

The mental health hospital shall develop and implement a policy and procedures for post examination process that includes at least the following:

a) Final report data fulfillment including at least: the identity of the laboratory, patient identification, tests performed, ordering clinician, date and time of specimen collection and the source of the specimen, reporting date and time, test results and reference interval, identification of the verifying individual **(Approved),**

interpretation of results, appropriate, advisory, or explanatory comment when needed.
b) Reviewing, verifying, and reporting results by an authorized staff member
c) All laboratory tests (TAT) shall be defined by the laboratory.
d) The laboratory shall define the tests that can be ordered on a STAT base.
e) Criteria for specimen storage.
f) The defined retention time of laboratory results
g) The defined retention time of patient samples
h) Confidentiality of the released test results.
i) Released test results to authorized recipients (the requesters or responsible).

Survey process guide:
- The GAHAR surveyors may observe and review specimen storage and retention times.
- The GAHAR surveyors may review the patient's medical record and assess laboratory result report time and authorization.
- The GAHAR surveyors may interview staff to inquire about their experience regarding laboratory retention time.

Evidence of compliance:
1. The mental health hospital has an approved policy to guide the post-examination process that includes all elements mentioned in the intent from a) through i).
2. The laboratory defines the authorized staff member who reviews and releases the patient's results.
3. The laboratory has a STAT List of tests with an acceptable STAT reporting time for each laboratory test, which is defined.
4. Delays in turnaround time are notified to requestors, investigated and proper actions are taken accordingly.
5. The retention process of a final laboratory report is implemented with easy retrieval.
6. The procedure of specimen storage and retention and retrieving is implemented.

Related standards:
ICD.16 Critical results, DAS.12 Verified / Validated test methods, WFM.03Job Description, IMT.04 Confidentiality and Security of data and information, ACT.02 Patient Identification.

Safe laboratory services

DAS.16 NSR.16 A comprehensive documented laboratory safety program is implemented.

Safety

Keywords:
Laboratory Safety Program.

Intent:
The laboratory environment can be a hazardous place to work.
Laboratory staff members are exposed to numerous potential hazards including chemical, biological, physical, and radioactive hazards, as well as musculoskeletal stresses.
Laboratory safety is governed by numerous regulations and best practices. Over the years, multiple guides were published to make laboratories increasingly safe for staff members.
Laboratory management should design a safety program that maintains a safe environment for all laboratory staff, patients, and families.
The laboratory should have a documented program that describes the safety measures for laboratory facilities according to the national requirements.
This program should be properly implemented and communicated to all staff. The program shall include at least the following:
a) Safety measures for healthcare professionals.
b) Safety measures for the specimen.

c) Safety measures for the environment and equipment.
d) Incident handling and corrective action are taken when needed.
e) Proper disposal of laboratory waste.
f) Material Safety Data Sheets (MSDS) Requirements.
g) Handling chemical spills/spill clean-up.
h) Instructions for the use of personal protective equipment.
i) Risk management process.

Survey process guide:

- The GAHAR surveyors may review the laboratory safety program, which should include at least: a list of chemicals and hazardous materials, dealing with spills, safety requirements, suitable PPE, maintenance and calibration of medical equipment, staff orientation, and proper waste disposal.
- The GAHAR surveyors may review laboratory safety reports, lab equipment safety, storage of chemicals, labeling, and waste disposal process.

Evidence of compliance:

1. A written program that describes safety measures for laboratory services and facilities is documented and includes the items in the intent from a) to i).
2. Laboratory staff is trained in the laboratory safety program.
3. Laboratory risk assessment is performed, and safety reports are issued at least semi-annually to the mental health hospital environment and facility safety committee.
4. Spill kits, safety showers, and eye washes are available, functioning, and tested.
5. Safety precautions are implemented.
6. The mental health hospital tracks , collects, analyzes, and reports data on laboratory safety programs and it acts on identified improvement opportunities.

Related standards:
EFS.01 Mental health hospital environment and facility safety structure, EFS.06 Safety Management Plan, IPC.04 Infection risk assessment, EFS.05 Hazardous materials safety, EFS.09 Pre-Construction risk assessment, QPI.02 Performance Measures, WFM.07 Continuous education and training program, IPC.06 Standard precautions measures.

Effective Point of care testing

DAS.17 Point-of-care testing is monitored for providing accurate and reliable results.

Effectiveness

Keywords:
Point of care testing.

Intent:
Point-of-care testing (POCT) is defined by the College of American Pathologists as “tests designed to be used at or near the site where the patient is located, that do not require permanent, dedicated space, and that are performed outside the physical facilities of the clinical laboratories.”
The laboratory shall assign a responsible staff member to ensure the quality of these devices and that the reagents and other laboratory supplies are consistently available for it.
The laboratory shall have a clearly defined approach to POCT to ensure that it is performed safely and correctly and that the results generated are accurate and reliable.
The mental health hospital shall identify all POCT sites, and the testing performed, prepare an audit form, perform an inspection to determine if any deficiencies currently exist, and implement corrective actions for any deficiencies identified in the inspection.

Survey process guide:

- The GAHAR surveyors may review the procedure manual in each point of care testing area, patient results and reporting process, quality control, maintenance, and function checks, evidence of testing staff member training and competency records.

Evidence of compliance:

1. The laboratory assigns a competent responsible staff member for supervising the point-of-care testing services.
2. Staff members who are responsible for performing point-of-care testing are competent to do so.
3. There is a defined process for performing and reporting point of care testing (POCT).
4. Quality control procedures for POCT are recorded and implemented.

Related standards:

DAS.11 Pre-examination process, Specimen reception, tracking, and storage, DAS.14 Laboratory control programs, DAS.15 The post-examination process, Laboratory TAT, STAT, WFM.03 Job Description.

MENTAL HEALTH PROCEDURES

Chapter intent:

Electroconvulsive therapy has been an important treatment in psychiatry since the 1930s. ECT is a safe and effective treatment that involves passing a carefully controlled electrical current through a person's brain to trigger a seizure — a rapid discharge of nerve impulses throughout the brain.

ECT is a valuable tool in the treatment of certain psychiatric disorders and can provide rapid, significant improvements in severe symptoms of several mental health conditions.

Each weak hundreds of patients are treated with ECT. This procedure can be done on an inpatient or outpatient basis. Recent studies demonstrate that ECT delivered with ultra-brief pulses produces less memory loss and other cognitive side-effects than ECT delivered with standard pulses.

The use of anesthesia and procedural sedation is a common and complex process in a healthcare organization. It requires complete and comprehensive patient assessment, integrated care planning, continued patient monitoring, and criteria-determined transfer for continuing care, rehabilitation, and eventual transfer and discharge.

Anesthesia and procedural sedation are commonly viewed as a continuum from minimal sedation to full anesthesia. As patient response may move along that continuum, anesthesia and procedural sedation use should be organized in an integrated manner. Thus this chapter addresses anesthesia and procedural sedation where the patient's protective reflexes needed for a patent airway and ventilation function maintenance are at risk.

These standards are applicable in whatever setting anesthesia and/or procedural sedation are used and other procedures that require consent are performed. Such settings include outpatients and inpatients.

The scope of this chapter covers any procedure performed in any of the following services/places:

1) ECT rooms whether for hospitalized patients, outpatients
2) Drug-assisted interview in the mental health hospital setting for inpatients and outpatients.
3) Any other unit in the hospital either with or without anesthesia or sedation, including local anesthesia.

Procedural sedation is defined as the technique of administering sedatives or dissociative agents with or without analgesics to induce an altered state of consciousness that allows the patient to tolerate painful or unpleasant procedures, emotions, or memories while preserving cardiorespiratory function.

The GAHAR surveyors shall survey all areas where ECT, drug-assisted interview procedures, anaesthesia, or sedation are taking place; to ensure patient safety, staff competency, and effective utilization of these areas

Chapter purpose:

1. To ensure that organizations provide/maintain safe, timeliness, patient-centeredness, and effective procedural, anesthesia care, and sedation services.
2. To describe processes before, during, and after the invasive procedure.
3. To define anesthesia leadership, followed by pre-anesthesia, during anesthesia, and post-anesthesia required processes.
4. To describe sedation care including pre-sedation, during sedation, and post-sedation care.
5. To set the rules and minimum quality requirements of management of the rapid tranquilization, drug assessed interview.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Constitution
2) Egyptian law for the care of psychiatric patients, 71/2009
3) Law no. 210/2020 amendment for the law of psychiatric patient care, 71/2009.
4) Regulations for the care of psychiatric patients,128/2010
5) Regulations for the care of psychiatric patients, 55/2021
6) Law 51/1981 amended by law 153/2004, Healthcare facilities organization
7) Standards for licensed mental health facilities for the National Council of Mental Health
8) Prime Minister decree, Management of Emergency cases, 1063/2014
9) MOH Ministerial decree on anaesthesia service requirements, 236/2004
10) MOH Ministerial Decree 153/2004 on minimum requirements for anaesthesia services
11) Egyptian code of medical ethics 238/2003 (Medical Syndicate Publications)
12) Egyptian code of nursing ethics (Nursing Syndicate Publications)
13) Emergency Department unified protocol, Egyptian ministry of health and population curative and critical sector
14) WHO Surgical Safety checklist
15) Protocol for electroconvulsive therapy (ECT) treatment center within the healthcare, 2019.
16) Guideline for the Administration of Electroconvulsive Therapy. State of Queensland (Queensland Health), September 2018.
17) ECT Accreditation Service (ECTAS) Standards for the administration of ECT. The fourteenth edition revised: January 2019.

Anesthesia and sedation services

MHP.01 Anesthesia sedation services are available and provided according to applicable laws and regulations and clinical guidelines/protocols.

Safety

Keywords:
Provision of anesthesia, Sedation services.

Intent:
The provision of anesthesia and sedation is a complex process and problem-prone service; Laws, regulations, and guidelines set governing frameworks to control these services.
Sedation and anesthesia require complete patient assessment, continued patient monitoring, and identified recovery criteria. The mental health hospital shall define sedation and anesthesia services required to provide according to its patient population, clinical services provided, and health care practitioners' needs.
Management of anesthesia emergencies and complications is the most critical part of providing anesthesia care. Written protocols for the management of complications ensure professional management of these conditions if occurred. To unify the provision of anesthesia services, clinical protocols shall be developed for the approved anesthesia techniques based on approved guidelines.
For the safe provision of anesthesia and sedation, a minimum setup shall be available, which includes equipment, medications, medical supplies, and medical gases.
Anesthesia and sedation services are provided based on the applicable professional practice standards for providing anesthesia and sedation care and meet all applicable national laws and regulations.

Survey process guide:

- The GAHAR surveyors may review clinical guidelines and protocols for anesthesia.
- The GAHAR surveyors may interview staff to check their awareness of the standardized techniques for anesthesia.
- The GAHAR surveyors may observe the structure of the place, available equipment, medications, and medical supplies followed by observing the process.

Evidence of compliance:

1. The provision of sedation and anesthesia service meets the applicable professional practice guidelines, national laws, and regulations.
2. Sedation and anesthesia services are available to meet patient needs.
3. Anesthesia services are standardized and uniformly implemented throughout the hospital.
4. The mental health hospital has an approved protocol for the management of any potential anesthesia emergencies or complications.

Related standards:
ICD.03 Clinical practice guidelines, WFM.10 Clinical Privileges, MHP.02 Qualified Anesthesiologist, MHP.03 Pre- anesthesia assessment_ Pre-induction assessment, PCC.07 Informed consent MHP.07, Procedural sedation.

MHP.02 Anesthesia and sedation services are provided under the direction of a qualified anesthesiologist.

Effectiveness

Keywords:
Qualified Anesthesiologist.

Intent:
Safe provision of anesthesia and sedation services requires the appointment of an experienced and qualified individual(s) (anesthesiologist) to perform and supervise the services provided. The job description shall determine his responsibility that includes at least the following:

a. Determines the resources required including staffing, equipment, medications, and medical supplies.
b. Develop all required policies, procedures, applicable guidelines, and protocols
c. Supervise all activities related to anesthesia and sedation services
d. Evaluates the outcome of anesthesia and sedation services
e. Perform anesthesia staff ongoing performance evaluation.

The mental health hospital shall determine the required qualifications, training, expertise, and experience of the anesthesiologist that all are consistent with the applicable laws and regulations.

Survey process guide:

- The GAHAR surveyors may review the staff file for the anesthesia and sedation leader to check the availability of all requirements in his job description.
- The GAHAR surveyors may interview the anesthesia leader to check his awareness of the assigned responsibilities.

Evidence of compliance:

1. A clear, specific job description for the anesthesia and sedation leader is available in the leader's staff file, which includes items from a) to e) in the intent.
2. Sedation and anesthesia services are managed by qualified individuals/(s), throughout the hospital.
3. The qualified individual/(s) (anesthesiologist) is fully understood, and aware of his responsibilities mentioned in the job description.

Related standards:
MHP.01 Provision of anesthesia, Sedation services, WFM.03 Job Description, WFM.10 Clinical Privileges, OGM.03 The Mental health hospitals' leaders., WFM.05 Verifying credentials.

MHP.03 A qualified anesthesiologist performs a pre-anesthesia assessment and pre-induction assessment

Safety

Keywords:
Pre- anesthesia assessment_ Pre- induction assessment.

Intent:
Anesthesia services usually start with a pre-anesthesia assessment performed by a qualified anesthesiologist. Pre-anesthesia assessment determines the patient's condition, risk scoring for receiving anesthesia, and required interventions/care before, during, and after receiving anesthesia. The mental health hospital shall develop a policy for pre-anesthesia and pre-induction assessments that clearly identifies when and how those assessments are performed. The pre-anesthesia assessment shall be completed prior to or shortly before the invasive procedure
The pre-induction assessment is separate from the pre-anesthesia assessment, as it determines the physiological stability and readiness of the patient for anesthesia and occurs immediately prior to the induction of anesthesia.
In case of emergency, the pre-anesthesia assessment and pre-induction assessment shall be performed immediately, simultaneously, but are documented independently.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for pre-anesthesia assessment.
- The GAHAR surveyors may observe and trace a patient who received anesthesia to evaluate the process of pre-anesthesia assessment.

Evidence of compliance:

1. The mental health hospital has an approved policy of pre-anesthesia and pre-induction assessments that identifies when and how those assessments are performed.
2. Pre-anesthesia assessment is performed for each patient to evaluate risk scoring for receiving anesthesia.
3. The pre-anesthesia assessment and pre- induction assessment are recorded separately in the patient's medical record.
4. Pre-induction assessment is performed for each patient immediately before induction of anesthesia.
5. Relevant staff is educated and fully aware of how to apply the policy.

Related standards:
MHP.01 Provision of anesthesia, Sedation services, MHP.02 Qualified Anesthesiologist, MHP.04 Anesthesia plan, IMT.06 Patient's medical record management.

MHP.04 The mental health hospital ensures performing anesthesia plan for each patient receiving anesthesia.

Effectiveness

Keywords:
Anesthesia plan.

Intent:
Anesthesia care shall be planned and documented in the medical record. The plan includes at least the following:

a. Information from the complete patient assessments and identifies the appropriate anesthesia to be used,
b. The method of administration,
c. Other medications and fluids needed,
d. Monitoring procedures,
e. Anticipated post-anesthesia outcome.
f. The anesthesia agent, and anesthetic technique
g. The signature and full name of participating anesthesia team shall be documented in the medical record.

Survey process guide:

- The GAHAR surveyors may review a sample of the patient's medical records to check for the anesthesia care plan's complete documentation.
- The GAHAR surveyors may interview the relevant staff to check their awareness of the anesthesia care plan.

Evidence of compliance:

1. Each patient's anesthesia care plan is performed and documented in the patient's medical record.
2. The anesthesia care plan includes all items from a) to g) in the intent.

3. The anesthesiologist, anesthesia assistants, and all participating teams are identified in the patient's medical record.

Related standards:
IMT.06 Patient's medical record management, MHP.02 Qualified Anesthesiologist, MHP.03 Pre- anesthesia assessment_ Pre-induction assessment, PCC.07 Informed consent, ICD.13 Plan of care.

MHP.05 Qualified anesthesiologist performs continuous monitoring of the patient's physiological status during anesthesia and Electroconvulsive Therapy.

Safety

Keywords:
Continuous monitoring during anesthesia and Electroconvulsive Therapy.

Intent:
Administering anesthesia for performing invasive procedures and electroconvulsive therapy (ECT) are associated with changes in the patient physiologic status that could be very rapid. Accordingly, the patient physiologic status is required to be continuously monitored starting before receiving the anesthesia to determine the baseline of the patient condition, which is used in determining the patient criteria of discharge from the post-anesthesia care unit. Continuous monitoring allows the anesthesiologist for on-time intervention for any changes in the patient's condition. The type and frequency of anesthesia monitoring are determined according to, at least the following:

a. Patient's condition and age,
b. Pre-anesthesia assessment
c. Anesthesia plan
d. Type of anesthesia,
e. Type and duration of invasive procedure performed
f. The applicable approved clinical practice guidelines.

Survey process guide:

- The GAHAR surveyors may observe a patient while receiving the anesthesia service to evaluate the process of patient monitoring and the staff involved in this process.
- The GAHAR surveyors may review samples of patient's medical records to check for anesthesia monitoring documentation.

Evidence of compliance:

1. The frequency and type of monitoring during anesthesia and the invasive procedure are determined according to item a) through item f) from the intent.
2. Monitoring of the patient's physiological status is consistent with the hospital clinical practice guidelines.
3. The results of monitoring are documented in the patient's medical record.
4. A qualified anesthesiologist/(s) performs the anesthesia monitoring.

Related standards:
MHP.01 Provision of anesthesia and sedation services, ICD.03 Clinical practice guidelines, MHP.02 Qualified Anesthesiologist, MHP.03 Pre- anesthesia assessment_ Pre-induction assessment, MHP.04 Anesthesia plan.

MHP.06 Post anesthesia care, monitoring, and discharge are done by a competent individual.

Safety

Keywords:
Post-anesthesia care.

Intent:
Post-anesthesia care includes monitoring of the patient physiologic status that allows the anesthesiologist to determine the patient's criteria for discharge from the post-anesthesia care unit.
Administration of any medications ordered shall be recorded in the patient's medical record.
The mental health hospital is required to record any special or unusual events that occurred inside the post-anesthesia care unit with the management provided, the time of receiving the patient, and the time of transfer from the post-anesthesia unit. If the patient is transferred directly from the procedure room to the receiving unit, monitoring and documentation are the same as would be required in the ordinary recovery room. The mental health hospital shall develop and implement the policy of post-anesthesia care and monitoring that describe the process of post-anesthesia care, assign responsibility and describe the documentation requirements.
The patient is discharged, by a fully qualified anesthesiologist or other individual authorized by the anesthesiologist who is responsible for managing the anesthesia services. The anesthesiologist is immediately contactable until all patients recover full consciousness and are physiologically stable. A qualified individual records at least the following:

a) The patient's physiologic status and vital signs.
b) Time of receiving the patient
c) Used type of anesthesia.
d) Administered medications with dose, route, and time of administration.
e) The occurrence of any unusual event.
f) The patient's condition before leaving according to defined criteria
g) Patient disposition
h) Time of transfer/discharge from the post-anesthesia care unit
i) Signature of the physician who orders patient discharge or disposition.

Survey process guide:

- The GAHAR surveyors may review the post-anesthesia care and monitoring policy.
- The GAHAR surveyors may observe the process of post-anesthesia care and monitoring process
- The GAHAR surveyors may review a sample of patients' medical records to check for post-anesthesia care plan documentation
- The GAHAR surveyors may interview the relevant staff to check their awareness of the policy and process.

Evidence of compliance:

1. The mental health hospital has an approved policy of post-anesthesia care and monitoring that clearly describes the process of post-anesthesia care, assigns responsibility, and describes the documentation requirements.
2. Post-anesthesia care plan documented in the patient's medical record including items from a) to i) in the intent.
3. The time of patient arrival at and discharge from the recovery area are documented in the patient's medical record.
4. The mental health hospital has a clear process of monitoring when the patient is transferred directly from the procedural room to a receiving unit.

Related standards:
MHP.01 Provision of anesthesia and sedation services, MHP.02 Qualified Anesthesiologist, ACT.09 Patient Transportation, MHP.03 Pre- anesthesia assessment_ Pre-induction assessment.

Safe and uniform sedation services

MHP.07 Procedural Sedation administration is standardized throughout the mental health hospital, monitoring and management of complications are guided by evidence-based guidelines

Safety

Keywords:
Procedural sedation.

Intent:
The American College of Emergency Physicians (ACEP) defines procedural sedation as "a technique of administering sedatives or dissociative agents with or without analgesics to induce a state that allows the patient to tolerate unpleasant procedures while maintaining cardiorespiratory function.
In the mental health hospital, the number of noninvasive and minimally invasive procedures performed has increased exponentially over the last several decades. Hence, sedation may be needed for many of these interventional and invasive procedures
To ensure uniformity of sedation services, sedation techniques shall be based on approved guidelines and provided according to the scope of service of the mental health hospital and the type of invasive procedures provided.
The hospital shall determine the individuals privileged to perform sedation and provide them with adequate training that includes at least the following items:

a. Proper use and administration of sedation techniques and methods.
b. Management of complications that could occur by providing sedation and the process followed if any.
c. Monitoring requirements
d. Advanced life support (appropriate for the age of the patient)
e. Use of emergency medical equipment and supplies

The mental health hospital is required to perform a pre- sedation assessment for all patients prior to transfer or performing the procedures. A pre-sedation assessment of the patient shall be done and includes at least the following:

I. Identify any airway problems.
II. Evaluate at-risk patients
III. Plan the type of sedation and the level of sedation the patient will need based on the procedure being performed.
IV. The outcome of the assessment includes the risk scoring of receiving sedation and the sedation plan.

Patients continue to require monitoring until they have reached near their baseline level of consciousness and hemodynamic parameters.
The responsible physician decides on the patient's transfer/discharge from the procedural sedation area according to defined criteria defined by the mental health hospital.

Survey process guide:

- The GAHAR surveyors may review guidelines/protocols guiding the provision of the sedation.
- The GAHAR surveyors may check staff files to check the required training of the staff to provide sedation services.

- The GAHAR surveyors may check patients' medical records to check the completeness of pre sedation assessment.

Evidence of compliance:

1. The administration of procedural sedation is standardized throughout the hospital and performed by a qualified individual trained on at least from (a) to (e) in the intent.
2. There is a pre-sedation assessment performed and documented by a qualified individual and includes at least I) through IV) in the intent.
3. A copy of sedation records is kept in the patient's medical record.
4. There are defined criteria for discharge from the procedural sedation area.
5. The discharge from the procedural sedation area is done by the responsible physician.

Related standards:
MHP.02 Qualified Anesthesiologist, WFM.10 Clinical Privileges, ICD.03 Clinical practice guidelines, ICD.20 Cardiopulmonary resuscitation and medical emergencies, ACT.07 Patient Care Responsibility.

MHP.08 Rapid tranquilization provision and administration in mental health hospitals are safe and guided by evidence-based practices and guidelines

Effectiveness

Keyword
Rapid tranquilization (RT).

Intent
Rapid tranquilization (RT) reduces anxiety and induces a sense of tranquility without drowsiness or sedation. It is an intervention used to control agitation or aggression in patients with mental disorders, allowing psychiatric assessment to take place while maintaining communication with patients with psychomotor agitation. It shall be used when all other appropriate psychological and behavioral approaches have failed to de-escalate the disturbing behavior. Administration of rapid tranquilization is a complex process and problem-prone service as it is recognized that rapid tranquilization may lead to deep sedation.
The mental health hospital shall ensure that rapid tranquilization is ethical, clinically effective, and continent to patient needs. The Mental health hospital shall develop and implement policy and procedures for rapid tranquilization (RT) administration, monitoring, and management. The policy shall address at least the following:

a) Reason for rapid tranquilization administration.
b) Patient assessment is required before the administration of rapid tranquilization.
c) Determine any actual or potential complications that may occur and identify measures to avoid their occurrence. Complications such as loss of consciousness, airway obstruction, respiratory arrest, hypotension or cardiovascular collapse, seizure, and extrapyramidal side-effects (EPSEs)
d) Continuous physiological monitoring
e) Staff privilege and required training that is appropriate for the age of the patient.
f) Process of patient transfer or discharge after receiving the tranquilization.
g) Use of emergency medical equipment and supplies
h) Documentation requirements.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the administration and monitoring of rapid tranquilization.
- The GAHAR surveyors may interview responsible staff to check their awareness of the hospital policy.
- The GAHAR surveyors may review patients' medical records to check the documentation of administration and monitoring of rapid tranquilization.
- The GAHAR surveyors may review staff files to check for the training records and qualifications of the responsible staff for rapid tranquilization.

Evidence of compliance:

1. The mental health hospital has an approved policy that guides the rapid tranquilization's safe administration, monitoring, (as well as) management, and addresses all elements mentioned in the intent from a) through h)
2. Staff is aware and trained on how to apply the hospital policy
3. The administration of rapid tranquilization is standardized throughout the hospital and provided by a qualified individual(s).
4. Rapid tranquilization administration, monitoring, and management of complications are documented in the patient medical record.

Related standards:
ICD.05 Patient medical assessments, OGM.12 Ethical Management, PCC.03 Patient, family, and carer rights, WFM.03 Job Description, MMS.10 Medication preparation and administration, MMS.12 Medication Monitoring, Medication errors, adverse drug events and near misses, IMT.06 Patient's medical record management, ICD.03 Clinical practice guidelines, EFS.10 Medical Equipment plan.

MHP.09 The mental health hospital ensures safe and compassionate delivery of drug-assisted interview

Safety

Keywords:
Drug-assisted interview.

Intent:
Drug-assisted interview or abreaction involves interviewing individuals under the influence of a drug, such as benzodiazepines or barbiturates. Drug-assisted interviews have been used in both diagnostic and therapeutic roles

Although drug-assisted interviews are not widely used, they are beneficial for selected patients who do not respond to conventional treatments such as supportive psychotherapy or psycho-pharmacotherapy or when the patient is unable to recall important personal information and the situation requires a quick resolution of selective amnesia for legal reasons and implications.
The medication selected to be used in the drug-assisted interview according to certain criteria include at least the following:

I. The fewer possible side effects,
II. Appropriate to the age of the patient,
III. Patient current medical condition,
IV. The availability of the antagonist.

The hospital shall develop and implement a policy and procedures to describe the provision of the drug-assisted interview that includes at least the following:

a) The process of obtaining written informed consent before the procedure containing disclosure of information statement.
b) The patient assessment required before the drug-assisted interview.
c) Determine who shall attend the drug-assisted interview (unless the patient states otherwise in the written consent).
d) Staff privilege and required training that is appropriate for the age of the patient.
e) The use and type of sedation needed for the technique.
f) Availability of the specific reversing agent/(s).
g) Availability of emergency medical equipment and supplies.
h) Measures to maintain patient confidentiality and privacy
i) Required monitoring during and after the drug-assisted interview.
j) Patient education and follow-up instructions.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding the provision of drug-assisted interviews and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check for documentation of drug-assisted interview's written consent and the selected medication and may review patient education and follow-up instructions.

Evidence of compliance:

1. The mental health hospital has an approved policy that describes the process of drug-assisted interviews including elements from a) to j) in the intent
2. Relevant staff is aware of the policy.
3. The drug-assisted interview's written consent is documented in the patient medical record.
4. Medications are selected for use based on the items mentioned in the intent from i) to iv).
5. Patient education and follow-up instructions are documented in the patient medical record.

Related standards

PCC.07 Informed consent, ICD.05 Patient medical assessments, WFM.10 Clinical Privileges, EFS.10 Medical Equipment plan, MMS.12 Medication Monitoring, Medication errors, adverse drug events and near misses, PCC.06 Patient, family, and carer education process, IMT.04 Confidentiality and Security of data and information.

Safe and effective invasive procedures and Electroconvulsive Therapy

MHP.10 The mental health hospital ensures that the provision of Electroconvulsive Therapy and any invasive procedures is effective, safe, and appropriate to the patient's needs.

Safety

Keywords:
Electroconvulsive Therapy and any invasive procedures.

Intent:
The mental health hospital is required to ensure the safe provision of invasive procedures by providing the required resources as obliged by the national laws and regulations. Units designed for invasive procedures shall have appropriate spacing, ventilation, and infrastructure including appropriate equipment, medical supplies, and medication. The Electroconvulsive Therapy (ECT) unit preferred to be composed of three main rooms: a waiting room, a treatment room, and a recovery room.
Immediate reporting of the invasive procedure has a significant role in the continuity of care. Planning for post-procedure care depends on findings and special events that occurred during the procedure. Failure to report these events markedly compromises patient care.
The mental health hospital is requested to immediately report the procedure details before the patient leaves the invasive procedure unit. Recording the names of all staff involved in the procedure has a medico-legal aspect and communication aspect. Details of the ECT or any invasive procedure shall be clearly stated. The procedure report shall address at least the following;

I. Time of start and time of the end of the procedure.
II. Name of all staff involved in the procedure, including anesthesia medical staff.
III. The procedures performed with detail, in case of ECT, the report shall include at least the following:
    i. Electrode placement
    ii. Seizure pattern
    iii. Seizure duration
    iv. Number of trials
    v. Current session stimulus(stimulus parameters)
IV. The occurrence of complications or not
V. Time of transfer from the procedure unit
VI. Signature of the performing Psychiatrist/(s).

The hospital shall develop and implement a policy and procedures for a safe provision of Electroconvulsive Therapy (ECT) and invasive procedure that addresses at least the following:

a) The scheduling process for an invasive procedure.
b) Recording of an invasive procedure whether they are scheduled, performed, or canceled.
c) Procedure report's documentation requirements in detail.
d) Patient's identification verification process.
e) How to call patients for the invasive procedure
f) Time recording of all steps of patient flow inside the procedure unit
g) Analysis of the postponed and canceled sessions

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding a safe provision of invasive procedures including Electroconvulsive Therapy (ECT)
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy.
- The GAHAR surveyors may review the patient's medical records to check the completeness of the invasive procedure report.

- The GAHAR surveyors may review staff files to check for the qualifications and privilege of the staff who is permitted to perform an invasive procedure such as Electroconvulsive Therapy.
- The GAHAR surveyors may observe the punctuality of the invasive procedure unit.
- The GAHAR surveyors may review the monitoring process for postponed and canceled sessions.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide the safe provision of Electroconvulsive Therapy (ECT) and any invasive procedures that address all elements mentioned in the intent from a) through g).
2. Analysis of postponed and canceled sessions is continuously monitored, reported, and acted upon.
3. Punctuality of the invasive procedure unit is maintained and recorded starting by patient call until room cleaning after the procedure.
4. Staff who are permitted to perform Electroconvulsive Therapy or any invasive procedure is qualified and privileged to perform those procedures.
5. The invasive procedure report is readily available for all patients who underwent a procedure before leaving the invasive procedure unit.
6. The ECT Procedure Report includes all elements mentioned in item III) from the intent and is kept in the patient's medical record.

Related standards:

ICD.02 Pre-hospitalization services, WFM.10 Clinical Privileges, QPI.04 incident reporting system, MHP.13 Pre- verification process, IMT.06 Patient's medical record management, EFS.01 Mental health hospital environment, and facility safety structure., EFS.10 Medical Equipment plan, QPI.02 Performance measures.

MHP.11 The mental health hospital uses an easily noticeable mark for invasive procedure site identification that is consistent throughout the hospital.

Safety

Keywords:

Site marking and identification.

Intent:

Visible and clear site marking is an error reduction strategy that should be performed by the responsible physician who will perform the invasive procedure (the patient's most responsible physician) with the involvement of the patient if the patient is an adult and fully conscious or patient's family/carer in other situations. The site marking in each organization should be unified, detectable, and placed on the nearest site to the invasive procedure site.

When performing an invasive procedure, healthcare professionals should verify the right patient, the right type of procedure, the right site, right side. The site is marked in all cases including laterality, and multiple structures (fingers, toes). Alternative methods for dental site marking include using images of the patient's teeth or paper diagrams of teeth to mark the site.

Survey process guide:

- The GAHAR surveyors may interview staff to check their awareness of the site marking procedure

Evidence of compliance:

1. Invasive procedure' site marking is done by the person performing the procedure.

2. The patient is actively involved in the site marking process with the exception of some circumstances.
3. The mark is visible after the patient is prepped, draped, and prepared for the procedure.

Related standards:
MHP.13 Pre- verification process, MHP.14 Time-out, ACT.07 Patient Care Responsibility.

MHP.12 NSR.17 The mental health hospital assures and improves the quality of administration of Electroconvulsive Therapy (ECT).

Safety

Keywords:
Electroconvulsive Therapy (ECT).

Intent:
Electroconvulsive Therapy (ECT) is a therapeutic medical procedure for the treatment of severe psychiatric disorders. Its primary purpose is to rapidly relieve psychiatric symptoms. ECT involves the delivery of a small electrical current to the brain sufficient to induce a seizure for therapeutic purposes while the patient is under anesthesia.
Electroconvulsive therapy (ECT) seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental health conditions. It often works when other treatments are unsuccessful. Electroconvulsive Therapy (ECT) shall be given in a controlled setting to achieve the most benefit with the fewest possible risks.
The mental health hospital shall ensure that Electroconvulsive Therapy (ECT) is performed according to laws, regulations, and approved guidelines
An experienced, qualified individual/(s) or team shall perform and supervise the services provided and includes at least the psychiatry specialist, anaesthesiologist, and competent nurse.
Mental health hospital shall develop and implement policy and procedures for safe Electroconvulsive Therapy administration that addresses at least the following:

a) Reasons for the administration of Electroconvulsive Therapy (ECT)
b) Written instructions required to be informed to the patients, families, and carers before treatment commences which shall include at least the following:
    I. Fasting hours before treatment.
    II. Restrictions to the patient's daily activities. For example; patients are not allowed to drive during a course of ECT, or for at least 48 hours after the general anesthesia.
    III. Determine the need to assign a person who will be accompanied the patient after the end of the ECT session.
    IV. Patients need to be under direct supervision by a responsible adult for the 24 hours following each ECT treatment.
c) Obtaining informed consent from the patient before the procedure (according to the patient's mental capacity and in accordance with the psychiatric patient care laws and regulations)
d) Documentation of pre-ECT work-up which includes at least the following;
    i. Full patient assessment before the procedure, which includes at least the patient's Diagnosis, Indication of ECT, Number of sessions required, Time of re-assessment, Signature of a psychiatrist, History of ECT's previous administration, and its outcome.
    ii. Availability of the pre-anesthesia and pre-induction assessment before the procedure.
    iii. Results of required investigations are available for healthcare professionals before the ECT procedure

iv. Medication especially psychotropic medications shall be reviewed and adjusted as appropriate before commencing the ECT procedures.

e) The process to verify the availability of all required resources in treatment and recovery rooms required for the administration of ECT and management of any emergencies**.**

f) Qualifications and competencies of staff privileged to perform ECT procedures, including emergency procedures.
g) Documentation of adequate treatments and procedures for managing any adverse events that may arise in the patient`s medical record and ECT logbook.
h) Reporting any adverse events or complications that happened, and determining the time for reporting.
i) Requirements for ECT sessions for children under 18 (the third opinion of a psychiatry consultant known to work with children is required).

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding safe Electroconvulsive Therapy administration and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check for the completeness of pre-ECT work-up
- The GAHAR surveyors may observe the available resources in the treatment and recovery room and may inquire about the verification of the availability of the required resources.

Evidence of compliance:

1. The mental health hospital has an approved policy and procedures for safe administration of ECT that addresses items from a) to i) in the intent.
2. Relevant staff is aware of the ECT safe administration policy
3. All pre-ECT work-up is completed, reviewed, and documented in the patient medical record as mentioned in item d from the intent.
4. Any adverse events resulting from the administration of ECT are timely reported, analyzed, and actions are taken to reduce re-occurrence as per the hospital policy.

Related standards:
MHP.03 Pre- anesthesia assessment_ Pre- induction assessment, PCC.06 Patient, family, and carer education process, WFM.10 Clinical Privileges, PCC.07 Informed consent, MHP.13 Pre-verification process, QPI.04 Incident reporting system.

MHP.13 NSR.18 The mental health hospital has a pre-invasive procedure verification process to ensure safe and appropriate care.

Safety

Keywords:
Pre- verification process.

Intent:
The mental health hospital shall ensure the availability of all needed items and supplies before commencing the invasive procedure in order to optimize patient safety and appropriateness of care delivered to the served patients.
Ensuring the availability and functioning of needed equipment minimizes the risk of errors by preventing the use of malfunctioning equipment or cancellation of the procedure after the

patient went to the procedure unit. Moreover, all equipment required for the administration of ECT shall be maintained according to accepted standards. Implementing regular checkups is a quality improvement process that shall be guided by well-designed checklists performed by well-trained staff.

Survey process guide:

- The GAHAR surveyors may observe the mental health hospital's pre-invasive procedure verification process.
- The GAHAR surveyors may interview responsible staff to check their awareness of the pre-invasive procedure verification process.
- The GAHAR surveyors may review the hospital checklist showing the availability and functioning of needed equipment.

Evidence of compliance:

1. The mental health hospital has a defined process for pre-invasive procedure verification including all needed documents and equipment.
2. Pre-invasive procedure verification of all needed documents and equipment is documented before each procedure.
3. Responsible staff is aware of the pre-verification process.

Related standards:
MHP.11 Site marking and identification, WFM.03 Job Description, IMT.01 Document management system, EFS.10 Medical Equipment plan.

MHP.14 NSR.19 **Time-out is effectively and timely performed, just before starting the Electroconvulsive Therapy or any invasive procedure.**

Safety

Keywords:
Time-out.

Intent:
A time-out is a structured pause before a medical procedure that aims to improve the safety of the procedure. Time-Out before Electroconvulsive Therapy (ECT) and any invasive procedure aim to verification of the correct patient and correct procedure, it also aims to improve the safety and reduce error in the administration of Electroconvulsive Therapy (ECT) and any invasive procedure.

