الهيئة العامة للاعتماد والرقابة الصحية
GAHAR

GAHAR HANDBOOK FOR

HOSPITAL REGISTRATION REQUIREMENTS



VERSION 2
EFFECTIVE MAY 1ST 2021

HOSPITAL REGISTRATION REQUIREMENTS

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EFFECTIVE MAY 1ST 2021

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تقـــــديم

إن الهـدف الأسـمى مـن الرعايـة الصحيـة هـو تقديـم الخدمـات الصحيـة عاليـة الجـودة إلـى جميـع مـن يحتاجهـا بالكيفيـة المناسـبة وفـي التوقيـت المناسـب. وتعتمـد جـودة الرعايـة الصحيـة علـى مسـتوى القيمـة الـذي تقدمـه المنشـآت الصحيـة لجميـع المتعامليـن معهـا وفـي نطـاق الخدمـات الخـاص بهـا.

وتأتـي متطلبـات التسـجيل للمستشـفيات ٢٠٢١ ضمـن مجموعـة مـن إصـدارات الهيئـة العامـة للاعتمـاد والرقابـة الصحيـة فـي إطـار التأكيـد علـى جهـود كافـة أجهـزة الدولـة ومؤسسـاتها فـي المضـي قدمـاً نحـو تحقيـق (رؤيـة مصـر ٢٠٣٠) وأهدافهـا وخاصـة الارتقـاء بجـودة حياة المواطـن المصـري وتحقيـق العدالـة فـي الحقـوق والفـرص. وذلـك مـن خـلال تحقيـق الحـد المقبـول مـن مسـتويات الجـودة فـي الرعايـة الصحيـة وسـلامة الإنسـان فـي كافـة المستشـفيات فـي مصـر.

تعتمـد متطلبـات التسـجيل للمستشـفيات ٢٠٢١ علـى أربعـة محـاور رئيسـية وهـي: الإشـتراطات الأساسـية، المتطلبـات الوطنيـة للسـلامة، متطلبـات الجـودة الأساسـية والدليـل التشـغيلي. كمـا تعتمـد فـي مرجعيتهـا بشـكل أساسـي علـى القوانيـن واللوائـح ذات الصلـة فـي رؤيـة مصـر ٢٠٣٠ وكذلـك علـى معاييـر الهيئـة العامـة للاعتمـاد والرقابـة الصحيـة للمستشـفيات ٢٠٢١ والمعتمـدة مـن الجمعيـة الدوليـة لجـودة الرعايـة الصحيـة (الإسـكوا) بتاريـخ فبرايـر ٢٠٢١.

علمـاً بـأن حصـول المستشـفيات علـى التسـجيل وفقـاً لهـذه المتطلبـات يعـد الخطـوة الرئيسـية نحـو وصـول تلـك المستشـفيات إلـى المرحلـة الأكبـر والأهـم فـي سـبيل تحقيـق جـودة الرعايـة الصحيـة وهـو الحصـول علـى الاعتمـاد وفقـاً لمعاييـر المستشـفيات ٢٠٢١.

نظام تسجيل/اعتماد المنشآت الصحية

استناداً إلى قانون رقم (٢) لسنة ٢٠١٨ بشأن نظام التأمين الصحي الشامل والصادر يناير ٢٠١٨ ولائحته التنفيذية الصادرة بقرار رئيس مجلس الوزراء في مايو ٢٠١٨ وقرار رئيس مجلس الوزراء رقم ٢٠٤٠ لسنة ٢٠١٨ بتشكيل مجلس إدارة الهيئة العامة للاعتماد والرقابة الصحية.

ملاحظة: تعريف المنشآت الطبية كما ورد بالقانون رقم ٢ لسنة ٢٠١٨.

وفي إطار الخطوات الحثيثة والمتلاحقة التي تخطوها الدولة نحو تنظيم القطاع الصحي بما يضمن سلامته واستقراره وتحسين جودته وتأكيد الثقة في جودة مخرجات الخدمات الصحية بجمهورية مصر العربية على كافة المستويات المحلية والإقليمية والدولية؛ فقد قرر مجلس إدارة الهيئة العامة للاعتماد والرقابة الصحية ما يلي:

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

أ. تحقق الاشتراطات الأساسية للمنشآت الصحية.
ب. تحقق المتطلبات الوطنية للسلامة بالمنشآت الصحية بما يضمن سلامة المرضى والمرافقين والزوار والعاملين بتلك المنشآت.
ج. تحقق متطلبات الجودة الأساسية بما يضمن كفاءة وفعالية الخدمة الصحية ورضا المنتفعين من الخدمة.
د. تحقق متطلبات دليل تشغيل للمنشأة الصحية بما يحقق أداءاً احترافياً مستقراً للمنشأة في كافة أقسامها وعلى كافة مستويات تقديم الخدمة بها في جميع الأوقات وجميع الحالات.

ثانياً: تلتزم المنشآت المسجلة بالهيئة بالتقدم للحصول على اعتماد الهيئة خلال موعد أقصاه ثلاث سنوات من تاريخ دخول المحافظة نطاق تنفيذ قانون التامين الصحي الشامل او ثلاث سنوات من تاريخ التسجيل للمنشآت بالمحافظات التي لم تدخل نطاق تطبيق القانون وذلك من تاريخ التسجيل وإلا اعتبر التسجيل لاغياً.

ثالثاً: تكون مدة تسجيل المنشأة سنة ميلادية قابلة للتجديد مع مراعاة احكام ما ورد في البند السابق.

رابعاً: تقوم الهيئة العامة للاعتماد والرقابة الصحية بتعريف وتوعية الأطراف المعنية بإجراءات تسجيل المنشآت الصحية وفق خطة محددة ومفهوم لا يتعارض مطلقاً مع أي من القواعد الحاكمة لمبدأي الشفافية وتجنب تضارب المصالح.

خامساً: متطلبات تسجيل المستشفيات:

أ. الإشتراطات الأساسية.
ب. المتطلبات الوطنية للسلامة.
ج. متطلبات الجودة الأساسية.
د. الدليل التشغيلي.