The time-out procedure shall be conducted in the location at which the Electroconvulsive Therapy (ECT) or any invasive procedure will be done and involves the active participation of the entire team. (Including the psychiatrist, the nurse, and the anesthesiologist when applicable). Patient participation is not obligatory.

Completion of the time-out procedure shall be documented in the patient medical record and includes the date and time that the time-out was completed.

The mental health hospital shall develop and implement a policy and procedures for defining the steps and responsibilities of time- out process to ensure the correct procedure and correct patient.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for a time-out and may interview responsible staff to check their awareness.
- The GAHAR surveyors may observe the participation of the psychiatrist, the nurse, and the anesthesiologist in the time-out process.

- The GAHAR surveyors may review patients' medical records to check for the documentation of the time-out procedures.

Evidence of compliance:

1. The mental health hospital has an approved policy for time-out to ensure the correct patient, procedure.
2. Relevant staff is trained and fully aware of the time-out policy.
3. Time out is implemented immediately before the start of the ECT procedure.
4. The ECT team is involved in the time-out process, including the performing psychiatrist, the nurse, and the anesthesiologist when applicable.
5. The time-out procedure is documented in the patient medical record.

Related standards:

MHP.13 Pre- verification process, MHP.10 Electroconvulsive Therapy and any invasive procedures, MHP.11 Site marking and identification, WFM.03 Job Description.

Medication Management and Safety

Chapter intent:

Getting the most from medications for both patients and society is becoming increasingly important as more people are taking more medications. Medications are offered by health services throughout the world. Medications prevent, treat, or manage many illnesses or conditions and are the most common interventions in healthcare.

Medication is defined as any prescription medications including narcotics, psychotropic medications, vitamins, nutraceuticals, over-the-counter medications; vaccines; biological, diagnostic, and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; parenteral nutrition; blood products; medication containing products, and intravenous solutions with electrolytes and/or medications. The definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases unless explicitly stated.

Medications in mental health hospitals play a critical role in the treatment of various mental health disorders. The right medication can reduce or eliminate symptoms and significantly improve a patient's quality of life. Psychotropic medication can only be prescribed by a licensed medical professional such as a psychiatrist according to law and regulations.

The use of medications is one of the major therapeutic interventions for people with serious mental illness. It can reduce symptoms and prevent relapses of symptoms and is often used in combination with other treatment approaches such as psychotherapies and brain stimulation therapies.

Medication management is one of the major responsibilities in any hospital. It is a complex process that involves different phases, including planning, procurement, storage, prescribing, transcribing, ordering, dispensing, administration, monitoring of the medications, and evaluation of the program. Evidence suggests that, at each phase of the cycle, errors do occur adversely influencing patients' safety, which is a priority in today's practice. However, with substantial and increasing medication use comes a growing risk of harm. This is compounded by the need to prescribe for a special population, including pediatrics, pregnancy, and the aging population with increasingly complex medical needs and the introduction of many new medications. These issues are particularly relevant in hospitals.

Additionally, medication errors are one of the most commonly occurring errors in healthcare institutes, and they can occur at any step along the pathway of medication management. It is further stated that morbidity from medication errors results in high financial costs for healthcare institutions and adversely affects the patient's quality of life. Preventing medication errors is a major priority in the health system and many international organizations such as the JCI and the WHO have launched medication safety as part of their global patient safety initiatives.

Chapter purpose:

The main objective of this chapter is to:

1. Highlight the principle of medication management and safety in Mental health hospital
2. Promote safe, quality use of medications, and medication management throughout the provision of mental health services
3. Provide a framework for effective and safe medication management and safety program.
4. Evaluate the continuity of medication management processes; from planning to monitoring and evaluation with a special focus on the identification of risk points to improve patients' outcomes and safety

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) The Pharmacy Profession Law 127/1955.

2) MOHP Decree for the Re-Regulation of Handling of the Pharmaceutical Substances and Products Affecting the Mental State 172/ 2011.
3) MOHP Decree for the Re-Regulation of Handling of the Pharmaceutical Substances and Products Affecting the Mental State 475/ 2019.
4) The Egyptian Drug Authority Decree for the Re-Regulation of Handling of The Pharmaceutical Substances and Products Affecting the Mental State 340/ 2021.
5) Narcotics Law No. 182/1960.
6) MOHP Ministerial Decree Number 496/ 2012.
7) MOHP Ministerial Decree for Developing a Pharmacovigilance Center Number / 2012.
8) Prime Minister's Decree about the EDA Executive Bylaws Number 777/2020.
9) Rational Drug Use Publication No: 1, the Year 2019 of the Egyptian Crash Cart And Emergency Drug List.
10) The Egyptian Drug Authority Decree on the Regulation of Drug Storage Requirements for Pharmaceutical Institutions Number 271/ 2021.
11) MOHP Ministerial Decree Number for the Regulation of Expiry Drugs. 104/ 2003.
12) The Minister of Finance Decree on the Regulation of Tenders and Auctions Law Promulgated, and Its Implementing Regulations No. 182, the Year 2018.
13) MOHP Ministerial Decree for the Re-Regulation of the Health Requirements for Pharmaceutical Institutions. No. 380, the Year 2009.
14) The Egyptian Guidelines of Medication Management Standards First Edition (2018).
15) Institute for Safe Medication Practices. ISMP Medication Safety Tools and Resources. Accessed Dec 6, 2017. Https://Www.Ismp.Org/Tools.

Medication Use, Selection, and Procurement

MMS.01 The mental health hospital has an effective medication management program.

Effectiveness

Keywords:
Medication management program.

Intent:
Medication management remains a primary concern in any healthcare setting and is often an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. The unsafe use of medication is not the only safety problem in any healthcare system, but it is certainly one of the most significant issues. Ensuring a safer medication management program at an organizational level is a major challenge.
The mental hospital shall develop and implement a medication management and safety program that is accessible to all staff who are involved in the patient's medications and address at least the following

a) Planning
b) Selection and procurement
c) Storage
d) Ordering and prescribing
e) Preparing and dispensing
f) Administration
g) Monitoring
h) Evaluation

All medication management and safety processes in mental health hospitals are conducted and implemented according to Egyptian laws and regulations (The Egyptian Drug Authority (EDA), and the Egyptian Ministry of Health (MOH). Mental health hospital is equipped with updated and appropriate medication-related information source(s) in electronic or paper-based formats for staff members involved in medication use.
A qualified licensed individual shall directly supervise the medication management and safety program throughout the mental health hospitals and only a licensed medical health professional (psychiatrist) shall prescribe the medications according to the national law and regulations
The interdisciplinary Drug and Therapeutic Committee (DTC) (also known as the pharmacy and therapeutic committee (PTC)) shall be developed with clear terms of reference. The PTC is involved in the development and evaluation of the medication management program. In addition, a program review shall be performed at least annually.
It shall be a collaborative process to implement, maintain, manage and enforce an efficient medication management program that supports patient safety and allow for improvements and changes in the quality of care.

Survey process guide:

- The GAHAR surveyors may review the medication management program and may interview the responsible staff to check their awareness.
- The GAHAR surveyors may review the terms of reference of the pharmacy and therapeutic committee.
- The GAHAR surveyors may review staff files to evaluate the qualifications of individuals supervising the medication management program.

Evidence of compliance:

1. The mental health hospital has an updated program that clearly describes the medication management and safety processes which are in intent from a) to h).

2. Qualified and licensed individuals are responsible for supervising medication management and safety activities.
3. There are clear terms of reference for the pharmacy and therapeutic committee (PTC).
4. The medication management and safety program are evaluated and updated at least on an annual basis, findings are acted upon.
5. Responsible Staff members are aware of the medication management program and processes.

Related standards:
MMS.02 Medication selection and procurement, MMS.03 Medication storage and Medication labeling, MMS.04 Emergency Medications, MMS.05 High-risk medications, concentrated electrolytes, MMS.08 Medication safe ordering, prescribing, transcribing, MMS.10 Medication preparation and administration., MMS.12 Medication Monitoring, Medication errors, adverse drug events, and near misses, WFM.03 Job description.

MMS.02 Hospital medications are selected, listed, and procured based on approved criteria.

Efficiency

Keywords:
Medication selection and procurement.

Intent:
Medication selection and procurement is a collaborative process; it involves criteria for determining the availability of appropriate medications for dispensing or administering to patients that include improved medication treatment, decreased adverse drug reactions, improved efficiency in procurement/inventory management, and decreased overall health care cost. Also, the medication procurement process shall be approved by the hospital's pharmacy and therapeutic Committee (PTC) on time to meet patients' needs. The procurement process of narcotic and psychotropic medications shall be carried out in accordance with the law and regulations. The criteria of selection and procurement shall be as per the organization's mission, the patient needs and safety, and cover at least the following (to):

a) Select the most cost-effective essential medications.
b) Treat commonly encountered diseases.
c) Quantify the needs.
d) Pre-select potential suppliers.
e) Manage procurement and delivery.
f) Ensure good product quality.

The process for evaluating new suppliers can include checking the licensure, providing formal visit(s), reference checks with past clients and agencies, test purchases in small quantities, and informal local information gathering.
The mental health hospital shall develop and implement a policy and procedures to guide the appropriate selection and procurement of medications and establish defined steps in non-formulary medications will be procured only on an exceptional basis or in emergency events, In case of medication unavailability, temporary shortage of supply or outage, delay in delivery, or other unexpected reason.
The mental health hospital shall develop a continually updated list of medication (known as a formulary list) of all the medications it stocks that identify the medications that are the most medically appropriate and cost-effective inventory medication list of all the medications it

stocks. The medications listed in the formulary shall be selected from the EDA and other national authorizing bodies legally approved medications based on community needs.

The formulary list shall include (but is not limited to):

I. Name(s) of medication(s)
II. Strength(s)/concentration(s) of medication(s)
III. Dosage form(s) of the medication(s)
IV. Indication
V. Expiration date

The list shall be reviewed and updated based upon the following criteria (indication for usage, efficacy, availability of alternative formulary drugs, adverse effects, medication errors, effectiveness and safety, drug interactions, and, cost analysis) In addition, a medication formulary list shall review and updated at least annually. The ongoing revision and update shall respect and reflect the clinical judgment of the medical staff as physicians, pharmacists, and other experts in treating and diagnosing patients and improving patient care.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding selection and procurement of medications and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review the mental health hospital formulary list and may review patients' medical records (medication orders) to evaluate their compliance.

Evidence of compliance:

1 The mental health hospital has an approved policy and procedures that address the criteria of appropriate selection and procurement of medications which is intent from a) to f).
2 The mental health hospital has an approved and updated formulary list of the medications, which covers at least items from I) to V) in the intent.
3 The mental health hospital has a defined process for handling the non-formulary medications
4 Responsible staff members are aware of the policy.
5 There is a defined process for handling medication' shortages and outages

Related standards:
MMS.01 Medication management program, MMS.03 Medication storage, and Medication labeling, MMS.07 Drug recall system.

Safe medication storage and labeling

MMS.03 NSR.20 Medications are safely and securely stored in a manner to maintain their quality.

Safety

Keywords:
Medication storage and medication labeling.

Intent:
Well-designed and appropriate storage of medications can reduce waste, incorrect medication dispensing, and handling. The mental health hospital maintains proper medication storage conditions (temperature, light, and humidity) in medication storage areas to protect their stability 24 hours a day, and 7 days a week according to the manufacturer/marketing

authorization requirements. The stability and effectiveness of the medications depend on storing them at the correct temperature, for example, those medications requiring refrigeration and multi-dose containers. A loss of electricity could easily affect certain medications, and those affected medications may no longer be considered safe and effective for use. After a power outage, the mental health hospital shall have a process to deal with an electric power outage to ensure the integrity of any affected medications before use.

There should be clear evidence that mental health hospital ensures the storage of medications in a manner to maintain their quality and integrity. Also, the mental health hospitals limit access to medication storage areas with the level of security required to protect it against loss or theft depending on the types of medications stored the storage requirements for narcotics and psychotropic medications shall be separated from other medications with special precautions in accordance to the national law and regulations. Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original containers and placed into unlabeled containers. This unsafe practice neglects the basic principles of safe medication management. Mental health hospitals shall ensure that the labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. Also Expired/ outdated medications should be stored in separate locations and labeled as expired medications. This practice addresses a recognized risk point in the administration of medications. The following data are clearly shown on the labels (If not apparent on the original packages or boxes):

a) The name,
b) concentration/strength,
c) expiration date,
d) batch number, and
e) Any applicable warnings.

Survey process guide:

- The GAHAR surveyors may observe the medication storage areas throughout the mental health hospital to assess storage conditions and labeling.
- The GAHAR surveyors may observe the storage areas for narcotics and psychotropic medications to assess security and storage conditions.
- The GAHAR surveyors may review the implemented process to deal with an electric power outage.

Evidence of compliance:

1. Medications are safe, organized, and securely stored based on the manufacturer's recommendations and in accordance with national laws and regulations.
2. Psychotropic and narcotic medications are stored in accordance with the applicable laws and regulations.
3. The mental health hospital has a process for the handling and storage of multi-dose medications to ensure their stability and safety.
4. The mental health hospital has an established process to deal with an electric power outage to ensure the integrity of medications.
5. Medications, medication containers, and the components used in their preparation are clearly labeled (if not apparent on the original packages or boxes) with elements from a) to e) in the intent.

Related standards:

MMS.01 Medication management program, MMS.02 Medication selection, and procurement, MMS.05 High-risk medications, concentrated electrolytes, MMS.06 Look-alike, sound-alike medications, MMS.07 Drug recall system, EFS.12 Utility Management.

MMS.04 Emergency medications are available, accessible, and secured at all times.

Safety

Keywords:
Emergency Medications.

Intent:
When patient emergencies occur, quick access to appropriate emergency medications is critical and maybe live saving. The mental health hospital shall develop a policy and procedures that ensure the availability and location of emergency medications and the medications to be supplied in these locations. For example, anesthesia reversing agents and antidotes. Emergency medications shall be accessible, securely stored, and protected from loss or theft in all storage areas and are uniformly stored and arranged, and managed
The policy shall include at least the following:

a) Distribution and availability of the Emergency medications.
b) Standardization of Emergency medications management and arrangement
c) Replacement of emergency medication at the most appropriate time when used, damaged, or outdated.
d) Strategies for prevention of abuse, loss, or theft in all storage areas.
e) Clarify the accountability of staff who have the responsibility for managing emergency medication.

Survey process guide:

- The GAHAR surveyors may review the policy guiding the management of emergency medications and may interview responsible staff to check their awareness.
- The GAHAR surveyors may observe the storage areas of emergency medications to assess the distribution, availability, and security of the emergency medications.

Evidence of compliance:

1. The mental health hospital has an approved policy of emergency medication management that include items as mentioned in the intent from a) to e).
2. Emergency medications are uniformly stored, available, and accessible to the patient care areas when required.
3. There is a defined process for the replacement of emergency medications within a predefined timeframe when used, damaged, or outdated.
4. Responsible authorized staff is aware of the policy of emergency medications management including the availability, accessibility, and security.
5. Emergency medications received are documented in the patient's medical record according to the relevant law and regulations.

Related standards:
ICD.20 Cardiopulmonary resuscitation and medical emergencies, ICD.21 Emergency Services, MMS.02 Medication selection and procurement, MMS.03 Medication storage and Medication labeling.

MMS.05 NSR.21 High alert medications and concentrated electrolytes are managed in a way that assures that risk is minimized.

Safety

Keywords:
High-risk medications, concentrated electrolytes.

Intent:
High-risk medications are those bear a heightened risk of causing significant patient harm when they are used in error. Examples of high-risk medications include, but are not limited to, anticoagulants, hypoglycemic agents, medications with a narrow therapeutic range, anesthesia medications, inotropic agents, and look-alike/sound-alike medications.
The mental health hospital needs to develop its list of high alert medications based on its own data and both national and internationally recognized organizations (e.g., the Institute of Safe Medication Practice (ISMP) and the World Health Organization (WHO)). In addition, mental health hospital has strategies in place to prevent the inadvertent use and administration of these medications. And High-risk Medications and concentrated electrolytes list shall review and updated at least annually.
Concentrated electrolytes include, but not limited to, potassium chloride [equal to or greater than 2 mEq/mL concentration], potassium phosphate [equal to or greater than 3 mmol/mL concentration], sodium chloride [greater than 0.9% concentration], and magnesium sulfate [equal to or greater than 50% concentration]. There are several reports of accidental deaths due to the inadvertent administration of concentrated electrolytes. Avoiding the storage of concentrated electrolytes in patient care areas is one method to minimize the risk of death or injury associated with these medications.
The mental health hospital shall establish special precautions for the safe, effective, and efficient management of medications such as narcotic, psychotropic medications, and investigational medications.

Concentrated electrolytes shall be safely stored including separation, and labeling throughout the hospital, and stored in limited quantities in the designated areas.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital's list of high-risk medications.
- The GAHAR surveyors may observe the implemented measures for safe storage, dispensing, and administration of high-risk medications.
- The GAHAR surveyors may interview responsible staff to check their awareness of the implemented process to safely manage high-alert medications.

Evidence of compliance:

1. The mental health hospital has an annually updated list(s) of high-alert medications and concentrated electrolytes.
2. The mental health hospital has a uniform process for the safe storage and administration of high alert medications and concentrated electrolytes, including separation, and labeling.
3. Responsible staff members are aware of the strategies implemented when managing high-alert medications and concentrated electrolytes.

Related standards:
MMS.03 Medication storage and Medication labeling., MMS.06 Look-alike, sound-alike medications, MMS.12 Medication Monitoring, Medication errors, adverse drug events and near misses.

MMS.06 NSR.22 Look alike sound alike medications are managed in a way that assures that risk is minimized.

Safety

Keywords:
Look-alike, sound-alike medications.

Intent:
Look-alike/sound-alike (LASA) medications are those visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics.
Any confusion between these medications may lead to harmful errors. The Institute for Safe Medication Practices (ISMP) maintains an ongoing list of LASA medication names to highlight medications that may require special safeguards or strategies to help prevent healthcare providers from accidentally mistaking one medication or strategies to help prevent healthcare providers from accidentally mistaking one medication for another.

Another strategy that the ISMP recommends for reducing LASA medication name errors is to include both the brand name and nonproprietary name, dosage form, strength, directions, and indication for use, which can help differentiate LASA medication names. If LASA medications have different indications, then associating an indication with medication may help differentiate it from another medication with a similar-sounding name.
Other recommendations aimed at minimizing name confusion include conducting a periodic analysis of new product names; physically separating and segregating these medications in medication storage areas prevents confusion and promotes safety.

Mental health hospital needs to establish risk management strategies to minimize adverse events with LASA medications, enhance patient safety and protect against inadvertent administration. In addition, the Look-alike/sound-alike (LASA) list shall review and updated at least annually.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital list of look-alike and sound-alike medications followed by Interviewing responsible staff to check their awareness about processes to minimize the risk associated with using look-alike sound-alike medications.
- The GAHAR surveyors may observe the pharmacy, medication carts, medication storage, and medication preparation areas to check LASA medication storage and labeling.

Evidence of compliance:

1. The mental health hospital has an annually updated list of look-alike sound-alike medications.
2. The mental health hospital has a defined process for the safe handling of look-alike sound-alike medications including separation, labeling, and administration.
3. Responsible staff members are aware of the strategies implemented when managing look-alike sound-alike medications.

Related standards:
MMS.03 Medication storage and Medication labeling, MMS.05 High-risk medications, concentrated electrolytes, MMS.12 Medication Monitoring, Medication errors, adverse drug events and near misses.

MMS.07 The mental health hospital has a drug recall system in place.

Effectiveness

Keywords:
Drug recall system.

Intent:
A drug recall is required when safety issues arise, and defective products are required to be returned to the manufacturer/distributor. This includes expired, outdated, damaged, dispensed but not used, and/or contaminated medications. Drug recalls can be extremely costly and can damage consumer confidence in the product or company, so naturally, all companies try the maximum to avoid such scenarios.
The mental health hospital shall have a system in place for the proper identification and retrieval of medications recalled by the Egyptian Drug Authority (EDA), the manufacturer/marketing authorization hold, or other well-recognized bodies
Recalled medications are clearly labeled and separated from regular stock pending removal by the manufacturer/marketing authorization holder or destruction. The recall system includes:

a) The process to retrieve recalled medications
b) Labeling
c) Separation
d) Disposal or removal
e) Patient notification (when applicable)

The mental health hospital shall develop and implement a policy and procedures to ensure that medications meet the required standards for product integrity, and that expired medications cannot be inadvertently used or administered. Regular monitoring of disposal of unused, unwanted, or expired medications assists in identifying the potential for, and actual unauthorized, diversion of medications.
It is the responsibility of the mental health hospital to ensure that all staff members dealing with medications are aware of the drug recall system and the procedures for handling expired, damaged, outdated, or contaminated medications.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy managing expired, damaged, and contaminated medication and may interview responsible staff to check their awareness.
- The GAHAR surveyors may observe the pharmacy, medication carts, medication storage, medication preparation, and patient care areas to check the presence of recalled, expired, outdated, damaged, dispensed but not used, and/or contaminated medications
- The GAHAR surveyors may request to trace a recalled drug from the reception of drug recall notice till disposal or removal

Evidence of compliance:

1 The mental health hospital has a drug recall system that includes elements from a) to e) in the intent.
2 The mental health hospital has an approved policy and procedures in place for the removal, storage, and disposal of expired, damaged, or contaminated medications.
3 Recalled medications are clearly labeled and separated according to the manufacturer/marketing recommendation.
4 Staff members involved in the drug recall process are aware of the drug recall system and the process of handling expired medications.

Related standards:
MMS.02 Medication selection and procurement, MMS.03 Medication storage and Medication labeling.

Safe medication ordering, prescribing, transcribing, reconciliation

MMS.08 Medications are safely ordered, prescribed, and transcribed.

Safety

Keywords:
Medication safe ordering, prescribing, transcribing.

Intent:
Treating a patient by medication(s) requires specific knowledge and experience. When prescribed and used effectively, medications have the potential to significantly improve the quality of life and improve patient safety and outcomes. However, the challenges associated with prescribing the right medications, and supporting patients to use them effectively should not be underestimated.
The psychiatrist shall perform a comprehensive assessment prior to medication prescription to make sure of the appropriate dose for the optimal length of time/ in a timely manner for each patient.

In mental health hospital, prescribing shall be undertaken cautiously and implementing integrated procedures that ensure the appropriate use and oversight of prescription medications, including prescribing the psychotropic medications, such as prescribing antipsychotics off label for children and adolescents and the use of more than two antipsychotics or multiple dosing of more than psychotropic medications.
Psychiatrists when prescribing a psychotic medication especially High Dose Antipsychotic Treatment (HDAT) for a particular indication the risk/benefit ratio shall be taken into account. Example (Antipsychotic drugs may cause extrapyramidal side effects, including tardive dyskinesia. They are therefore not recommended for treatment of anxiety.)
The mental health hospital shall develop and implement policy and procedures to guide the processes of ordering, prescribing, and transcribing medications including narcotics and psychotropic agents. The policy shall contain at least the following:

a) The Accepted approved medication order writing standards (Medication order writing standards define the elements of complete medication order).
b) Types of Medication Orders, are acceptable for use to minimize the potential for errors when orders are recorded. Such as emergency, standing, or automatic stop orders.
c) Strategies or preventive measures for look-alike or sound-alike medication orders and take actions to prevent errors involving the interchange of these medications.
d) Determine staff who is authorized to prescribe the medication orders
e) Action is taken when medication orders are incomplete, illegible, or unclear.
f) Criteria for specific types of medication orders to be prescribed safely. Example (Standing orders prohibited in patient's treats with psychotropic medications).
g) Transcription process and use

All medication orders must be written or printed legibly, clearly understood, and transcribed accurately in a timely manner and shall comply with medication order writing standards to minimize the potential for errors when orders are recorded. Elements of a complete order include at least the following:

i. Patient's identifications
ii. Patient's demographics
iii. Medication name
iv. Dosage form

v. Strength or concentration
vi. Dosage, frequency, and duration of medication
vii. Route of administration
viii. Rates of administration (when intravenous infusions are ordered
ix. Indications for use and the maximum frequency and maximum daily dose (for PRN orders)
x. Date and time of the order
xi. Approved abbreviations and prescriber's signature

Abbreviation avoidance prevents misunderstanding, miscommunications, and administration of incorrect prescriptions. The mental health hospital shall ensure the standardized use of approved symbols and abbreviations across the organization.
In mental health hospitals, Patients receiving treatment have an absolute right to know the relevant information about the medications they are prescribed.
The Patient, the family, and the carer (according to the patient's mental capacity) shall be encouraged to be active participants in his/her care when it comes to making decisions about medication and be aware of the risks and benefits of treatment.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy guiding ordering, prescribing, and transcribing of medications and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review a sample of medication orders to check the completeness of the order and may observe the implemented process when the order is incomplete, illegible, or unclear.

Evidence of Compliance:

1. The Mental health hospital is responsible for identifying those individuals permitted by law and regulation, qualification, training, experience, and job description to order/prescribe and transcribe medications.
2. The mental health hospital has an approved policy and procedure for safe and complete medication ordering, prescribing, and transcribing which covers items elements from a) to g) in the intent.
3. All relevant staff are aware and trained on how to apply the policy
4. Complete medication order is written or printed legibly, clearly understood, and transcribed accurately, in accordance with medication order writing standards.
5. There is a defined process when a medication order is incomplete, illegible, or unclear.
6. Psychotropic and narcotic/controlled medications are safely prescribed in accordance with the applicable laws and regulations.

Related standards:
MMS.01 Medication management program, IMT.03 Standardized symbols and Abbreviations, WFM.10 Clinical Privileges.

MMS.09 The mental health hospital identifies information required for safe, consistent medication reconciliation

Effectiveness

Keywords:
Medication Reconciliation.

Intent:
Patients often receive new medications or have changes made to their existing, current medications at times of transitions in care (mental health hospital admission, or discharge from the mental health hospital). As a result, the new medication regimen prescribed at the time of discharge may inadvertently omit needed medications, unnecessarily duplicate existing therapies, or contain incorrect dosages. These discrepancies place patients at risk for adverse drug events (ADEs).

Medication reconciliation is a formal process in which healthcare professionals work together with patients, families, and carers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care by comparing the patient's current list of medications against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital. In a mental health hospital, medication reconciliation may need to differ from the general hospital as obtaining information is more difficult. The prevalence of cognitive impairment and dementia with age presents a barrier to drug matching in this population and poor medication-taking history
And increase the omitted medications that result in patients being unclear about the medications they are taking. The patient's family and carer shall therefore be involved in the reconciliation process. Mental health hospital shall develop and implement a structured reconciliation process that addresses at least the following:

a) Situations where medication reconciliation is required:
    i. On admission (matching the current medication list with the best possible medication history (BPMH).
    ii. Registration as outpatients.
    iii. On discharge (checking that medications ordered on the discharge prescription match those on the discharge plan and the medications list and confirming that changes have been documented).
b) Identify responsibility to perform medication reconciliation.
c) Patients and family involvement.
d) Documentation requirements; complete and accurate list of current medications in the patient medical record including the medication name, dose, frequency and route of administration, history of past allergic response, or other adverse reactions to psychotropic medications.
e) Describe all required steps to complete the medication reconciliation process such as collecting the list of medications, vitamins, nutritional supplements, over-the-counter drugs, and vaccines used by patients, clarification whether these medications and their dosages are appropriate, matching with a new list of medication, and recording changes.
f) Determine actions to be taken when any discrepancies (such as omissions, unnecessary duplications, or dosing errors) are identified and documented.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital process for medication reconciliation and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to assess the recording of current medications upon admission.

- The GAHAR surveyors may check if the patient's own medications are matching the recorded current medications upon admission and are included in the medication reconciliation process.

Evidence of compliance:

1. The mental health hospital has a defined process to ensure accurate medication reconciliation is performed for all patients, the process includes items from a) to f) in the intent.
2. A complete and accurate list of current medications is recorded in the patient's medical record and included all elements mentioned in item d) from the intent.
3. Relevant staff is aware of how to apply the medication reconciliation process.
4. All medication orders are compared to the list of current medications, as per the hospital's established process.

Related standards:
MMS.08 Medication safe ordering, prescribing, transcribing, PCC.06 Patient, family and carer education process, ACT.10 Patient's Discharge.

Medication preparation, dispensing, and administration.

MMS.10 All medications are safely and accurately prepared and administered

Keywords:
Medication preparation and administration.

Intent:
a safe, clean, and organized working environment provides the basis for good medication preparation practice. This includes qualified/trained staff, appropriate environmental surroundings, adequate shelving and storage areas, proper work surfaces, suitable equipment, and necessary packaging materials.

The mental health hospital shall identify the standards of practice for a safe medication preparation and administration environment. Healthcare professionals who prepare medications are requested to use techniques to ensure accuracy (e.g., double-checking calculations), and avoid contamination, including using clean or aseptic techniques as appropriate; maintaining clean, and uncluttered areas for product preparation. Moreover, healthcare professionals preparing compounded sterile products or preparing medications using multi-dose vials or hazardous medications are competent and trained on the principles of medication preparation and aseptic technique. Similarly, laminar airflow hoods are available and used when indicated by professional practices (e.g., preparation of cytotoxic medications).
Prepared medications are labeled in a standardized manner. This requirement applies to any medication that is prepared but not administered immediately (this requirement does not apply to a medication prepared and administered immediately in emergencies). At a minimum, labels (if not apparent from the container) must include the following:

a) Patient identifications (2 unique identifiers)
b) Medication name
c) Strength/concentration
d) Amount
e) Expiration date
f) Beyond use date
g) Directions for use
h) Any special/cautionary instructions

i) Date and time of preparation and the diluent for all compounded intravenous (IV) admixtures, and parenteral solutions (if available).

The mental health hospital shall follow a clear, establish process for the preparation and administration of psychotropic, and narcotic medications in accordance with the applicable laws and regulations. The safe administration of medications shall include at least the following:

I. Right patient
II. Right medication
III. Right time and frequency of administration
IV. Right dosage amount and regimen
V. Right route of administration
VI. Right reasons/indication of medication therapy.
VII. Review if the patient is allergic to any medication in the prescription or order.
VIII. Provision of information about the medications that they are going to be given and the patients are given the chance to ask questions.

The mental health hospital shall educate patients and/or their families, and carers about the safe and effective use of medication(s) prescribed and to be administered including (if needed) any potential significant adverse reactions, or other concerns about administering medication.

Survey Process Guide:

- The GAHAR surveyors may observe the process of preparing/compounding medication orders and may observe the labeling of the prepared products.
- The GAHAR surveyors may review staff files to check the competencies of the responsible staff for medication preparation and administration.
- The GAHAR surveyors may review the medication administration process including the narcotics and psychotropic medications.

Evidence of Compliance**:**

1. The mental health hospital ensures that competent and well-trained healthcare professionals prepare and/or administer medications and admixtures, with or without supervision.
2. The mental health hospital has a process to guide the preparation and compounding of sterile and non-sterile preparations.
3. All medications prepared in the mental health hospital are correctly labeled in a standardized manner with at least the elements from a) to i) in the intent.
4. The mental health hospital has a process for safe medication administration that includes elements from I) to VIII) in the intent.
5. Psychotropic and narcotic medications are prepared and administered in accordance with the applicable laws and regulations.

Related standards:
MMS.01 Medication management program, MMS.05 High-risk medications, concentrated electrolytes, MMS.06 Look-alike, sound-alike medications, MMS.03 Medication storage and Medication labeling, MMS.08 Medication safe ordering, prescribing, transcribing, IPC.08 Safe injection practices.

MMS.11 Medication orders are safely dispensed after review for appropriateness and accuracy.

Safety

Keywords:
Medication dispensing.

Intent:

All medication orders shall be reviewed before dispensing and administration. Mental health hospitals shall perform medication order reviews to appropriately monitor the medication and ensure that medications each patient receives, are clinically indicated.

Each prescription shall be reviewed for the completion, accuracy, and appropriateness of the medication for the right patient and the right clinical needs prior to dispensing and administration except in an emergency that could harm the patient and delay the desired outcome. Each prescription/order is reviewed by a qualified, competent healthcare professional. Appropriateness review shall cover at least the following;

a. Suitability of the medication to the patient's characteristics and condition
b. Dose, frequency, route of administration, and duration
c. Therapeutic duplication.
d. Drug interactions, including interaction with food.
e. Possibility of organ toxicity.
f. Any allergies or sensitivities.
g. Weight-based dosing.
h. Patient's specific clinical information
i. Any possible contraindications

The mental health hospital shall have a process for providing medications to meet the patients' needs when the pharmacy is closed. And determine staff who is authorized to conduct the appropriateness review in such situations. A second review shall be conducted by the licensed healthcare professional within 24 hours.

Also, dispensing medications within the hospital shall follow standardized processes to ensure patient safety. The mental health hospital shall dispense medications in the most ready-to-administer form possible to minimize opportunities for error during distribution and administration. Only a licensed pharmacist is responsible for dispensing a medication order according to laws and regulations.

The mental health hospital shall maintain medication order records in accordance with law and regulation, licensure, and professional standards of practice.

The dispensing process shall be provided verbal or written information and instructions in understandable language to the patient or family, or carer concerning prescribed medications, the information provided shall include at least:

i. Indication for use
ii. Potential drug-drug and/or food-drug interactions
iii. Common side effects and precautions for use
iv. Instructions for use
v. Storage instructions

Survey Process Guide:

- The GAHAR surveyors may interview responsible staff for dispensing medication to check their awareness of the appropriateness reviews.
- The GAHAR surveyors may observe the implemented safe dispensing process.

Evidence of compliance:

1. Each prescription/order is reviewed by a qualified, competent healthcare professional for completion, accuracy, and appropriateness prior to administration and dispensing, and covers at least elements from a) to i) in the intent.
2. The mental health hospital ensures the safe and accurate medication dispensing process which covers elements from i) to v) in the intent.
3. Relevant staff members involved in the medication reviewing and dispensing process are aware and trained on how to apply the appropriateness process

4. The mental health hospital has an established process when a qualified, competent healthcare professional is not available.

Related standards:
MMS.01 Medication management program, MMS.08 Medication safe ordering, prescribing, transcribing, MMS10 Medication preparation and administration, PCC.06 Patient, family, and carer education process.

Adverse drug events, medication errors, and near misses.

MMS.12 The mental health hospital has a process for both monitoring the medication effects on patients and detecting, acting on, and reporting adverse drug events, medication errors, and near misses.

Safety

Keywords:
Medication Monitoring, Medication errors, adverse drug events, and near misses.

Intent:
Medications are monitored for clinical effectiveness and adverse medication effects.
The purpose of monitoring is to evaluate the therapeutic response of the medication(s), including safety and effectiveness in order to adjust the dosage or type of medication when required, evaluate for any medication interaction, and evaluate the patient for adverse effects or allergic reactions. Monitoring medication effects include observing and documenting any adverse effects. This is done using a standardized format (The Egyptian National Forms).
Reporting to the authorized institutions is done in a timely manner as per national regulations.
The mental health hospital shall develop and implement a medication monitoring process that shall contain at least the following categories:

a) Monitoring the response to the first dose of a new medication, the first dose shall be assessed and evaluated because any adverse reactions, including serious ones, are more unpredictable if the medication has never been used before with the patient.
b) Monitoring patients receiving psychotropic medications: All medications have side effects but antipsychotic medications have special monitoring requirements such as: (cardio-metabolic and clozapine monitoring) and also for patients who use multiple antipsychotic medications.
c) Monitoring the gradual dose reductions, and withdrawal management of patients.
d) Monitoring action with PRN orders for psychotropic medications.
e) Monitoring the children and adolescents: for safe and effective use of antipsychotic medications
f) Monitoring the elderly patients: may tolerate doses of psychotropic medications lower than those required and fall injuries which can cause serious adverse outcomes in older persons including increased mortality risk.
g) Monitor pregnant patients during, after delivery, and before starting psychotropic medication & as clinically indicated.

Medication errors and near misses are particularly important given the large and growing global volume of medication use. This is especially critical in healthcare settings where a significant proportion of prescribing occurs.
It is important that the mental health hospital has a process to identify and report medication errors and near misses. The process includes defining a medication error and near miss, and educating staff on the process and importance of reporting

Survey process guide:

- The GAHAR surveyors may review the process for medication monitoring and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review the process for reporting adverse drug events.
- The GAHAR surveyors may review the process for reporting medication errors and near-miss events.

Evidence of compliance:

1. Adverse drug events (ADEs) are reported in a manner consistent with national and international guidelines.
2. The mental health hospital has an established process for monitoring the response to psychotropic medications, especially for patients who are receiving multiple antipsychotic medications.
3. Actual or potential medication adverse drug effects on patients are monitored and documented in the patient's record, including the action(s) to be taken as an immediate response.
4. The mental health hospital has clear definitions for medication error(s), and near miss(es) and implements a process for acting on and reporting medication errors, and near misses in a manner consistent with the national guidelines.

Related standards:

MMS.01 Medication management program, MMS.08 Medication safe ordering, prescribing, transcribing, QPI.04 Incident Reporting System, QPI.06 Near Miss events.

Section 3: Organization-Centered Standards

While in the previous section, Patient safety and centered care were the focus. Yet, Patients are not the only customers of healthcare systems. Healthcare professionals face risks, as well. Although debate continues regarding whether worker wellbeing should be considered part of patient safety initiatives, many organizations think about it that way, including major players in the healthcare industry worldwide. Three major aspects may affect a worker's well-being; Safety, Stress, and Hospital Structure.

Regarding Safety, according to the United States Department of Labor, Occupational Safety and Health Administration (OSHA), a hospital is one of the most hazardous places to work. Healthcare professionals experience some of the highest rates of non-fatal illness and injury surpassing both the construction and manufacturing industries. In 2011, U.S. hospitals recorded 253,700 work-related injuries and illnesses, a rate of 6.8 work-related injuries for every 100 full-time staff. From 2002 to 2013, the rate of serious workplace violence incidents (those requiring days off for an injured worker to recuperate) was more than four times greater in healthcare than in private industry on average. In fact, healthcare accounts for nearly as many serious violent injuries as all other industries combined, OSHA reported that nurses and mental health workers were exposed to acts of workplace violence while working with patients who presented aggressive behavior. Many more assaults or threats go unreported. Workplace violence comes at a high cost; however, it can be prevented.

On the other hand, being exposed to stress for too long may lower a person's efficiency and could trigger negative consequences on one's health or family and social life. Nevertheless, not every manifestation of stress is always workplace stress. Workplace stress may be caused by various factors. Some professions are inherently more stressful than others. Some studies showed that healthcare professions are among the first six most stressful ones. Not all health professionals develop the same level of stress, and not all of them develop signs of professional burnout either. According to several studies, Intensive Care Unit medical/nursing staff report that dealing with death is their first source of stress, compared to nurses who work in internal medicine or surgical departments. For those professionals, workload and adequate workforce planning may be the most important stress source.

The hospital structure provides guidance to all staff by laying out the official reporting relationships that govern the workflow of the company. A formal outline of a hospital structure makes it easier to add new positions in the hospital, as well, as provides a flexible and ready means for growth. Organization management needs to be according to a clear ethical framework that is responsive to community needs. Organizations have an obligation to act for the benefit of the community at large. Workers, as community members, need to be engaged in assessing community needs and responding to them, in addition, to being protected from safety and stress hazards while working in the hospital.

Nevertheless, both the hospital and the staff have the responsibility to keep the workforce safe. For example, while management provides personal protective equipment (PPE), such as safety glasses to keep debris and chemical splashes away from the eyes, it is the staff's responsibility to wear the PPE when performing work that management has identified as requiring it. More generally, it is the responsibility of management to prepare detailed work instructions that clearly describe how work should be performed in order to prevent quality and safety failures; the staff is responsible for following these procedures.

Thus, this section shall focus on some of the newer ideas about healthcare workplace suitability to provide a safe, efficient, and improving environment for healthcare service. One of the tools used to design this section is called Health-WISE, which is an action tool developed by the International Labor Organization (ILO) in collaboration with the WHO. This tool emerged from traditional thinking about patient safety and improvement more generally. It describes a process and structure that may lead to improved safety in a variety of healthcare settings.

The aim of HealthWISE is to provide healthcare institutions with a practical, participatory and cost-effective tool to improve work conditions, performance, occupational health and safety for health workers, and the quality of health services provided. Improvements are introduced and sustained by the combined efforts of management and staff, brought together in a dedicated team. HealthWISE puts the health workforce in focus and addresses topics that are key to delivering quality care. It encourages everyone to participate in making their workplace not only a good place to work but a quality healthcare environment appreciated by patients and the community.

Elements for safe healthcare

As organization management is responsible for providing an efficient hospital structure, where a governing body is well defined and responsive to the hospital's needs, Leaders work collaboratively to run the hospital towards preset approved strategic directions. A well-established structure includes defining the capacity and roles of the hospital workforce, providing sufficient orientation and education, and continuous monitoring and evaluation. Hence, strong information management and technology are needed to record data and information, in addition to a strong quality management program that can capture and interpret data and information.

Environmental and Facility Safety

Chapter intent:
Environmental and Facility Safety (EFS) in mental health hospitals aims at minimizing potential risks for patients, visitors, staff, and buildings through compliance with local laws, regulations, fire, and building codes for providing a safe and secure work environment.
From an environmental standpoint, it involves creating a systematic approach to compliance with environmental regulations, such as managing waste and maintaining a safe environmental condition. From a safety standpoint, it involves creating organized efforts and procedures for identifying workplace hazards and reducing accidents and exposure to harmful situations and substances. It also includes training staff members in accident prevention, accident response, emergency preparedness, and the use of protective clothing and equipment. Globally, Healthcare design standards were developed to maintain a proper hospital structure that maintains safety and efficiency for all users. Facility Guideline Institute issues periodical research-based standards for healthcare facility designs. OSHA, CDC, WHO, and other international healthcare players set certain standards for various aspects of healthcare design. Locally, Regulatory requirements play an important role in EFS. The hospital shall identify and understand all relevant EFS regulations to implement the required measures. National initiatives include but are not limited to (Organization building codes, licensure requirements for the whole organization and the individual functions/machine/equipment/units inside the hospital, Civil defense laws, Green hospital initiatives, and Environmental laws). The GAHAR surveyors are going to meet the concerned staff in EFS and discuss the different standards of the chapter and review the documents, trace the activities and functions, and measure the facility's awareness of safety. A facility tour is an important tool used by surveyors to measure environmental safety risks in a hospital.

Chapter purpose:
This chapter started by planning and effective management of the hospital's environmental facility safety. Followed by requiring the development, implementation, monitoring, improvement, evaluation, and annual update of the environmental safety plans. The main objective is to ensure that organization is able to identify the safety issues and provide a safe and effective program to handle and maintain environmental safety. The chapter discusses the following:

- **Fire safety**:
  Prevention, early detection, response, and safe evacuation in case of fire.
- **Hazardous materials**:
  Safe handling, storage, transportation, and use of hazardous materials, and waste disposal.
- **Safety**:
  Providing a safe work environment for all occupants, ensuring that the hospital buildings, construction areas, and equipment do not pose a hazard or risk to patients, staff, and visitors.
- **Security**:
  Protection of all occupants' properties from loss, theft, destruction, tampering, or unauthorized access or use.
- **Medical equipment:**
  Selection, inspection, testing, maintenance, and safe use of medical equipment.
- **Utility systems:**
  Ensures efficiency and effectiveness of all utilities through regular inspection, maintenance, testing, and repair of essential utilities to minimize the risks of operating failures.
- **Disaster preparedness:**
  Responding to the disasters and emergencies that have the potential of occurring within the geographical area of the hospital with an evaluation of the structural integrity of the patient care environment.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) The Egyptian code for healthcare facilities design.
2) Egyptian civil defense requirement
3) Egyptian law for the care of psychiatric patients, 71/2009
4) Law no. 210/2020 amendment for the law of psychiatric patient care, 71/2009.
5) Regulations for the care of psychiatric patients,128/2010
6) Regulations for the care of psychiatric patients, 55/2021
7) Law 51/1981 amended by law 153/2004, Healthcare facilities organization
8) Standards for licensed mental health facilities for the National Council of Mental Health
9) MOH ministerial Decree for design standards of healthcare facilities number 402/2015
10) National Labor Law number 12/2007
11) Law of waste management number 202/2020
12) Prime minister decree for regulation of waste management number 722/2022.
13) National Law 4/1994 for environment amended by Law No. 9 of 2004
14) The Egyptian Drug Authority Decree on the regulation of Drug storage requirements for pharmaceutical institutions Number 271/ 2021.
15) Presidential decree number 3185/2016
16) Food safety Egyptian Guidelines.
17) Environmental Safety: Egyptian Guideline for Medical Device Vigilance System /2013.
18) Environmental Safety: National strategy in disasters management.
19) The Green Pyramid Rating System (GPRS)
20) WHO Early Warning Alert and Response Network in emergencies
21) WHO International Health Regulation, 2005.
22) WHO Core Medical equipment, 2011.

Safe, appropriate hospital structure and infrastructure

EFS.01 The mental health hospital facilities comply with laws, regulations, fire, and national building codes.

Safety

Keywords:
Mental health hospital environment and facility safety structure.

Intent:
While mental hospital hospitals are meant to provide healing and comfort, they also include certain dangers. Mental health hospitals contain hazardous chemicals, and infectious matter, among other threatening items. For this reason, governmental authorities enforce laws and regulations to ensure protection against these exposures. In addition, there are also dangers from fire and smoke that can be particularly perilous for vulnerable hospital patients.
Building codes were established to provide guidance on safety measures while designing hospital settings. The hospital shall comply with relevant laws, regulations, and codes like civil defense, fire, and building codes to ensure the safety of patients, staff, visitors, vendors, and the environment. The hospital shall develop and maintain an environmental and facility safety program, the program shall include at least the following:

a) The exact space required to provide the clinical and diagnostic services according to applicable laws, regulations, and the mental health hospital's scope of service.
b) Valid and current permits, licenses, and hospital design drawings.
c) Presence of qualified environmental safety personnel whose skills and qualifications are matching the requirements of the mental health hospital's scope of services, laws, and regulations.
d) Budget for upgrading and/or replacement of instruments or systems to keep environmental safety and/or to expand services provided within the mental health hospital.
e) review methodology of the aggregated essential data, incident reports, drill reports, surveillance reports, safety plan measures, actions are taken, and following up to ensure full compliance with all safety requirements
f) environmental and facility safety committee overseeing environmental safety activities and training with a clear term of reference complying with laws and regulations
g) Continuous monitoring mechanisms for environment and facility safety programs.
   A comprehensive report shall be submitted to the mental health hospital leaders and all stakeholders, on a regular way, at least quarterly with appropriate feedback and actions taken. If an external authority or agency, such as civil defense, reported an observation during its inspection, the hospital's leaders are responsible for providing a corrective action plan for any non-compliance within the required timeframe

Survey process guide:

- The GAHAR surveyors may review the mental health hospital environment and facility safety program
- The GAHAR surveyors may observe compliance with laws and regulations and matching of allocated spaces to services and functions.
- The GAHAR surveyors may review documents demonstrating hospital drawings, budget, safety staff qualifications, external authorities' reports with action plans, and recorded committee meeting notes and agendas.

Evidence of compliance:

1. The mental health hospital leadership maintains compliance with environmental safety laws, regulations, and national building codes.
2. The mental health hospital maintains the basic requirement for the development of an environment and facility safety program that included at least items from a) through g).
3. The mental health hospital has environmental and facility safety committee overseeing environmental safety with approved terms of reference.
4. The environment and facility safety committee meet regularly and meetings are recorded.
5. Evidence of environment and facility safety regular external inspections are recorded and monitored.
6. The mental health hospital's leadership ensures compliance with external inspection reports and correction of observations within the required timeframe.

Related standards:
OGM.01Governing body Structure and clear responsibilities, OGM.02 The Mental Health Hospital director, DAS.01 Planning and provision of Medical imaging services, DAS.08 Radiation Safety Program, DAS.09 Laboratory services planning and management, DAS.16 Laboratory Safety Program, EFS.02 Fire and smoke safety plan, EFS.06 Safety Management Plan, EFS.13 Emergency preparedness plan.

Effective and safe environment and facility safety plans

EFS.02 NSR.23 **The fire and smoke safety plan addresses prevention, early detection, response, and safe evacuation in case of fire or other internal emergencies.**

Safety

Keywords:
Fire and smoke safety plan.

Intent:
One of the critical considerations in the safety design for the mental health hospital is the prevention of fire, particularly concerning the combustibility of construction and furnishing materials and the spread of fire and smoke. In the event of either accidental or malicious fires, suppression equipment needs to be readily accessible to combat these fires. Staff members of the hospital need to have work knowledge of how to use the equipment and avoid panic. Moving all patients, visitors, and staff out of dangerous and/or damaged facilities as safely as possible is always the goal of an evacuation.
The mental health hospital shall develop a fire and smoke safety plan that addresses at least the following:

a) An ongoing risk assessment that shall have the following features:
    i. Assesses compliance with civil defense regulations.
    ii. Includes fire and smoke separation, high-risk areas for example stores, oxygen supply storage areas, electrical control panels, medical records room, garbage room, etc.
    iii. Addresses the safety of all occupants including patients, families, full-time staff, part-time staff, visitors, suppliers, contractors, and others.
    iv. Addresses evacuation for fire and non-fire emergencies.
    v. A special risk assessment is performed during renovation and construction.
b) Early detection of fire and smoke system, including the control panel connected to all areas in the mental health hospital according to its functionality, and ensure continuous monitoring 24/7.
c) Measures of smoking control.

d) Fire suppression systems such as water systems, and automated or manual fire extinguishers.
e) Listing of firefighting and alarm systems includes maintenance testing and inspection schedule.
f) Availability of safe fire exits, with clear signage to assembly areas and emergency lights, in addition to other related signage like how to activate the fire alarm using a fire extinguisher and hose reel.
g) Inspection of all firefighting and alarm systems should be in place, and results are recorded with the needed corrective actions.
h) Safe storage and handling of highly flammable materials.
i) proper training and orientation of all staff practically to make sure that everyone in the mental health hospital can:
    I. Demonstrate RACE and PASS.
    II. Safely evacuate all occupants (eg. evacuation pathway, clear signage, trained staff, safe and clear exits, assembly points. etc….).
j) Documentation of all results in a proper way and repetition according to the training plan.

The plan is evaluated annually and, if needed, according to related performance measures results or major incidents including corrective action.

Survey process guide:

- The GAHAR surveyors may review the fire safety plan, facility fire safety inspections, and fire system maintenance.
- The GAHAR surveyors may interview staff to check their awareness
- The GAHAR surveyors may observe that fire alarm; firefighting and smoke containment systems are working effectively and complying with civil defense requirements.

Evidence of compliance:

1. The mental health hospital has a fire and smoking safety plan that includes all elements from a) through j) in the intent.
2. The mental health hospital fire alarm, firefighting, and smoke containment system are available, functioning, and complying with civil defense requirements.
3. Inspection, testing, and maintenance of fire alarms, firefighting, and smoke containment systems are performed and recorded.
4. The hospital provides training for fire response and evacuation to all staff at least twice annually.
5. The mental health hospital has a safe evacuation process for all occupants in case of fire and/or other internal emergencies.
6. The fire and smoke safety plan is evaluated annually with aggregation and analysis of necessary data.

Related standards:

EFS.01 Mental health hospital environment and facility safety structure, EFS.03 Smoking-Free Environment, EFS.04 Fire drills, EFS.06 Safety Management Plan, EFS.09 Pre-Construction risk assessment, EFS.13 Emergency preparedness plan, QPI.03 Risk Management Program, ACT.04 Wayfinding signage.

EFS.03 The hospital's clinical and non-clinical areas are smoking-free with respect to approved exceptions according to patient status

Safety

Keywords:
Smoking-Free Environment.

Intent:
According to the Center for Disease Control (CDC), Smoking causes about 90% (or 9 out of 10) of all lung cancer deaths. More women die from lung cancer each year than from breast cancer. Smoking causes about 80% (or 8 out of 10) of all deaths from chronic obstructive pulmonary disease (COPD). Cigarette smoking increases the risk for death from all causes in men and women.
Literature shows that although hospitals restrict smoking inside, many people continue to smoke outside, creating problems with second-hand smoke, litter, fire risks, and negative role modeling.
Smoke-free policies are an important component of an ecological and social-cognitive approach to reducing tobacco use and tobacco-related disease.
In addition, Anti-smoking policies were reported to cause numerous positive effects on employee performance and retention.
The mental health hospital shall develop and implement a policy and procedures for smoking control including but not limited to;

a. Assigned places for smoking
b. Exceptions for no smoking according to patient status
c. Smoking restricted areas
d. Smoking and nonsmoking labels
e. Penalties for violation according to laws and regulations
f. Staff orientation regarding the policy

Survey process guide:

- The GAHAR surveyors may review the mental health hospital smoking-free policy
- The GAHAR surveyors may interview staff to check their awareness of the policy
- The GAHAR surveyors may observe evidence of not complying with the policy such as cigarette remnants and cigarette packs, especially in remote areas.

Evidence of compliance:

1. The hospital has an approved policy for a smoking-free environment that addresses all items in the intent from a) to f)
2. Staff, patients, and visitors are aware of the hospital policy.
3. Occupants, according to laws and regulations, do not smoke in all areas except designated areas.
4. The mental health hospital monitors compliance with the smoking-free policy.

Related standards:
EFS.01 Mental health hospital environment and facility safety structure, EFS.02 Fire and smoke safety plan, EFS.06 Safety Management Plan, QPI.03 Risk Management Program.

EFS.04 NSR.24 The mental health hospital performs effective fire drills in all different clinical and non-clinical areas.

Safety

Keywords:
Fire drills.

Intent:
Fire drills are designed to Ensure through regular training and simulations, staff members will: have knowledge and understanding of the fire safety plan so that they can act swiftly, safely, and in an orderly manner.
Have increased self-confidence and power to fulfill their responsibilities in the event of a fire.
The mental health hospital staff shall be well trained on firefighting and safe evacuation through practical simulations and regular drills to ensure staff readiness in case of fire and/or other internal emergencies.
The mental health hospital shall record fire drills details including, but not limited to, the following:

a) Dates and timings.
b) Staff who participated in the drill.
c) Involved areas.
d) Shifts.
e) Drill evaluation and corrective action plan.
f) Interviewing staff to check the awareness of fire safety plans and basic procedures in such cases as RACE and PASS.

Survey process guide:

- The GAHAR surveyors may review the records of fire and evacuation drills with dates, timings, staff who participated, the involved areas in the hospital, and corrective action plans based on the drill evaluation.
- The GAHAR surveyors may Interview staff to check the awareness of the fire safety plan and basic procedures in such cases as (Rescue, Alarm, Confine, Extinguish/Evacuate and Pull, Aim, Squeeze and Sweep).

Evidence of compliance:

1. Fire drills are performed based on a predefined time interval.
2. Staff members participate in fire drills at least annually.
3. Fire drill results are recorded from a) through f) in the intent.
4. Fire drill results evaluation is performed after performing each drill.
5. The hospital plans for corrective actions, whenever indicated by drill findings

Related standards:
EFS.02 Fire and smoke safety plan, EFS.03 Smoking-Free Environment, EFS.13 Emergency preparedness plan, WFM.07 Continuous education and training program, QPI.03 Risk Management Program.

Safe hazardous materials and waste management plan

EFS.05 NSR.25 The mental health hospital plans safe handling, storage, usage, and transportation of hazardous materials and waste disposal.

Safety

Keywords:
Hazardous materials and waste management.

Intent:
Hazardous materials are substances, which, if released or misused, can pose a threat to the environment, life, or health. Industry, agriculture, medicine, research, and consumer goods use these chemicals. Hazardous materials come in the form of explosives, and flammable and combustible substances. These substances are most often released because of transportation accidents or chemical accidents in hospitals. Because the effects of hazardous materials can be devastating and far-reaching, it is important that mental hospitals plan their safe use and establish a safe working environment. Healthcare waste includes infectious, chemical, expired pharmaceuticals, and sharps. These items can be pathogenic and environmentally unsafe. Other waste items generated through healthcare but not hazardous include medication boxes, the packaging of medical items and food, remains of food, and waste from offices.
The mental health hospital shall identify and control hazardous material and waste all over the hospital to ensure that staff, patients, relatives, vendors, and the environment are safe and shall be kept away and not easily accessible at any time by patients. Hazardous material and waste are categorized into the following categories according to the WHO classification:

i. Infectious
ii. Pathological and anatomical
iii. Pharmaceutical
iv. Chemical
v. Heavy metals
vi. Pressurized containers
vii. Sharps
viii. Genotoxic/cytotoxic
ix. Radioactive

Hazardous materials and waste management shall ensure full compliance with laws and regulations, availability of required licenses, and/or permits.
The plan shall include, but is not limited to, the following:

a) A current and updated inventory of hazardous materials used in the mental health hospital, inventory shall include the material name, hazard type, location, usage, consumption rate, and responsibility.
b) Material safety data sheet (MSDS) shall be available and includes information such as physical data, hazardous material type (flammable, cytotoxic, corrosive, carcinogenic, etc.), safe storage, handling, spill management, exposures, first aid, and disposal.
c) Appropriate labeling of hazardous materials.
d) Procedure for safe usage, handling, storage, and spillage of hazardous materials.
e) Appropriate segregation, labeling, handling, storage, transportation, and disposal of all categories of hazardous waste.
f) Availability of required protective equipment and spill kits.
g) Investigation and documentation of different incidents such as spills and exposure.
h) Staff training and orientation.

The mental health hospital shall evaluate and update hazardous materials and waste management plan annually or when required

Survey process guide:

- The GAHAR surveyors may review the hazardous material and waste disposal plan, hazardous material, and waste inventories, as well as Material Safety Data Sheet (MSDS)

- The GAHAR surveyors may interview responsible staff to check their awareness of the hazardous material and waste disposal plan
- The GAHAR surveyors may observe hazardous material labeling and storage in addition to waste collection segregation storage and final disposal.

Evidence of compliance:

1. The mental health hospital has hazardous material and waste management plan that addresses all elements from a) through h) in the intent.
2. The mental health hospital ensures staff safety when handling hazardous materials/or waste.
3. The mental health hospital ensures the safe usage, handling, storage, and labeling of hazardous materials.
4. The mental health hospital has a process for spill management, investigation, and recording and documentation of different incidents related to hazardous materials.
5. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:
EFS.01 Mental health hospital environment and facility safety structure, EFS.06 Safety Management Plan, IPC.09 Environmental cleaning activities, DAS.08 Radiation Safety Program, DAS.16 Laboratory Safety Program, QPI.03 Risk Management Program, EFS.12 Utility Management, IPC.06 Standard precautions measures.

Safety and security plan

EFS.06 A safe work environment plan addresses high-risk areas, procedures, risk mitigation requirements, tools, and responsibilities.

Safety

Keywords:
Safety Management Plan.

Intent:

Health services are committed to providing a safe environment for patients, staff, and visitors.

Hospital safety arrangements keep patients, staff, and visitors safe from inappropriate risks such as electricity and inappropriate behavior such as violence and aggression.

The hospital shall have a safety plan that covers the building, property, medical equipment, and systems to ensure a safe physical environment for patients, families, staff, visitors, and vendors.

The safety plan shall include at least the following:

a) Proactive risk assessment.
b) Effective planning to prevent accidents, injuries, and suicide and minimize potential risks, to maintain safe conditions for all occupants.
c) Processes for pest and rodent control.
d) The hospital identifies potential risks because of system failure, staff or patient behavior, for example, wet floor; water leakage from the ceiling beside electrical compartments; improper handling of sharps; non-compliance to personal protective equipment in case of working at heights, cutting, and welding, dealing with high voltage; and unsafe storage, Suicidal attempts
e) Regular inspection with documentation of results, performing corrective actions, and appropriate follow-up.
f) Improvements for long-term upgrading or replacement.
g) Safety training depends on job hazard analysis.

Survey process guide:

- The GAHAR surveyors may review the hospital safety plan, risk assessment, and the documented results of the regular inspections.
- The GAHAR surveyors may interview staff to check their awareness of the plan
- The GAHAR surveyors may observe the implemented safety measures and may observe safe instructions in high-risk areas.

Evidence of compliance:

1. The mental health hospital has an approved plan to ensure a safe work environment that includes all elements from a) through g) in the intent.
2. Staff is aware of safety measures pertinent to their job.
3. Safety measures are implemented in all areas.
4. Safety instructions are posted in all high-risk areas.
5. The safety management plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:
EFS.01 Mental health hospital environment and facility safety structure, EFS.02 Fire and smoke safety plan, EFS,03, EFS.05 Hazardous materials and waste management, EFS.08 Violence prevention program, EFS.09 Pre-Construction risk assessment, EFS.13 Emergency preparedness plan, IPC.04 Infection risk assessment, QPI.03 Risk Management Program, IPC.06 Standard precautions measures.

EFS.07 Security plan addresses the security of all occupants and properties including restricted and isolated areas with risk mitigation, control measures, tools, and responsibilities.

Safety

Keywords:
Security Plan.

Intent:
Security issues such as violence, aggression, thefts, harassment, suicide, bomb threat, terrorism, gunshot, and child abduction are common in hospitals.
Usually, hospitals enforce a code of behavior that does not tolerate physical or verbal aggression, or abuse towards staff, patients, family members, or visitors.
To keep staff, patients, and visitors safe, hospitals may use a range of security measures, including the use of CCTV cameras, duress alarms for staff members, and electronic access control systems for doorways. Some hospitals also employ security staff.
The hospital ensures the protection of all occupants from violence, aggression, thefts, harassment, suicide, bomb threat, terrorism, gunshot, and child abduction.
The security plan includes, but is not limited to, the following:

a) Security risk assessment.
b) Ensuring the identification of patients, visitors, and staff in the hospital.
c) Identification of vendors/contractors with the restriction of their movement within the mental health hospital.
d) Vulnerable patients such as the elderly, children, and handicapped should be protected from the abuse and above-mentioned harms.
e) Patients escape preventive measures with one drill at least annually
f) Children abduction preventive measures with one drill at least annually
g) Monitoring of remote and isolated areas.
h) Staff training and orientation.
i) The plan is evaluated annually and, if needed, according to related performance measures results or major incidents.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital security plan, security risk assessment, and the documented results of the regular inspections.
- The GAHAR surveyors may observe the implemented security measures including child abduction and patient escape preventive measures.

Evidence of compliance:

1. The mental health hospital has an approved security plan that includes items a) through i) in the intent.
2. Patient escape preventive measures are implemented.
3. Security measures are implemented including identification of occupants.
4. Child abduction preventive measures are implemented.
5. Restricted and isolated areas are protected and secured.
6. The Security plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:
PCC.09 Patient's belongings, EFS.08 Violence prevention program, IMT.04 Confidentiality and Security of data and information, QPI.03 Risk Management Program.

Violence prevention program.

EFS.08 NSR.26 **The mental health hospital implements a violence prevention program.**

Safety

Keywords:
Violence prevention program.

Intent:
Workplace violence is known in different healthcare settings, but it is a frequent event in mental health hospitals regarding the special nature of patients receiving care in these hospitals.
Healthcare workers in mental health hospitals are more exposed to acts of workplace violence while working with patients who presented aggressive behavior, including but not limited to: direct attacks involving punches, kicks, scratches, and being hit with objects.
Healthcare workers in mental health hospitals could experience injuries including concussions, hematomas, fractures, bruises, lacerations, and bites while providing care to aggressive and violent individuals.
Implementing a workplace violence prevention program is everyone's responsibility, it will definitely protect employees and increase their loyalty towards their work which ensures all measures to protect them.
The program should include at least the following:

a) A Workplace analysis.
b) Hazards identification, prevention, and control.
c) Development of workplace violence controls, including implementation of engineering and administrative controls and methods used to prevent potential workplace violence incidents.
d) Staff training and involvement in the program.
e) Reporting incidents that result from workplace violence with written findings, recommendations, and plan(s) for corrective actions.
f) Recordkeeping and program evaluation and review with adherence to a defined timeframe.

Survey process guide:

- The GAHAR surveyors may review the workplace violence prevention program.
- The GAHAR surveyors may interview staff to check their awareness.
- The GAHAR surveyors may observe the used engineering and administrative controls and methods to prevent potential workplace violence incidents.
- The GAHAR surveyors may review registers for violence incident reporting.

Evidence of compliance:

1. The hospital has a workplace violence prevention program that includes items a) through f) in the intent.
2. Staff is aware of their roles and responsibilities relative to the workplace violence prevention program.
3. Records and registers specified for violence incident reporting are completed with findings, analysis, recommendations, and plan(s) for corrective actions.
4. The program is evaluated annually and, if needed, according to related performance measures results or major incidents.

Related standards:
EFS.06 Safety Management Plan, EFS.07 Security Plan, OGM.11 Positive Workplace Culture, QPI.03 Risk Management Program.

Safe pre-construction and renovation risk assessment

EFS.09 The mental health hospital performs a pre-construction risk assessment when planning for construction or renovation.

Safety

Keywords:
Pre-Construction risk assessment.

Intent:
New construction or renovation in a hospital has an impact on all occupants, who could suffer from changing air quality by dust or odors, noise, vibration, and wreckage.
Upon new construction or renovation in the mental health hospital, a pre-construction risk assessment (PCRA) should be performed and evaluated in order to develop a plan that will minimize associated risks.
The mental health hospital ensures the involvement of all departments affected by construction or renovation, including project management, infection control, safety, security, housekeeping, information technology, engineering, clinical departments, and external constructors.
The pre-construction risk assessment includes, but is not limited to, the following:

I. Noise level
II. Vibration
III. Infection control
IV. Air quality
V. Fire risk
VI. Utilities affected (electricity, water, gases, etc.)
VII. Hazardous materials
VIII. Waste and wreckage
IX. Any other hazards related to construction/renovation

The mental health hospital ensures monitoring, documentation of all activities, and all risks related to construction and renovation.

Survey process guide:

- The GAHAR surveyors may review pre-construction risk assessment documents and check the implementation of risk assessment recommendations.

- The GAHAR surveyors may interview staff, patients, or contractors in the construction area to check if they are aware of the required precautions.

Evidence of compliance:

1. The mental health hospital performs a pre-construction risk assessment before any construction or renovation that addresses items from I) to IX) in the intent.
2. All affected departments are involved in the risk assessment.
3. The mental health hospital plans corrective actions according to risk assessment.
4. If a contractor is used, the contractor's compliance is monitored and evaluated by the mental health hospital.

Related standards:
EFS.02 Fire and smoke safety plan, EFS.05 Hazardous materials and waste management, EFS.06 Safety Management Plan, EFS.12 Utility Management, IPC.04 Infection risk assessment, QPI.03 Risk Management Program.

Safe medical equipment selection, inspection, calibration, and maintenance

EFS.10 NSR.27 **Medical equipment plan ensures safe selection, inspection, testing, maintenance, and safe use of medical equipment.**

Safety

Keywords:
Medical Equipment Plan.

Intent:
Medical equipment is critical to the diagnosis and treatment of patients. In mental health hospitals, a trained qualified individual/(s) shall oversee and manage the medical equipment management plan. He is responsible for the entire bio-medical inventory, dealing with medical equipment hazards, and monitoring the extensive array of devices. Poor maintenance lead to inappropriate results which seriously affect both patient and staff safety in addition to frequent downtime, delayed and inadequate services.
This is why it is crucial to establish some basic equipment safety and service guidelines.
Alarms are intended to induce immediate appropriate action from staff members to either check device malfunction or initiate action that will revert the situation. This can be ensured when all the staff members become fully aware of alarm settings (values and volume) and their significance and are trained on the required actions to be taken when triggered.
The mental health hospital shall develop a plan for medical equipment management that addresses at least the following:

a) Developing criteria for selecting new medical equipment.
b) Acceptance test of new medical equipment upon procurement.
c) Periodic Quality control test according to WHO protocol or manufacturer's recommendation
d) Training of staff on safe usage of medical equipment upon hiring on the installation of new equipment, and on a predefined regular basis by a qualified person/company.
e) Training of staff on safe handling of the specialized equipment.
f) Inventory of medical equipment including availability, criticality, and functionality.
g) Identification of critical medical equipment that should be available for the operator even though the provision of back- up such as life-saving equipment, ventilator, and DC shock.
h) Periodic preventive maintenance according to the manufacturer's recommendations which usually recommends using tagging systems by tagging dates and due dates of periodic preventive maintenance or labeling malfunctioned equipment.
i) Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.

j) Malfunction and repair of medical equipment.
k) Dealing with equipment adverse incidents, including actions taken, backup system, and reporting.
l) Records are maintained including Updating, retiring, and/or replacing medical equipment in a planned and systematic way. These records are implemented for at least the following:
    i. Equipment inventory list.
    ii. User training,
    iii. Equipment identification cards
    iv. Company emergency contact
    v. Testing on installation
    vi. Periodic preventive maintenance
    vii. Calibration
    viii. Malfunction history.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital medical equipment plan.
- The GAHAR surveyors may interview staff to check their awareness.
- The GAHAR surveyors may review medical equipment records.
- The GAHAR surveyors may observe the functionality of the medical equipment.

Evidence of compliance:

1. The mental health hospital has an approved medical equipment management plan that addresses all elements from a) through l) in the intent.
2. Staff is aware and trained on the hospital's medical equipment management plan
3. Records are maintained for all elements from i) through viii) in the intent, the Critical medical equipment list is identified, and backup availability is ensured.
4. Only trained and competent staff handle the specialized equipment(s).
5. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:
EFS.06 Safety Management Plan, EFS.11 clinical alarms, WFM.07 Continuous education, and training program, IPC.09 Environmental cleaning activities, EFS.11 Clinical alarms.

EFS.11 NSR.28 The mental health hospital has an approved policy and procedure for managing clinical alarms.

Safety

Keywords:
Clinical alarms.

Intent:
The clinical alarm is defined as "A component of some medical devices that are designed to notify caregivers of an important change in a patient's physiologic status. A clinical alarm typically provides audible and/or visible notification of the changed patient status.
Mental health hospitals typically do not have the abundance and variety of clinical alarms that acute care hospitals have. However, there are some types of alarms used in mental health hospitals that do fit into this category such as doorway movement alarms sometimes used on adolescent units.

Alarms are intended to induce immediate appropriate action from staff members to either check device malfunction or initiate action that will revert the situation. This can be ensured when the responsible staff members become fully aware of alarm settings and parameters (i.e values and volume) and their significance and are trained on the required actions to be taken when triggered.

Annual competency testing for staff members is needed to ensure the safe use of monitors and other devices that has clinical alarming systems. The mental health hospital shall develop and implement a policy and procedures for the safe handling and use of clinical alarms. The policy addresses at least the following:

a) Inventory of clinical alarms and their regular preventive maintenance plan.
b) Testing of clinical alarm systems to ensure that alarms are not false or impact the mental health's specific patient populations.
c) Clinical appropriate settings required to activate the alarms.
d) Authorization for disabling alarms or changing their settings is determined.
e) Ensure that alarms are sufficiently visible and/ or audible with respect to distances and competing for noise within the unit.
f) Measure to be taken when alarm signals contribute to alarm noise and alarm fatigue.

Survey process guide:

- The GAHAR surveyors may review hospital policy for maintenance and testing of clinical alarms.
- The GAHAR surveyors may review the inventory of all devices with clinical alarms.
- The GAHAR surveyors may review maintenance records, evidence of function, reporting of malfunction, and remedial actions.
- The GAHAR surveyors may review the schedules of alarm tests and a list of current active settings in different care areas.
- The GAHAR surveyors may interview the responsible staff to check their awareness of clinical alarm settings and response to their activation.
- The GAHAR surveyors may observe (listen) or activate clinical alarms to check for the suitability of alarm volume to the working space.

Evidence of compliance:

1. The mental health hospital has an approved policy of the safe management and use of clinical alarms that addresses all the elements mentioned in the intent from a) through f).
2. Authorized staff members for handling devices with clinical alarms are aware of the hospital policy.
3. Competent individuals are responsible for the management and use of clinical alarms.
4. The hospital has an identified process to ensure the suitability of alarm volume to working space.

Related standards:

EFS.06 Safety Management Plan, EFS.10 Medical Equipment Plan, WFM.07 Continuous education and training program, QPI.03 Risk Management Program.

Safe utility plan

EFS.12 NSR.29 Essential utilities plan addresses regular inspection, maintenance, testing, and repair.

Safety

Keywords:
Utility Management.

Intent:
Mental health hospitals are expected to provide safe and reliable healthcare to their patients. Planning appropriate response and recovery activities for a failure of the hospital's utility systems is essential to satisfy this expectation.
These systems constitute the operational infrastructure that permits safe patient care to be performed.
Some of the most important utilities include mechanical (e.g., heating, ventilation, and cooling); electrical (i.e., normal power and emergency power); domestic hot and cold water as well as other plumbing systems; waste; technology systems, including the myriad communications and data-transfer systems; vertical transportation utilities; fuel systems; access control, duress alarm and surveillance systems; medical gases, air, and vacuum systems; and pneumatic tube systems.
The mental health hospital shall have a utility management plan to ensure efficiency and effectiveness of all utilities that include at least the following:

a) Inventory of all utility key systems, for example, electricity, water supply, medical gases, heating, ventilation, air conditioning, communication systems, sewage, fuel sources, fire alarm, and elevators.
b) The layout of the utility system.
c) Staff training on utility plan.
d) Regular inspection, testing, and corrective maintenance of utilities.
e) Testing of the electric generator with and without a load on a regular basis.
f) Providing fuel required to operate the generator in case of an emergency.
g) Cleaning and disinfecting of water tanks and testing of water quality with regular sampling for chemical and bacteriological examination with documentation of the results at least quarterly and/or more frequently if required by local laws and regulations or conditions of the source of water.
h) Preventive maintenance plan, according to the manufacturer's recommendations.
i) The mental health Hospital performs regular, accurate data aggregation, and analysis, for example, frequency of failure, and preventive maintenance compliance for proper monitoring, updating, and improvement of the different systems.

Survey process guide:

- The GAHAR surveyors may review the utility management plan to confirm the availability of all required systems, regular inspection, maintenance, and backup utilities.
- The GAHAR surveyors may interview responsible staff to check their awareness.
- The GAHAR surveyors may review inspection documents, preventive maintenance schedules, contracts, and equipment, as well as testing results of generators, tanks, and/or other key systems to make sure of facility coverage 24/7.

Evidence of compliance:

1. The mental health hospital has an approved plan for utility management that includes items a) through i) in the intent
2. The mental health hospital has qualified staff members to oversee utility systems.
3. Staff is trained on the utility systems plan at least twice annually.
4. Records are maintained for utility systems inventory, testing, periodic preventive maintenance, and malfunction history.
5. Critical utility systems are identified and backup availability is ensured.

6. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:
EFS.06 Safety Management Plan, QPI.03 Risk Management Program.

Safe emergency preparedness plan

EFS.13 Emergency preparedness plan addresses responding to disasters that have the potential of occurring within the geographical area of the hospital.

Safety

Keywords:
Emergency preparedness plan.