سادساً: يكون تسجيل المنشأة وفقا لمجال الخدمات المقدمة مع طلب التسجيل. يجب ابلاغ الهيئة بحدوث أي تغيير في مجال الخدمات المقدمة (اضافة خدمة جديدة أو إلغاء خدمة قائمة أوزيادة حجم خدمة قائمة بأكثر من ١٥٪) كتابياً على البريد الالكتروني reg@gahar.gov.eg. خلال شهر على الأقل قبل تنفيذ هذا التغيير.

سابعاً: في حالة حدوث خطأ/ حدث جسيم sentinel event يتم ابلاغ الادارة العامة لتسجيل واعتماد المنشآت الصحية خلال ٧ أيام من وقوعه أو من الإعلام به على البريد الالكتروني reg@gahar.gov.eg. على أن يتم موافاتها بالتحليل الجذري لأسباب وقوع الخطأ/ الحدث الجسيم في موعد أقصاه ٤٥ يوماً من تاريخ حدوث الخطأ/ الحدث الجسيم أو من الإعلام به (التعريف الوارد بالمعيار QPI.13 ص131) مرفقاً به الخطة التصحيحية لمنع/ الحد من تكراره حسب طبيعة الحدث.

ثامنـا: تلتـزم المنشـأة بتسـجيل ٦٠٪ مـن كل فئـة مـن أعضـاء المهـن الطبيـة علـى الأقـل قبـل الزيـارة التقييميـة علـى أن يتـم اسـتكمال تسـجيل الباقـي خـلال ثلاثـة أشـهر مـن تاريـخ التسـجيل.

تاسعاً: تكون المنشأة عرضة لتعليق التسجيل لمدة لا تزيد عن ستة أشهر، في الحالات التاليه:

١. وُجدت أحداث جسيمه تتعلق بسلامة المرضى أو العاملين أو الزوار لم يتم ابلاغ الهيئة عنها كما ورد في البند (سابعاً).
٢. عدم اجتياز المنشأة المسجلة زيارة تقييمية غير معلنة وفقاً لقواعد اتخاذ القرار.
٣. عدم تطابق بيانات المنشأة المسجلة في طلب التسجيل مع الوضع الحالي للمنشأة عند زيارات التقييم الغير معلنة.
٤. في حال لم يتم ابلاغ الهيئة بحدوث أي تغيير في مجال الخدمات المقدمة (اضافة خدمة جديدة أو إلغاء خدمة قائمة أوزيادة حجم خدمة قائمة بأكثر من ١٥٪) خلال شهر على الأقل قبل تنفيذ هذا التغيير.
٥. الإخلال بالإشتراطات الأساسية للتسجيل.
٦. الإخلال بما جاء في البند (ثامناً).

عاشراً: مع عدم الإخلال بما ورد بالقانون رقم ٢ لسنة ٢٠١٨ ، تكون المنشأة عرضة لإلغاء التسجيل في الحالات التالية:

١. اكتشاف أي تلاعب أو تزوير أثناء عمليات التقييم أو بعدها أو ثبوت عدم صحة الوثائق المرفقه والمقدمه من المنشأة.
٢. إعاقة المنشأة لعمل فرق الرقابة الصحية مثل إعاقة الحصول على الوثائق والبيانات ذات الصلة بمجال عمل الرقابة الصحية أو الدخول للأماكن والخدمات في نطاق التدقيق والتفتيش.
٣. لم تتمكن المنشأة من اجتياز زيارة الفرصه الثانيه في حالة التسجيل المشروط.
٤. رفض المنشأة المسجلة استقبال فريق المراجعين في الزيارات التقييمية المعلنة / الغير معلنة.
٥. إلغاء ترخيص المنشأة أو صدور قرار إدارى أو حكم قضائى بغلقها مؤقتا أو نهائيا.
٦. نقل المنشأة من مكانها الوارد بإستمارة التسجيل أو في حالة هدم المنشأة أو إعادة بناؤها.
٧. تجاوز المدة المقررة لتعليق التسجيل كما جاء في البند (تاسعاً) دون تصحيح أسباب تعليق التسجيل.

خطوات تسجيل المنشأة الصحية لدى هيئة الاعتماد والرقابة الصحية:

١. تتقدم المنشأة بطلب التسجيل لدى الهيئة، وذلك عن طريق ملء وتقديم الإستمارة المخصصة لذلك.
٢. تقوم الهيئة بدراسة الطلب المقدم من المنشأة والرد عليها ببيان بمتطلبات ورسوم التسجيل لتلك المنشأة.
٣. تقوم المنشأة صاحبة الطلب بدفع رسوم التسجيل وتسليم الوثائق اللازمة لهيئة الاعتماد والرقابة الصحية وفقاً لمتطلبات التسجيل الواردة في رد الهيئة في البند السابق.
٤. تقوم الهيئة بمراجعة الوثائق المستلمة من المنشأة والتأكد من اكتمالها ومخاطبة المنشأة لاستكمال وتقويم ما ترى الهيئة ضرورة استكماله وتقويمه من الوثائق اللازمة لإتمام عملية التسجيل.
٥. بعد التأكد من اكتمال جميع الوثائق المطلوبة في البند (٣) تقوم الهيئة بتحديد موعد لإجراء زيارة للمنشأة للتدقيق والتحقق من البنية والعمليات المرتبطة بالوثائق المقدمة من المنشأة.
٦. يقوم فريق من المراجعين بزيارة التقييم والتحقق للمنشأة.

إعاده التسجيل:

- إذا لم تتقدم المنشأه المسجله للاعتماد خلال السنه الأولى من تاريخ قبول التسجيل، يكون لها الحق في طلب إعادة التسجيل لمدة عام أخر على أن يتم إحتساب الفتره الزمنيه ابتداءاً من تاريخ تسجيل المنشأة (في حال انها لم تكن من المحافظات التي دخلت نطاق تطبيق منظومة التأمين الصحي الشامل) أو تاريخ دخول المحافظه التابعه لها المنشأة إلي منظومة التأمين الصحي الشامل.
- طبقاً للقانون رقم (٢) لسنة ٢٠١٨ يتم تقييم المنشأت التي انتهت صلاحية تسجيلها لدى الهيئة لإعادة التسجيل (لمدة/لمدد) أخرى بحد أقصى ثلاث سنوات من تاريخ دخول المحافظة نطاق تنفيذ قانون التأمين الصحي الشامل أو من تاريخ أول تسجيل لدى الهيئة (أيهما أقرب).

إشتراطات عامة

١. تلتزم المنشأة بصحة الوثائق والبيانات المقدمة في جميع مراحل عملية التسجيل و في حال ثبوت عدم صحة الوثائق المقدمة في أي مرحلة من مراحل الزيارة تكون المنشأة عرضة لإلغاء الزيارة التقييمية.
٢. تلتزم المنشأة بعدم استخدام أي شهادة أو شعار للهيئة بصورة مُضللة.
٣. تلتزم المنشأة بعدم إعطاء بيانات مُضللة تسيء لشهادة التسجيل الصادرة من الهيئة.
٤. تلتزم الهيئة بإبلاغ المنشأة بالقرار خلال فترة لا تزيد عن ١٥ يوم عمل من تاريخ انتهاء أعمال التقييم.
٥. يحق للهيئة إعلام المجتمع بنتائج التسجيل أو تعليقه أو إلغائه حسب متطلبات قانون رقم ٢ لسنة ٢٠١٨.

Look Back Period

Surveyors are required to review the hospital's compliance with the registration requirements over a look back period.

A look back period is the period before the survey visit during which any hospital should comply with the registration requirements. Failure to comply with this rule shall affect the registration decision.

A hospital seeking initial registration should comply with registration requirements for at least **one month** before the surveyors' visit.

Hospital seeking re-registration should comply with registration requirements for the whole period from the initial registration till the re-registration survey.

Scoring System

Scoring of Basic Requirements

Hospitals are either compliant or noncompliant with the basic requirements.
The compliance is assessed before the survey.
The noncompliance may result in being non-eligible for GAHAR registration/accreditation survey.

Scoring of National Safety Requirements (NSRs)

During the survey visit, each NSR is scored for the evidence of compliance (EOC). These are mathematical rules that depend on summation and percentage calculation of scores of each EOC as follows:

- **Met:** when the hospital shows 80% or more compliance with requirements during the required lookback period with a total score of 2.
- **Partially met:** when the 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 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 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.

Example:
Evidences of compliance of NSR.01:

1. The 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 aware of hospital policy.
3. The patient's identification occurs according to the policy.

In this example; 2nd and 3rd evidences of compliance are dependent on the 1st one.

Scoring of each NSR 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 but not less than 50%.
- **Not met:** when the average score of the applicable EOCs of this standard is less than 50%.
- **Not applicable:** when the surveyor determines that all EOCs are not applicable.

Scoring of the Essential Quality Requirements (EQRs)

During the survey visit, each EQR is scored for the evidence of compliance (EOC). These are mathematical rules that depend on summation and percentage calculation of scores of each EOC as follows:

- **Met:** when the hospital shows 80% or more compliance with requirements during the required lookback period with a total score of 2.
- **Partially met:** when the 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 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 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 EQR 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 but not less than 50%.
- **Not met:** when the average score of the applicable EOCs of this standard is less than 50%.
- **Not applicable:** when the surveyor determines that all EOCs are not applicable.

Scoring of the Operating Manual

Surveyors review random sample of at least 10 documents other than those required for NSRs and EQRs to evaluate the percentage of the minimum contents covered in the operating manual (when applicable) as follows:

- **Met:** when the hospital shows 80% or more compliance with the minimum contents with a total score of 2.
- **Partially met:** when the hospital shows less than 80% but more than or equal to 50% compliance with the minimum contents with a total score of 1.
- **Not met:** when the hospital shows less than 50% compliance with the minimum contents with a total score of 0.
- **Not applicable:** when the surveyor determines that, the requirements are out of the organization scope (the score is deleted from the numerator and denominator)

NB. Only approved current documents are considered valid for evaluation.

Overall scoring

Relative weight of different sections:

- NSRs constitute 45% of the total score.
- EQRs constitute 45% of the total score.
- Operating manual constitutes 10% of the total score.

Registration Decision Rules

1st Decision: Status of registration for one year

- Compliance to basic requirements, and
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is 80% or more, and
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is not less than 80%, and
- No single national safety requirement (whole standard) is scored not met.

2nd Decision: Status of registration that requires passing the 2nd survey visit within 6 months (conditioned registration)

- Compliance to basic requirements, and
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is 70% to less than 80%, or
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is 70% to less than 80%, or
- No more than one national safety requirement (whole standard) is scored not met.

NB. The hospital can be registered under terms and conditions of "conditioned registration" only once.

3rd Decision: Status of registration that requires passing the 2nd survey visit within 4 months (conditioned registration).

- Compliance to basic requirements, and
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is 60% to less than 70%, or
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is 60% to less than 70%, or
- No more than two national safety requirements (whole standards) are scored not met.

NB. The hospital can be registered under terms and conditions of "conditioned registration" only once.

4th Decision: Denial of registration

- Non-compliance to basic requirements, or
- Overall compliance of the 3 requirements' sections (section 2 to section 4) is less than 60%, or
- Compliance score of each individual section of the 3 requirements' sections (section 2 to section 4) is less than 60%, or
- More than two national safety requirements (whole standards) are scored not met, or
- The presence of any imminent life threatening situation that is detected by the survey team and agreed upon by the accreditation committee.

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 hospitals to interpret the standards: Process, Policy, Procedure, Program, Plan, Guideline, Protocol Whenever 'Process' is used in a standard, it indicates a requirement that is necessary to follow.

- Process: A series of actions or steps taken in order 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.
- 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, dentistry, and other independent practitioners.

Section 1: Basic Requirements

Reading and Interpretation of Basic Requirements

- For an organization seeking GAHAR registration/re-registration and accreditation/re-accreditation, compliance with the basic regulatory requirements are submitted to reg@gahar.gov.eg. to be assessed before the on-site survey.
- This section consists of basic regulatory requirements for participation in the GAHAR registration process as an initial step for GAHAR full accreditation.