Intent:
The last few decades have witnessed an increased frequency of disasters causing tremendous human casualties, in terms of loss of life and disability in addition to huge economic losses. Although these may not be totally preventable their impact can be minimized by effective planning. Equally important are the peripheral emergencies like road, rail, and air accidents, fire, drowning, and stampedes in mass gatherings, industrial accidents, explosions, and terrorist attacks that have an inherent potential to convert into mass casualty incidents. The loss of life and disability is compounded by the lack of adequate medical preparedness both qualitatively and quantitatively across the country. The mental health hospital shall develop a risk assessment tool to prioritize potential emergencies based on probability and impact and shall develop an emergency preparedness plan, the frequency of reviewing and updating the plan is done in accordance with the results of the current risk assessment and analysis. The emergency preparedness plan shall include at least the following.

a) Risk assessment of potential emergencies. internal and external disasters, such as heavy rains, earthquakes, floods, hot weather, wars, bomb threats, terrorist attacks, traffic accidents, power failure, fire, and gas leakage, in addition to epidemics, may affect the hospital's building and/or activities.
b) Degree of preparedness according to the level of risk.
c) Communication strategies: Internal communication may be in the form of a clear call tree that includes staff titles and contact numbers, and External communication channels may include civil defense, ambulance centers, and police.
d) Clear duties and responsibilities for hospital leaders and staff.
e) Identification of required resources such as utilities, medical equipment, medical, and non-medical supplies, including alternative resources.
f) Emergency responses and preparedness:
    i. Triaging.
    ii. The staff's main task is maintained in case of emergencies.
    iii. Alternative care sites, and backup utilities.
    iv. Safe patient transportation in case of emergency is arranged by the hospital.
    v. Climate resilience measures for example floods, heavy rains, and other natural emergencies
g) Drill schedule. The mental health hospital shall have a drill schedule for emergencies at least annually and ensure the attendance of staff; Proper evaluation and recording of the drill includes, but is not limited to:
    I. The Scenario of the drill
    II. Observations on: code announcement, timing, staff attendance, response, communication, triaging, and clinical management.
    III. Clear corrective actions if needed.
    IV. Feedback to the environmental safety committee.
    V. Debriefing.

Survey process guide:

- The GAHAR surveyors may review the emergency preparedness plan and its records to confirm that it covered all the identified risks.
- The GAHAR surveyors may interview staff to check their awareness of the plan.
- The GAHAR surveyors may observe preparedness measures for identified emergencies.

Evidence of compliance:

1. The mental health hospital has an emergency preparedness plan that includes items a) through g) in the intent.
2. The staff is aware of the emergency preparedness plan.
3. The mental health hospital performs at least one drill annually that includes items i) through v) in the intent.
4. The mental health hospital demonstrates preparedness measures for identified emergencies.
5. The plan is evaluated and reviewed regularly (at least annually) with aggregation and analysis of necessary data.

Related standards:

EFS.02 Fire and smoke safety plan, EFS.06 Safety Management Plan, QPI.03 Risk Management Program, WFM.07 Continuous education, and training program.

Infection Prevention and Control

Chapter intent:

Infection Prevention and Control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and/or health workers. It is grounded in infectious diseases, epidemiology, social science, and health system strengthening. IPC occupies a unique position in the field of patient safety and quality universal health coverage since it is relevant to health workers and patients at every single healthcare encounter.

The IPC program aims at identifying and reducing or eliminating the risks of acquisition and transmission of infections among patients, healthcare workers, volunteers, visitors, and the community. Usually, the IPC program is risk-based; this means that a risk assessment is required to promptly identify and proactively address possible infection risks among individuals and in the environment. Then, solutions shall be tailored accordingly by developing appropriate policies and procedures, in conjunction with proper staff education. Therefore, IPC activities shall differ from one organization to another, depending on the hospital's clinical activities, the scope of services, and served patient population.

It is the responsibility of the IPC team members to oversee the IPC program, and they should all have detailed job descriptions. The staff member(s) shall be qualified enough to meet the hospital's needs. These needs are driven by the hospital size, complexity of activities, and level of risks, as well as the program's scope. The required qualifications could be in the form of education, training, experience, and certification.

The IPC program and its activities are based on current scientific knowledge, national guidelines, and accepted international practice guidelines (CDC, APIC, IFIC), besides applicable laws and regulations. The program shall need to be planned, disseminated, taught, and monitored.

Chapter purpose:

1. To ensure the effective structure of infection prevention and control.
2. To address the standard precautions policies and procedures, implementation, and monitoring.
3. To highlight the environmental cleaning and disinfection activities.
4. To describe safe injection practices.
5. To explain the transmission-based precautions and patient placement.
6. To explain the infection prevention and control program in all supportive services (CSSD, kitchen, laundry, and waste management).
7. To illustrate the preventive measures during construction and renovation.
8. To link infection control activities to the organizational quality program and determine needs for IPC improvement projects.

Implementation guiding documents:

(*All mentioned references need to be read in the context of their conditions, amendments, substitutes, updates, and annexes)*

1) Infection Control: National Guidelines for Infection Control, the Last Update.
2) MOHP Ministerial Decree Number for Infection Control Personnel Number 187/2004.
3) Law of Waste Management, 202/2020.
4) Prime Minster Decree for Regulation of Waste Management Number 722/2022.
5) MOHP Decree for Reuse of Single Used Devices and Instruments Number 523 / 2015.
6) The Egyptian Code for Healthcare Facilities Design.
7) MOH Ministerial Decree for Design Standards of Healthcare Facilities Number 402/2015
8) National Law 4/1994 for Environment Amended by Law No. 9 / 2004

Identified structure of the infection prevention and control program

IPC.01 Dedicated and qualified healthcare professional(s) oversee the infection prevention and control activities according to applicable laws and regulations, and national and international guidelines.

Effectiveness

Keywords:
IPC assigned team.

Intent:
The presence of a qualified and dedicated IPC professional(s) in the mental health hospital ensures increased effectiveness of the IPC program in all its phases including development, implementation, and monitoring.
The mental health hospital shall assign a qualified team to be responsible for all activities related to the IPC. The program supervises it, puts an action plan to implement this program, and educates all staff members on their roles.
The team members' qualifications and numbers shall meet the mental health hospital's needs. These needs are driven by the mental health hospital size, complexity of activities, and level of risks, as well as the program's scope

Survey process guide:

- The GAHAR surveyors may review staff files to check for the qualifications of the assigned IPC team members.
- The GAHAR surveyors may interview IPC team members to check their awareness of their job description.

Evidence of compliance:

1. The mental health hospital has an assigned dedicated IPC team .
2. The IPC team leader and each member has a defined job description .
3. The IPC Team members are qualified by certification and education that match their job description requirements .
4. The IPC team member(s) effectively communicate with the top management and all other relevant departments\disciplines

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.03 IPC committee, meetings, OGM.03 The Mental health hospitals' leaders, WFM.02 Staffing Plan, WFM.03 Job Description.

IPC.02 A comprehensive infection prevention and control program is developed, implemented, and monitored.

Safety

Keywords:
Infection prevention and control (IPC) program.

Intent:
Previously, the risk of healthcare-associated infections (HAI) in mental health hospitals are relatively low because there are less invasive procedures conducted. Recently, patients are being increasingly treated in mental health hospitals. In addition, invasive procedures and advanced technologies are being used with increasing frequency in healthcare settings. All these factors increase the potential risk for HAI in mental health hospitals .

Therefore, healthcare-associated infections can be a common risk encountered in any mental health hospital. Consequently, constructing a comprehensive IPC program is of utmost importance to effectively reduce these risks .

The IPC program is an integrated part of performance improvement and patient safety plans, using measures that are epidemiologically important to the mental health hospital. The IPC program must be based on the annual mental health hospital risk assessment plan, national and international guidelines such as CDC, APIC, IFIC, etc., accepted practices, and applicable laws and regulations .

An effective IPC program must be comprehensive and includes all aspects of patient care, staff health, and the entire services provided by the mental health hospital such as (hand hygiene guidelines implementation, antimicrobial stewardship, safe injection, etc.) .

The program shall also assure the education and training of all working staff members and provide the necessary education to patients, visitors, and families .

Measurement information is essential to improve infection prevention and control activities and reduce healthcare-associated infection rates. Thus, mental health hospitals can best use measurement data and information by understanding similar rates and trends in other similar organizations .

Each mental health hospital can design its own performance measures to monitor, assess, and improve the IPC program. Examples of performance measures include the percentage of hand hygiene compliance and the results of sterilization monitoring.

Survey process guide:

- The GAHAR surveyors may review the IPC program to check that the program covers patients, staff, and visitors and is based on IPC risk assessment.
- The GAHAR surveyors may review the documentation of monitored data, performance measures, data analysis reports, and recommendations for improvement and may observe the implementation.

Evidence of compliance:

1. The mental health hospital has a program that includes the scope, objectives, expectations, and surveillance methods .
2. The program included all areas of the mental health hospital and covers patients, staff, and visitors according to the scope of the mental health hospital.
3. The IPC program includes a training plan for all staff .
4. The mental health hospital tracks, collects, analyzes, and reports data on its infection control program .
5. The mental health hospital acts on improvement opportunities identified in its infection control program .

Related standards:

IPC.01 IPC assigned team, IPC.03 IPC committee, meetings, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, IPC.16 Infection surveillance process, OGM.02 The Mental Health Hospital director, QPI.03 Risk Management Program, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan

IPC.03 The mental health hospital establishes a functioning multidisciplinary IPC committee that meets at least monthly.

Effectiveness

Keywords:
IPC committee, meetings.

Intent:
IPC challenges continuously arise in the different mental health hospital disciplines, which in turn provide input for the IPC team for their continuous evaluation of the situation.
There is a structured infection control committee; all relevant disciplines should be represented in the committee for example (but not limited to), the medical department, nursing services, housekeeping, laboratory, pharmacy, sterilization services, etc., and the committee should have the right to summon whoever it deems appropriate.
The IPC committee is responsible for at least the following:

a) Setting criteria to define mental health hospital-associated infections.
b) Surveillance methods and process.
c) Strategies to prevent infection and control risks.
d) Reporting infection prevention and control activities.

Survey process guide:

- The GAHAR surveyors may review the committee matrix, and terms of reference and may review a sample of monthly minutes of the meeting.
- The GAHAR surveyors may review evidence of recommendations for follow-up and implementation.

Evidence of compliance:

1. There are clear terms of reference for the infection control committee that includes at least from a) to d) in the intent.
2. The committee meets at least monthly.
3. The committee meetings are recorded.
4. Recommendations taken by the committee are implemented and followed up at the end of each meeting.

Related standards:
IPC.01 IPC assigned team, IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.16 Infection surveillance process, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders.

IPC.04 The mental health hospital identifies the procedures and processes that are associated with an increased risk of infection.

Safety

Keywords:
Infection risk assessment.

Intent:
The mental health hospital assesses and cares for patients using many simple and complex processes, each being associated with a particular level of infection risk to patients and staff. On the other hand, mental health settings can receive efflux of patients, clustering of patients, and may have a significant number of patients in common waiting areas.

Therefore, it is important for the mental health hospital to assess and review those processes and, as appropriate, implement the required strategies, such as policies, procedures, education, and evidence-based activities, to reduce this risk.

The mental health hospital identifies the procedures associated with increased risk by defining policies, procedures followed by staff education, and evidence-based activities, to reduce these identified risks.

Survey process guide:

- The GAHAR surveyors may review IPC risk assessment and analysis by focusing on high-risk procedures and processes.
- The GAHAR surveyors may interview responsible staff to check their awareness of the risk of infection identification and mitigation.

Evidence of compliance:

1. The mental health hospital has a process that identifies departments, services, and procedures with an increased potential risk of infection.
2. Responsible staff is aware of the process implemented for risk identification, mitigation, and reporting.
3. The mental health hospital tracks, collects, analyzes, and reports data of infection risk assessment and analysis.
4. The mental health hospital acts on improvement opportunities identified in its infection assessment and analysis process.

Related standards:

IPC.02 Infection prevention and control (IPC) program, IPC.06 Standard precautions measures, IPC.08 Safe injection practices, IPC.09 Environmental cleaning activities, IPC.10 Aseptic techniques, IPC.11 Isolation precaution, EFS.06 Safety Management Plan, QPI.03 Risk Management Program, QPI.08 Performance improvement, and patient safety plan, QPI.02 Performance Measures.

Safe, effective infection prevention practice

IPC.05 NSR.02 **Evidence-based hand hygiene guidelines are adopted and implemented throughout the hospital in order to prevent healthcare-associated infections.**

Safety

Keywords:

Hand Hygiene.

Intent:

Hand hygiene is the cornerstone of reducing infection transmission in all healthcare settings. It is considered the most effective and efficient strategy for infection prevention and control.

Hand hygiene facilities shall be present in appropriate numbers.

Hand hygiene supplies (hand soap, hand antiseptics, and single-use towels) shall be present in the appropriate places.

Alcohol-based hand rubs are now the preferred products for routine hand hygiene in healthcare facilities unless hands are visibly soiled to overcome the shortage in sinks.

Survey process guide:

- The GAHAR surveyors may review the mental health policy of the hand hygiene
- The GAHAR surveyors may review the policy of hand hygiene and hand hygiene guidelines .
- The GAHAR surveyors may review hand hygiene education posters and records.

- The GAHAR surveyors may interview hospital staff, to check their awareness of hand hygiene techniques and the WHO's five moments of hand hygiene.
- The GAHAR surveyors may observe hand washing facilities at each patient care area and check the availability of supplies (soap, tissue paper, alcohol hand rub, etc.) .
- The GAHAR surveyors may observe the compliance of healthcare professionals with hand hygiene techniques and the WHO's five moments of hand hygiene.

Evidence of compliance:

1. The Mental health hospital has approved hand hygiene policies and procedures based on evidence-based guidelines.
2. Healthcare professionals are trained on how to apply this policy.
3. Hand hygiene posters are displayed in required areas, as per the hospital policy.
4. Hand hygiene facilities are available in numbers and places, as per the hospital policy.
5. Compliance of healthcare professionals with hand hygiene policy is monitored.
6. Results of staff compliance are linked and documented in the staff appraisal\ evaluation process.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, IPC.10 Aseptic technique, WFM.07 Continuous education and training program, WFM.08 Staff Performance Evaluation, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan.

IPC.06 Standard precautions measures and the minimum infection prevention practices apply in any setting where healthcare is delivered.

Safety

Keywords:
Standard precautions measures.

Intent:
According to CDC, standard precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. In addition to hand hygiene, standard precautions include:

a) Use of personal protective equipment (PPE) (e.g., gloves, masks, eyewear).
b) Use of antiseptics techniques.
c) Respiratory hygiene/cough etiquette.
d) Clean and disinfect environmental surfaces.

Proper selection of standard precautions depends on risk assessments that are performed at the points of care, and according to the patient's suspected infection so staff education and training are therefore of utmost importance.

Survey process guide:

- During GAHAR Survey, the surveyor may check the availability and accessibility of PPE.
- and may interview staff members to inquire about the constant availability, accessibility, and proper use of PPE.

Evidence of compliance:

1. The mental health hospital has PPE that is easily accessible and available.

2. Selection and use of PPE are based on the risk assessments that are performed at the points of care and according to the patient's suspected infection.
3. Responsible staff is aware of PPE's proper use and disposal.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.05 Hand Hygiene, IPC.10 Aseptic techniques, IPC.11 Isolation precaution, EFS.06 Safety Management Plan, QPI.03 Risk Management Program, DAS.08 Radiation Safety Program, DAS.16 Laboratory Safety Program.

IPC.07 Respiratory hygiene is implemented as an element of standard precautions.

Safety

Keywords:
Respiratory Hygiene Protocol.

Intent:
Respiratory hygiene and cough etiquette interventions are intended to limit the spread of infectious organisms from persons with potentially undiagnosed respiratory infections.

In order for respiratory hygiene interventions to be effective, early implementation of infection prevention and control measures needs to exist at the first point of entry to the hospital and be maintained throughout the duration of the stay.

The effort of respiratory hygiene interventions shall be targeted at patients and accompanying significant others with respiratory symptoms and applies to any person entering a hospital with signs of respiratory illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions.

Survey process guide:
- The GAHAR surveyors may observe the availability of respiratory hygiene/cough etiquette posters in appropriate places.
- The GAHAR surveyors may observe the availability and accessibility of resources such as tissues and surgical masks.

Evidence of compliance:
1. Respiratory hygiene /cough etiquette posters are displayed at appropriate places.
2. Resources such as tissues and surgical masks are available in numbers matching patients' and staff members' needs.
3. The Mental health hospital has a defined pathway for patients with a suspected respiratory infection.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, IPC.11 Isolation precaution, IPC.17 Multi-Drug Resistant Organisms, EFS.06 Safety Management Plan, QPI.03 Risk Management Program.

IPC.08 The mental health hospital ensures safe injection practices.

Safety

Keywords:
Safe injection practices.

Intent:
In the Mental health hospital, patients are continuously in need of injections whether for diagnostic or therapeutic purposes, unfortunately however it carries an associated risk of infection for the patients. Moreover, needle stick injuries among healthcare professionals are a common accident and, unsafe injection practices are associated with the transmission of blood-borne pathogens.so, Safe injection practices are crucial to ensure both patient and healthcare professionals' safety. Healthcare professionals shall always use a sterile, single-use disposable syringe, and needle for each injection given, and ensure that all injection equipment and medication vials remain free from contamination.

Survey process guide:

- The GAHAR surveyors may observe the Intravenous bottles and multi-dose vials and check their use.
- The GAHAR surveyors may interview staff to check their awareness of safe injection practices

Evidence of compliance:

1. Single-use Intravenous bottles/bags, and fluids infusion /administration sets (e.g., tubing and connections) are disposed of immediately after use.
2. The use of multi-dose vials is done in accordance with the manufacturers' recommendations to ensure that vials remain free from contamination.
3. The mental health hospital ensures that all staff has trained and aware of safe injection practices.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, MMS.10 Medication preparation and administration, EFS.06 Safety Management Plan, QPI.03 Risk Management Program.

IPC.09 Environmental cleaning activities are aligned with current evidence-based guidelines.

Safety

Keywords:
Environmental cleaning activities.

Intent:
The healthcare environment is considered a reservoir for pathogens and may be a significant source of healthcare-associated infections so, cleaning and disinfection of environmental surfaces is an important tool to prevent the development of these infections.

Contact with contaminated surfaces in the mental health hospital can easily lead to cross-contamination of microorganisms between the environment and healthcare professionals

To provide quality of care, the hospital shall have a clear method and schedule for environmental cleaning and disinfection including walls, floors, ceilings, and furniture; this shall be performed according to the classification of areas.

The environmental cleaning schedule shall address environmental cleaning activities for each area as follows:

a) Activities to be done every day
b) Activities to be done every shift
c) Deep cleaning activities

Survey process guide:

- The GAHAR surveyors may review the environmental cleaning schedule for the mental health hospital.
- The GAHAR surveyors may interview responsible staff to check their awareness of the processes of environmental cleaning.
- The GAHAR surveyors may observe the matching between the selected disinfectant and the cleaned area.

Evidence of compliance:

1. Cleaning activities with determined times are listed for each area and include all elements mentioned in the intent from a) through c).
2. Responsible staff is trained on the process of environmental cleaning activities that include availability, accessibility, use of disinfectant, and spill kits.
3. Disinfectants selection and cleaning methods used are matching the requirements of each area.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, WFM.07 Continuous education and training program, EFS.05 Hazardous materials and waste management, EFS.06 Safety Management Plan.

IPC.10 Current evidence-based aseptic techniques are followed during all medical procedures.

Safety

Keywords:
Aseptic technique.

Intent:
Aseptic technique refers to practices designed to render and maintain objects and areas maximally free from microorganisms.
The term ‘aseptic technique’ encompasses several key elements: clean environment, conscientious practicing of hand hygiene, use of appropriate personal protective equipment, and use of standardized routine cleaning, disinfection, and sterilization practices.
All healthcare professionals shall be cognizant of their movement, barrier use, and practices to prevent inadvertent breaks in aseptic techniques, alerting others when the field or objects are potentially contaminated.
Choice of the level of antisepsis shall be risk assessment based.
Asepsis is defined as the process of keeping away disease-producing microorganisms.
The Mental healthcare hospitals shall develop a policy for aseptic techniques that define and outline the procedures including at least the following:

a. **Surgical asepsis** is the use of a sterile technique to prevent the transfer of
    i. any organisms from one person to another or from one body site to another. The goal of the sterile technique is to maintain the microbe count at a minimum.
b. **Medical asepsis or clean technique** refers to practice interventions that reduce the number of microorganisms to prevent and reduce transmission risk from one person (or place) to another.

Survey process guide:

- The GAHAR surveyors may review the policy for aseptic techniques.
- The GAHAR surveyors may interview healthcare professionals to check their awareness of the policy.
- The GAHAR surveyors may observe the implemented levels of antisepsis.

Evidence of compliance:

1. The mental health hospitals have an approved policy for aseptic techniques that define items from a) and b) in the intent.
2. Healthcare professionals are trained and educated on aseptic techniques as relevant to their jobs.
3. The choice of the level of antisepsis is based on the IPC. Risk assessment and analysis.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, WFM.07 Continuous education, and training program, QPI.03 Risk Management Program.

Communicable diseases preventive measures and transmission-based precautions

IPC.11 Patients with clinically suspected and/or confirmed communicable diseases follow isolation precautions according to probable mode(s) of transmission.

Safety

Keywords:
Isolation precaution.

Intent:
In addition to standard precautions, transmission-based precautions are used for patients known or suspected to be infected or colonized with a certain infectious agent.
Isolation precautions create barriers between people and microorganisms that help in preventing the spread of germs in mental health hospitals.
If the patient is determined to be at an increased risk for transmission of microorganisms, the patient is placed in the mental health hospital's standardized isolation room. The mental health hospitals must have one or more standardized isolation room(s).
When the standardized isolation room(s) is not currently available, the patient should be separated into separate assigned areas/rooms.
Patients who present with clinical respiratory syndromes are instructed to practice respiratory hygiene and cough etiquette and given a surgical mask to wear until an examination room can be provided.
The mental health hospitals shall develop a policy to identify patients with known or suspected airborne infections. Patients requiring airborne precautions are placed in a negative pressure room. If a negative pressure room is not available, place the patient in an examination room with a portable high-efficiency particulate air (HEPA) filter. If no portable HEPA filter is available, ensure that the patient wears a surgical mask. Regardless of the type of patient's room, contacting staff must always wear appropriate respiratory protection (such as N95 respirator).
The safe handling of contaminated surfaces and equipment in Mental Hospital settings should be done according to evidence-based guidelines, approved policies, and procedures.

Survey process guide:

- The GAHAR surveyors may review the policy for infection transmission-based precautions.

- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may observe the isolation room(s)
- The GAHAR surveyors may observe the adherence of healthcare professionals to the suitable PPE and hand hygiene practices according to the type of isolation.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide transmission-based precautions.
2. Healthcare professionals are trained and aware of approved policies.
3. Standardized isolation room(s) and assigned areas for the suspected infectious patient is designated according to the hospital's capacity and the national laws and regulations
4. Patients with suspected/ confirmed clinical communicable diseases are identified and placed in assigned areas/rooms.
5. Healthcare professionals caring for patients with a suspected communicable disease are adherent to suitable PPE and hand hygiene practices according to the type of isolation.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.05 Hand Hygiene, EFS.01 Mental health hospital environment and facility safety structure, EFS.06 Safety Management Plan, WFM.07 Continuous education and training program, QPI.03 Risk Management Program.

IPC.12 The mental health hospital effectively addresses the virology screening process upon patient admission.

Safety

Keywords:
Virology screening process.

Intent:
Transmission of blood-borne infections is common among substance use disorders. Those who inject drugs are likely to be exposed to viral infection. Overdose, HIV, , unintentional injuries, and suicide are the most frequent causes of death due to drug use. The mental health hospital shall develop and implement policy and procedures for early virology screening, which include at least:

a) Availability of virology tests that matches the need and type of individual served.
b) How to maintain the confidentiality of patient data
c) Methodology of coordination with community viral treatment programs, prevention programs, and social support services
d) Patient education about viral infection preventive measures and its effects on physical and mental health. including prevention, treatment, testing procedures, confidentiality, reporting, follow-up care, counseling, safer sex, social responsibilities, universal precautions, and sharing of intravenous injection equipment
e) Standards precautions during care of the confirmed infected patients
f) Reporting to relevant authorities as the Ministry of health according to the applicable laws and regulations.

Survey process guide:

- The GAHAR surveyors may review the policy of the virology screening process
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy

- The GAHAR surveyors may review patients' medical records to check for the documentation of virology tests and screening.

Evidence of compliance:

1. The mental health hospital has an approved policy of virology screening process provision that addresses all elements mentioned in the intent from a) to f)
2. All relevant staff are aware of the hospital policy
3. Patient education about viral infection preventive measures is provided to all patients
5. Patient virology screening tests are performed prior to patient admission
6. Documents of virology tests and screening are timely recorded in the patient's medical record in a manner that respects patients' confidentiality as per the hospital policy.

Related standards:

IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, IPC.16 Infection surveillance process, STP.07 Addiction prevention and treatment program, EFS.06 Safety Management Plan, QPI.03 Risk Management Program, PCC.06 Patient, family and carer education process.

Disinfection and sterilization

IPC.13 Patient care equipment is disinfected/sterilized based on evidence-based guidelines and manufacturer recommendations.

Safety

Keywords:

Disinfection, sterilization.

Intent:

Processing of patient care equipment is a very critical process inside any healthcare facility. The mental health hospital settings should perform semi-critical to critical reprocessing of the medical instruments according to applicable standard practices, guidelines, and regulations. Mental Hospitals shall develop and implement a policy and procedures to guide the process of sterilization/disinfection that addresses at least the following:

a. Receiving and cleaning of used items.
b. Preparation and processing.
   I. Processing method to be chosen according to Spaulding classification. Disinfection of medical equipment and devices involves low, intermediate, and high-level techniques. High-level disinfection is used (if sterilization is not possible) for only Semi-critical items that come in contact with mucous membranes or non-intact skin as gastrointestinal endoscopes, respiratory and anesthesia equipment, bronchoscopes, laryngoscopes, etc. Chemical disinfectants approved for high-level disinfection includes glutaraldehyde, ortho-phtaldehyde (OPA), and hydrogen peroxide.
   ii. Sterilization must be used for all critical and heat-stable semi-critical items.
   iii. Low-level disinfection (for only non-critical items) is used for items such as stethoscopes and other equipment that touch intact skin. In contrast to critical and some semi-critical items, most non-critical reusable items may be decontaminated where they are used and do not need to be transported to a central processing area.
c. Labeling of sterile packs.
d. Storage of clean and sterile supplies: properly stored in designated storage areas that are clean, dry, and protected from dust, moisture, and temperature extremes. Ideally, sterile supplies are stored separately from clean supplies, and sterile storage areas must have limited access.
e. Logbooks are used to record the sterilization process.
f. Inventory levels.

g. Expiration dates for sterilized items.

Survey process guide:

- The GAHAR surveyors may review the policy for the disinfection \sterilization process.
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy.
- The GAHAR surveyors may observe the physical barriers between cleaning, packaging, sterilizations, and storage areas.
- The GAHAR surveyors may observe clean and sterile supplies stores to check for proper storage.

Evidence of compliance:

1. The mental health hospitals have an approved policy to guide the process of disinfection and sterilization that addresses all elements in the intent from a) through g).
2. Healthcare professionals are trained on the approved policy.
3. Sterilization or disinfection process is performed according to the national laws and regulations, Spaulding classification, and manufacturer requirements\recommendations.
4. Clean and sterile supplies are properly stored in designated storage areas that are clean, dry, and protected from dust, moisture, and temperature extremes.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, IPC.14 Disinfection/Sterilization quality control program, EFS.06 Safety Management Plan, QPI.03 Risk Management Program, WFM.07 Continuous education and training program.

IPC.14 A disinfection/sterilization quality control program is developed and implemented

Effectiveness

Keywords:
Disinfection/Sterilization quality control program.

Intent:
Managing the routine quality control (QC) of medical equipment disinfection/sterilization is a major responsibility to monitor and ensure the reliability of the disinfection/sterilization processes. Moreover, quality controls can identify performance problems that are not identified automatically and help to determine the safety of procedures.
QC management includes developing the protocols, implementing the program, oversight the program, and responsible for determining the need for corrective action. QC data shall be reviewed at regular intervals and shall be recorded. Outliers or trends in performance, that may indicate problems in the disinfection/sterilization process, shall be analyzed and followed up and preventive actions shall be taken and recorded before major problems arise.
The mental health hospital shall develop and implement a policy for quality control, which includes at least the following:
a) Quality control elements, method and frequency include
   i. Physical parameters (temperature, time, and pressure), which are monitored every cycle.
   ii. Chemical parameters (internal chemical indicator inside the sterilization pack-external chemical indicator on the outside of the sterilization pack), which are monitored every pack.
   iii. Biological indicator, which is done at least weekly.

iv. The test for adequate steam penetration and rapid air removal shall be done every day before starting to use the autoclave using Class 2 internal chemical indicators and process challenge devices, which are either porous challenge devices or hollow challenge devices.
v. Porous challenge Pack: Bowie-Dick Sheets (class 2 indicator) inside a porous challenge pack (every load). Hollow load challenge (Helix test): a class 2 chemical indicator (strip) inside a helix (every load).
vi. Chemical test strips or liquid chemical monitors shall be used for determining whether an effective concentration of high-level disinfectants is present despite repeated use and dilution.

The frequency of testing shall be based on how frequently these solutions are used.

b) Quality control performance expectations and acceptable results shall be defined and readily available to staff so that they will recognize unacceptable results to respond appropriately.
c) The quality control program is approved by the designee prior to implementation.
d) Responsible authorized staff member reviews Quality Control results at a regular interval.
e) Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

Survey process guide:

- The GAHAR surveyors may review the policy for the disinfection \sterilization process.
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy.
- The GAHAR surveyors may observe the physical barriers between cleaning, packaging, sterilizations, and storage areas.
- The GAHAR surveyors may observe clean and sterile supplies store to check for proper storage.

Evidence of compliance:

1. The mental health hospital has an approved policy describing the quality control process of disinfection/sterilization process addressing all elements in the intent from a) through e).
2. The quality of packaging material, as well as chemical and biological indicators, are determined based on standardized product specifications.
3. Staff who are involved in sterilization/disinfection are competent in quality control performance.
4. Quality control tests for monitoring sterilization and high-level disinfectants are done as per hospital policy.
5. All quality control processes are recorded.
6. Corrective action is taken whenever results are not satisfactory.

Related standards:

IPC.13 Disinfection, sterilization, QPI.08 Performance improvement and patient safety plan, WFM.07 Continuous education, and training program

Safe laundry and healthcare textile services

IPC.15 Laundry service and healthcare textile management are safe.

Safety

Keywords:
Laundry service, textile management.

Intent:
Contaminated healthcare textiles can be a major source of pathogenic microorganisms that can be acquired by improper handling of healthcare textiles or by direct contact with the patient.
The provision of healthcare textiles is essential and rigorous standards must be followed during the reprocessing of the textiles to reduce the risk of infection and ensure patient safety. Physically separated areas for sorting, washing, drying, and/or storing laundry are needed. Healthcare professionals shall follow the manufacturer's instructions for detergents and disinfectant use and washing instructions.

- The hospital shall develop and implement a policy and procedures to define laundry and healthcare textile services. The policy shall address at least the following:
    a. Processes of collection and storage of contaminated textiles.
    b. Cleaning of contaminated textiles.
    c. A number of washing machines are needed according to hospital capacity.
    d. Water temperature, detergents, and disinfectant usage.
    e. Processes of storage and distribution of clean textiles.
    f. Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for safe laundry and healthcare textile services management.
- The GAHAR surveyors may interview staff involved in laundry and health textile management to check their awareness of the process.
- The GAHAR surveyors may observe the laundry and health textile management' area to check for the presence of physical barriers between sorting, washing, drying, and/or storing laundry.
- The GAHAR surveyors may review records of water temperature, detergents, and disinfectants amount, and other quality control records.

Evidence of compliance:

1 The mental health hospital has an approved policy to guide the safe laundry and healthcare textile services management that addresses all elements in the intent from a) through f).
2 Staff members involved in laundry and health textile management are aware of the approved policy.
3 Contaminated textile is collected, stored, and transported safely.
4 There are at least three physically separated areas for sorting, washing, drying, and/or storing the laundry.
5 A quality control program, including water temperatures, is implemented and recorded.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, EFS.01 Mental health hospital environment and facility safety structure, EFS.06 Safety

Management Plan, QPI.08 Performance improvement and patient safety plan, EFS.12 Utility Management

Utilities Management

Effective epidemiological surveillance and monitoring

IPC.16 Healthcare-associated infections surveillance process and outbreak investigations are implemented.

Effectiveness

Keywords:
Infection surveillance process.

Intent:
Surveillance is an essential component of an effective IPC program; since the use of data contributes to improving the healthcare quality system. Moreover, it helps in detecting emerging and reemerging healthcare-associated infections. An effective surveillance program shall be based on comprehensive epidemiological and statistical principles. Surveillance plays a critical role in identifying outbreaks, emerging infectious diseases, and multidrug-resistant organisms in order to institute appropriate IPC measures. Surveillance reports shall be reviewed on a regular basis (at least quarterly) by the IPC committee and recommendations for improvement are documented. The mental health hospital shall implement an effective reporting system for notifiable communicable diseases and outbreaks investigation analysis and reports.
Outbreaks of infectious diseases can occur in healthcare settings and pose a threat to patient safety. The outbreak investigations aim to identify the most probable contributing factors to stop the outbreaks and prevent their recurrence. Outbreaks can be suspected in cases of increased rates of healthcare-associated infections or when new or unusual pathogens are recovered from samples. Effective management of outbreaks shall require cooperation between the infection prevention and control team and other clinical specialties. Outbreak management shall include immediate control measures, general control measures, and recovery measures.

Survey process guide:

- The GAHAR surveyors may review the policy of the surveillance process and types.
- The GAHAR surveyors may interview staff to check their awareness of the surveillance process.
- The GAHAR surveyors may review surveillance documents, quarterly surveillance reports that are reviewed by the IPC committee, and recommendations for improvement.
- The GAHAR surveyors may review reporting system for notifiable communicable diseases and outbreaks investigation analysis reports.

Evidence of compliance:

1. The mental health hospital has an approved policy to guide the surveillance process.
2. Responsible staff is trained on how to apply the policy.
3. Outbreak management includes immediate control measures, general control measures, and recovery measures.
4. The hospital reports data on its surveillance program to be reviewed by the IPC committee on a regular basis(at least quarterly).

5. Data collected from the surveillance program is analyzed, investigated, and acted upon

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.03 IPC committee, meetings, IPC.04 Infection risk assessment, QPI.08 Performance improvement and patient safety plan

IPC.17 Multi-Drug resistant organisms (MDROs) are controlled.

Safety

Keywords:
Multi-Drug Resistant Organisms.

Intent:
MDROs have increased in prevalence over the last three decades and have become a global health-threatening problem, and cause important implications for patients' safety.
This concern is due to the extremely limited treatment options for treating patients with these infections.
Also, MDRO infections are associated with increased lengths of stay, costs, and mortality.
Successful prevention and control of MDROs require effective administrative and scientific leadership as well as a financial and human resources commitment.
Resources shall be provided for infection prevention and control, including expert consultation, laboratory support, adherence monitoring, and data analysis in order to prevent transmission.

Survey process guide:
- The GAHAR surveyors may review the policy of MDRO spread control.
- The GAHAR surveyors may interview healthcare professionals to check their awareness of the MDRO spread control policy.
- The GAHAR surveyors may observe the taken measures to control MDRO spread.

Evidence of compliance:
1 The mental health hospital has an approved policy for MDRO spread control.
2 Healthcare professionals are aware of and trained on the approved policy.
3 Measures are taken to control the MDRO infection spread.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, IPC.16 Infection surveillance process, QPI.03 Risk Management Program

Proper handling and delivery of water and food services

IPC.18 The mental health hospital provides and maintains safe water services.

Safety

Keywords:
Safe Water services.

Intent:
Water delivery systems are essential components of the environment of care in hospitals that shall be continually maintained safely.

Failure of safe water delivery will increase infection risk either directly through unsafe water consumption or use, or indirectly due to the inability of healthcare professionals to comply with basic infection control measures such as hand hygiene.
The water of appropriate quality used in the mental health hospital protects patients from adverse effects arising from known chemical and microbiological contaminants that may be found in water.
Safe water services are dependent upon the maintenance of water quality standards employed by the community public water supplier, typically a municipality in the region of the hospitals.
This responsibility for water quality then transitions to the facility once water enters the facility's water distribution infrastructure, reflecting complementary roles for the prevention of infections.
The Mental health hospital shall develop and implement a policy and procedures for the safe management of water services.
The policy shall address at least the following:

a) Routine maintenance and monitoring of water distribution and treatment systems.
b) Continuing training and education of operators of water treatment systems.
c) Monitoring of water at all stages (feed, and product).
d) Methods and frequency of measuring microbiological and chemical contaminants.
e) Maximum allowable concentrations of microbiological contaminants.

Survey process guide:

- The GAHAR surveyors may review the hospital policy for safe management of water services and may interview staff to check their awareness.
- The GAHAR surveyors may review chemical and bacteriological analysis reports for water services.
- The GAHAR surveyors may review the records of routine maintenance and monitoring of water treatment systems.
- The GAHAR surveyors may assess corrective actions that were taken by the hospital.

Evidence of compliance:

1. The mental health hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. Relevant staff is aware of how to apply the policy.
3. Routine maintenance and monitoring of water distribution and treatment systems are recorded as per hospital policy.
4. Regular chemical and microbiological analyses for water services are performed, kept, and recorded according to national law and regulations.
5. The mental health hospital aggregates, analyses data, and corrective actions are performed

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment, EFS.06 Safety Management Plan, EFS.12 Utility Management, WFM.07 Continuous education and training program, QPI.03 Risk Management Program, QPI.08 Performance improvement and patient safety plan

IPC.19 The mental health hospital ensures the provision of safe food services throughout the hospital.

Safety

Keywords:
Safe Food Services.