Compliance to current relevant laws and regulations and their updates as follows:

مستشفى حكومى

١. ترخيص تداول النفايات الخطرة
٢. ترخيص بنك الدم
٣. ترخيص أجهزة الآشعة المؤينة
٤. ترخيص استخدام الليزر
٥. ترخيص وحدة غسيل كلوى
٦. ترخيص وحدة قسطرة قلب
٧. ترخيص استخدام المواد المشعة
٨. شهادة مطابقة اشتراطات الحماية المدنية
٩. ترخيص المصاعد
١٠. ترخيص المولدات الكهربية

مستشفى خاص أو تابع لجهة غير حكومية

١. ترخيص المستشفى
٢. ترخيص تداول النفايات الخطرة
٣. ترخيص الصيدلية
٤. ترخيص المعمل
٥. ترخيص بنك الدم
٦. ترخيص أجهزة الآشعة المؤينة
٧. ترخيص استخدام الليزر
٨. ترخيص وحدة غسيل كلوى
٩. ترخيص وحدة قسطرة قلب
١٠. ترخيص استخدام المواد المشعة
١١. ترخيص مركز علاج طبيعى
١٢. شهادة مطابقة اشتراطات الحماية المدنية
١٣. ترخيص المصاعد
١٤. ترخيص المولدات الكهربية

مستشفى حكومي أو خاص به قسم طب نفسى

- موافقة المجلس الإقليمى للصحة النفسية

NB. For references; please check the annex.

Section 2: National Safety Requirements

► Reading and Interpretation of National Safety Requirements (NSRs)

National Safety Requirements is to enhance the individual's safety in hospitals. The General Authority for Healthcare Accreditation and Regulation (GAHAR) selected the standards that may affect the individual's safety to establish them as basic requirements for hospitals looking for enrollment in the Universal Health Insurance system.

As a part of GAHAR registration process, hospitals have to show commitment to patient safety. This requires compliance with each of the national safety requirements (NSRs). During the registration surveys, surveyors evaluate consistent implementation of each of the NSRs in all relevant practices.

- 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, and evidence of compliance.
- Standard statement:
  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:
  The standard keywords are meant to help hospitals understand the most important element(s) of standard statements, as these are words or concepts of great significance. Keywords answer the question of what the standard is intended to measure.
- Intent:
  The intent is meant to help hospitals 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 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 hospitals 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.
- Survey process guide:
  Facilitates and assists the surveyors in the standards' ratings for the required EOCs.

- Evidence of compliance (EOC):
  - The EOC of a standard indicates what is reviewed and assigned a score during the on-site survey process.
  - The EOCs for each standard identify the requirements for full compliance with the standard as scoring is done in relation to met EOCs.

► National Safety Requirements

NSR	Keyword
General Patient Safety	
NSR.01	Patient identification
NSR.02	Verbal and telephone order
NSR.03	Hand hygiene
NSR.04	Catheter and tube misconnection
NSR.05	Fall screening and prevention
NSR.06	Pressure ulcer prevention
NSR.07	Handover communication
NSR.08	Critical alarms
NSR.09	Recognition of and response to clinical deterioration
NSR.10	Venous thromboembolism prophylaxis
NSR.11	Critical results
Medication Management and Safety	
NSR.12	Abbreviations
NSR.13	Medication reconciliation
NSR.14	Medication storage and labeling
NSR.15	High alert medication and concentrated electrolytes
NSR.16	Look-Alike and sound-alike medications
Surgery, Anesthesia and Sedation	
NSR.17	Surgical site marking
NSR.18	Pre-operative checklist
NSR.19	Timeout
NSR.20	Instrument retention prevention
Environmental and Facility Safety	
NSR.21	Fire safety
NSR.22	Fire drill
NSR.23	Hazardous material safety
NSR.24	Safety management plan
NSR.25	Radiation safety program
NSR.26	Laboratory safety program
NSR.27	Medical equipment safety
NSR.28	Utilities safety

General Patient Safety

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

Safety

Keywords:
Patient identification

Intent:
Providing care or performing interventions on the wrong patient are significant errors, which may have grave consequences. Using two identifiers for each patient is the key driver in minimizing such preventable errors, which is especially important with the administration of high alert medications or performing high risk or invasive procedures.
The hospital develops and implements a policy and procedures to guide the process of patient identification. The policy addresses at least the following:

a. Two unique identifiers (personal).
b. Occasions when verification of patient identification is required.
c. Elements associated with care such as medications, clinical specimens, blood and blood products and others.
d. Method to document identifiers such as wrist bands, ID cards, and others.
e. The exclusion criteria for the patient identification such as the patient's bed number, patient's room number and others.
f. Special situations when patient identification may not follow the same process, such as for new born babies, unidentified patients, disasters and others.

Survey process guide:

- GAHAR surveyor may review relevant policy to check the required two identifiers (personal) and the occasions when they should be used.
- GAHAR surveyor may review an appropriate number of medical records and check each sheet for the presence of the two identifiers mentioned in the policy.
- GAHAR surveyor may interview a number of healthcare professionals (can be 10) to ask them about the two identifiers and when should they be used.
- GAHAR surveyor may observe patient identification wristbands for the two identifiers and to observe the patient identification process before procedures or care.

Evidence of compliance:

1. The 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 aware of hospital policy.
3. The patient's identification occurs according to the policy.

4. The patient's identifiers are recorded in the patient's medical record.
5. The hospital tracks, collects, analyzes, and reports data on the patient's identification process.
6. The hospital acts on improvement opportunities identified in its patient identification process.

NSR.02 Verbal or telephone orders are communicated safely and effectively.

Safety

Keywords:

Verbal and telephone orders

Intent:

Miscommunication is the commonest root cause for adverse events. Writing down and reading back the complete order, by the person receiving the information, minimizes miscommunication and reduces errors from unambiguous speech, unfamiliar terminologies, or unclear pronunciation. This also provides an opportunity for verification. The hospital develops and implements a policy and procedures of receiving verbal and telephone communication. The policy addresses at least the following:

a. Verbal orders
b. Telephone orders
c. Process of recording
d. Read-back by the recipient

Survey process guide:

- The GAHAR surveyor may review the policy of receiving verbal or telephone orders to check whether it clearly describes the process of recording, read-back by the recipient.
- The GAHAR surveyor may review recording in dedicated registers and/or patient's medical record.
- The GAHAR surveyor may interview healthcare professionals to assess their knowledge and compliance to hospital policy.

Evidence of compliance:

1. The 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 d).
2. Healthcare professionals are aware of the elements of the policy.
3. All verbal orders and telephone orders are recorded in the patient's medical record within a predefined timeframe.
4. The hospital tracks, collects, analyzes, and reports data on verbal and telephone order process.
5. The hospital acts on improvement opportunities identified in verbal and telephone order process.

NSR.03 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 and supplies (hand soap, hand antiseptics, and single-use towels) must be present in appropriate numbers and 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:

- GAHAR surveyor may review policy of hand hygiene and hand hygiene guidelines.
- GAHAR surveyor may review hand hygiene education posters and records.
- GAHAR surveyor may interview hospital staff, enquiring about hand hygiene technique and WHO five moments of hand hygiene.
- GAHAR surveyor may observe hand washing facilities at each patient care area and check availability of supplies (soap, tissue paper, alcohol hand rub, etc.).
- GAHAR surveyor may observe compliance of healthcare professionals with hand hygiene technique and WHO five moments of hand hygiene.

Evidence of compliance:

1. Hospital has approved Hand Hygiene policies and procedures based on current evidence-based guidelines.
2. Healthcare professionals are trained on these policies and procedures.
3. Hand hygiene posters are displayed in required areas and hand hygiene facilities are present in required numbers and places.
4. The hospital tracks, collects, analyzes, and reports data on hand hygiene process.
5. The hospital acts on improvement opportunities identified in hand hygiene process.

NSR.04 Systems are implemented to prevent catheter and tubing misconnections.

Safety

Keywords:

Catheter and tube misconnections

Intent:

Tubing and catheters are important steps of daily healthcare provision for the delivery of medications and fluids to patients. Patients, especially within critical and specialized care

areas, 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 wrong material via the wrong route resulting in grave consequences. The hospital develops a policy and procedures for catheter and tubing misconnections. The policy addresses at least the following:

a. Responsibility of connection and disconnection of tubes should not be left to non-clinical staff members, families, or visitors.
b. Labeling of high-risk catheters (e.g. arterial, epidural, intrathecal).
c. Avoidance of 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:

- GAHAR surveyor may review the policy during documents review session.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the policy.
- GAHAR surveyor may observe compliance tube misconnection policy during patient tracers.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f).
2. All staff members using tubes and catheters are aware of the hospital policy.
3. Competent individuals are responsible for the management and use of tubes and catheters.
4. Management and the use of tubes and catheters is safe.
5. Management and use of tubes and catheters are recorded in the patient's medical record.

NSR.05 Patient's risk of falling is screened, assessed, periodically reassessed, and managed safely and effectively.

Safety

Keywords:

Fall screening and prevention

Intent:

All patients are liable to fall; however, some are more prone to. Identifying the more prone is usually done through a risk assessment process in order to offer tailored preventative

measures against falling. Effective preventive measures to minimize falling are those that are tailored to each patient and directed towards the risks being identified from risk assessment. The hospital develops and implements a policy and procedures to guide the Fall screening and prevention process. The policy addresses at least the following:

a. Patient risk screening at admission.
b. Risks include medication review and other risk factors.
c. Timeframe to complete fall screening.
d. Frequency of reassessment of risk of fall.
e. General measures are used to reduce risk of falling such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.
f. Tailored care plans based on individual patient fall risk assessment.

Survey process guide:

- The GAHAR surveyor may review the policy for fall prevention to check for patient risk assessment at admission, status change; noticing that medication review is part of the assessment, presence of general measures generated to reduce risk of falling and for tailored care plans based on individual patient fall risk assessment.
- The GAHAR surveyor may review medical records for fall risk assessment including medication review, fall prevention care plan forms, fall risk labels, patient, and family education material.
- The GAHAR surveyor may interview healthcare professionals, patients, and their families to check their understanding and implementation of fall risk assessment and prevention measures.
- The GAHAR surveyor may check hospital-wide general preventive measures such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.

Evidence of compliance:

1. The hospital has an approved policy to guide screening for patient's risk for fall and to define its content and timeframe based on guidelines. Policy includes all elements in the intent from a) through f).
2. Healthcare professionals are qualified and aware of the elements of approved policy.
3. Patients who have higher level of fall risk and their families are aware and involved in fall prevention measures.
4. All fall risk screens are completed and recorded within an approved timeframe and responsibilities.
5. General measures and tailored care plans are recorded in the patient's medical record.
6. All fall risk reassessments are done within an approved timeframe.

NSR.06 Patient's risk of developing pressure ulcers is screened, assessed, periodically reassessed, and managed safely and effectively.

Safety

Keywords:

Pressure ulcers prevention

Intent:

Use of pressure ulcer risk assessment tools or scales is a component of the assessment process used to identify patients at risk of developing a pressure ulcer. Use of a risk assessment tool 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 hospital develops and implements a policy and procedures to guide the Pressure ulcer screening and prevention process. The policy addresses at least the following:

a. Patient risk assessment at admission including skin assessment.
b. Timeframe to complete pressure ulcer screening.
c. Frequency of reassessment of risk of pressure ulcer development.
d. General measures are used to reduce risk of pressure ulcer such as pressure relieving devices and mattresses.
e. Tailored care plans based on individual patient pressure ulcer assessment.

Survey process guide:

- The GAHAR surveyor may review the policy for pressure ulcer prevention to check for patient pressure ulcer assessment at admission, status change; presence of general measures generated to reduce risk of developing pressure ulcers and for tailored care plans based on individual patient pressure ulcer risk assessment.
- The GAHAR surveyor may review medical records for pressure ulcer risk assessment, care plans, patient, and family education material.
- The GAHAR surveyor may interview healthcare professionals, patients, and their families to check their understanding and implementation of pressure ulcer risk assessment and prevention measures.
- The GAHAR surveyor may check hospital-wide general preventive measures and bundles such as pressure-relieving devices and mattresses.