Intent:
Food services provided by the hospital's kitchen can be a potential source of infection if improperly prepared, handled, and/or stored.
Foodborne illnesses can pose a significant health threat, especially to immunocompromised patients.
Consequently, effective IPC measures are crucial to prevent these infections.
Safe food services involve all processes starting from receipt of food and other nutritional products throughout their storage, preparation, handling, and until they are safely delivered.
The hospital shall develop and implement a policy and procedures to guide safe food services.
The policy shall address at least the following:

a) Food receiving process.
b) A safe storage process includes a food rotation system that is consistent with first in first out principles.
c) Monitoring of temperature during preparation and storage.
d) Prevention of cross-contamination of food whether directly from raw to cooked food or indirectly through contaminated hands, working surfaces, cutting boards, utensils, etc.
e) The food transportation process.
f) Valid staff health certificate

Survey process guide:

- The GAHAR surveyors may review hospital policy guiding safe food services.
- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may observe the separation between receiving, storage, and preparation areas and may observe the taken measures to prevent cross-contamination.

Evidence of compliance:

1. The Mental health hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f).
2. Staff members involved in food services are aware of the approved policy.
3. There are separate areas for receiving, storage, and preparation of food and nutritional products.
4. Measures to prevent the risk of cross-contamination are implemented.
5. The hospital prepares and distributes food using proper sanitation and temperatures.

Related standards:
IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment , IPC.06 Standard precautions measures, EFS.01 Mental health hospital environment and facility safety structure, EFS.06 Safety Management Plan, QPI.03 Risk Management Program
, OGM.13 Staff Health program, OGM.09 Contracted services management.

Proper handling and management of postmortem care

IPC.20 The mental health hospital reduces the risk of infection by proper handling and management during the postmortem care

Effectiveness

Keywords:
Postmortem Care.

Intent:

Postmortem care includes the process of preparing the deceased for burial. Postmortem care presents occupational risks that need to be anticipated and addressed in the policy. The hospital shall develop and implement a policy and procedures for postmortem care. The policy shall include at least the following:

a) Infection risk assessment.
b) Procedures to minimize these risks.
c) Use of appropriate engineering devices and personal protective equipment to minimize exposure.
d) Sorting of waste.
e) Record keeping.
f) Environmental cleaning procedures.
g) Reporting accidental exposures.

Generally, standard IPC precautions are applied and any transmission-based precautions that were applied to patients shall be continued after death.

Survey process guide:

- The GAHAR surveyors may review hospital policy guiding postmortem care.
- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may observe the implemented postmortem care practices.

Evidence of compliance:

1. The mental health hospital develops a policy that addresses all the elements mentioned in the intent from a) through g).
2. Staff members involved in postmortem care are aware of the approved policy.
3. Safe postmortem care practices are implemented according to current evidence-based guidelines, laws, and regulations.

Related standards:

IPC.02 Infection prevention and control (IPC) program, IPC.04 Infection risk assessment , IPC.06 Standard precautions measures, EFS.06 Safety Management Plan, EFS.12 Utility Management, QPI.03 Risk Management Program, ICD.03 Clinical practice guidelines

Organization Governance and Management

Chapter intent

This chapter is concerned with structures for governance and accountability that may differ according to the hospital and its size, mandate, and whether it is publicly or privately owned. Possible structures include an individual or group owner, government committee or ministry, or Board of Directors. Having a defined governance structure provides clarity for everyone in The hospital, including managers, clinical leadership, and staff, regarding who is accountable for making final decisions and oversight of The hospital's overall direction. While governance provides oversight and support, it is the commitment and planning efforts of the hospital leadership as well as the departments and services leaders that ensure the smooth and efficient management of the hospital.

Effective planning is initiated by identifying the stakeholders' needs and designing the service accordingly, Egypt's 2030 vision that has been recently developed provides a direction and common goal to all hospitals to ensure effective safe, and patient-centered care is provided equally for all Egyptians and is to be considered the cornerstone for organization planning. The hospital's plan should be continuously aligned with the governmental-initiated campaigns addressing therapeutic, prophylactic, social, and nutritional aspects of healthcare. The chapter guides the mental health hospital to assign duties to the different levels of management and to ensure effective communication to achieve planned goals and objectives.

Recently the landscape of healthcare is shifting closer to a fully quality-driven future and pay-for-performance model. The chapter has focused on the financial side of healthcare, a focus that affects both patients and providers. With value-based care and higher levels of efficiency on the rise, the keys to medical practice success are evolving rapidly. The chapter handles various organization-wide topics such as contracted services, ethical management, and staff engagement, which may reflect efficient and effective collaborative management efforts.

GAHAR surveyors, through leadership/ staff interviews, observations, and process evaluation, shall assess the efficiency and effectiveness of the governance and leadership structure. The ability of leaders to motivate and drive the staff is instrumental to the success of a hospital and can be assessed throughout the survey.

Chapter purpose:

The chapter focuses on checking the hospital structure resilience by looking into the following:

1. Effectiveness of governing body.
2. Effectiveness of direction.
3. Effectiveness of leadership.
4. Effectiveness of financial stewardship.
5. Efficient contract management.
6. Ethical management.
7. Effective staff engagement, health, and safety.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes.)

1) Egyptian Constitution
2) Egypt 2030 Vision, Ministry of Planning
3) Law 51/1981 Amended by Law 153/2004, Healthcare Facilities Organization
4) Egyptian Law for the Care of Psychiatric Patients, 71/2009
5) Law No. 210/2020 Amendment for Law of Psychiatric Patient Care, 71/2009.
6) Regulations for the Care of Psychiatric Patients,128/2010
7) Regulations for the Care of Psychiatric Patients, 55/2021
8) MOH Ministerial of Patient Right to Know The Expected Cost of Care, 186/2001
9) Egyptian Consumer Protection Law, 181/2018
10) Egyptian Standards for Accounting, 609/2016
11) Women Council Publications on Gender Equality
12) Egyptian Code of Medical Ethics 238/2003.
13) Advertisement for Healthcare Services Law, 206/2017
14) National Labor Law Number 12/2007
15) Scientific Research Law 214/2020
16) Who-Health Wise Action Manual
17) Who Standards and Operational Guidance for Ethics Review of Health-Related Research With Human Participants2011
18) Who Standards and Operational Guidance for Ethics Review of Health-Related Research With Human Participants, 2011.
19) Staff Health and Safety Regulations.

Effective governing body

OGM.01 The mental health hospital has a governing body structure with identified responsibilities.

Effectiveness

Keyword:
Governing body Structure and clear responsibilities.

Intent:
The governing body is responsible for defining the mental health hospital's direction and ensuring the alignment of its activity with its purpose. It is also responsible for monitoring its performance and future development. mental health hospital's governing body can be a group of individuals (such as the board of directors), one or more individual owners, and in a centralized system, several subsidiary hospitals are governed by one governing body, in order to ensure the proper governance and efficient management of any resources thus its structure has to be well defined. Therefore, defining the governing structure of a mental health hospital shows lines of authority and accountability and ensures that it operates effectively and efficiently.
The mission statement is a description of any mental health hospital's core purpose. Defining the main purpose of the mental health hospital in the form of a mission is one of the fundamental roles of the governing body, as the mental health hospital's mission must be aligned with the national healthcare mission, and communicated to all relevant stakeholders, including staff, patients, and visitors.
The mental health hospital shall develop a policy that describes the structure responsibilities and accountabilities of the governing body. The governing body's responsibilities include at least the following:

a. Developing and disseminating the mission, vision, values statements
b. Developing and achieving the strategic plan
c. Developing the operational plan and budget
d. Promoting and supporting the quality management, patient safety, and risk management programs, performance improvement plan
e. Allocating resources and effective financial planning
f. Promoting and monitoring safety culture activities and reports.
g. Responsiveness to internal and regulatory inspection reports.
h. Supporting the community assessment and involvement program.
i. Clear delegation of responsibilities to the hospital director

The governing entity shall be represented or displayed in an organizational chart or other similar documents with a clear determination of the flow of orders through the approved line of authority. The mental health hospital shall define the types of communication channels between the governing body, leaders, and the mental health hospital staff. Communication channels may be in the form of social media, monthly meetings or annual conferences, or other channels.

Survey process guide:

- The GAHAR surveyors may review the policy that describes the structure, responsibilities, and accountabilities of the governing body.
- The GAHAR surveyors may observe governing body structure and the flow of orders through the approved line of authority.
- The GAHAR surveyors may interview staff to check their awareness of the policy.

Evidence of compliance:

1. The mental health hospital has an approved policy that defines the structure, responsibilities, and accountabilities of the governing body that include items from a) to i) in the intent.
2. The mental health hospital has a vision and mission statement approved by the governing body and, is visible in public areas to staff, patients and visitors.
3. There is a defined process of communication between the governing body and the mental health hospitals 'leaders, directors, and staff.
4. Staff is aware of the methods for the flow of orders through the approved line of authority.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, OGM.04 Scope of services, OGM.05 Strategic Plan, OGM.10 Safety Culture.

Effective organization direction

OGM.02 The mental health hospital appoints a qualified director responsible to manage the hospital

Effectiveness

Keywords:
The Mental Health Hospital director.

Intent:
The executive director is the person who is responsible and accountable for implementing the governing body's decisions and acts as a link between the governing body and the mental health hospital s' leaders and staff. Such a position requires certain qualifications guided by relevant laws and regulations and/or as further defined by the governing body.
The mental health hospital shall appoint a qualified director and define any leadership delegation of authority for managing the hospital in the absence of its director. The director is responsible for the hospital's compliance with all applicable governmental laws and regulations.
The mental health hospital director must have appropriate training and/or experience in healthcare management, as defined in the job description.
The job description covers at least the following:

a) Providing oversight of day-to-day operations.
b) Ensuring clear and accurate posting of the mental health hospital services and hours of operation to the community.
c) Ensuring that policies and procedures are developed, implemented by leaders, and approved by the governing body.
d) Providing oversight of human, non-human, and financial resources.
e) Annual evaluation of the performance of the mental health hospitals' committees and meeting minutes.
f) Ensuring appropriate response to reports from any inspecting or regulatory agencies, including national or international accreditation.
g) Ensuring that there is a functional, organization-wide program for performance improvement, patient safety, and risk management with appropriate resources.
h) Setting a framework to support coordination within and/or between departments or units, as well as a clear process of coordination with relevant external services.
i) Regular reporting to the governing body on how legal requirements are being met.

Director shall ensure the overall compliance of the hospital with the National Safety Requirements (NSR) and set priorities for improvement activities. Director shall represent

an effective role in decision-making by using various tools for mixing distributed knowledge and abilities of different parties in the hospital such as the committee, which is the most effective tool that can be used. A multidisciplinary selection of members of every committee and regular holding can enhance overall productivity. the mental health hospital shall develop a policy that defines committee types and formulation. The policy shall include at least the following:

I. Terms of reference that include its membership, duties, accountability/reporting, frequency of meeting, quorum, and baseline agenda.
II. Meeting minutes' documentation requirements and responsibility.
III. Type of committee according to hospital scope of services. the mental health hospital has at least the following committees:
    i. Patients' rights protection Committee
    ii. Environmental safety committee
    iii. Infection control committee
    iv. Pharmacy and therapeutics committee
    v. Performance improvement and patient safety committee
    vi. Mortality and Morbidity Committee

Survey process guide:

- The GAHAR surveyors may review mental health hospital director's job description.
- The GAHAR surveyors may interview mental health hospital director to check his awareness of his responspilities.
- The GAHAR surveyors may review the policy for committee, types, and formulation.
- The GAHAR surveyors may review the delegation letters for tasks that the director delegated to any other staff member when needed.

Evidence of compliance:

1. There is a qualified, trained director managing the mental health hospital.
2. There is a job description for the mental health hospital director covering the standard requirements from a) through i) as in the intent.
3. The mental health hospital has an approved policy for committee types and formulation that include elements from I) to III) in the intent.
4. There is evidence of delegation of authority for tasks, when needed.

Related standards:
OGM.01 Governing body Structure and clear responsibilities, OGM.03 The Mental health hospitals' leaders, OGM.05 Strategic Plan, OGM.06 Operational Plan, WFM.03 Job Description, QPI.01 Quality management program, Performance improvement and patient safety plan.

OGM.03 The responsibilities and accountabilities of the mental health hospitals' leaders are identified.

Effectiveness

Keywords:
The Mental health hospitals' leaders.

Intent:
While another standard addresses the mental health hospital's director's responsibilities, the mental health hospital usually has a nursing director, medical director, financial director, and sometimes-operational director which is why the mental health hospital shall establish a collective of responsibilities in written documents for mental health hospital leaders. The

leader of the mental health hospital must be familiar with the concepts of performance improvement and patient safety plan(s) and thus can perform his roles and responsibilities. The mental health hospital leaders are responsible for:

a. Sustaining firm mental health hospital structure:
    i. Planning for upgrading or replacing systems, buildings, or components needed for continued, safe, and effective operation.
    ii. Collaboratively developing a plan for staffing the mental health hospital that identifies the numbers, types, and desired qualifications of staff.
    iii. Providing appropriate facilities and time for staff education and training.
    iv. Ensuring all required policies, procedures, and plans have been developed and implemented.
    v. Providing adequate space, equipment, and other resources based on strategic and operational plans and needed services.
    vi. Selecting equipment and supplies based on defined criteria that include quality and cost-effectiveness.
b. Running smooth directed operations:
    i. Creating a "Just Culture" for reporting errors, near misses, and complaints, and using the information to improve the safety of processes and systems.
    ii. Designing and implementing processes that support continuity, coordination of care, and risk reduction.
    iii. Ensuring that services are developed and delivered safely according to applicable laws and regulations and approved organization strategic plan with input from the patient /staff.
c. Continuous monitoring and evaluation:
    i. Ensuring that all quality management and patient safety activities are implemented, monitored, and action is taken when necessary.
    ii. Ensuring the mental health hospital meets the conditions of facility inspection reports or citations.
    iii. Annually assessing the operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle.
    iv. Annually report to the mental health hospital governing body or authority on system or process failures and near misses, and actions are taken to improve safety, both proactively and in response to actual occurrences.
d. Continuous Improvement.

Data from all over the mental health hospital shall be collected, reviewed, analyzed, and reported to the upper management in order to determine the opportunities for improvement through effective data-driven decision-making.

Survey process guide:

- The GAHAR surveyors may interview mental health hospital leaders to check their awareness of their roles and responsibilities.
- The GAHAR surveyors may review mental health hospital leaders' job descriptions.

Evidence of compliance:

1. The mental health hospital leaders are identified based on the service provided, and their accountabilities are described in written documents and include at least items from a) through d) in the intent.
2. The mental health hospital leaders are educated in the concepts of quality improvement and patient safety plans.
3. The mental health hospital leaders are fully aware of their written responsibilities.

Related standards:
OGM.01 Governing body Structure and clear responsibilities, OGM.02 The Mental Health Hospital director, OGM.05 Strategic Plan, OGM.06 Operational Plan, OGM.10 Safety Culture, OGM.12 Ethical Management, WFM.03 Job Description, OGM.11 Positive Workplace Culture.

OGM.04 The mental health hospital's director together with governing body and leaders develops the hospital's scope of services based on community needs assessment.

Effectiveness

Keyword:

Scope of services.

Intent:
The scope of services is the range of activities provided by the mental health hospital, (i.e. preventive, health promotion, curative,). The scope of services shall include the specialty services provided by the hospital, the number of departments and clinics for each specialty, the level of expertise needed (for example; consultant versus specialist), and the staffing plan for each department and clinic. The scope of services shall include the age group, volume, and mix of patients served, and the actual working hours in addition to any emergency services that may be provided.
The mental health hospital shall identify a process to involve the community to determine and analyze their health needs. The process helps the hospital to prioritize the community health needs, and plan and act upon the unmet community health needs. Many methods exist for conducting the community needs assessment, for example, stakeholder meetings, community focus groups, surveys, interviews with community leaders, population health, and other health-related data. This assessment shall be updated in a regular manner (at least annually) or as determined by the hospital's governing body and leaders.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital's scope of services.
- The GAHAR surveyors may interview the responsible staff to check their awareness of the scope of services provided by the hospital
- The GAHAR surveyors may review the implemented methods for community health needs assessment.

Evidence of compliance:

1. The mental health hospital has an approved scope of services.
2. Methods exist for conducting the community needs assessment
3. The mental health hospital governing body, and leaders perform and update the community needs assessment (at least annually).
4. The mental health hospital's scope of services is matched to the current community needs assessment.

Related standards:
OGM.01 Governing body Structure and clear responsibilities, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, OGM.05 Strategic Plan, ACT.01 Granting access, PCC.01 Mental health hospital advertisement.

OGM.05 A strategic plan is developed under the oversight and guidance of the governing body.

Effectiveness

Keyword:
Strategic Plan.

Intent:
Strategic planning is a process of establishing a long-term plan to achieve the mental health hospital's specified vision and mission through the attainment of high-level strategic goals.
A strategic plan looks out over an extended time horizon. The plan establishes where the mental health hospital is currently, where leadership wants to go, how they will get there, and how they will know when they have achieved the target.
Stakeholders must be involved in developing the plan to ensure legitimacy, ownership, and commitment to the plan. A strategic plan shall be established on a higher level (governing body) with the involvement of mental health hospital leaders. The strategic plan provides an overall framework within which all stakeholders can find their appropriate roles and make their appropriate contributions The strategic plan shall be based on a comprehensive evaluation of the internal and external environmental factors (e.g., SWOT analysis, PESTEL analysis). The strategic plan spans shall be over a period of 3 - 5 years and shall be reviewed on a regular basis.

Survey process guide:
- The GAHAR surveyors may review the mental health hospital's strategic plan.
- The GAHAR surveyors may interview the mental health hospital leaders to check their involvement and monitoring of the strategic plan.

Evidence of compliance:
1. The mental health hospital has a strategic plan with a defined achievable timeline for each desired goal/ outcome.
2. The strategic plan includes the broad goals and objectives required to fulfill the hospital's mission.
3. The strategic plan addresses all clinical and non-clinical services and programs.
4. There are progress review reports to monitor the strategic plan at least annually.

Related standards:
OGM.01 Governing body Structure and clear responsibilities, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, OGM.04 Scope of services, OGM.06 Operational Plan, "QPI.02 Performance Measures.

OGM.06 Operational plans are developed to achieve the hospital goals and objectives, with inputs from staff, service providers, and other stakeholders.

Effectiveness

Keywords:
Operational Plan.

Intent:

Operational plans are the means through which organizations fulfill their mission. They are detailed, containing specific information regarding targets and related activities and needed resources within a timed framework. An operational plan is a comprehensive way in which each department or discipline plans to use its resources to achieve the hospital's goals.

Incorporation of an operational plan to link with other main plans within the organization could make the operational plan more comprehensive and effective.

Leaders establish operational plans that include at least the following:

a) Clear goals and objectives (in line with the hospital's strategic plan).
b) Specific activities and tasks for implementation.
c) Timetable for implementation.
d) Assigned responsibilities.
e) Delegation of authority.
f) Sources of the required budget and resources.
g) Means of achievement measurement

Leaders regularly assess the annual operational plans of the services provided to determine the required resources needed for the next operational cycle. Any operating cycle ends with an analysis or an assessment phase through which planners understand what went well and what went wrong with the plan. This analysis or better-called lessons learned should feed into the new cycle of planning to improve mental health hospital performance.

Survey process guide:

- The GAHAR surveyors may interview staff and leaders to check their awareness of the operational plan they follow and give them an opportunity to talk about their inputs and how they are communicated.
- The GAHAR surveyors may review the evidence of monitoring operational plan progress, identification of opportunities for improvement, and actions taken to improve performance.

Evidence of compliance:

1. The mental health hospital has operational plans that include a) to g) in the intent.
2. The staff is aware and actively participates in designing the operational plans.
3. The plans are communicated throughout the mental health hospital.
4. The governing body approves resources that are required for the implementation of the operational plan.
5. There are progress review reports to monitor the operational plans at least annually.

Related standards:
OGM.01 Governing body Structure and clear responsibilities, OGM.05 Strategic Plan, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, QPI.02 Performance Measures.

Efficient supply chain management

OGM.07 The mental health hospital has effective supply chain management.

Efficiency

Keywords:
Supply Chain Management.

Intent:
The supply chain generally refers to the resources needed to deliver goods or services to a consumer. A supply chain shall include all activities related to manufacturing, the extraction of raw materials, processing, storing and warehousing, and transportation. In healthcare, managing the supply chain is typically a very complex and fragmented process.
Healthcare supply chain management shall involve obtaining resources, managing supplies, and delivering goods and services to providers and patients. To complete the process, physical goods and information about medical products and services usually go through a number of independent stakeholders, including manufacturers, insurance companies, hospital providers, group purchasing organizations, and several regulatory agencies.
For critical supplies, i.e. supplies vital to the support of operations, the mental health hospital shall identify the steps in the supply chains to decide where the significant risks reside.
Resources include financial, human resources, technology, and information systems. The governing bodies shall develop plans for resource allocation to increase efficiency and transparency so; the mental health hospital shall develop a policy and procedures for supply chain management. The policy shall describe the process of resource procurement prioritization and selection criteria. Prioritization criteria shall be known to all leaders to ensure a fair and transparent resource allocation process.
The policy of the supply chain management addresses at least the following:

a) Supplier's identification and selection process.
b) Methods for suppliers and/or distributors' monitoring and evaluation, to ensure that the purchased supplies are provided from reliable sources that refrain from dealing with counterfeit, smuggled, or damaged supplies.
c) Setting pre-defined acceptance criteria for suppliers that may include evaluation based on the suppliers' response upon request, quality of received supplies, lot number, and expiry date.
d) Supplies monitoring and evaluation, to ensure that no recalled medications, samples, devices, medical supplies, or equipment are provided.
e) Monitoring transportation of supplies, to ensure that it occurs according to applicable laws and regulations, and manufacturer's recommendations.
f) The mental health hospital shall highlight in the policy the procedures for managing stock\ inventory addressing at least the following:
    i. Compliance with the applicable laws, regulations, and organization policies
    ii. The inventory control system that includes identification of utilization rate, re-order limit for each item, and monitoring of out-stock events.
    iii. Compliance of the stock's management with the safe storage strategies that require at least the following records for stock items: date received, lot number, expiration date, date of disposition, if not used.
    iv. Identify and track the use of critical resources and supplies.

Survey process guide:

- The GAHAR surveyors may review supply chain management policy and records.
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy.

- The GAHAR surveyors may observe the evaluation process for supplies and the proper implementation of safe storage strategies.

Evidence of compliance:

1. The mental health hospital has an approved policy of supply chain management that addresses all elements from a) through f).
2. Supplies are monitored and evaluated to ensure matching with the pre-defined acceptance criteria that are determined in the hospital's policy.
3. Critical supplies are identified and clear processes are followed in case of shortage.
4. Basic information is recorded for stock items as mentioned from i) through iv) of item f) in the intent.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.06 Operational Plan, OGM.09 Contracted services management.

OGM.08The mental health hospital manages the patient billing system.

Efficiency

Keywords:
Billing System.

Intent:
The mental health hospital provides patients and their families with a receipt for services rendered, including insurance patients. It is one of the patient and family's rights to receive an initial estimated cost for their treatment if requested. For third-party payer systems, the process for billing is based on the requirements of insurance companies/agencies, which generally have reimbursement rules with a predetermined time frame.
The mental health hospital shall develop a policy and procedures for the billing process that addresses at least the following:

a) Availability of an approved price list for services provided to patients and their sponsors.
b) Patients and families/carers are informed of an initial estimated cost of required services and any potential cost pertinent to the planned care.
c) The process to ensure that patients and families/carers obtained an accurate invoice for services rendered.
d) Use of the approved codes for diagnoses, interventions, and diagnostics, if applicable.
e) Payment methods. e.g. itemized bill, package deal.

Survey process guide:

- The GAHAR surveyors may review the billing policy and mental health hospital's price lists.
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy and the different payment methods.

Evidence of compliance:

1. The mental health hospital has an approved policy for billing patients that include items from a) to e) in the intent.
2. In the case of a third-party payer (or health insurance), the timeliness of approval processes is monitored.
3. Responsible staff is fully aware of the various health insurance processes and different payment methods.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, PCC.03 Patient, family, and carer rights, IMT.03 Standardized symbols, and Abbreviations.

OGM.09 The mental health hospital implements a process for selection, evaluation, and continuously monitoring of contracted services.

Effectiveness

Keywords:
Contracted services management.

Intent:
Mental health hospital leadership defines the nature and scope of services provided by contracted services, including clinical and non-clinical services. Mental health hospital leaders shall describe, in writing, the contractual agreements that outline the nature and type of the services to be provided through the contract. For example, outsourced laboratory and radiology services or laundry services.
Leaders shall participate in the selection, evaluation, and continuously monitoring of contracted services to ensure that the service providers fully comply with the environmental safety, patient safety, and quality requirements and all relevant accreditation standards requirements.
The quality of services provided by independent practitioners is monitored as a component of the mental health hospital's quality management program.
The contracted services shall be monitored through performance measures and evaluated at least annually to determine if a contract should be renewed or terminated. Findings and results of contract monitoring shall be reported to mental health hospital leaders to be acted upon. The Mental health hospital leaders shall determine the reporting frequency and mechanism, and develop a process for how the mental health hospital will respond when the quality requirements are not met.

Survey process guide:
- The GAHAR surveyors may review the approved documents for contracted services.
- The GAHAR surveyors may interview hospital leaders and responsible staff to determine contract monitoring, evaluation, and renewal processes.
- The GAHAR surveyors may review performance measures for monitoring contracted services

Evidence of compliance:
1. The Mental health hospital has a documented process that describes the nature and scope of the services provided through a contractual agreement, including all outsourced clinical and non-clinical services.
2. Each contract is evaluated at least annually to determine if it should be renewed or terminated
3. The Mental health hospital has a documented process for contract monitoring and evaluation.
4. The performance measures for monitoring contracted services are integrated into the hospital quality management program.
5. Significant results of contract monitoring are reported to hospital leaders.
6. If contracts are terminated, the mental health hospital has a clear process to maintain the continuity of patient care.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, QPI.02 Performance Measures

Leadership role in quality and patient safety.

OGM.10 The mental health hospital leaders create and support a culture of safety and quality within the hospital.

Effectiveness

Keywords:
Safety Culture.

Intent:
Healthcare is complex, and sometimes, due to unintentional errors, it can harm patients and even staff. To minimize such risk, causes of errors and near misses should be explored and efforts made to prevent their occurrence in the future. Leaders shall create a just culture to encourage reporting errors and near misses. For this to happen, a safety culture within the facility is essential where staff is engaged and feel confident when reporting on a safety incident that they will be treated fairly, in a confidential manner, and that the information they provide will be used to improve the care process and environment. Leaders shall demonstrate their commitment to a culture of safety and set rules for those who work in the mental health hospital with behaviors that are not consistent with a safe culture. The mental health hospital shall develop a policy to describe a safety culture. The policy shall explain the key elements for the culture of safety that include at least the following;

a. Identification of the high-risk activities and persistence to achieve safe operations;
b. Deploy an environment in which staff can report errors/ incidents without fear of blame or punishment
c. Encourage all disciplines and staff to highlight their patient safety problems and try to find a suitable solution.
d. Documentation requirements.
e. A commitment of leaders to perform regular safety rounds.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy and describe the safety culture.
- The GAHAR surveyors may interview staff to check their awareness of the safety culture policy.
- The GAHAR surveyors may review the evidence of leaders' safety rounds.

Evidence of compliance:

1. The mental health hospital has an approved policy of safety culture that include elements from a) to e) in the intent.
2. Leaders provide all required resources needed to promote and support the culture of safety.
3. There is evidence that leaders participate in safety rounds on an- ongoing basis.
4. All staff is fully aware of how to apply the safety culture policy.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, QPI.04 Incident Reporting System, OGM.11 Positive Workplace Culture.

Safe, ethical, and positive organizational culture

OGM.11 The mental health hospital ensures positive workplace culture.

Effectiveness

Keywords:
Positive Workplace Culture.

Intent:
Studies highlighted the importance to provide healthcare workers especially healthcare professionals with a safe and comfortable work environment.
The mental health hospital shall develop an approved policy and procedures of positive workplace culture. The policy addresses at least the following:

a) Workplace cleanliness, safety, and security measures
b) Management of workplace violence, discrimination, and harassment
c) Communication channels between staff and mental health hospital leaders
d) Staff feedback measurement
e) Planning for staff development
f) Planning to maintain the staff's healthy lifestyle.

The mental health hospital shall plan to maintain their staff's healthy lifestyle, for example, promoting physical and mental health camps/activities in order to reduce stress, providing a weight management program, and introducing stress consultation and counseling services for staff.

Survey process guide:

- The GAHAR surveyors may review the approved policy for positive workplace culture
- The GAHAR surveyors may observe workplace measures to prevent violence discrimination and harassment.
- The GAHAR surveyors may review the analyzed data on staff satisfaction and feedback.

Evidence of compliance:

1. The mental health hospital has an approved policy for positive workplace culture, and addresses at least items a) to f) in the intent.
2. The workplace is clean and safe, and security measures are implemented.
3. Measures to prevent workplace violence, discrimination, and harassment are implemented.
4. Staff feedback and satisfaction are measured and periodically analyzed.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, OGM.12 Ethical Management, OGM.13 Staff Health program, EFS.07 Security Plan, EFS.08 Violence prevention program, QPI.02 Performance Measures, WFM.01 Workforce Laws, and regulations, OGM.10 Safety Culture.

OGM.12 The mental health hospital establishes an appropriate framework for ethical management.

Effectiveness

Keywords:
Ethical Management.

Intent:

The mental health hospital shall develop an appropriate ethical framework that includes professional, clinical, and legal aspects. Hospital's ethical framework shall be congruent with the hospital's vision, mission, values, and scope of services provided.
Medical ethics involves examining a specific problem, usually a clinical case, and using values, facts, and logic to decide what the best course of action should be. Healthcare professionals may deal with a variety of ethical problems and dilemmas, for example, conflict of interest and inequity in patient care. The policy of ethical management shall cover and be aligned with at least the following items:

a) The hospital code of ethics and conduct
b) Protecting patient confidentiality and rights
c) Handling medical errors and medico-legal cases
d) Identifying and disclosing any conflict of interest
e) Reporting methods of any raised ethical concerns with a defined time frame of reporting.
f) Avoid the non-discrimination that may affect the staff employment practices or provision of patient care
g) Gender equality issues and concerns.
h) Managing clinical research (if applicable)

Survey process guide:

- The GAHAR surveyors may review mental health hospital ethical management policy.
- The GAHAR surveyors may interview staff to check their awareness of the hospital's policy, code of ethics, and values.
- The GAHAR surveyors may review the process for addressing ethical concerns.

Evidence of compliance:

1. The mental health hospital has an approved policy for ethical management that addresses at least a) to h) from the intent.
2. The Staff is aware and trained on how to apply the policy.
3. The mental health hospital has a process for addressing ethical concerns that may arise, within a pre-determined time frame as per the hospital's policy.

Related standards:
APC.05 Professional standards during surveys, PCC.01 Mental health hospital advertisement, PCC.03 Patient, family, and carer rights, OGM.01 Governing body Structure and clear responsibilities, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, OGM.11 Positive Workplace Culture, OGM.15 Clinical Research Ethical Framework

Effective staff engagement, safety, and health

OGM.13 The mental health hospital has an effective staff health program in accordance with the applicable laws and regulations.

Safety

keywords:
Staff Health program.

Intent:
The mental health hospital shall implement a staff health program to ensure the safety of the staff according to workplace exposures.

A cornerstone of the staff occupational health program is the hazard/risk assessment, which identifies the hazards and risks related to each occupation.

This is done in order to take the necessary steps to control these hazards to minimize possible harm arising and, if not possible, to lessen its negative sequel.

This is achieved through a mental health hospital-wide risk assessment program that identifies high risks areas and processes.

The program scope covers all staff, the program address at least the following:

a) Pre-employment medical evaluation of new staff
b) Periodic medical evaluation of staff members
c) Screening for exposure and/or immunity to infectious diseases.
d) Exposure control and management to work-related hazards
    I. Ergonomic hazards that arise from the lifting and transfer of patients or equipment, strain, repetitive movements, and poor posture
    II. Physical hazards such as lighting, noise, ventilation, electrical, and others
    III. Biological hazards from blood-borne and airborne pathogens and others
    IV. Psychological hazards like psychological sequels after a patient death.
e) Staff education on the risks within the mental health hospital environment as well as on their specific job-related hazards.
f) Staff preventive immunizations.
g) Recording and management of staff incidents (e.g., injuries or illnesses, taking corrective actions, and setting measures in place to prevent recurrences).
h) Infection control staff shall be involved in the development and implementation of the staff health program as the transmission of infection is a common and serious risk for both staff and patients in healthcare facilities.
i) All staff occupational health program-related results (medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulation
j) A pre-employment medical examination is required for all employee categories to evaluate their appropriateness for safe performance, and staff that is exposed to certain hazards, such as radiation should have periodic specific medical evaluations (tests and examinations). A situational examination may be required in case of exposure to specific substances. Results of the medical evaluation are documented in staff health records, and action is taken when there are positive results, including employee awareness of these results and provision of counseling and interventions as might be needed.
k) A situational examination may be required in case of exposure to specific substances. Results of the medical evaluation are documented in staff health records, and action is taken when there are positive results, including employee awareness of these results and provision of counseling and interventions as might be needed.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital's staff health program and the occupational health risk assessment.

- The GAHAR surveyors may interview staff members who are involved in developing and executing staff health programs to check program structure, risks, education, and orientation records
- The GAHAR surveyors may interview staff to check their awareness of risks within the mental health hospital environment, their specific job-related hazards, and periodic medical examination.
- The GAHAR surveyors may review a sample of staff health records to check the evidence of immunizations, post-exposure prophylaxis and interventions, and other staff occupational health program-related results.

Evidence of compliance:

1. There is an approved mental health hospital**'s** staff health program that covers a) through k) in the intent.
2. There is an occupational health risk assessment that defines occupational risks within the mental health hospital.
3. Staff members are educated about the risks within the mental health hospital environment, their specific job-related hazards, and periodic medical examination.
4. All staff members are subjected to the immunization program and to work restrictions according to the approved mental health hospital guidelines.
5. All test results, immunizations, post-exposure prophylaxis, and interventions are recorded in the staff's health record.
6. There is evidence of taking action and informing employees in case of positive results.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, IPC.08 Safe injection practices, IPC.04 Infection risk assessment, EFS.06 Safety Management Plan, QPI.03 Risk Management Program, OGM.11 Positive Workplace Culture, WFM.01 Workforce Laws and regulations

OGM.14 the mental health hospital care services are in line with international, national, regional, or local community initiatives.

Effectiveness

Keywords:
Community Initiatives.

Intent:
A community is a group of individuals, families, groups, facilities, or organizations that interact with one another, cooperate in common activities, and solve mutual concerns, usually within the geographic area served by mental health hospital. The mental health hospital shall develop and implement a plan for community involvement that may include initiatives such as the implementation of international women's health, oncology health, and diabetes health initiatives or the national initiatives of Universal Health Insurance, 100 Million Healthy Lives, or others.

Survey process guide:

- The GAHAR surveyors may review the community involvement plan to check that is it aligned with other national initiatives and with laws and regulations
- The GAHAR surveyors may interview staff to check their awareness of community initiatives.

Evidence of compliance:

1. The mental health hospital plans reflect alignment with international, regional, and/or national community initiatives

2. All staff is aware of the community involvement plan and initiatives.
3. The community involvement plan is updated periodically to meet the needs of the community.

Related standards:
OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, STP.08 Promotion of mental health and wellbeing, ACT.03 Physical access and comfort, OGM.04 Scope of services

Effective research framework

OGM.15 When provided by the mental health hospital, The hospital establishes an ethical framework for clinical research activities.

Patient-centeredness

Keywords:
Clinical Research Ethical Framework.

Intent:
When the hospital provides clinical research activities, the primary concern is how to respect and maintain the research ethics, national laws, and regulations while protecting patients' health and wellbeing.
Usually, hospitals assign the responsibility of ethical review of research protocols and their supporting documents to a committee. The research ethics committee (REC) has a multidisciplinary membership which shall be established according to a charter or other document that establishes the manner in which members and the Chair will be appointed.
The mental health hospital shall support REC with staff, adequate numbers, and training to enable it to carry out its technical and administrative responsibilities; also with adequate resources for the staff to fulfill its assigned functions.
The mental health hospital shall ensure committee members are aware and trained on their role and responsibilities in the REC, which addresses at least the following:

a. Ethical considerations are relevant to research with human participants.
b. Basic aspects of research methodology and design (for members who lack such background).
c. Impact of different scientific designs and objectives on the ethics of a research study.
d. Various approaches for recognizing and resolving the tensions that can arise among different ethical considerations.
e. Modes of ethical reasoning.

Approval or disapproval is based on the ethical acceptability of the research, including its social value and scientific validity, an acceptable ratio of potential benefits to risks of harm, the minimization of risks, adequate informed consent procedures (including cultural appropriateness and mechanisms to ensure voluntariness), measures to ensure the protection of vulnerable populations, fair procedures for the selection of participants, and attention to the impact of research on the communities from which participants will be drawn, both during the research and after it is complete. The review considers any prior scientific reviews and applicable laws and regulations.

Survey process guide:

- The GAHAR surveyors may review the research ethics committee (REC) charter and review the members' responsibilities.
- The GAHAR surveyors may interview REC members to check their awareness of their responsibilities.
- The GAHAR surveyors may review the requirements for approval of research protocols.

Evidence of compliance:

1. The mental health hospital ensures that the research ethics committee has a multidisciplinary membership and that it includes individuals with backgrounds relevant to the areas of research.
2. The committee members are trained on how to perform their roles and responsibilities.
3. The committee sets minimum requirements for approval of research protocols.
4. The committee review all research protocols that involve human subjects before its approval as required by the applicable law and regulation.

Related standards:
OGM.12 Ethical Management, OGM.16 Consent for Clinical Research, OGM.17 Research Patient Rights, PCC.03 Patient, family, and carer rights.