Evidence of compliance:

1. The hospital has an approved policy to guide screening for patient's pressure ulcer risk and to define its content and timeframe based on guidelines. Policy addresses all elements mentioned in the intent from a) through e).
2. Healthcare professionals are aware of the elements of the pressure ulcer screening process and of prevention measures.

3. Patients who have higher level of pressure ulceration risk and their families are aware and involved in prevention measures.
4. All pressure ulcer risk screens are completed and recorded within an approved timeframe and responsibilities.
5. General measures and tailored care plans are recorded in the patient's medical record.
6. All pressure ulcer risk reassessments are done within an approved timeframe.

NSR.07 A standardized approach to hand over communications, including an opportunity to ask and respond to questions, is implemented.

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 clarifications, which subsequently decreases medical errors.

The hospital develops and implements a policy and procedures to guide the process of handover communication. The policy addresses at least the following:

a. The recommended framework of communication, such as SBAR, ISOBAR, I PASS the BATON, and others.
b. Occasions when this framework is used; this includes but not limited to in-between different shifts (in the same department), in-between different levels of care (different departments/ services).
c. The requirement of staff presence.
d. Staff responsibilities.
e. Recommended environment.
f. Recording of the process, such as handover logbook, endorsement form, electronic Handover tool, and/or other methods as evidence of implementation.

Survey process guide:

- GAHAR surveyor may review the policy of handover of patients in-between different shifts (in the same department) as well as in-between different levels of care (different department/ services) to check the presence of recommended framework (such as SBAR, ISOBAR, I PASS the BATON, etc.), staff responsible, recommended environment, and recording.
- GAHAR surveyor may review medical records, handover logbooks, endorsement form, electronic handover tool, and/or other methods as evidence of implementation.
- GAHAR surveyor may interview staff to check their knowledge of handover agreed framework.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through f).
2. All healthcare professionals are aware of hospital policy.
3. Handover communications are recorded and available when required.
4. The hospital tracks, collects, analyzes, and reports data on the handover communication process.
5. The hospital acts on improvement opportunities identified in the handover communication process.

NSR.08 The hospital has an approved policy and procedure for managing critical alarms.

Safety

Keywords:

Critical alarms

Intent:

Medical devices especially those related to vital functions are fitted with alarms that alert staff members on conditions of device malfunction or patient's critical situation. Losing that function exposes patients to increased risk of morbidity and mortality. 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.

Annual competency testing for staff members is needed to ensure the safe use of monitors and other devices that has critical alarming systems.

The hospital develops and implements a policy and procedures for the safe management and use of critical alarms. The policy addresses at least the following:

a. Inventory of critical alarms and their preventive maintenance.
b. Testing of critical alarm systems.
c. Alarms are tested and activated with appropriate settings.
d. Priorities for competing alarms, staff members' authorization for disabling alarms or changing their settings, and monitoring of response to alarm activation.
e. Staff members responsibility, control measures, assurance measures and remedial action.
f. Alarms are sufficiently audible with respect to distances and competing for noise within the unit.

Survey process guide:

- The GAHAR surveyor may review policy for maintenance and testing of critical alarm systems, which should include staff responsible, control measures, assurance measures,

and remedial action GAHAR surveyor may check whether the procedures cover testing of alarms, appropriate settings procedures, priorities for competing alarms, staff authorization for disabling alarms or changing their settings, and monitoring of response to alarm activation.

- The GAHAR surveyor may review inventory of all devices with critical alarms including setting guidelines.
- The GAHAR surveyor may review maintenance record for evidence of responsible staff, responsible company, schedule, agreed settings, evidence of function, reporting of malfunction, and remedial action.
- The GAHAR surveyor may review the schedules of alarm tests and list of current active settings at difference care areas.
- The GAHAR surveyor may interview staff around devices with critical alarm and maintenance staff to check their knowledge of critical alarm settings and response to their activation.
- The GAHAR surveyor may observe (listen) or activate critical alarms to check for suitability of alarm volume to working space.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f).
2. All staff members using devices with critical alarms are aware of the hospital policy.
3. Competent individuals are responsible for the management and use of critical alarms.
4. Management and the use of critical alarms is safe.
5. Management and use of critical alarms are recorded according to policy including evidence of responsible staff members, responsible company, schedule, agreed settings, evidence of function, reporting of malfunction, and remedial action.

NSR.09 The hospital has an approved policy and procedures to ensure hospital-wide recognition of and response to clinical deterioration.

Safty

Keywords:

Recognition of and response to clinical deterioration

Intent:

Early detection of warning signs and provision of urgent care on the right time leads to better functional and long-term outcome than resuscitation of patients with cardio-pulmonary arrest. Studies have shown that this strategy has positive impact on reducing in-hospital mortality and improving patient safety.

The hospital develops and implements a policy and procedures to ensure safe process of recognition of and response to clinical deterioration. The policy addresses at least the following:

a. Defined criteria of recognition of clinical deterioration.

b. Education of staff members on the defined criteria.
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.
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.

Survey process guide:

- The GAHAR surveyor may review the policies for hospital wide recognition of and response to clinical deterioration system.
- The GAHAR surveyor may review the process to build rapid response teams and to ensure regular rehearsals including reviewing minutes of meetings of the concerned committee (such as Code Blue or Medical Emergencies committee) as evidence of regular monitoring of the processes.
- The GAHAR surveyor may review the process to measure and recording observations such as respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc.
- The GAHAR surveyor may check evidence of staff training concerning recognition and communication of clinical deterioration.
- The GAHAR surveyor may observe compliance with policies for recognition of and response to clinical deterioration.
- The GAHAR surveyor may observe the process of response to clinical deterioration if possible.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. All staff members involved in direct patient care are aware of the hospital policy.
3. Competent individuals are responsible for the recognition of and response to clinical deterioration.
4. Recognition of and response to clinical deterioration occurs safely.
5. Recognition of and response to clinical deterioration are recorded in the patient's medical record.

NSR.10 Patient's risk of developing venous thromboembolism (deep venous thrombosis and pulmonary embolism) is screened, assessed, periodically reassessed, and managed safely and effectively.

Safety

Keywords:

Venous thromboembolism prophylaxis

Intent:

Venous thromboembolism (VTE) is considered an important silent killer in hospitals. Adopting guidelines to reduce the risk of developing this condition is important for decreasing preventable adverse events and mortalities. The hospital adopted and implemented a guideline for VTE prophylaxis. The guideline addresses at least the following:

a. Patient risk assessment at admission.
b. Timeframe to complete VTE screening.
c. Reassessment of risk of VTE.
d. General measures are used to reduce risk of VTE such as mobilization and medication.
e. Tailored care plans based on individual patient VTE risk assessment.

Survey process guide:

- The GAHAR surveyor may review the guidelines of identifying and management of patients at risk of venous thromboembolism (deep venous thrombosis and pulmonary embolism).
- The GAHAR surveyor may interview healthcare professionals to check their understanding of VTE prophylaxis.
- The GAHAR surveyor may interview patients and families to check that they received information about the risks of venous thromboembolism and the preventive measures.
- The GAHAR surveyor may observe compliance with guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).

Evidence of compliance:

1. The hospital has an approved policy to guide screening for patient's VTE risk and to define its content and timeframe based on guidelines. Policy addresses all elements mentioned in the intent from a) through e).
2. Healthcare professionals are aware of the elements of the VTE screening process and of prevention measures.
3. Patients who have higher level of VTE risk and their families are aware and involved in prevention measures.
4. All VTE risk screens are completed and recorded within an approved timeframe and responsibilities.
5. There is evidence that compliance to guideline is monitored.

NSR.11 Critical results are communicated timely, accurately and safely.

Safety

Keywords:

Critical results

Intent:

Patient safety and quality of care can be compromised when there are delays in completion of critical tests or in communicating the results of critical tests or critical test results to the

requestor.

Miscommunication is the commonest root cause for adverse events. Writing down and reading back the results, by the person receiving the information, minimizes miscommunication and reduces errors from unambiguous speech, unfamiliar terminologies, or unclear pronunciation.

This also provides an opportunity for verification. The laboratory, medical imaging service, non-interventional cardiology laboratory and point of care testing program are defined and the critical values for specific tests/ studies. The process includes instructions for immediate notification of the authorized individual responsible for the patient with results that exceed the critical intervals.

a. The hospital develops and implements a policy and procedures to guide the process of identifying and reporting critical results. The policy addresses at least the following:
b. Lists of critical results and values.
c. Critical test results reporting process including timeframe and read-back by the recipient.
d. Process of recording.
    i. The mean of notification.
    ii. Date and time of notification.
    iii. Identification of the notifying responsible staff member.
    iv. Identification of the notified person.
    v. Description of the sequence of conveying the result.
    vi. Examination results conveyed.
    vii. Any difficulties encountered in notifications.
e. Measures to be taken in case of critical results.

Survey process guide:

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

Evidence of compliance:

1. The 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 the elements of the policy.
3. All critical results are recorded in the patient's medical record within a predefined timeframe including all elements in the intent from i) through vii).
4. The hospital tracks, collects, analyzes, and reports data on critical results reporting process.

5. The hospital acts on improvement opportunities identified in critical results reporting process.

Medication Management and Safety

NSR.12 The hospital defines standardized diagnosis codes, procedure codes, definitions, symbols, and abbreviations.

Efficiency

Keywords:
Abbreviations

Intent:
Usually, the use of codes, symbols and abbreviations is done to squeeze a lot of writing into a small space. This may cause miscommunication between healthcare professionals and potential errors in patient care.
The hospital developed a policy and procedures for approved and non-approved codes, symbols, and abbreviations according to the hospital scope of service and approved official language of communication inside the hospital that addresses at least the following:

a. Approved symbols/abbreviations list
b. Not-to- use symbols/abbreviations list.
   Implementation of do-not-use abbreviation list for medication is guided by 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
   - qod
   - MS
   - MSO4
   - MgSO4
   - No Trailing Zero
   - No leading Zero
c. Non-English abbreviation and illegible handwriting
d. Situations where Symbols and abbreviations (even the approved list) must not be used; such as informed consent and any record that patients and families receive from the hospital about the patient's care.

Survey process guide:

- GAHAR surveyor may review hospital policy for abbreviations.
- GAHAR surveyor may review appropriate number of medical records (not less than 10) to check for the used abbreviations with medication orders.

- GAHAR surveyor may interview medical staff for awareness of the prohibited abbreviations.

Evidence of compliance:

1. The hospital has an approved policy that includes all the elements in the intent from a) through d).
2. All staff who records in the patient's medical record are aware of the policy requirements.
3. Approved codes are matching those provided by health authorities and/or 3rd party payers.
4. Symbols and abbreviations (even the approved list) are not used in informed consent and any record that patients and families receive from the hospital about the patient's care.

NSR.13 Medications are reconciled across all interfaces of care in the hospital.

Safety

Keywords:

Medication reconciliation, best possible medication history (BPMH)

Intent:

Patients often receive new medications or have changes made to their existing medications at times of transitions in care (hospital admission, transfer from one unit to another during hospitalization, or discharge from the 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).

The medication reconciliation process is a multidisciplinary activity with responsibilities shared among physicians, nurses, pharmacists, and other clinicians involved in the patient's care.

Medication reconciliation refers to the process of avoiding such inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care.

The hospital develops and implements a policy and procedures to guide the medication reconciliation process that addresses at least the following:

a. Situations where medication reconciliation is required:
    i. On admission (matching the current medication orders with the best possible medication history (BPMH), ideally within 24 hours of admission).
    ii. During the episode of care (verifying that the current list of medications is accurately communicated each time care is transferred and when medications are recorded).
    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. Steps of 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 new list of medication and recording changes.
e. Timeframe for completion of the medication reconciliation process.