OGM.16 The hospital provides complete, accurate information to patients and families and ensures obtaining their consent prior to the conduction of the clinical research.

Safety

Keywords:
Consent for Clinical Research.

Intent:
In ethically acceptable research, risks shall be minimized and reasonable in relation to the potential benefits of the study. The nature of the risks may differ according to the type of research to be performed, harm may occur either at an individual level or at the family or population level. Enrollment into a research experiment or trial might carry uncertainty and fear to participants. Also, withdrawal from it may make the participants fearful of being discriminated against. Hence, the mental health hospital shall obtain informed consent before the patient participates in clinical research or clinical trials. The information provided to patients and families shall include at least the following:

a. Benefits and potential risks;
b. All possible alternatives.
c. A complete and comprehensive description of procedures that are required to be followed.
d. Patient right to refuse or withdraw participation without fear of retribution.

Patient informed Consent to participate in clinical research or trials is completed, and documented according to the documentation requirements mentioned in the informed consent standard (PCC.07). The ethical foundation of informed consent is the principle of respect for persons. Competent individuals with mental capacity) are entitled to choose freely whether to participate in research and to make decisions based on an adequate understanding of what the research entails.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital process to obtain patient consent for participation in clinical research.
- The GAHAR surveyors may interview responsible staff to check their awareness.
- The GAHAR surveyors may review patients' medical records to check the documentation of patients' consent for participation in clinical research.

Evidence of compliance:

1. The mental health hospital has an established process to obtain the patient consent for participation in the clinical research that includes items from a) to d) in the intent.
2. Patients and families are informed about the process for obtaining consent.
3. Relevant staff is aware of the process for obtaining consent.
4. Signed patient consent for participation in the clinical research is documented in the patient's medical record.

Related standards:
OGM.12 Ethical Management, PCC.07 Informed consent, PCC.03 Patient, family, and carer rights, OGM.17 Research Patient Rights, OGM.15 Clinical Research Ethical Framework, PCC.06 Patient, family and carer education process.

OGM.17 Patient rights are protected during the research activities.

Patient-centeredness

Keywords:
Research Patient Rights.

Intent:
Invasions of patient privacy and breaches of confidentiality during conducting the research activities are disrespectful and can lead to feelings of loss of control or embarrassment, as well as tangible harms such as social stigma, rejection by families or communities, or lost opportunities such as employment.
The mental health hospital shall develop a research policy and procedures complying with psychiatric patient care laws and regulations that shall include at least the following:

a) Eligibility for enrollment in research activities and protocols.
b) Compliance with all regulatory requirements related to research.
c) Protection of patient rights during research enrollment.
d) Confidentiality guarantees for photographs and patient information included in the research.
e) Compensation process for patients who participate in clinical research and experience an adverse event.
f) Conditions in which research recordings and films are prohibited according to psychiatric patient care laws and regulations such as compulsory admission of patients.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital research policy.
- The GAHAR surveyors may interview relevant staff to check their awareness of hospital policy.
- The GAHAR surveyors may review the compensatory process for patients who participate in clinical research and experience an adverse event.

Evidence of compliance:

1. The mental health hospital has an approved research policy that includes all the items in the intent from a) to f).
2. Relevant staff is aware of the policy requirements.
3. Compliance with all regulatory requirements related to research is documented and regularly evaluated as per hospital policy.
4. There is a clear process followed for the patients who participate in clinical research and experience an adverse event.

Related standards:
PCC.03 Patient, family, and carer rights, PCC.07 Informed consent, OGM.12 Ethical Management, OGM.15 Clinical Research Ethical Framework, OGM.16 Consent for Clinical Research, IMT.04 Confidentiality and Security of data and information, QPI.04 Incident Reporting System.

Workforce Management

Chapter intent:
Mental health hospitals have a special nature of work, dealing with a special type of patients, thus needing a variety of skilled, qualified people to fulfill their mission and to meet patient needs. The mental hospital workforce refers to the staff within the hospital. Planning the appropriate number and skill mix of the workforce is essential. Developing clear job descriptions, strong orientation, and training programs help staff in delivering proper healthcare and wellbeing. A good organization should always have a clear structure of its medical staff, including departments, divisions, and medical committees.

This chapter defines the medical staff leaders' roles and responsibilities in credentialing, privileging, bylaws development, committees, and departments' management (head), as well as performance improvement. The medical staff includes licensed physicians and licensed dentists, it's particularly important to carefully review the credentials of all medical staff and other healthcare professionals, The hospital should provide medical staff with opportunities to learn and to advance personally and professionally Independent practitioners are other licensed healthcare professionals as (pharmacists, nutritionist…) that are permitted by law and regulation to provide patient care services independently in the hospital, those special group of healthcare professionals shall be identified by the hospital and their clinical privileges shall be clarified and reviewed.

In some countries, licenses are renewable, which means that physicians, nurses, and other healthcare professionals need to go through a renewal process periodically and prove their competence and continuous development. National bodies that govern medical and nursing education are established in different countries. National performance evaluation and ranking of healthcare professionals is on the rise, with many healthcare systems moving towards the pay-per-performance concept.

The new Universal Health Insurance system tackled the pay-per-performance concept in its initial phases. Licenses are not linked to the frequent evaluation of professional development yet, but discussions are established to build a system for monitoring this process. MOHP licensing body requires specific lists of documents for almost all healthcare professionals.

The GAHAR surveyors shall review the implementation of laws and regulations, medical bylaws, nursing bylaws, Policies, procedures, and plans reflecting processes of the human resources department through interviews with leadership and staff and reviewing different healthcare professionals' staff files.

Chapter purpose:

The main objective is to ensure that hospitals maintain an effective Workforce Management program; the chapter addresses the following objectives:

1. Effective workforce planning.
2. Effective orientation, continuous medical education, and training program
3. An efficient mix of staff
4. Periodic evaluation of staff performance.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Code of Medical Ethics 238/2003.
2) Egyptian Code of Nursing Ethics (Nursing Syndicate Publications).
3) Code of Ethics and Behavior for Civil Service Staff, 2019.
4) Pharmacist Code of Ethics.
5) Presidential Decree for Performance Evaluation Number 14 / 2014.
6) Egyptian Law for the Care of Psychiatric Patients, 71/2009.
7) Law No. 210/2020 Amendment for Law Of Psychiatric Patient Care, 71/2009.
8) Regulations for the Care of Psychiatric Patients, 128/2010.
9) Regulations for the Care of Psychiatric Patients, 55/2021.
10) The Pharmacy Profession Law 127/1955.
11) National Law for Laboratories 367/ 1954.
12) Regulation of Medical Imaging Work, Law 59/1960.
13) MOH Ministerial Decree for Practicing of Foreign Experts 90/1999.
14) MOH Ministerial Decree on Anaesthesia Service Requirements, Number 236/2004.
15) MOH Ministerial Decree on Minimum Requirements for Anaesthesia Services Number153/2004.
16) Law of Trade Unions and Protection 213/2017.
17) MOHP Ministerial Decree for Medical Responsibility and Suspension of Medical Practice Number 25/2002.
18) MOHP Ministerial Decree for Promotion of Doctors Number 665/2018.
19) MOH Ministerial Decree on the Promotion of Healthcare Professionals Number 62/2004.
20) Regulation on Teaching Institutes Number 1002/1975.

Efficient workforce planning

WFM.01 Workforce recruitment, employment, and appraisal processes comply with laws and regulations.

Effectiveness

Keywords:
Workforce Laws and regulations.

Intent:
Labor laws and regulations mediate the relationship between workers, mental health hospital syndicates, and the government. The labor law, which provides for the rights of employees to work, is enforced through the employment contract. The mental health hospital shall identify all applicable laws and regulations including syndicates' codes and requirements and shall define the legal framework for its workforce management.
The mental health hospital shall develop a policy and procedures that guide the management of staff files after recruitment (it includes the independent healthcare practitioners), the policy shall address at least the following:

a) Staff file initiation process and requirements.
b) Standardized contents such as;
    I. Certificate, license, education, training and work history,
    II. Current job description,
    III. Record of the general, departmental, and specific/ in-service job orientation
    IV. Evidence of probationary (pre-employment) evaluation, to ensure that the staff member able to perform the assigned job,
    V. Ongoing In-service education received,
    VI. Copies of the probationary evaluation and copies of the annual evaluations
    VII. Any required health information as mandated by law or hospital policy
c) Updates of file contents
d) Storage
e) Retention time
f) Disposal

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for staff files.
- The GAHAR surveyors may interview responsible staff to check their awareness of the policy.
- The GAHAR surveyors may review a sample of staff files to assess the standardization of the content and compliance with the hospital policy.

Evidence of compliance:

1. The mental health hospital has an approved policy for staff files that addresses at least elements from a) through f) in the intent.
2. Responsible staff is aware of the staff file management policy and procedures.
3. Staff files are standardized, current, maintained, and kept confidential according to mental health hospital policy.
4. Staff files contain all elements listed in point b) from the intent.

Related standards:
WFM.02 Staffing Plan, WFM.03 Job Description, WFM.04 Recruitment process, WFM.05 Verifying credentials, IMT.01 Document management system.

WFM.02 The mental health hospital develops a staffing plan to ensure that the provided services are consistent with patient needs, hospital mission, and professional practice recommendations.

Efficiency

Keywords:
Staffing Plan.

Intent:
Staff planning is the process of making sure that a hospital has the right people to carry out the work needed for business success through matching up detailed staff data including skills, potential, aspirations, and location with business plans.
The shortage of competent healthcare professionals in multiple areas is an alarming sign, especially in critical care disciplines such as anesthesia.
The mental health hospital shall comply with the laws, regulations, and recommendations of professional practices that define desired education levels, skills, or other requirements of individual staff members or that define staffing numbers or a mix of staff for the hospital.
The staffing plan is monitored and reviewed on an ongoing basis and updated as necessary by the leaders of each clinical or managerial area who defined the individual requirements of each staff position. The plan shall include at least the following:

I. The number, types, and desired qualifications of staff.
II. Assignment and reassignment of staff in response to the change in patient need or staff shortages.
III. Situations and a clear process for the transfer of responsibility from one individual to another are needed.

Leaders shall consider the following factors to project the staffing needs:

a) The mental health hospital mission, strategic and operational plans
b) Complexity and severity mix of patients served by the hospital
c) Services provided by the mental health hospital
d) Work load during working hours and different shifts
e) Technology and equipment used in providing patient care

Survey process guide:

- The GAHAR surveyors may review the mental health hospital staffing plan
- The GAHAR surveyors may interview the mental health hospital leaders to discuss the used factors to establish and monitor the staffing plan.

Evidence of compliance:

1. The mental health hospital has an approved staffing plan that matches the patient's needs, hospital mission, service provided, and professional practice recommendations.
2. The staffing plan addresses items mentioned in the intent from I) to III).
3. The hospital's leaders collaboratively participate in performing, supervising, and monitoring the staffing plan, using factors illustrated in the intent from a) to e).
4. The staffing plan is monitored, reviewed, and updated at least annually

Related standards:
WFM.01 Workforce Laws and regulations, WFM.03 Job Description, WFM.04 Recruitment process, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders.

WFM.03 the mental health Hospital develops job descriptions to address each position's requirements and responsibilities.

Effectiveness

Keywords:
Job Description.

Intent:
The job description is a general written statement of a specific job, based on the findings of a job analysis. It generally includes duties, purpose, responsibilities, scope, and working conditions of the job.
In mental health hospitals, a job description is required to make sure that staff responsibilities are current and aligned with mental health hospital policy.
The mental health hospitals shall ensure that the job description is based on the education, training, and experience level of each staff. The job description is important to identify and authorize the individual to practice independently in the hospital and to evaluate the extent to which the staff fulfills their job responsibilities.
Job descriptions are required for all types of staff, clinical, non-clinical, full-time, and part-time, temporary staff, and those who are under training or supervision.
Each hospital leader or head of the department is responsible to develop a staff job description that fulfills all the requirements approved by the mental health hospital. It includes at least;

a) Job title,
b) Main duties and responsibilities,
c) Reporting relationships,
d) Qualifications, education, experience, training, and technical skills necessary for entry into this job
e) Special demands and requirements may be needed.

Survey process guide:

- The GAHAR surveyors may review a sample of staff files to check for the availability of job descriptions.
- The GAHAR surveyors may interview staff to check their awareness of their job description.

Evidence of compliance:

1. There is a current, approved job description for every position and recorded in the staff's file
2. Job descriptions include the requirements and responsibilities of each position and include all items from a) to e) in the intent.
3. All staff is aware of their job description specifications and requirements.
4. Job descriptions are discussed with staff members, signed, and recorded in the staff file.
5. Staff performance evaluations (appraisals) are based on the requirements and responsibilities written in the job description.

Related standards:
WFM.01 Workforce Laws and regulations, WFM.02 Staffing Plan, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, WFM.08 Staff Performance Evaluation, WFM.09 Medical Staff Structure.

WFM.04The mental health hospital implements a uniform recruitment process.

Equity

Keywords:
Recruitment process.

Intent:
Recruitment and selection of a person for a certain job begin with advertising a vacant position and choosing the most appropriate person for this job.
The mental health hospital shall provide an efficient and centralized process for recruiting and hiring staff members for available positions
The recruitment process shall be uniform with similar criteria of selection, and forms required across the hospital for similar types of staff. The mental health hospital shall develop a policy and procedures that guide the process of recruitment of new staff.
The policy shall address at least the following:

a) Collaboration with service/department leaders to identify the need for a job
b) Communicating available vacancies to potential candidates
c) Announcing criteria of selection
d) Application process
e) Recruitment procedures
f) Process of obtaining information from references, agencies, or outside entities.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy describing the recruitment process.
- The GAHAR surveyors may interview staff members who are involved in the recruitment process to check their awareness.
- The GAHAR surveyors may observe the uniformity of the recruitment process for a similar type of staff.

Evidence of compliance:

1. The mental health hospital has an approved policy to recruit staff that addresses all the elements from a) through f) in the intent.
2. Staff who are involved in the recruitment process are aware of the hospital policy.
3. The recruitment process is uniform across the hospital for similar types of staff.

Related standards:
WFM.01 Workforce Laws, and regulations, WFM.02 Staffing Plan, OGM.03 The Mental health hospitals' leaders, WFM.08 Staff Performance Evaluation, WFM.09 Medical Staff Structure.

Credential verification and evaluation

WFM.05 The mental health hospital implements an effective process to verify the credential of all staff members

Effectiveness

Keywords:
Verifying credentials.

Intent:
Credentials are documents that are issued by a recognized entity to indicate completion of requirements or the meeting of eligibility requirements, such as a diploma from a medical school, specialty training (residency) completion letter or certificate, completion of the requirements of the related syndicates, authorities and/or others, a license to practice.
These documents, some of which are required by law and regulation, need to be verified from the original source that issued the document. The mental health hospital shall develop a process of verifying credentials for all staff members (including independent practitioners)

and match the requirements of the position with the qualifications of the prospective staff member.

Survey process guide:
- The GAHAR surveyors may review the credential verification process.
- The GAHAR surveyors may review a sample of staff members (including independent practitioners) files to check the availability of required credentials for each position.
- The GAHAR surveyors may interview staff members who are involved in the credentialing process to check their awareness of the process.

Evidence of compliance:
1. There is a defined process for verifying the credential of all staff in the mental health hospital
2. Required credentials for each position are identified and available in each staff file (including independent practitioners' files).
3. Actions are taken and documented when credentials cannot be verified.

Related standards:
APC.02 Healthcare Professionals Registration requirements, WFM.01 Workforce Laws and regulations, WFM.03 Job Description, WFM.10 Clinical Privileges, WFM.09 Medical Staff Structure, WFM.12 Nursing Structure

Effective orientation program

WFM.06 Appointed, contracted, and outsourced staff undergoes a formal orientation program.

Effectiveness

Keywords:
Orientation Program.

Intent:
A new staff member, no matter what his or her employment experience, needs to understand the entire hospital structure and how his/ her specific clinical or nonclinical responsibilities contribute to the mental health hospital's mission.
This is accomplished through a general orientation to the hospital and defining his/ her role by a specific orientation to the job responsibilities of his/ her position
Staff orientation shall ensure alignment between the mental health hospital mission and staff activities. It helps to create a healthy hospital culture where all staff works with a shared mental model and towards agreed-upon objectives.
The mental health hospital shall build a comprehensive orientation program that is provided to all staff members regardless of their terms of employment.
Staff orientation shall occur on three levels: General orientation, department orientation, and job-specific orientation;

I. The general orientation program shall address at least
   a. Review of the mental health hospital's mission, vision, and values
   b. Mental health Hospital structure
   c. Mental health Hospital policies for the environment of care, infection control, performance improvement, patient safety, and risk management

II. The department orientation program shall address at least:
   d. Review of relevant policies and procedures
   e. Operational processes,
   f. Work relations.

III. Job Specific orientation shall address at least:
   g. High-risk processes

h. Technology and equipment use
i. Staff safety and health requirements and measures

Survey process guide:

- The GAHAR surveyors may interview staff members to check for general, department, and Job specific orientation programs.
- The GAHAR surveyors may review a sample of staff files to check for the completeness of orientation programs.

Evidence of compliance:

1. The general orientation program is performed, and it includes at least the elements from a) through c). in the intent
2. The department orientation program is performed, and it includes at least the elements from d) through f). in the intent
3. Job specific orientation program is performed, and it includes at least the elements from g) through i). in the intent
4. Any staff member attends an orientation program regardless of employment terms.
5. There is evidence that each staff member has completed the orientation program and is recorded in his file.

Related standards:
WFM.03 Job Description, WFM.07 Continuous education, and training program, EFS.06 Safety Management Plan, IPC.02 Infection prevention and control (IPC) program, QPI.01 Quality management program, EFS.02 Fire and smoke safety plan.

Effective training and education

WFM.07 The mental health hospital has a continuous education and training program

Effectiveness

Keywords:
Continuous education and training program.

Intent:
Staff education and training are fundamental steps toward organizational and individual development. For any mental health hospital to fulfill its mission, it has to ensure that its human resources have the capacity to deliver its services over time.
Continuous education and training programs help guarantee that the training plan, especially if designed to satisfy staff needs necessary to deliver the mental health hospital's mission.
The program shall be designed in a flexible manner that satisfies all staff categories based on services provided, evaluation of the staff needs assessment, tailored training plan, delivery, and reflection.
The mental health hospital shall ensure that education and training are provided and recorded according to each staff member's relevant job responsibilities and cover at least the following areas:

a) Patient assessment
b) Infection control policy and procedures, needle stick injuries, and exposures
c) Environment safety plans including fire safety plan.
d) Occupational health hazards and safety procedures, including the use of personal protective equipment
e) Information management, including patient's medical record requirements as appropriate to responsibilities or job description
f) Clinical guidelines used in the hospital
g) Basic cardiopulmonary resuscitation training at least every two years for all staff that provides direct patient care
h) Quality concept, performance improvement, patient safety, and risk management.

i) Patient rights, Patient satisfaction, and the complaint/ suggestion process.
j) Interpersonal communication between patients and other staff cultural beliefs, needs, and activities of different groups served
k) Defined abuse and neglect criteria
l) Medical equipment and utility systems operations and maintenance

Survey process guide:

- The GAHAR surveyors may review the mental health hospital's continuous education and training program.
- The GAHAR surveyors may check a sample of staff files to check for evidence of attendance in the education and training program

Evidence of compliance:

1. There is a program of continuing education and training for all staff categories that includes elements in the intent from a) through l).
2. Resources needed to deliver the program are identified in the education and training program.
3. The program is based on the needs assessment of all staff categories.
4. The results of a performance evaluation (appraisal) are linked to the training program's re-design and renewal.

Related standards:
WFM.03 Job Description, WFM.06 Orientation Program, WFM.08 Staff Performance Evaluation, WFM.14 Education of house officers and residents, WFM.15 Professional post-graduate education program, EFS.06 Safety Management Plan, IPC.02 Infection prevention and control (IPC) program, QPI.01 Quality management program, QPI.08 Performance improvement and patient safety plan, QPI.02 Performance Measures.

Equitable staff performance evaluation

WFM.08 Staff performance and competency are regularly evaluated.

Equity

Keywords:
Staff Performance Evaluation.

Intent:
Staff performance evaluation is an ongoing process that is also called performance appraisal or performance review, which is a formal assessment for managers to evaluate an employee's work performance, identify strengths and weaknesses, offer feedback, and set goals for future performance
Performance evaluation effectively contributes to the individual, team, the mental health hospital improvement when based on a defined transparent process with clear declared criteria relevant to the job functions.
The mental health hospital shall provide probationary (pre-employment) evaluation after the probationary period in accordance with national laws and regulations, and then regular re-evaluation is performed at least annually or as necessitated by the hospital.
It is the department head's responsibility to ensure all staff is evaluated within the prescribed cycles and that performance ratings issued by the immediate supervisor reflect staff's actual performance.
Recorded process of employees' performance evaluation (appraisal) including performance review methods, tools, evaluation dimensions, criteria, time interval, appeal process, and responsible person for each staff category.
Performance evaluation criteria for medical staff members shall include those related to patients' medical record recording and medication use. Such as:

a. Patient's medical record review for completeness and timeliness.

b. Utilization practice and medication use.
c. Compliance with approved clinical guidelines
d. Complications, outcomes of care, mortality, and morbidity
e. Professional development

Competency is the process to determine the ability of staff to fulfill the primary responsibilities of the position for which a person was hired. Observing and measuring competency for every position in the hospital is one of the most important duties of the department leaders and to ensure that each staff member shall understand the expectations, responsibilities, activities, and competencies required for his or her position.
Competency shall be done after the probationary period (initial competency assessment), then on an ongoing basis at least annually for at least the following (the nursing staff, staff who provide medical imaging services, laboratory services, procedural c services, POCT services, and staff who are handling critical medical equipment).

Survey process guide:

- The GAHAR surveyors may interview department/service or hospital leaders and inquire about the used methods and tools for staff performance evaluation and competency evaluation.
- The GAHAR surveyors may review a sample of staff files to assess the completion of performance and competency evaluations.

Evidence of compliance:

1. Performance evaluation is performed at least annually for each staff member and linked to the education and training provided.
2. Performance evaluation records for medical staff members include at least all elements from a) through e) in the intent
3. Performance and competency evaluation is performed based on the current job description.
4. Clear procedures for the effective management of underperformance are implemented
5. There is evidence of employee feedback on performance and competency evaluation
6. Performance and competency evaluations are recorded in staff members' files.

Related standards:
WFM.01 Workforce Laws and regulations, WFM.03 Job Description, WFM.07 Continuous education, and training program, WFM.09 Medical Staff Structure, WFM.10 Clinical Privileges ,WFM.12 Nursing Structure, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders.

Efficient medical staff structure

WFM.09 An organized medical staff structure is developed to provide oversight on quality of care, treatment, and services.

Effectiveness

Keywords:
Medical Staff Structure.

Intent:
In general**,** medical staff is all physicians, and dentists, who are licensed to practice independently (without supervision) and who provide preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services to patients; or who provide interpretative services for patients, such as radiology, or laboratory services.

The mental health hospital shall define those other practitioners, such as house officers, junior doctors, and resident doctors who are no longer in training, but may or may not be permitted by the hospital to practice independently. Those medical staff shall have a diagram describing the line of authority within the hospital.
The hospital shall set a clear framework of its medical staff rules and responsibilities. It can be achieved by the development and approval of the medical staff bylaws. The medical staff bylaws are a document approved by the hospital that establishes the requirements for the members of the medical staff to perform their duties, and standards for the performance of those duties. It shall describe the process of medical staff appointment
Which shall be performed according to applicable laws and regulations including the process of appointment of independent practitioners for emergency needs or a temporary period.

The mental health hospital shall determine who is responsible to supervise, review, update, monitoring, and implementing the medical staff bylaws. Criteria of re-appointment of the medical staff shall be described clearly in the medical staff bylaws and ensure at least the following:

a) The medical staff member has not been subjected to any disciplinary action that threatens to withdraw or cancel his license or certificates.
b) The medical staff is physically and mentally able to provide care and treatment to patients without supervision.
c) The staff file contains the documents that support his request for new or extended privileges

Survey process guide:

- The GAHAR surveyors may review a document describing medical staff structure and medical staff bylaws.
- The GAHAR surveyors may interview staff members to check their awareness of the medical staff structure.

Evidence of compliance:

1. The mental health hospital has a defined medical staff structure that is developed according to the hospital's scope of services and recommendations of professional practices to meet patient needs and be consistent with relevant laws and regulations.
2. The medical staff structure is approved by the governing body.
3. Medical staff structure clearly defines lines of authority and responsibilities during working hours and after hours.
4. Medical staff appointments are performed according to the hospital medical staff bylaws.
5. Medical staff re-appointment is performed according to the hospital medical staff bylaws and includes items from a) to c) in the intent.

Related standards:
OGM.01 Governing body Structure and clear responsibilities, WFM.02 Staffing Plan, WFM.05 Verifying credentials, WFM.08 Staff Performance Evaluation, WFM.10 Clinical Privileges, WFM.14 Education of house officers and residents, WFM.15 Professional post-graduate education program, WFM.01 Workforce Laws and regulations.

Efficient medical workforce structure

WFM.10 Medical staff members have current and specific delineated clinical privileges that approved by the medical staff committee

Safety

Keywords:
Clinical Privileges.

Intent:
The mental health hospital shall define the required clinical privileges to apply for all medical staff members based on the evaluation of the individual's credentials and performance. The determination of a medical staff member's current clinical competence and deciding about what clinical services the medical staff member will be permitted to perform is often called privileging which is the most critical determination that the hospital will protect the safety of patients and help to advance the quality of its clinical services by it.
Decisions regarding a practitioner's clinical competence, and thus what clinical privileges he/she is to be granted, are based primarily on information and documentation received from outside the hospital. Independent practitioners who provide patient care services on the premises of the mental health hospital but are not employees or permanent staff are privileged and evaluated.
Specialty training programs may identify and list the general competencies of that specialty in areas of diagnosis and treatment with the hospital assigning privileges to diagnose and treat patients in those specialty competency areas.
The mental health hospital shall develop a defined process of clinical privileges delineation.
The process shall address and cover at least the following:

a) Ensuring that the medical staff members and independent practitioners with clinical privileges are subjected to medical staff bylaws
b) Privileges indicate if the medical staff can admit, consult, and treat patients.
c) Privileges define the scope of patient care services and the types of procedures they may provide in the mental health hospital.
d) Privileges are determined based on documented evidence of competency (experience- qualifications – certifications-skills) that are reviewed and renewed at least every three years.
e) Privileges are available in areas where medical staff shall provide services pertinent to granted privileges.
f) Medical staff members with privileges do not practice outside the scope of their privileges.

Survey process guide:

- The GAHAR surveyors may review the clinical privileges delineation process.
- The GAHAR surveyors may interview medical staff to check their awareness of the clinical privilege delineation process.
- The GAHAR surveyors may review medical staff files to check for the recording of clinical privilege.

Evidence of compliance:

1. The mental health hospital has a defined process of clinical privileges delineation that addresses at least all elements from a) through f) in the intent
2. Medical staff members are aware of the process of clinical privileges delineation and what to do when they need to work outside their approved clinical privileges
3. Clinical privileges are delineated to medical staff members based on defined criteria
4. Medical staff files contain personalized recorded clinical privileges, including the renewal when applicable.
5. Compliance medical staff with their granted clinical privileges are monitored and linked to their staff performance evaluation and appraisal.

Related standards:
WFM.03 Job Description, WFM.08 Staff Performance Evaluation, WFM.09 Medical Staff Structure, DAS.02 Medical imaging services healthcare professionals, DAS.10 Laboratory Staff, MHP.09 Drug-assisted interview, MHP.10 Electroconvulsive Therapy and any invasive procedures, WFM.01 Workforce laws and regulations, MHP.02 Qualified Anesthesiologist.

WFM.11 The mental health hospital has staff burnout and turnover preventive measures and strategies.

Safety

Keywords:
Staff burnout and turnover.

Intent:
Attention to the health and well-being of healthcare providers and workers becomes more important when we consider the fact that employees are the greatest asset in an organization. Burnout is a combination of exhaustion, cynicism, and perceived inefficacy resulting from long-term job stress. The consequences of burnout are not limited to the personal well-being of healthcare providers and workers; many studies have demonstrated that provider burnout is detrimental to patient care. The mental health hospital shall ensure the management of staff working hours and application of the national laws and regulations efficiently to avoid burnout.
The policy of efficient working hours shall address at least the following:

a) Measures to avoid staff burnout.
b) Planned rest times.
c) Maternity protection and arrangements for breastfeeding.
d) Setting staff working hours according to the national laws and regulations

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for working hours and may interview staff to check their awareness.
- The GAHAR surveyors may observe the staff rest areas and rest times.

Evidence of Compliance:

1. The mental health hospital has an approved policy and procedures that ensure safe and efficient working hours, the policy address a) to d) in the intent.
2. The staff schedules ensure suitable working hours and planned rest times.
3. The staff is aware of how to apply the policy.

Related standards:
OGM.11 Positive Workplace Culture., WFM.01 Workforce Laws and regulations, WFM.09 Medical Staff Structure, WFM.02 Staffing Plan.

Organized nursing structure

WFM.12 The hospital has a defined nursing structure that is led by a qualified nurse director.

Effectiveness

Keywords:
Nursing Structure.

Intent:
The nursing director has an influential role in the creation of a safe, healthy, productive working environment for nursing staff that promotes collaboration, productivity, and professional

growth. Successful nursing directors have qualifications and expertise in management and leadership.

Standards of nursing practice provide and outline the expectations of the professional role for nurses, including scope and standards of practice and related competencies. They reflect a desired and achievable level of performance against which a nurse's actual performance can be compared. The main role of the nursing director is to direct and maintain safe and effective nursing practice.

Nursing staff newly hired and freshly graduated nurses shall practice under supervision after receiving all education and training needed for the job. The mental health hospital shall clearly define its nursing structure. The nurse director shall have at least the following responsibilities;

a) Responsible for developing and implementing written nursing standards of practice and recording for nursing assessment, nursing care plan, nursing reassessment, and treatments
b) Responsible for evaluating the effectiveness of nursing Practices
c) Member of the senior leadership team of the hospital and attending the senior leadership staff meetings
d) Ensuring that schedules and assigned tasks to the staff are completed

The mental health hospital shall define the trainee nurses and their role in the hospital during the training period. Also, supervisors of the trainee nurses shall monitor and evaluate their performance during the training period. The mental health hospital shall set guidelines for nursing practices.

Survey process guide:

- The GAHAR surveyors may review the nursing director's job description.
- The GAHAR surveyors may review the nursing director's file to check for licensure, qualification, and expertise.
- The GAHAR surveyors may interview trainee nurses to check their awareness of their job description.
- The GAHAR surveyors may observe the implementation of the nursing standards of practice.

Evidence of compliance:

1. There is a current, approved job description for the nursing director describing responsibilities as addressed in the intent from items a) to d).
2. The nursing director file fulfills the licensure, qualification, and expertise as required by the job description.
3. The hospital defines trainee nurses and the duration of working under a training
4. Trainee nurses practice under supervision through their job description and their performance is monitored and evaluated.
5. Nursing standards of practice are adopted, educated, and implemented

Related standards:

WFM.03 Job Description, WFM.01 Workforce Laws and regulations, WFM.05 Verifying credentials, WFM.08 Staff Performance Evaluation, WFM.11 Staff burnout, and turnover, WFM.02 Staffing Plan.

Effective learning environment

WFM.13 For academic (teaching) mental health hospital, the hospital ensures providing a supportive learning culture and environment throughout the hospital

Effectiveness

Keywords:
Learning culture and environments.

Intent:
The clinical learning environment is multidisciplinary, so an effective learning culture will value and support trainees and students from all professional groups. Students and trainees will have a good educational experience and education providers will be valued where there is a hospital commitment. The mental health hospital shall assign the responsibility of overseeing medical education activities to a committee, a task force, or a staff member to build effective systems of education and training. the responsibility of the assigned committee or staff individual(s) shall address at least the following:

a) Preparing the education and training programs based on principles of equality and diversity.
b) Prioritization of patient care processes throughout the medical education and training program.
c) Continuous monitoring and assessment of the education and training program's outcomes
d) Establishing and maintaining supportive learning culture and environment.
e) Setting the main performance measures (indicators) and identifying the improvement activities that may be needed.
f) Overseeing and supervising the local delivery of the curricula, teaching programmers, and training opportunities (medical education activities)

The hospital shall ensure the availability of resources, capacity, and facilities to deliver safe and relevant clinical learning opportunities, clinical supervision, and practical experiences for students and learners.
To improve the educational and training performance of the mental health hospitals, current education, and training programs to be reliably assessed. Measuring hospital performance is currently based on different aspects including supervisory assessments. The mental health hospital shall develop a set of indicators to improve educational activities in hospitals, considering the fact that performance indicators could propose concerns regarding quality improvement and performance management

Survey process guide:

- The GAHAR surveyors may review the assigned responsibilities of the committee or staff individual overseeing the medical education activities and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review the performance measures list of medical education activities and may assess the monitoring process.

Evidence of compliance:

1. The mental health hospital has an assigned committee or a staff individual(s) to oversee and supervise medical education activities with clear responsibility, which include items from a) to f) in the intent.
2. A responsible staff member is aware of their assigned roles and responsibilities.
3. The mental health hospital has a set of (performance measures) or indicators to monitor and improve the educational activities in hospitals

4. Hospitals' education and training programs are constantly reviewed, monitored, and evaluated.

Related standards
WFM.07 Continuous education and training program, WFM.14 Education of house officers and residents, WFM.15 Professional post-graduate education program, WFM.01 Workforce Laws and regulations

WFM.14 For academic (teaching) mental health hospital, the hospital has an effective education program to ensure safe and effective patient care provided by the house officers and residents

Effectiveness

Keywords:
Education of house officers and residents.

Intent:
The primary goal of the education program is for residents to achieve sufficient competence to deliver safe and effective patient care when they enter into practice. The inherent inexperience of residents as they learn need not affect patient safety if they are adequately supervised by more experienced physicians guiding them toward gradual independence
While the learning process depends on learners' abilities and dedication, support is needed from hospitals to ensure that house officers and residents are able to demonstrate what is expected in good medical practice and achieve the learning outcomes required by their curriculum. The mental health hospital shall build an education program for house officers and residents. This program shall cover at least the following:

a) Establishing the scope of practice and grant privilege for the house officer and resident (in the assessment and treatment of patients or any other type of patient direct care).
b) Determine staff who is authorized to supervise the house officer and resident
c) Providing educational support according to needs assessment and plan
d) Designing postgraduate curricula and regular assessment requirements
e) Respecting and protecting the time determined for learning while house officers and residents are doing clinical or medical work, or during academic training, and for attending organized educational sessions, training days, courses, and other learning opportunities.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital education program for house officers and residents.
- The GAHAR surveyors may interview house officers and residents to check their awareness of their privilege and scope of practice.
- The GAHAR surveyors may review staff files to check compliance with medical staff bylaws.

Evidence of compliance:

1. The mental health hospital has an approved education program that includes all the elements in the intent from a) through e).
2. House officers and residents are aware of their privilege and scope of practice.
3. Compliance of the house officers and residents with the hospital's medical staff bylaws and regulations are monitored, evaluated, and linked to their staff files.

Related standards:
WFM.13 Learning culture and environments, WFM.15 Professional post-graduate education program, WFM.07 Continuous education, and training program, WFM.01 Workforce Laws and regulations

WFM.15 For academic (teaching) mental health hospital, the hospital builds and establishes a professional post-graduate education program

Effectiveness

Keywords:
Professional post-graduate education program.

Intent:
While the learning process depends on learners' abilities and dedication, Support is needed from hospitals to ensure that medical specialty trainees are able to demonstrate what is expected in good medical practice and to achieve the learning outcomes required by their curriculum.
The hospital builds a professional graduate education program that includes at least the following:

a) Clear curriculum and regular assessment requirements.
b) An educational induction program to make sure that trainees understand their curriculum.
c) Sufficient practical experience to achieve and maintain the clinical or medical competencies (or both) required by their curriculum.
d) The opportunity to work and learn with other members of medical staff to support inter professional multidisciplinary working.
e) Regular, useful meetings with clinical and educational supervisors.

Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little education or training value. When assessments are required, they should be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.
Someone with appropriate expertise in the area being assessed shall carry out assessments, and who has been appropriately selected, supported, and appraised.

Survey process guide:

- The GAHAR surveyors may review the post-graduate education program.
- The GAHAR surveyors may interview medical specialty trainees to check their awareness.
- The GAHAR surveyors may review the medical specialty trainees' evaluation process.

Evidence of compliance:

1. The mental health hospital has an approved program that includes all the points in the intent from a) through e).
2. Medical specialty trainees are oriented to and comply with medical staff rules and regulations, hospital policies, and procedures.
3. Educators are trained and evaluated in the assessments they are required to perform.

Related standards:
WFM.13 Learning culture and environments, WFM.14 Education of house officers and residents, WFM.07 Continuous education and training program, WFM.01 Workforce Laws and regulations

Information Management and Technology

Chapter intent

Information management is the process by which relevant information is provided to decision-makers in a timely manner. An effective information management system is a vital component of the healthcare service. Information management and technology in mental health hospitals include clinical, managerial information, and information required by external authorities and agencies. There are major risks associated with information management and technology in healthcare. One of these risks is the potential breach of patient confidentiality. Patient confidentiality means that personal and medical information given to a healthcare professional shall not be disclosed to others unless the patient has given specific permission for such release. Maintaining patient confidentiality is an ethical and legal concern, especially with the emerging technology of the implementation of electronic information systems.

Another risk is associated with the use of abbreviations that may cause misunderstanding and affect patient safety. Implementation of a do-not-use abbreviation list for medication shall be guided by reliable references, e.g., The Institute for Safe Medication Practices (ISMP) list. Abbreviations also may cause harm regardless of the language used; organizations need to identify the approved reference in English or Arabic language.

Globally, Information management and technology are emerging in healthcare. Artificial intelligence is on the surge where symptom checkers and clinical decision support systems becoming widely used. More hospitals are moving to be paperless, and special certifications are dedicated to encouraging that movement.

Locally, Egyptian laws and regulations have taken big steps recently to support electronic transactions. The electronic signature law was released. Electronic payment is approved. A new law on data privacy is expected.

Practically, Hospitals need to provide resources for the implementation of an information management system that ensures patient safety, continuity of care, security, and confidentiality of information

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During GAHAR Survey, surveyors shall be able to measure how organizations implement information management systems and technologies through reviewing documents pertinent to this chapter and doing patient tracers and interviews with staff. The leadership interview session may touch on this topic, as well.

Chapter purpose:

1. To address Effective Information Management Processes
2. To Maintain Information Confidentiality and Security
3. To ensure the Availability of patients' medical records
4. To describe effective Information Technology in Healthcare.

Standards included in this chapter applies to paper and electronic data and information.

Implementation guiding documents:

(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) Egyptian Law for the Care of Psychiatric Patients, 71/2009.
2) Egyptian Code of Medical Ethics 238/2003.
3) Law No. 210/2020 Amendment for Law of Psychiatric Patient Care, 71/2009.
4) Regulations for the Care of Psychiatric Patients, 128/2010.
5) Regulations for the Care of Psychiatric Patients, 55/2021.
6) Egyptian Code of Nursing Ethics (Nursing Syndicate Publications).
7) Ministry of Finance Decree for Governmental Archives List Number 270/2009.
8) Ministry of Finance Decree: Non-Monetary Payment, 18/2019.
9) MOH Ministerial Decree for Medical Reports Regulations Number 187/2001.
10) MOH Ministerial Decree for Discharge Summary Requirements 254/2001.
11) Ministry of Communication and Information Technology Decree for Electronic Signature Number 109/2005.
12) National Census and Statistics, Law 35/1960.
13) Establishment of Central Agency for Public Mobilization and Statistics, Law 2915/1964.
14) Jeddah Declaration on Patient Safety, 2019.
15) HIPAA— Health Insurance Portability and Accountability Act Regulations1996.
16) Institute for Safe Medication Practices (ISMP): List of Error-Prone Abbreviations, Symbols, and Dose Designations.

Effective documentation management processes

IMT.01 Document management system is developed for all the mental health hospital documents.

Effectiveness

Keywords:
Document management system.

Intent:
The document management system is important for the standardization of the document formatting as well as developing a controlled process for creation, distribution, amendment, and disposal of documents. Documents may be of internal origin as policies, instructions for use, flow charts, procedures, specifications, forms, and documents of external origin such as regulations, standards, and textbooks from which the interventional procedures are taken. Unified document formatting will allow easier tracking and searching for any information Egyptian laws and regulations address topics related to the information management system including confidentiality and release of patient information, the retention period for documents, reporting of specific information to inspecting, regulatory agencies, etc. A periodic review of the whole document ensures that the obsolete document is not used. The mental health hospital shall develop an approved process of the document management system to cover the main organizational key functions such as emergency service, assessment, referral, discharge, procurement, and other operational and clinical key functions
The mental health hospital shall develop and implement a policy and procedures for a document management system that addresses at least the following:

a) Standardized formatting
b) Tracking system for tracking of any changes
c) The document control system (document to be identified by title, date of issue, edition and/or current revision date, the number of pages, who authorized issue and/or reviewed the document, and identification of changes of version).
d) Controlling of obsolete documents (it shall be dated and marked as obsolete).
e) Availability and dissemination of policies to the relevant staff.
f) Requirements and rules of policies revisions and updates.

Survey process guide:

- The GAHAR surveyors may review the policy of documentation management system followed by checking for the standardized format, tracking system, identified approver, issuing and revision date for all policies of the mental health hospital
- The GAHAR surveyors may interview staff to check their awareness of the process of developing, approving, tracking, and revising policies
- The GAHAR surveyors may check staff awareness of the proper access to relevant policies, tracking changes in the policies and process for management of retirement of documents.

Evidence of compliance:

1. The mental health hospital has an approved policy that guide the process of document management and includes elements in the intent from a) to f).
2. Staff is fully aware and trained in the document management system
3. There are standardized formats for all similar documents throughout the mental health hospital
4. The implementation of document management policy is continuously monitored, and any concerns that may arise are identified and corrected on time.

Related standards:
QPI.01 Quality management program, IMT.02 Information management plan, IMT.03 Standardized symbols, and Abbreviations, IMT.04 Confidentiality and Security of data and

information, IMT.05 Retention of medical records, data and information, IMT.06 Patient's medical record management, IMT.08 Health information technology

IMT.02 The mental health hospital has an effective Information management plan

Effectiveness

Keywords:
Information management plan.

Intent:
An information plan includes the identification of the information needs of different departments and the implementation of a process to meet those needs.
The information plan is aiming to provide accurate, meaningful, comprehensive, and timely information to assist in an information-based decision-making process.
Sometimes it is critical to record some processes because it affects the continuity of care or patient safety. In these instances, another plan is developed to satisfy recording requirements.
The mental health hospital shall develop an information management landscape in response to the identified needs. The hospital shall establish an organized framework for the dissemination of data and information to ensure that the user's needs are efficiently met taking into account that information is provided in a timely manner to support continuity of care and patient safety. Development of an effective information management plan shall include at least the following:

a. Identify the information needed for hospital clinical and managerial leaders.
b. Identify the information needs and requirements from external authorities and agencies.
c. Match the scope, size, and type of services provided by the hospital.
d. Identify and prioritize the hospital critical processes
e. Determine the adequate time- frame required in the information dissemination process (either internal or external dissemination).
f. Education and training of staff according to their responsibilities, job descriptions, and data and information needs

Survey process guide:

- The GAHAR surveyors may review the hospital information management plan.
- The GAHAR surveyors may interview staff to check their awareness of the information management plan.
- The GAHAR surveyors may observe the sent and received information at time intervals to assess compliance with the hospital policy.

Evidence of compliance:

1. The mental health hospital has an approved information management plan that addresses elements from a) through f) in the intent.
2. All staff members are educated and trained on the information management plan and the principles of the hospital's information use and management.
3. There is evidence that data and information are used in the relevant decision-making process.
4. Information is received in a timely manner as per the hospital-established plan.

Related standards:
IMT.01 Document management system, IMT.08 Health information technology, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, OGM.04 Scope of services, QPI.01 Quality management program, QPI.02 Performance Measures.

IMT.03 NSR.30 The mental health hospital defines standardized diagnosis codes, procedure codes, definitions, symbols, and abbreviations.

Effectiveness

Keywords:
Standardized symbols and Abbreviations.

Intent:
The main goal of using codes, symbols, and abbreviations is to downsize the writing. Uniform, consistent use of approved symbols and abbreviations across the mental health hospital
International classification of the disease (ICD) intends to define the diseases, disorders, injuries, and other related health conditions, listed in a comprehensive, hierarchical fashion that allows for sharing and comparing health information between different healthcare-providing settings. The mental health hospital shall adopt a well-recognized, evidence-based classification of diseases to ensure that codes and abbreviations are matched to those provided by national health authorities and/or 3rd party payers.

The mental health hospital shall develop a policy that defines the processes implemented to prevent and reduce the risk to patient safety. Patients and families may not be familiar with or understand the abbreviations and may not be comfortable asking for clarification. In addition, if a summary of the patient's care and treatment contains abbreviations and is sent with a patient being transferred to another health care organization, there is a risk to patient safety if the receiving organization uses some of the same abbreviations but with different meanings, or simply does not know the meanings of the abbreviations in the summary. The abbreviations policy shall address at least the following:

a) Not-to- use symbols/abbreviations list. For example; adopt a "do-not-use abbreviation list" for medication from reliable references, e.g., The Institute for Safe Medication Practices (ISMP) list, and includes at least the following:
    - U/IU
    - Q.D.,
    - QD,
    - q. o. d
    - q.o.d
    - MS
    - MSO4
    - MgSO4
    - Trailing Zero
    - No leading Zero

b) Situations where Symbols and abbreviations (even the approved list) are not allowed; such as informed consent and patient rights documents, discharge/home instructions, discharge summaries, and any record that patients and families receive from the mental health hospital about the patient's care.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for abbreviations and may interview responsible staff to check their awareness.
- The GAHAR surveyors may review a sample of medical records to check for the standardized diagnosis and procedure codes and the used abbreviations.

Evidence of compliance:

1. The mental health hospital has an approved policy for abbreviations that includes all the elements in the intent from a) through b).
2. Staff who records the patient's medical record are educated and trained on the process of the standardization and uniform use of the hospital's codes, symbols, and abbreviations.

3. There is a uniform use of standardized diagnosis and procedure codes across the mental health hospital.
4. Approved codes are matched to those provided by health authorities and/or 3rd party payers.

Related standards:
IMT.01 Document management system, IMT.06 Patient's medical record management, IMT.07 Medical Record Review, MMS.08 Medication safe ordering, prescribing, transcribing, OGM.08 Billing System

Ensuring confidentiality, integrity, and security of information

IMT.04 the mental health hospital ensures data and information confidentiality, security, and integrity.

Effectiveness

Keywords:
Confidentiality and Security of data and information.

Intent:
Patient confidentiality means that personal and medical information given to a health care provider shall not be disclosed to others unless the patient has given specific permission, for such release, the information shall be protected from being accessed by unauthorized individuals.
Maintaining data integrity is an important aspect of information management. data integrity is maintained during planned and unplanned downtime of data systems. This is accomplished through the implementation of downtime recovery tactics and ongoing data backup processes.
Patient's medical records and information are protected at all times and in all places. Including protecting it from water, fire, or other damage, and unauthorized access.
The medical records storage area must implement measures to ensure medical records protection, e.g., controlled access and suitable type of fire extinguishers
All staff must be committed to information confidentiality and security by signing an agreement that they understand the details of the confidentiality policy and procedures and know their roles well.
Egyptian laws and regulations address topics related to confidentiality, the release of patient information, and reporting of specific information to inspecting and regulatory agencies. The mental health hospital shall make the needed efforts and take steps to comply with relevant laws and regulations in the field of information management.

The mental health hospital shall develop and implement a policy and procedures to ensure data confidentiality, security, and integrity that addresses at least the following:

a. Determination of who can access (list of authorized individuals).
b. The circumstances under which access is granted.
c. Confidentiality agreements with all those who have access to patient data.
d. Procedures to follow if confidentiality or security of information has been breached
e. Procedures to secure medical report release, in accordance with the psychiatric patient care law and regulations.

Survey process guide:

- The GAHAR surveyors may review the hospital policy for data confidentiality, security, and integrity and may interview responsible staff to check their awareness of the policy.
- The GAHAR surveyors may observe the implemented measures for medical records and information protection.

- The GAHAR surveyors may review staff files to check for the signed confidentiality agreement.

Evidence of compliance:

1. The mental health hospital has an approved policy that includes all the points in the intent from a) through e).
2. All staff is aware of the policy requirements.
3. Only authorized individuals have access to patient's medical records according to the level of accessibility
4. There is a signed confidentiality agreement in each staff member's file
5. Procedures are followed if confidentiality or security of information has been violated.
6. The medical records department storage area has measures to ensure medical records and information protection.

Related standards:

IMT.02 Information management plan, IMT.06 Patient's medical record management, IMT.07 Medical Record Review, PCC.03 Patient, family, and carer rights, OGM.17 Research Patient Rights

Effective, safe document retention process.

IMT.05 The mental health hospital determines the retention time of records, data, and information.

Effectiveness

Keywords:

Retention of medical records, data, and information.

Intent:

Data, information, and medical records have an important role in patient care. The mental health hospital has to retain all types of documents for a sufficient period of time. This retention time shall be determined by the national, applicable laws and regulations.

The mental health hospital shall ensure the retention of records, data, and information is consistent with hospital confidentiality and security policy,

The mental health hospital shall develop and implement a retention policy that addresses at least the following:

a) The retention time for each type of document in accordance with national law and regulations.
b) Measures to maintain information confidentiality during the retention time.
c) Retention conditions, archival rules, and permissible means of storage, access, and encryption.
d) Data destruction methods that respect security and confidentiality measures.

Survey process guide:

- The GAHAR surveyors may review the hospital medical records policy, data, and information retention.
- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may observe the implemented measures to maintain information confidentiality during the retention time.

Evidence of compliance:

1. The mental health hospital has an approved policy of medical records, data, and information retention that includes all the items in the intent from a) through d).
2. Responsible staff is aware of the policy requirements.

3. Destruction and/ or removal of records, data, and information are done as per the hospital policy and in accordance with the applicable law and regulations.
4. The hospital has clear measures to maintain information confidentiality during the retention time.

Related standards:
IMT.01 Document management system, IMT.04 Confidentiality, and Security of data and information, IMT.06 Patient's medical record management, IMT.07 Medical Record Review, IMT.08 Health information technology.

Effective Patient Medical Record Management and Review.

IMT.06 Patient's medical record is managed effectively.

Effectiveness

Keywords:
Patient's medical record management.

Intent:
The mental health hospital has a standardized process for proper medical record flow management that include; Initiation of a patient's medical record, assigning the unique identifiers, tracking medical records movement, and storage requirements.
The main goal of developing a uniform structure of the patient's medical record is to facilitate the accessibility of data and information to provide more effective and efficient patient care.
The mental health hospital shall assign a medical record's unique number to locate, retrieve a patient's medical record easily and document the care of the patient over time, and track medical records movement and circulation through the hospital
Patient medical records are available to assist healthcare professionals in having quick access to patient information and to promote continuity of care and overall patient satisfaction.
The mental health hospital shall develop a policy for medical record management that addresses at least the following:

a) Availability of medical records within a pre-determined timeframe.
b) Medical record contents and order uniformity.
c) Medical record standardized use and storage methods.
d) A patient's medical record is released according to law and regulations
e) Management of voluminous patient's medical record.

Survey process guide:

- The GAHAR surveyors may review the hospital policy of medical record management.
- The GAHAR surveyors may interview staff to check their awareness of the policy.
- The GAHAR surveyors may observe patient medical record availability when needed by healthcare professionals within the pre-determined timeframe.

Evidence of compliance:

1. The mental health hospital has an approved policy that includes all the items in the intent from a) through e)
2. Responsible staff is aware of the policy requirements.
3. The patient's medical record contents, format, and location of entries are standardized.
4. The patient's medical record is available and accessible when needed by a healthcare provider within a timeframe described in the hospital's policy.
5. A patient medical record is initiated for every patient receiving care.

Related standards:
IMT.01 Document management system, IMT.02 Information management plan, IMT.03 Standardized symbols, and Abbreviations, IMT.04 Confidentiality and Security of data and information, IMT.05 Retention of medical records, data, and information, IMT.07 Medical Record Review.

IMT.07 Patient's medical record is reviewed effectively.

Effectiveness

Keywords:
Medical Record Review.

Intent:
Each mental health hospital shall determine the content and format of the patient medical record and has a process to assess medical record standardized content and the completeness of records. Patient medical record review is based on a sample review methodology. Random sampling and selecting approximately 5% of patients' medical records is preferable. The review process shall be conducted by authorized responsible staff. The review focuses on the timeliness, accuracy, completeness, and legibility of the medical record. Medical record review shall be done on a regular basis and in compliance with the organizational -wide quality management program; the opportunities for improvements are identified from the analysis of results when needed.

Survey process guide:
- The GAHAR surveyors may interview the responsible staff performs the medical record review to check their awareness of the process.
- The GAHAR surveyors may review monitoring results of patient medical records review and actions taken to improve the performance.

Evidence of compliance:
1. The mental health hospital has a process for tracking and monitoring data collected and analyzed from the medical record review process.
2. An authorized responsible staff performs the medical record review focusing on timeliness, accuracy, completeness, and legibility of the medical record.
3. Significant medical review results are reported to the mental health hospital's leader(s).
4. Corrective interventions are taken by the mental health hospital leader(s) when needed

Related standards:
IMT.01 Document management system, IMT.02 Information management plan, IMT.03 Standardized symbols and Abbreviations, IMT.04 Confidentiality and Security of data and information, IMT.06 Patient's medical record management, QPI.02 Performance measures.

Selection and Implementation of Health Information Technology.

IMT.08 The use of health information technology systems is safe and efficient.

Effectiveness

Keywords:
Health information technology.

Intent:
Implementation of health information technology systems can facilitate workflow; improve the quality of patient care and patient safety. The selection and implementation of health

information technology systems require coordination between all involved stockholders to ensure proper selection and integration with all interacting processes. Following implementation, an evaluation of the usability and effectiveness of the system shall be done.
A downtime event is any event where a health information technology system (computer system) is unavailable or fails to perform as designed. It significantly threatens the safety of the care delivery and interruption the care provision in addition to the risk of data loss.
The mental health hospital shall develop a policy to ensure the continuity of safe patient care processes during planned and unplanned downtime including the measures/alternatives that had been undertaken. The policy shall address the downtime recovery process to ensure data integrity.
Data backup is a copy of data that is stored in a separate location from the original, which may be used to restore the original after a data loss event, having a backup is essential for data protection. Backups shall occur regularly to prevent data loss. The mental health hospital shall ensure the backup information is secure and accessible only by those authorized to use it to restore lost data.

Survey process guide:

- The GAHAR surveyors may observe the mental health hospital health information technology systems.
- The GAHAR surveyors may interview staff to check their awareness of the health information technology systems.
- The GAHAR surveyors may review the mental health hospital policy for downtime and recovery process and may interview staff to check their awareness of the policy.

Evidence of compliance:

1. The hospital health information technology systems are selected, and implemented in collaboration with the hospital's leaders and stakeholders.
2. The hospital has an approved policy for downtime including the recovery process.
3. The staff is aware of the health information technology system and how to respond during the downtime
4. The data backup process and frequency of backup are identified according to the hospital policy.
5. The hospital tests the downtime program at least annually to ensure its effectiveness.
6. Backup data is secured during extraction, transfer, storage, and retrieval.

Related standards:
IMT.01 Document management system, IMT.02 Information management plan, IMT.04 Confidentiality, and Security of data and information, IMT.05 Retention of medical records, data, and information, QPI.02 Performance measures.

Quality and Performance Improvement

Chapter intent:
It is essential for organizations to have a framework to support continuous improvement and risk management activities. This requires leadership support, well-established processes, and active participation from all heads of departments and staff. Performance improvement and risk management are parts of both strategic and departmental operational plans.

Globally, mental health Hospitals have adopted, adapted, and even created improvement tools to help to enhance the services provided to patients. Florence Nightingale, a nurse, was one of the pioneers in improving healthcare quality. Dr. Avedis Donabedian was a founder of the study of the quality of healthcare and medical outcome research. Multiple quality improvement methodologies were used in hospitals such as PDCA, FOCUS PDCA, Six Sigma, Lean Methodology, and others.

Practically, Hospitals need to cherish the culture of continuous improvement. GAHAR standards do not mandate a specific improvement tool nor specific monitoring performance measures, yet, a minimum number of monitoring indicators are required. Among many improvement opportunities, GAHAR standards highlighted the importance of improving patient journey and supply chain. It is important that each one in the hospital understand his/her role in improving healthcare quality and safety by focusing on leadership support, department-level input and participation, measures and data collection, and sustaining improvement. The application of the standards should be according to applicable Egyptian laws and regulations.

During the GAHAR survey, surveyors are going to meet the leadership, heads of departments, and staff to discuss the QPI aspects, and projects. Surveyors may perform tracers to check data selection, collection, and analysis of data, and methods that are used to follow the improvement projects and the impact of projects on improving the quality dimensions.

Chapter purpose:
The main objective is to ensure that the hospital provides an effective performance improvement program; the chapter discusses the following objectives:

1. Effective leadership support
2. Effective departmental participation
3. Effective performance measurement and data management
4. Effective improvement and sustainability

Implementation guiding documents:
(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

1) MOH Quality and Safety Guide, 2019
2) Hospital Performance Indicators Guide by HIO, 2013
3) National EFQM-based excellence award www.Egea.gov.eg
4) National census and statistics Law, 35/1960
5) Establishment of Central Agency for Public Mobilization and Statistics Law, 2915/1964

Effective quality management program

QPI.01 The mental health hospital leaders plan, document, implement, and monitor an organizational-wide quality management program.

Effectiveness

Keyword
Quality management program.

Intent:
It is essential for organizations to have a framework for their quality management system to support continuous improvement. This requires leadership support, well-established processes, as well as active participation from all heads of departments and staff. To initiate and maintain the quality management and improvement process, leadership planning is essential. The mental health hospital leaders are included in the planning process.

The quality management program shall be integrated, comprehensive, and adequate to the size, complexity, and scope of services provided and addresses at least the following:

a) The commitment to regulatory requirements and accreditation standards.
b) The goals of the quality management program
c) The quality measures (clinical and managerial)
d) The quality management activities
e) The quality tools
f) Periodic review and update (at least annually).

Mental health hospital leaders shall assign a qualified individual to oversight and communicate the quality management activities to the leaders and responsible staff.

Survey process guide:

- The GAHAR surveyors may interview mental health hospital leaders to identify leadership's approach to developing a quality management program.
- The GAHAR surveyors may review the quality management program, related documents, and tools.
- The GAHAR surveyors may interview staff to check their awareness of the program

Evidence of compliance:

1. The mental health hospital leaders participate in planning a program for quality management.
2. The mental health hospital has a documented, updated, and approved quality management program containing the items in intent from a) to f).
3. A qualified individual with knowledge, skills, and experience in quality management, related tools, and activities is assigned to oversight the quality management program.
4. All staff is aware of the quality management program.
5. The quality management program is updated at least annually.

Related standards:
OGM.02 The Mental Health Hospital director. , OGM.03 The Mental health hospitals' leaders. IMT.01 Document management system. IMT.02 Information management plan QPI.02 Performance Measures. QPI.08 Performance improvement and patient safety plan QPI.09 Sustaining Improvement

Efficient data management and performance measurement

QPI.02 Performance measures are identified and monitored for all significant processes.

Effectiveness

Keywords:
Performance Measures.

Intent:
Performance measurement aims to monitor, evaluate, and communicate the extent to which various aspects of the health system meet their key objectives.
The performance measure is a quantitative variable that either directly measures or may indirectly reflect the quality of care provided and has to be aligned with accountability by enabling stakeholders to make informed decisions by collecting the data and being able to interpret it.
Performance measures must be Specific, Measurable, Achievable, Relevant, and Time-bounded (SMART). To define a measure properly, a description of at least the following is needed:

a) Definition
b) Defined data source
c) Specified frequency
d) Sampling techniques
e) Formula
f) Methodology of data collection and analysis

Collection of data will create a database that shall be aggregated and trended over time and used for comparison over time internally within the mental health hospital and for comparisons externally with other organizations and the performance results/data shall be made publicly available at least annually.

Survey process guide:

- The GAHAR surveyors may review the list of mental health hospital quality measures.
- The GAHAR surveyors may interview responsible staff to check their awareness of the data collection and interpretation process.
- The GAHAR surveyors may review performance measures analysis results.

Evidence of compliance:

1. There is an approved identification card for each selected performance measure, a standardized template is preferred, that includes all elements mentioned in the intent from a) through f)
2. There is a list of mental health hospital measures including both clinical and managerial processes
3. Staff responsible for the collection, interpretation, and/or use of performance measurement are aware of identification card contents.
4. The mental health hospital makes its performance results/data publicly available at least annually.
5. Results of measures analysis are regularly (at least quarterly) reported to the governing body

Related standards:
OGM.02 The Mental Health Hospital director., OGM.03 The Mental health hospitals' leaders. , IMT.02 Information management plan QPI.01 Quality management program, QPI.08 Performance improvement, and patient safety plan QPI.09 Sustaining Improvement, WFM.08 Staff Performance Evaluation.

Adverse Event Identification, Analysis, and Prevention

QPI.03 A risk management plan/program is developed

Safety

Keywords:
Risk Management Program.

Intent:
Risk management is designed to identify potential events that may affect the hospital and to protect and minimize risks to the mental health hospital property, services, and employees. The mental health hospital shall adopt a proactive approach to risk management such as risk analysis where it can assess the high-risk processes, including developing risk mitigation strategies. Plans, policies, procedures, a risk register, and processes shall support the risk management framework. The mental health hospital shall take reactive and proactive measures to address the identified risks.
A risk management plan/program contains essential components that include at least the following:

a) Scope, objective, and criteria for assessing risks
b) Risk management assigned responsibilities
c) Risk identification (risk register)
d) Risk policies and procedures that support the risk management framework.
e) Risk prioritization
f) Risk categorization (i.e. strategic, operational, reputational, financial, other)
g) Risk reporting and communication with stakeholders and governing bodies with a defined time frame.
h) Risk reduction plans and tools with priority given to high risks processes.
i) Staff training on risk management concepts and tools

The mental health hospital shall review the risk management plan/program on a regular basis as determined by the hospital's leaders and according to the results of the current risk analysis.
The mental health hospital shall review the risk management plan/program on a regular basis as determined by the hospital's leaders and according to the results of the current risk analysis.

Survey process guide:

- The GAHAR surveyors may review the risk management plan/program of the mental health hospital
- The GAHAR surveyors may review the proactive risk reduction tool for the high risks
- GARAR surveyor may review the risk register.
- The GAHAR surveyors may observe the implemented measures for risk reduction.

Evidence of Compliance

1. The mental health hospital has a risk management plan/ program that includes all the elements from a) to i) in the intent
2. High-risk processes are re-designed based on the result of the analysis.
3. The mental health hospital has an approved proactive risk reduction tool for at least one high-risk process, updated annually.
4. The risk management plan/program and the risk register are updated at least annually

Related standards:
EFS.06 Safety Management Plan, EFS.09 Pre-Construction risk assessment, EFS.08 Violence prevention program, IPC.04 Infection risk assessment, OGM.02 The Mental Health Hospital director, OGM.03 The Mental health hospitals' leaders, STP.04 Suicide prevention program, QPI.04 Incident Reporting System, QPI.07 Sentinel events.

QPI.04 An effective incident-reporting system is developed.

Safety

Keywords:
Incident Reporting System.

Intent:
Strong risk management is supported by efficient incident reporting systems that defined by the system can identify an incident that could be any event that affects patient or employee safety.
In most mental health hospitals injuries, patient complaints, medication errors, equipment failure, adverse reactions to drugs or treatments, or errors in patient care are to be included and reported. Incident reporting has an important influence on improving patient safety. They can provide valuable insights into how and why patients can be harmed at the mental health hospital level. What happens after an event is critical to the culture of safety, the first victim, is the patient and family affected by the adverse event, and attention shall be turned toward the second victim-providers involved in the adverse event, who is also the mental health hospital responsibility. Evidence suggests these second victims, if not given the correct support, can contribute to further patient safety problems; and, of course, each person in a working system affects the safety culture. The mental health hospital shall clearly define how the staff who contribute to the adverse event is treated.
The mental health hospital shall develop and implement an Incident reports policy that helps to detect, monitor, assess, mitigate, and prevent risks the policy includes at least the following:

a) Definition and classification of incidents
b) The incident management process includes how, when, and by whom incidents are reported and investigated.
c) Identify incidents requiring immediate notification to the management
d) Incident analysis tools, and results reporting
e) Indication for performing intensive analysis and its process
f) Procedures for managing adverse events consequences including the first and second victims affected.

Survey process guide:

- The GAHAR surveyors may review the incident reporting policy.
- The GAHAR surveyors may interview staff to check their awareness of the incident reporting system and the proper implementation.
- The GAHAR surveyors may check for evidence of corrective actions taken when gaps are detected.

Evidence of compliance:

1. The mental health hospital has an approved policy that defines the incident type and reporting system that include a) through f) in the intent.
2. All staff is aware of the incident-reporting system, including contracted and outsourced staff members.
3. The mental health hospital communicates with patient's/services users about adverse events they are affected by
4. Corrective actions are taken on time when gaps are detected.

Related standards:
QPI.01 Quality management program, OGM.10 Safety Culture. QPI.05 Significant process variations QPI.07 Sentinel events QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement, MMS.12 Medication Monitoring, Medication errors, adverse drug events and near misses

QPI.05 Significant process variations are easily detected, investigated, and corrected using the evidence-based methodology.

Effectiveness

Keywords:
Significant process variations.

Intent:
The mental health hospital shall collect data at regular intervals and from all areas of patient care services. Data collection should be sufficient to detect types of process variation and to determine the corrective actions needed to prevent the risk for patients. When data represent significant change (undesirable change from what is expected), intensive analysis shall be done to determine the best actions needed. Significant changes include deviations away from recognized standards, expected performance decrement, and wide variance from the performance of other similar organizations.
The mental health hospital has to perform a root cause analysis to identify actions that be taken to improve processes of care and prevent events from re-occurring.

The mental health hospital shall develop a significant variation and events policy that describes significant unexpected events that include at least the following;
a) List of significant unexpected/near misses events that can happen, such as:
   I. Patient attempted escape
   II. Significant anesthesia and sedation events that cause harm or have the potential to cause harm to a patient
   III. Significant adverse drug reactions that cause harm or have the potential to cause harm to a patient
   IV. Significant medication errors that cause harm or have the potential to cause harm to a patient.
   V. Pulmonary Embolism or Deep Venous Thrombosis developed due to missing appropriate thrombo-prophylaxis treatment and improper VTE assessment risk
b) The criteria and procedures for intensive analysis when significant unexpected events occur
c) The time required to complete the investigation and execute the required action plan.

Survey process guide:
- The GAHAR surveyors may review the mental health hospital policy that defines significant events and their management.
- The GAHAR surveyors may review evidence that ensures all significant events are analyzed and actions are taken to reduce recurrence.

Evidence of compliance:
1. The mental health hospital has a policy that describes the significant events and its intensive analysis process that include items from a) to c) in the intent.
2. All significant events (unexpected variations) are timely investigated, analyzed, and reported.
3. Corrective actions are taken with a clear time- frame, when gaps are detected.

Related standards:
QPI.01 Quality management program, QPI.02 Performance Measures. QPI.06 Near Miss events, QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement.

QPI.06 The mental health hospital has a defined process for the identification and analysis of near-miss events.

Effectiveness

Keywords:
Near Miss events.

Intent:
The mental health hospital shall collect data and information on the events identified as near miss and evaluates them to prevent their actual occurrence in the future. Near miss is defined as any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. An effective, valid, reliable reporting mechanism is implemented to determine when a proactive process is needed to reduce or eliminate the related near-miss events.

Survey process guide:

- GAHRAR surveyor may review the mental health hospital process for identification and reporting of near misses
- The GAHAR surveyors may interview staff to check their awareness of the process of near misses identification and reporting.
- The GAHAR surveyors may review evidence that near-miss events are analyzed and actions are taken to reduce recurrence.

Evidence of compliance:

1. The mental health hospital has a process for the identification and reporting of near misses.
2. All staff is aware of the near-miss identification and reporting process.
3. Near-miss events are analyzed, and actions are taken to reduce re-occurrence.

Related standards:
QPI.01 Quality management program, QPI.03 Risk Management Program ,QPI.05 Significant process variations ,QPI.04 Incident Reporting System ,QPI.07 Sentinel events, QPI.08 Performance improvement and patient safety plan

QPI.07 The mental health hospital defines investigates, analyzes, and reports sentinel events, and takes corrective actions to prevent harm and recurrence.

Safety

Keywords:
Sentinel events.

Intent:
A sentinel event is an unexpected occurrence that ends in death or ongoing morbidity or psychological injury, including loss of limb or function. A sentinel event signals an immediate investigation and response. The mental health hospital developed a policy for sentinel event management that includes at least the following:

a) Type of sentinel events that include at least the following:
    I. Unexpected mortality or major permanent loss of function not related to the natural course of the patient's illness or underlying condition
    II. Wrong patient, wrong site, wrong procedure events
    III. Patient suicide or attempted suicide
    IV. Patient self-harm or violence leading to death or permanent loss of function
    V. Transmission of a chronic or fatal disease or illness as a result of infusing blood or blood products (if applicable).

VI. Child abduction or a child sent home with the wrong parents.
VII. Discharge of a patient to the wrong family.
VIII. Patient abduction during receiving care, treatment, and services.
IX. Rape and physical harassment
X. Workplace violence such as assault (leading to death or permanent loss of function), or homicide (willful killing) of a patient, staff member, practitioner, medical student, trainee, visitor, or vendor.
XI. Any elopement (that is, unauthorized departure) leading to death, permanent harm, or severe harm.

b) Internal reporting of sentinel events.
c) External reporting of sentinel events.
d) Team member's involvement.
e) Root cause analysis.
f) Corrective actions plan taken.

All sentinel events are reported to GAHAR within seven days of the event or becoming aware of the event. All events that meet the definition must have a root cause analysis to have a clear understanding of contributing factors behind the system gaps. The analysis and action must be completed within 45 days of the event or becoming aware of the event.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital policy for sentinel events management.
- The GAHAR surveyors may review evidence of sentinel events analysis and the reporting.
- The GAHAR surveyors may review evidence of corrective actions taken to prevent the recurrence of the event.

Evidence of compliance:

1. The mental health hospital has a sentinel events management policy covering the intent from a) through f) and leaders are aware of the policy requirements.
2. All sentinel events are analyzed and communicated to the direct upper management by a root cause analysis in a time period specified by leadership as per hospital policy.
3. All sentinel events are reported to GAHAR within seven days of the event or becoming aware of the event.
4. The root cause analysis identifies the main reason(s) behind the event and the leaders take corrective action plans to prevent recurrence in the future.

Related standards:
APC.03 Accurate and complete information, QPI.01 Quality management program, QPI.05 Significant process variations QPI.06 Near Miss events, QPI.08 Performance improvement and patient safety plan, QPI.04 Incident Reporting System.

QPI.08 There is a mental health hospital-wide performance improvement, and patient safety plan.

Effectiveness

Keywords:
Performance improvement and patient safety plan.

Intent:
The mental health hospital needs to initiate and maintain improvement programs to reduce risks to patients and staff. Therefore, leadership and good planning are essential. The

hospital director is responsible for establishing and providing ongoing support mental health hospital's commitment to quality.
Leaders develop the performance improvement, and patient safety plan; the plan shall at least address the following:

a) The goal(s) (clinical and operational goals) that fulfill the hospital's mission.
b) Defined responsibilities of improvement activities and the approved reporting channels.
c) Performance measures road map selection criteria.
d) Data collection, data analysis tools, and validation process.
e) Defined criteria for prioritization and selection of performance improvement projects.
f) Quality improvement model(s) used.
g) Information flow and reporting frequency.
h) Training on quality improvement tools and methodologies.
i) Regular evaluation of the plan (at least annually).

The leaders select the approach to be used by the hospital to measure, assess, and improve quality, and patient safety, Leaders also determine how the plan will be directed and managed daily.

Survey process guide:

- The GAHAR surveyors may review the mental health hospital plan for performance improvement and patient safety.
- The GAHAR surveyors may interview responsible staff and the mental health hospital director to check for their roles in the planning, supporting, and monitoring of the performance improvement, and patient safety plan.
- The GAHAR surveyors may observe the implementation of the plan hospital-wide

Evidence of compliance:

1. There is a current and approved performance improvement, patient safety plan that defines at least items from a) to i) in the intent.
2. The mental health hospital director actively participates in the planning, supporting, and monitoring of performance improvement, and patient safety plan.
3. The plan is communicated to all relevant stakeholders.
4. The plan is implemented facility-wide, according to the timetable and plan of improvement.
5. The plan is reviewed, evaluated, and updated annually.

Related standards:
QPI.01 Quality management program, QPI.02 Performance Measures., QPI.09 Sustaining Improvement, OGM.02 The Mental Health Hospital director. , OGM.03 The Mental health hospitals' leaders, OGM.10 Safety Culture.

QPI.09 Appropriate and sustained improvement activities are performed within an approved time frame.

Effectiveness

Keywords:
Sustaining Improvement.

Intent:
Although staff plays a vital part in the continuous improvement process, it is management's role to train, empower and encourage the staff to participate with ideas.
An effective continuous improvement program needs continuous measurement and feedback.

Before starting, mental health hospital baseline performance needs to be measured, as new ideas for improving performance can then follow.
Plan-Do-Check-Check (PDCA) cycle, Focus PDCA, or other improvement tools allows for scientifically testing improvement progress.
The cycle ensures continuous improvement by measuring the performance difference between the baseline and target conditions.
This information gives immediate feedback on the effectiveness of the change that can help in measuring the impacts of a continuous improvement program and that is the most effective way of sustaining it.

Survey process guide:

- The GAHAR surveyors may review the written process for improvement.
- The GAHAR surveyors may review the improvement activities to learn how the hospital utilizes data to identify potential improvements and to evaluate actions' impact.
- The GAHAR surveyors may review the hospital monitoring and control mechanisms to sustain achieved improvements.

Evidence of compliance:

1. There is a written process of the methodology and tools used for improvement.
2. Actions to correct problems are taken timely and appropriately.
3. Improvement activities were tested and the results were recorded and implemented.
4. There is evidence that patient safety processes are improved and controlled.
5. Quality improvement activities are monitored and results are reported to the governing body on a regular basis as per the hospital's established process.

Related standards:
QPI.01 Quality management program., QPI.02 Performance Measures., QPI.08 Performance improvement and patient safety plan, OGM.02 The Mental Health Hospital director. , OGM.03 The Mental health hospitals' leaders.

Survey Activities and Readiness

Introduction:

- GAHAR survey process involves performing building tours, observations of patients' medical records, staff member files, credential files, and interviews with staff and patients.
- The survey is an information-gathering activity to determine the organization's compliance with the GAHAR standards.

Readiness Tips:

- To facilitate the completion of the survey within the allotted time, all information and documents should be readily available for the surveyors to review during the survey
- If certain staff members are missing, the team will continue to perform the survey; the appropriate missing staff members may join when they are available.
- Files may be in paper or in electronic format; however, the information should, at all times, be safe and secure from unauthorized access, up-to-date, accessible, and readily retrievable by authorized staff members.

	Activity	Timeframe	Location in survey agenda
1	Arrival and Coordination	15-30 minutes	1st day, upon arrival
2	Opening Conference	15 minutes	1st day, as early as possible
3	Hospital Orientation	30-45 minutes	1st day, as early as possible
4	Survey Planning	30 minutes	1st day, as early as possible
5	Document Review Session	60-180 minutes	
6	Patient Journey Tracer	60-90 minutes	Individual Tracer activity occurs throughout the survey; the number of individuals who surveyors trace varies by organization
7	Break	30 minutes	At a time negotiated with the organization Team Meeting/Surveyor Planning
8	Daily Briefing	15-30 minutes	Start of each survey day except the first day; can be scheduled at other times as necessary
9	Staff members file review	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the hospital
10	Environment and facility safety plans review	60-90 minutes	After some individual tracer activity has occurred; at a time negotiated with the hospital
11	Environment and facility safety tour	60-180 minutes	After environment and facility safety plans review
12	Leadership interview	60 minutes	During early or middle of survey
13	Financial Stewardship Review	60 minutes	After leadership interview
14	Patient's medical record review	60-120 minutes	Towards the end of survey

15	Medication Management Review	30-60 minutes	In the middle of survey
16	Infection Prevention and Control Review	60-90 minutes	In the middle of survey
17	Quality Program Review	60 minutes	Towards the end of survey
18	Report Preparation	60-120 minutes	Last day of survey
19	Executive Report	15 minutes	Last day of survey
20	Exit Conference	30 minutes	Last day, final activity of survey

Arrival and coordination

Why will it happen?
To start the survey process on time, The GAHAR surveyors shall use the time to review the focus of the survey in light of the submitted application.

What will happen?
The GAHAR surveyors shall arrive to the mental health hospital and may present themselves to hospital security or desk. The mental health hospital survey coordinator shall be available to welcome GAHAR surveyors.

How to prepare?
Identify a location where surveyors can wait for organization staff to greet them and a location where surveyors can consider as their base throughout the survey.
The suggested duration of this step is approximately 30 to 60 minutes. Surveyors need a workspace they can use as their base for the duration of the survey. This area should have a desk or table, internet and phone coverage, and access to an electrical outlet, if possible.
Provide the surveyors with the name and phone number of the survey coordinator

Who should collaborate?
Suggested participants include mental health hospital staff and leaders

Opening conference

Why will it happen?
This is an opportunity to share a uniform understanding of the survey structure, answer questions about survey activities and create common expectations

What will happen?
The GAHAR surveyors shall introduce themselves and describe each component of the survey agenda. Questions about the survey visit, schedule of activities, availability of documents or people, and any other related topics should be raised at this time.

How to prepare?
Designate a room or space that will hold all participants and will allow for an interactive discussion.

Who should collaborate?
Suggested participants include members of the governing body and senior leadership. Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives.

Hospital orientation
Why will it happen?

The GAHAR surveyors shall learn about the hospital through a presentation or an interactive dialogue to help focus subsequent survey activities.

What will happen?

The hospital representative (usually the hospital director or his/her designee) shall present information about the hospital.

How to prepare?

Prepare a brief summary (or a presentation) about the mental health hospital that includes at least information about:

- Mental health hospital mission, vision, and strategic goals
- Organization structure and geographic locations
- Information management, especially the format and maintenance of medical records.
- Contracted services
- Compliance with National Safety Requirements
- Hospital's patient population, most common 5 diagnoses.
- Whether the hospital has any academic or research activities.
- Whether the mental health hospital provides any home care or services outside the boundaries of the hospital facility
- Compliance with GAHAR reports and recommendations during the pre-accreditation visit period (if applicable).

Who should collaborate?

Suggested participants include the same participants as the Opening Conference.

Survey planning

Why will it happen?

To ensure the efficiency of survey time

What will happen?

Surveyors shall begin selecting patients for tracers based on the care, treatment, and services the mental health hospital provides

How to prepare?

The survey coordinator need to ensure that the following information is available for surveyors

- List of sites where deep or moderate sedation is in use
- List of sites where high-level disinfection and sterilization is in use
- List of departments/units/ areas/programs/services within the mental health hospital, if applicable
- List of patients that includes: name, location, age, diagnosis, and length of stay, admit date, point of admission.
- Lists of scheduled procedures, e.g. electroconvulsive therapy including the location of procedure and time.

Who should collaborate?

The GAHAR surveyors only.

Document review session

Why will it happen?

To help The GAHAR surveyors understand mental health hospital operations

What will happen?

The GAHAR surveyors shall review required policies (or other quality management system documents) and policy components based on GAHAR standards

How to prepare?

Survey coordinator shall ensure that all valid current and approved quality management system documents are available for review either in paper or electronic format (approval should be visible, clear, and authentic)

Use of bookmarks or notes is advisable to help surveyors find the elements being looked for

1) List of unapproved abbreviations
2) Performance improvement data from the past 12 months
3) Documentation of performance improvement projects being performed, including the reasons for performing the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
4) Patient flow documentation: Dashboards and other reports reviewed by mental health hospital leadership; documentation of any patient flow projects being performed (including reasons for performing the projects); internal throughput data collected by inpatient units, diagnostic services, and support services such as patient transport and housekeeping
5) Analysis from a high-risk process
6) Emergency Management Policy
7) Emergency management protocols
8) Annual risk assessment and Annual Review of the Program
9) Assessment-based, prioritized goals
10) Infection Control surveillance data from the past 12 months

Who should collaborate?

Survey coordinator and policy stakeholders

Patient journey tracer

Why will it happen?

Patient journey tracer is defined as an assessment, made by surveyors shadowing the sequential steps of a patient's clinical care, of the processes in an organization that guide the quality and safety of care delivered (Greenfield et al., 2012a: 495).

The GAHAR surveyors shall follow the course of care and services provided to the patient to assess relationships among disciplines and important functions and evaluate the performance of processes relevant to the individual

What will happen?

- The tracer process takes surveyors across a wide variety of services.
- The tracer methodology's use of face-to-face discussions with healthcare professionals, staff members, and patients, combined with a review of patient's medical records and the observations of surveyors
- Quality, timeliness of entries, and legibility of recording in patient's medical record is also crucial to safe, effective care because healthcare professionals rely on them to communicate with each other about treatment needs and decisions
- This shall help guide surveyors as they trace a patient's progress.
- The individual tracer begins in the location where the patient and his/her medical record are located. The surveyor starts the tracer by reviewing a file of care with the staff person responsible for the individual's care, treatment, or services. The surveyor then begins the tracer by following the course of care, treatment, or services provided to the patient from preadmission through post-discharge, assessing the interrelationships between disciplines, departments, programs, services, or units (where applicable), and the

important functions in the care, treatment or services provided which may lead to identifying issues related to care processes

- Most of the GAHAR standards can be triggered during a patient journey tracer activity which may also include interviewing staff, patients, or family members
- Staff members may be interviewed to assess organizational processes that support or may be a barrier to patient treatment and services, Communications and coordination with other staff members, Discharge planning, or other transitions-related resources and processes available through the mental health hospital, and Awareness of roles and responsibilities related to the various policies
- Patients or family members may be interviewed to assess coordination and timeliness of services provided, education, including discharge instructions, perception of care, treatment or services, understanding of instructions (e.g., diet or movement restrictions,
- medications, discharge, and healthcare professional follow-up), as applicable

How to prepare?

- Every effort needs to be exerted to assure confidentiality and privacy of patients during tracers including no video or audio recording and no crowdedness
- A surveyor may arrive in a department and need to wait for staff to become available. If this happens, the surveyor may use this time to evaluate the environment of care issues or observe the care, treatment, or services being assessed.
- All efforts will be done to avoid having multiple tracers or tours in the same place at the same time.

Who should collaborate?

Survey Coordinator and any staff member (when relevant)

Break

Why will it happen?

To allow time for a surveyor and for hospital staff to use the information learned

What will happen?

The GAHAR surveyors shall meet in their base alone

How to prepare?

Make sure that the place is not going to be used during the break time

Who should collaborate?

The GAHAR surveyors only.

Daily briefing

Why will it happen?

The GAHAR surveyors shall summarize the events of the previous day and communicate observations according to standards areas

What will happen?

The GAHAR surveyors briefly summarize the survey activities completed the previous day. The GAHAR surveyors shall make general comments regarding significant issues from the previous day and note potential noncompliance, with a focus on patient safety.

The GAHAR surveyors shall allow time to provide information that they may have missed or that they requested during the previous survey day.
*Note: Mental health hospital staff may present to surveyors information related to corrective actions being implemented for any issues of non-compliance. Surveyors may still record the observations and findings.

How to prepare?
A room shall be available to accommodate all attendees

Who should collaborate?
Suggested participants include representative(s) from governance, Hospital Director, Hospital leaders, individuals coordinating the GAHAR survey, and other staff at the discretion of hospital leaders

Staff members file review

Why will it happen?
The review of files, in itself, is not the primary focus of this session; however, the surveyor shall verify process-related information recorded in staff members' files. The surveyor shall identify specific staff whose files they would like to review.

What will happen?

- The GAHAR surveyors may ensure that a random sample of staff files is reviewed.
- The minimum number of records selected for review is 5 staff member files
- The minimum number of case file records required to be selected by the surveyor for review is no more than 5 (five) records total.
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Throughout the review process, if a big number of findings are observed, the survey team may document whether the findings constitute a level of non-compliance
- The total number of records within the six-month case period should be recorded on the review form.
- Surveyor may focus on the orientation of staff, job responsibilities, and/or clinical responsibilities, Experience, education, and abilities assessment, Ongoing education and training, performance evaluation, credentialing and privileging, and competency assessment

How to prepare?

- The hospital shall produce a complete list of all staff members including outsourced, contracted, full-timers, fixed-timers, part-timers, visitors, volunteers, and others.

Who should collaborate?
Representatives from medical management, nursing management, and human resources management teams

Environment and facility safety plans review

Why will it happen?
The GAHAR surveyors may assess the hospital's degree of compliance with relevant standards and identify vulnerabilities and strengths in the environment and facility safety plans

What will happen?

There shall be a group discussion. Surveyors are not the primary speakers during this time; they are listeners to the discussion. the surveyor shall review the Environment of Care risk categories as indicated in the hospital risk assessment and safety data analysis and actions taken by the hospital.

How to prepare?
Make sure that those responsible for environment and facility safety plans are available for discussion
Also, the following documents have to be available

- Mental health hospital licenses, or equivalent
- An organization chart
- A map of the organization, if available
- List of all sites that are eligible for the survey
- Environment and facility safety data
- Environment and facility safety Plans and annual evaluations
- Environment and facility safety multidisciplinary team meeting minutes prior to the survey
- Emergency Operations Plan (EOP) and documented annual review and update.
- Annual training

Who should collaborate?
Environment and facility safety responsible staff members such as the safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, and the person responsible for emergency management.

Environment and facility safety tour

Why will it happen?
The GAHAR surveyors observe and evaluate the hospital's actual performance in managing environment and facility risks.

What will happen?
The GAHAR surveyors may Begin where the risk is encountered, first occurs, or take a top-down/bottom-up approach.
The GAHAR surveyors may interview staff to describe or demonstrate their roles and responsibilities for minimizing the risk, what they are to do if a problem or incident occurs, and how to report the problem or incident
The GAHAR surveyors may assess any physical controls for minimizing the risk (i.e., equipment, alarms, building features), Assess the emergency plan for responding to utility system disruptions or failures(e.g., an alternative source of utilities, notifying staff, how and when to perform emergency clinical interventions when utility systems fail, and obtaining repair services), assess If equipment, alarms, or building features are present for controlling the particular risk, reviewing the implementation of relevant inspection, testing, or maintenance procedures
The GAHAR surveyors may also assess hazardous materials management, waste management, and safety or security measures.

How to prepare?
Ensure that keys, communication tools, and contacts are available, so The GAHAR surveyors may be able to access all hospital facilities smoothly
Who should collaborate?
Environment and facility safety responsible staff members such as the safety management coordinator, security management coordinator, facility manager, building utility systems

manager, information technology (IT) representative, and the person responsible for emergency management.

Leadership interview

Why will it happen?

The surveyor will learn about hospital governance and management structure and processes

What will happen?

The GAHAR surveyors address the following issues

- The structure and composition of the governing body
- The functioning, participation, and involvement of the governing body in the oversight and operation
- The governing body's perception and implementation of its role in the hospital
- Governing body members' understanding of performance improvement approaches and methods
- Pertinent GAHAR Leadership standards relevant to the governing body, direction, and leadership in the hospital including organizational culture
- Surveyors may explore, through hospital-specific examples, Leadership commitment to the improvement of quality and safety, creating a culture of safety, Robust process improvement

and Observations that may be indicative of system-level concerns

How to prepare?

The GAHAR surveyors may need a quiet area for a brief interactive discussion with hospital leaders The following documents may be reviewed during this session.

- Mental health hospital structure.
- Mental health hospital strategic plan.
- Mental health hospital ethical framework.
- Governing Body meeting minutes for the last 12 months.
- Leadership safety rounds.
- Safety culture assessment.
- Patient-centeredness initiatives Medical Staff Bylaws and Rules and Regulations
- Medical Executive Committee meeting minutes

Who should collaborate?

Required participants include at least the following: hospital director, governing body representative, clinical responsible leaders, Human resources management leader, performance improvement coordinator

Financial stewardship review

Why will it happen?

The surveyor will learn about hospital financial stewardship structure and processes

What will happen?

The GAHAR surveyors address topics related to financial stewardship such as observations noted during hospital tours and tracers, the billing process, contractor's performance, availability of staff, supplies, and equipment

How to prepare?

The GAHAR surveyors may need a quiet area for a brief interactive discussion with financial stewardship representatives

The following documents may be reviewed during this session

- List of all contracted services
- Agreement with referral laboratory, radiology, and other services
- Contractor monitoring data
- Feedback reports from payers
- Cost reduction projects
- Financial audit schedules focus, and major findings

Who should collaborate?
Required participants include at least the following:
  - hospital director
  - procurement responsible leader
  - clinical responsible leader
  - finance responsible leader

Patient's medical record review

Why will it happen?
The review of files, in itself, is not the primary focus of this session; however, the surveyor verifies process-related information through recording in patients' medical records. The surveyor identifies specific patients whose files they would like to review.

What will happen?
- The GAHAR surveyors may ensure that a random sample of the patient's medical record is reviewed.
- A sample of both open and closed cases Should be reviewed. Record review should include a random sample from each of the active and discharged cases.
- The sample selected represents a cross-section of the cases performed at the hospital.
- The minimum number of case file records required to be selected by the surveyor for review is no more than 5 (five) records total.
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Throughout the review process, if a big number of findings are observed, the survey team may document whether the findings constitute a level of non-compliance
- The total number of records within the six-month case period Should be recorded on the review form.

How to prepare?
- The mental health hospital is required to produce a log or other record of closed cases for the previous six-month period and the surveyor will select a sample of medical records to review.

Who should collaborate?
Representatives from mental health hospital medical, nursing, and other healthcare teams in addition to information management representatives.

Medication management review

Why will it happen?
The GAHAR surveyors will Learn about the planning, implementation, and evaluation of the medication management program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the mental health hospital to reduce medication errors.

What will happen?
The GAHAR surveyors will evaluate hospital medication management systems by performing system tracers. Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities, and communication among staff/units involved in the process with a focus on the management of high-risk medications, look-alike sound-alike, and medication errors

- Strengths in the processes and possible actions to be taken in areas needing improvement; with a special focus on the process for reporting errors, system breakdowns, near misses, or override, data collection, analysis, systems evaluation, and performance improvement initiatives

How to prepare?
The GAHAR surveyors may need a quiet area for a brief interactive discussion with staff who oversee the medication management program. The time may be spent where the medication is received, stored, dispensed, prepared, or administered. Medication management policies may be reviewed during this session

Who should collaborate?
Suggested participants include clinical and support staff responsible for medication management processes.

Infection prevention and control program review

Why will it happen?
The GAHAR surveyors will Learn about the planning, implementation, and evaluation of the infection prevention and control program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the mental health hospital to reduce infection.

What will happen?
The GAHAR surveyors will evaluate hospital IPC systems by performing system tracers. Discussions in this interactive session with staff include:

The flow of the processes, including identification and management of risk points, integration of key activities, and communication among staff/units involved in the process; How individuals with infections are identified, Laboratory testing and confirmation process, if applicable, Staff orientation and training activities, Current and past surveillance activity - Strengths in the processes and possible actions to be taken in areas needing improvement; Analysis of infection control data, Reporting of infection control data, Prevention, and control activities (for example, staff training, staff vaccinations and other health-related requirements, housekeeping procedures, organization-wide hand hygiene, food sanitation, and the storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment), staff exposure, Physical facility changes that can impact infection control and Actions taken as a result of surveillance and outcomes of those actions.

How to prepare?
The GAHAR surveyors may need a quiet area for a brief interactive discussion with staff who oversee the infection prevention and control process. Then time is spent where the care is provided The following documents may be reviewed during this session

- Infection prevention and control policies
- Infection control education and training records

- Infection control measures data

Who should collaborate?
Suggested participants include the infection control coordinator; healthcare professional from the infection control team; healthcare professionals from the laboratory; Safety management staff; organization leadership; and staff involved in the direct provision of care, treatment, or services.

Quality program review

Why will it happen?
The GAHAR surveyors will Learn about the planning, implementation, and evaluation of the quality management program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce risks

What will happen?
Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities, and communication among staff/units involved in the process; - Strengths in the processes and possible actions to be taken in areas needing improvement; Use of data
- Issues requiring further exploration in other survey activities;
- A baseline assessment of standards compliance.

How to prepare?
The GAHAR surveyors may need a quiet area for a brief interactive discussion with staff who oversee the quality management program. The time may be spent where improvement was implemented The following documents may be reviewed during this session

- Quality management program
- Performance Improvement projects
- Performance management measures
- Risk Management registers, records, and logs

Who should collaborate?
Suggested staff members include quality management staff, healthcare professionals involved in data collection, aggregation, and interpretation, performance improvement teams

Report preparation

Why will it happen?
To provide an opportunity for clarification and consolidation of any findings

What will happen?
Surveyors use this session to compile, analyze, and organize the data collected during the survey into a report reflecting the hospital's compliance with the standards.
Surveyors may also ask organization representatives for additional information during this session

How to prepare?

- The GAHAR surveyors may need a room that includes a conference table, power outlets, telephone, and internet coverage.

Who should collaborate?
The GAHAR surveyors only.

Executive report

Why will it happen?
To give an opportunity to brief the most relevant outcomes of the survey and help prioritization of post-accreditation activities.

What will happen?
The GAHAR surveyors will review the survey findings with the most senior leader and discuss any concerns about the report.

How to prepare?
- The GAHAR surveyors may need a quiet private area for a brief interactive discussion with the most senior leader.

Who should collaborate?
Hospital is available to most senior leaders and others at his/her discretion.

Exit conference

Why will it happen?
To thank the hospital team for participating and sharing the important findings in the accreditation journey.

What will happen?
Surveyors will verbally review the survey findings summary if desired by the most senior leader and review identified standards compliance issues.

How to prepare?
- Hospital available most senior leaders may invite staff to attend, an area that can accommodate attending staff is required.

Who should collaborate?
Suggested participants include the hospital's available most senior leader (or designee), senior leaders, and staff as identified by the most senior leader or designee.

Glossary

Abuse: Intentional mistreatment that may cause either physical or psychological injury.

Adverse drug event (ADE): This is an injury resulting from medication intervention related to a drug.

Adverse drug reaction (ADR): A response to a medication that is noxious and unintended, which occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease, or the modifications of physiological function.

Adverse effect: medical occurrence temporally associated with the use of a medicinal product, but not necessarily causally related.

Airborne: are particles ≤ 5μ in size that remain suspended in the air and travel great distances.

Antiseptics: are substances that reduce or stop the growth of potentially harmful microorganisms on the skin and mucous membranes. Or Antimicrobial substances that are applied to the skin to reduce the number of microbial flora.

Appointment The: process of reviewing an initial applicant's credentials to decide if the applicant is qualified to provide patient care services as well as the hospital's patient's need to support the hospital with qualified staff and technical capabilities.

Aseptic technique: It is a method designed to reduce the risk of microbial contamination in a vulnerable body site. This may include procedures like undertaking a wound dressing or performing an invasive procedure such as inserting a urinary catheter or preparing an intravenous infusion.

Best Possible Medication History: A complete and accurate list of all the medications that the patient is taking by using at least 2 sources of information including a client and/or family interview.

Beyond use date: the date or time after which a compounded sterile preparation (CSP) or compounded nonsterile preparation (CNSP) may not be stored or transported or used and is calculated from the date or time of compounding.

Carer: A person who provides personal care, support, and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely

because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care.

Certification: The procedure and action by which an authorized organization evaluates and certifies that a person, institution, or program meets requirements.

Chemical restraint: Occurs when medication is given primarily to control a person's behavior.

Cleaning: It is the process of removing foreign material (e.g. soil, organic material, micro-organisms) from an object.

Clinical pathway: An agreed-upon treatment regime that includes all elements of care.

Clinical guidelines Statements that help mental health healthcare professionals and patients to choose appropriate health care for specific clinical conditions. The healthcare professional is guided through all steps of consultation (questions to ask, physical signs to look for, assessment of the situation, and care to prescribe.

A communicable disease: it is a disease that is capable of spreading from one person to another through a variety of ways, including contact with blood and bodily fluids, breathing, etc.

Competence or competency: A determination of the staff's job knowledge, skills, and behaviors to meet defined expectations. Knowledge is the understanding of facts and procedures. Skill is the ability to perform specific actions, and behaviors, such as the ability to work in teams, which are frequently considered a part of competence.

Contamination: The presence of unwanted material or organism, such as an infectious agent, bacteria, parasite, or another contaminant, that is introduced to an environment, surface, object, or substance, such as water, food, or sterile medical supplies.

Contaminated textiles and laundry: OSHA define contaminated laundry as "laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Continuity: The degree to which the care, treatment, or services of individuals is coordinated among health care professionals, among organizations, and over time.

Credentialing is: The process of obtaining, verifying, assessing, and attesting the qualifications of a physician. The process determines if a staff member can provide patient care services in or for a healthcare organization. The process of periodically checking the physician's qualifications is called re-credentialing.

Credentials: Evidence of competence, current and relevant licensure, education, training, and experience. Other defined criteria may be added by a healthcare organization.

Critical results and values: Any value/result or interpretation where a delay in reporting may result in a serious adverse outcome for the patient.

Discharge summary: A section of the patient's medical record that summarizes the reasons for hospitalization, significant findings, procedures performed, treatment rendered, patient's condition on discharge, and any specific instructions given to the patient or family

Disinfectants: are substances that are applied to the surface of non-living objects in order to destroy microorganisms but not necessarily bacterial spores.

Disinfection: It is the process of reducing the number of pathogenic microorganisms, but not necessarily bacterial spores to a level that is no longer harmful to health. It may be high-level, intermediate-level, or low-level disinfection depending on the level of probable risk.

Dispensing: Preparing, packaging, and distributing to a patient a course of therapy on the basis of a prescription.

Pharmacy and Therapeutic Committee (PTC): The committee evaluates the clinical use of medications, policies for managing pharmaceutical use and administration, and manages the formulary system.

Drug Formulary: A manual containing a clinically oriented summary of pharmacological information about a selected number of medications. The manual may also include administrative and regulatory information about medication prescribing and dispensing.

Drug Recall: Is action taken at any time to call back or remove a defective or harmful drug product from the market when it is discovered to violate laws and regulations. This includes expired, outdated, damaged, dispensed but not used, and/or contaminated medications.

Drug Recall System: A system defined that alerts appropriate individuals when a company/manufacturer is calling back a drug product due to a defect in manufacturing, contamination, or being discovered to violate laws and regulations.

Emergency: An unexpected or sudden event that significantly disrupts the organization's ability to provide care, treatment, or services or the environment of care itself or that results in a sudden, significantly changed, or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity.

Emergency, life-threatening: A situation (for example, cardiac arrest, respiratory arrest) in which an individual may require resuscitation or other support to sustain life.

Epidemic infection: A higher than expected level of infection by a common agent in a defined population during a defined period.

Ergonomic hazards: are workplace situations that cause wear and tear on the body and can cause injury.

Evidence-based practices: Integrating the best research evidence with practitioner expertise and other resources, and with the characteristics, needs, values, and preferences of the population(s) served, to make decisions about how to promote health or provide care, treatment, or services.

Expired medication: is past the expiry date listed on the original packaging from the manufacturer.

Failure mode and effects analysis (FMEA): A systematic approach to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to help organizations create design improvements that shall have the most benefit. This tool assumes that no matter how knowledgeable or careful people are, errors shall occur in some situations and may even be likely to occur.

Guardian: A parent, a trustee, a conservator, a committee, or another individual or agency empowered by law to act on behalf of or be responsible for the patient or individual served.

Governing body is: the individual(s) or group that has ultimate authority and responsibility for developing policy, maintaining the quality of care, and providing for the organization management and planning for the organization.

Hand hygiene: A general term that applies to handwashing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

Handover: The transfer of responsibility for a patient and patient care that occurs in the healthcare setting. For example, in the hospital from one healthcare professional to another, from one level of care to another level, from an inpatient unit to a diagnostic or another treatment unit, and from staff to patients/families at discharge.

Hazardous materials and waste plan: The mental health hospital has written a document that describes the process it would implement for managing hazardous materials and waste from source to disposal. The plan describes activities selected and implemented by the hospital to assess and control occupational and environmental hazards of materials and waste (anything that can cause harm, injury, ill-health, or damage) that require special handling. Hazardous materials include radioactive or chemical materials. Hazardous wastes include the biological waste that can transmit disease (for example, blood, and tissues), radioactive materials, toxic chemicals, and infectious waste, such as used needles and used bandages.

Head of the department: The staff member who manages and directs the subgroups of the organization, commonly referred to as departments, services, units, or wards.

Health information: Any information, oral or recorded, in any form or medium, that is created by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse that relates to past, present, or future physical or mental health or condition; the provision of health care; or payment for the provision of health care to an individual.

Healthcare professional: He is any person working in a hospital, whether he is a physician, nurse, technician, housekeeper, administrator, etc.

HEPA filter: High-efficiency particulate air filter is defined as a filter with an efficiency of 99.97% in removing particles 0.3 microns or more in size, which makes it suitable for the prevention of airborne pathogens.

High alert medication: Medications that bear a heightened risk of causing significant patient harm when they are used in error.

High Dose Antipsychotic Therapy: - 'A total daily dose of a single antipsychotic which exceeds the upper limit stated in the BNF or summary of product characteristics (SPC) or a total daily dose of two or more antipsychotics which exceeds the summary of product characteristics or BNF maximum using the percentage method.

Hospital director: A job as a hospital director falls under the broader career that plan, directs, or coordinate medical and health services in hospitals, clinics, managed care organizations, public health agencies, or similar organizations.

Healthcare-associated infections (HAI) : Any infection(s) acquired by a patient while receiving care or services in a healthcare organization. Common HAIs are urinary infections, surgical wound infections, pneumonia, and bloodstream infections.

Hygiene: The practice that serves to keep people and environments clean and prevent infection.

Immunization: is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine (active immunization) or serum-containing desired antibodies (passive immunization). Vaccines stimulate the immune system to protect the person against subsequent infection or disease. Infection control practitioner.

Infection control program: An organized system of services designed to meet the needs of the hospital in relation to the surveillance, prevention, and control of infection, which impacts patients, staff, physicians, and/or visitors.

Infection The transmission of a pathogenic microorganism.

Interdisciplinary An approach to care, treatment, or services that involves two or more disciplines or professions (for example, social work, nursing, spiritual support, psychology, psychiatry, music, or art therapy) collaborating to plan, treat, or provide care, treatment, or services to an individual served and/or that person's family.

Inventory A written list of all the objects, abilities, assets, or resources in a particular place.

Investigational drug A chemical or biological substance that has been tested in the laboratory and approved for testing in people during clinical trials.

Compulsory treatment People who have illnesses stoped from recognizing that they need help, and they may be at risk to themselves or others, they may need to be assessed for treatment without their agreement.

IPC committee The Infection Control Committee is generally comprised of members from a variety of disciplines within the healthcare facility; bringing together individuals with expertise in different areas of healthcare.

Job description Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.

Just Culture is a system that holds itself accountable, holds staff members accountable and has staff members who hold themselves accountable. In a Just Culture, shared responsibility is the norm, and a commitment to eliminating the possibility of error is widespread Just Culture.

Laws and regulations Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.

Leader A person who sets expectations plans and implements procedures to assess and improve the quality of the mental health hospital governance, management, clinical, and support functions and processes.

Legibility The possibility to read or decipher. The writing is clearly written so that every letter or number cannot be misinterpreted. It is legible when any ONE individual can read the handwritten documentation or physician order.

Licensure A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as medicine, nursing, psychiatry, psychology, Clinical counseling, or clinical social work) or the operation of activity in a health care occupancy (for example, skilled nursing facility, residential treatment center, hospital).

Look-alike Sound-Alike medications These are medications that are visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics.

Medical staff bylaws Regulations and/or rules adopted by the medical staff and the governing body of the hospital for governance, defining rights and obligations of various officers, persons, or groups within the medical staff's structure.

Medical staff Licensed physician and licensed dentist.

Medication Any prescription medications including narcotics; herbal remedies; vitamins; nutraceuticals, over-the-counter medications; vaccines; biological, diagnostic, and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood products; medication containing products, and intravenous solutions with electrolytes and/or medications. The definition of the medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases unless explicitly stated.

Medication error Any preventable event that may cause inappropriate medication use or endangers patient safety. Examples are wrong patient, medication, dose, time, and the route; incorrect ordering, dispensing, or transcribing; missed or delayed treatments. Any professional/discipline/staff who handles medications can be involved in the error.

Medication Management: Medication management is defined as patient-centered care to optimize safe, effective, and appropriate drug therapy. Care is provided through collaboration with patients and their healthcare teams.

Medication reconciliation is a formal process that has been demonstrated to improve the continuity of medicines management.

Medical history A record consisting of an account of an individual's physical health History, obtained whenever possible from the individual, and including at least the Following information: chief complaint, details of the present illness or care needs, Relevant past history, and relevant inventory by body systems.

Multidisciplinary team A group of staff members composed of representatives from a range of professions, disciplines, or service areas.

N95 respirator it is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (0.3 microns) test particles.

Near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.

Non-ionizing radiation Non-ionizing radiation is any kind of radiation in the electromagnetic spectrum that does not have enough energy to remove an electron from an atom and turn it into an ion, so Non-ionizing radiation can generate heat.

Ordering is written directions provided by a prescribing practitioner for a specific medication to be administered to an individual. The prescribing practitioner may also give a medication order verbally to a licensed person such as a pharmacist or a nurse.
Outbreak An excess over the expected (usual) level of a disease within a geographic area; however, one case of an unusual disease may constitute an outbreak.

Pediatric: An infant older than 1 month to children and adolescents up to young adulthood.

Personal protective equipment it is equipment worn to minimize exposure to hazards that cause serious workplace injuries and/or illnesses.

Performance measures it is a quantifiable measures used to evaluate the success of mental health hospital employees, etc.

Plan of care A plan that identifies the patient's care needs lists the strategy to meet those needs, records treatment goals and objectives, defined criteria for ending interventions, and

records the patient's progress in meeting specified goals and objectives. It is based on data gathered during patient assessment.

Plan A detailed method, formulated beforehand that identifies needs lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies, procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.

Policy is a guiding principle used to set direction in a hospital.

Practice guidelines Tools that describe processes found by clinical trials or by consensus opinion of experts to be the most effective in evaluating and/or treating a patient who has a specific symptom, condition, or diagnosis, or describe a specific procedure. Synonyms include practice parameters, protocol, preferred practice pattern, and guidelines. Also, see evidence- (scientific) - based guidelines and clinical practice guidelines.

Practitioner: A licensed healthcare professional who is authorized within the institution to prescribe, dispense, or administer medications, such as a physician, physician assistant, CRNA, certified anesthesiologist assistant, nurse practitioner, nurse (including a circulating nurse, scrub nurse), pharmacist, or respiratory therapist.

Prescribing advising and authorizing the use of a medication or treatment for someone, especially in writing.

Prescriber A practitioner authorized by law and organizational policy to order medications for individuals served.

Privileging The process whereby specific scope and content of patient care services (clinical privileges) are authorized for a healthcare professional by the organization, based on the evaluation of the physician's credentials and performance.

PRN Latin abbreviation (Pro re nata) is frequently used to denote whenever necessary or As needed.

Processing All operations performed to render a contaminated reusable or single-use (disposable) device ready again for patient use. The steps may include cleaning and disinfection/sterilization. The manufacturer of reusable devices and single-use devices that are marketed as non-sterile should provide validated reprocessing instructions in the labeling.

Procurement The process of acquiring supplies, including those obtained by purchase, donation, and manufacture. It involves efforts to quantify requirements, select appropriate procurement methods, and prequalify suppliers and products. It also involves managing

tenders, establishing contract terms, assuring medication quality, obtaining the best prices, and ensuring adherence to contract terms.

Project A planned set of interrelated tasks to be executed over a fixed period and within certain costs and other limitations.

Protocol A detailed scientific treatment plan for using a new treatment.

Psychotherapy (sometimes called “talk therapy”) is a term for a variety of treatment techniques that aim to help a person identify and change troubling emotions, thoughts, and behavior.

Psychotropic medication is Any medication that affects the central nervous system and that is prescribed with the intention of affecting psychological processes such as perception, mental status, or behavior. Examples of classes of psychotropic medications include antipsychotics, antidepressants, anxiolytics, hypnotics, and sedatives.

The research ethics committee (REC) Reviews research proposals and gives an opinion about whether the research is ethical.

Recovery in the mental health care context is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability.

Referral The sending of a patient from one clinician to another clinician or specialist or from one setting or service to another or another resource.

Respiratory hygiene This comprises infection prevention measures designed to limit the transmission of respiratory pathogens spread by droplets or airborne routes.

Restraint The restriction of an individual’s freedom of movement by physical or mechanical means.

Risk assessment The identification, evaluation, and estimation of the levels of risks involved in a situation, their comparison against benchmarks or standards, and determination of an acceptable level of risk.

Root cause analysis A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

Safe injection It is a practice intended to prevent needle stick injuries and other possible contamination during syringe introduction in a patient; ultimately preventing transmission of blood-borne infectious diseases between one patient and another or between a patient and a healthcare professional.

Sanitation is a condition concerning public health, especially indicating the provision of clean drinking water and adequate sewage disposal.

Scope (care or services) The range and type of services offered by the hospital and any conditions or limits to the service coverage.

Seclusion The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behavior that is likely to cause harm to others.

Sentinel event A patient safety event (not primarily related to the natural course of an Illness or underlying condition of an individual served) that reaches an individual served and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.

Side effect is the pharmacological effect of a medication, normally adverse, other than the one(s) for which the medication is prescribed.

Single-use device Also referred to as a disposable device it is intended for use on one patient during a single procedure. It is not intended to be reprocessed (cleaned and disinfected or sterilized) and used on another patient. Using disposable items improves patient safety by eliminating the risk of patient-to-patient contamination because the item is discarded and not used on another patient (According to the Food and Drug Administration).

Spaulding classification is a method of classification of the different medical instrumentation based on device usage and body contact into three categories, critical, semi-critical, and non-critical dictated by the infection risk involved in using it.

Standing orders are standardized prescriptions for nurses to implement to any patient in clearly defined circumstances without the need to initially notify a provider.

Sterilization is the use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacterial endospores.

Stock A quantity of something accumulated, as for future use, regularly kept on hand, as for use or sale; staple; standard.

Substance use disorder (SUD) is a complex condition in which there is uncontrolled use of a substance despite harmful consequences.

Surveillance A systemic and ongoing method of data collection, presentation, and analysis, followed by dissemination of that information to those who can improve outcomes.

Therapeutic duplication One person using two medications, usually unnecessarily, from the same therapeutic category at the same time.

Timeliness The time between the occurrence of an event and the availability of data about the event. Timeliness is related to the use of the data.

Time-out: A formal process of active communication among all team members involved in a medical and/or surgical procedure, during which, immediately prior to the procedure, all team members pause to review a standardized checklist to confirm key aspects of the procedure, such as verification of the patient, the procedure being performed, procedure laterality, medications to be administered, and a patient monitoring and rescue plan.

Transcribing the legitimate copying of prescription information from one source to another without any alterations or additions.

Tracer methodology A process surveyors use during the on-site survey to analyze an organization's systems or processes for delivering safe, high-quality care, treatment, or services by following an individual served through the organization's care, treatment, or services in the sequence experienced by each individual. Depending on the setting, this process may require surveyors to visit multiple programs and services within an organization or within a single program or service to "trace" the care, treatment, or services rendered.

Transmission-based precautions Infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are Specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, and a combination of these.

Utilization The use, patterns of use, or rates of use of specified healthcare services. Overuse occurs when a healthcare service is provided under circumstances in which its potential for harm exceeds the possible benefits. Underuse is the failure to use a necessary healthcare service when it would have produced a favorable outcome for a patient. Misuse occurs when an appropriate service has been selected, but a preventable complication occurs. All three reflect a problem in the quality of healthcare. They can increase mortality risk and diminish the quality of life.

Variation The differences in results obtained in measuring the same event more than once. The sources of variation can be grouped into two major classes' common causes and special causes. Too much variation often leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services.

Violence A range of behaviors or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear.

Youth A person of age has not reached the age of majority, or as identified by law and regulation.

Survey A key component in the accreditation process whereby a surveyor(s) conducts an on-site evaluation of an organization's compliance with General Authority of accreditation and Regulation (GAHAR).

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