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing medical staff members, pharmacists, nurses, and other healthcare professionals to inquire about the medication reconciliation process.
- GAHAR surveyor may review a number of patient's medical records (usually more than 10) to assess recording of current medications upon admission.
- GAHAR surveyor may interview with appropriate number of patients to inquire about medication history assessment done by physicians and check their awareness regarding any interaction existed with newly prescribed medications.
- GAHAR surveyor may check if 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 hospital has an approved policy for medication reconciliation that includes all elements mentioned in the intent from a) through e).
2. Staff responsible for reconciling medications are trained to take the best possible medication history (BPMH) and reconcile medications.
3. Medication reconciliation occurs on admission, during the transition of care and upon discharge within a defined timeframe.
4. Medication prescribers compare the list of current medications with the list of medications to be prescribed and make clinical decisions based on the comparison.
5. Reconciled medications are clearly recorded, and related information is clearly communicated to healthcare professionals involved in the patient's medication prescribing.
6. Patients and families are involved in medication reconciliation.

NSR.14 Medications are safely and securely stored in stores, pharmacies, and patient care areas according to laws and regulations.

Safety

Keywords:

Medication storage and labeling

Intent:

Medications are normally stored in pharmacies, storage areas, or patient care areas in the hospital.

The stability/effectiveness of some medications depends on storing them at the correct conditions such as light, humidity, and temperature.
Appropriate storage of medications can reduce waste, incorrect medication dispensing, handling, and the incidence of missed doses.
Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects the basic principles of safe medication management, yet it is routine in many hospitals.
The hospital shall maintain appropriate storage conditions (temperature, light, humidity) in medication storage areas to protect the stability of medications 24 hours a day, seven days a week.
The hospital shall 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 hospital should ensure that the labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications.

Survey process guide:

During GAHAR survey, Surveyor may observe at the medication storage and preparation areas including areas in perioperative and procedural settings to assess storage conditions and labeling.

Evidence of compliance:

1. Medications are safely and securely stored under manufacturer/marketing authorization holder recommendations and kept clean and organized.
2. Psychotropic, controlled, and narcotic medications are stored according to applicable laws and regulations.
3. The hospital has an approved process for the use and storage of multi-dose medications to ensure its stability and safety.
4. The hospital has a clear process to deal with an electric power outage to ensure the integrity of any affected medications before use.
5. Medications in stores, pharmacies, and patient care areas are periodically (at least monthly) inspected to confirm compliance with proper storage conditions.
6. Medications, medication containers, other solutions, and the components used in their preparation are clearly labeled (if not apparent on the original packages or boxes) with the name, concentration/ strength, expiration date, batch number, and any applicable warnings.

NSR.15 High-Alert medications and concentrated electrolytes are identified, stored, and dispensed in a way that assures that risk is minimized.

Safety

Keywords:

High-alert medications, concentrated electrolytes

Intent:

High-alert medications are those bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of an error are clearly more devastating to patients. Examples of high-alert medications include, but not limited to, anticoagulants, hypoglycemic agents, medications with narrow therapeutic range, anesthesia medications and inotropic agents.

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 storage of concentrated electrolytes in patient care areas is a one method to minimize the risk of death or injury associated with these medications.

The hospital develops and implements a policy and procedures to guide the process of safe use of high-alert medications and concentrated electrolyte that addresses at least the following:

a. Lists of high-alert medications based on hospital own data and both national and international recognized organizations (e.g., Institute of Safe Medication Practice (ISMP) and the World Health Organization (WHO).
b. List and inventory of concentrated electrolytes.
c. Strategies are in place to prevent the inadvertent use and administration of these medications.

Concentrated electrolytes must be safely stored including separation, and labeling throughout the hospital.

Survey process guide:

- GAHAR surveyor may observe patient care areas and assess measures to ensure safety storage of high-alert medications (such as being labeled) and concentrated electrolytes (such as being removed whenever possible, labeled with a reminder of "MUST BE DILUTED" or separated in secure areas).
- GAHAR surveyor may interview nurses at different patient care areas to assess their understanding of preventive strategies for managing these medications and may interview medical staff members to inquire about evidence based immediate medical necessity allowing for storing of concentrated electrolytes in these areas.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements in the intent from a) through c).
2. The hospital provides initial and ongoing training to the healthcare professionals involved in management and use of high-alert or concentrated electrolytes.
3. The hospital has an approved list(s) of high-alert medications that are regularly updated for concentrated electrolytes.
4. High-alert medications and concentrated electrolytes are safely stored and labeled across the hospital.
5. The hospital implements a process to prevent inadvertent administration of high-alert medications and concentrated electrolytes.
6. The hospital tracks, collects, analyzes, and reports data on management of high alert medications and concentrated electrolytes. Identified improvement opportunities identified are acted upon.

NSR.16 Look-alike and sound-alike medications are identified and stored in a manner to minimize the risk of medication dispensing and administration errors.

Safety

Keywords:

Look-alike and 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.

One strategy that ISMP recommends for reducing LASA medication errors is to include both the brand and nonproprietary names, dosage form, strength, directions, and the indication for use can be helpful in differentiating LASA medication names. If LASA medications have different indications, then associating an indication with a medication may help differentiating it from another medication with a similar-sounding name. Other recommendations focus on ensuring prescription legibility through improved handwriting and printing.

Some hospitals may use physical separation and segregation of these medications in medication storage areas to minimize the risk In addition, some hospitals use specially designed labels or use “tall man” (mixed case) lettering (e.g., DOPamine versus DoBUTamine) to emphasize drug name differences.

The hospital develops risk management strategies to minimize adverse events with LASA medications and enhance patient safety.

The hospital develops and implements a policy and procedure to ensure safety of LASA that includes at least the following:

a. List of Look-alike Sound-alike medications
b. Storage requirements
c. Labeling requirements
d. Dispensing requirements

Survey process guide:

GAHAR surveyor may review the hospital policy and the updated list of look-alike and sound-alike medications followed by Interviewing pharmacists and nurses to inquire about processes to minimize the risk associated with using look-alike sound-alike medications. GAHAR surveyor may observe at the pharmacy, medication carts, medication storage, and medication preparation areas to check LASA medications labeling.
GAHAR surveyor may observe the LASA administration process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements in the intent from a) through d).
2. There is a list of LASA medications that is updated at least annually.
3. The hospital provides initial and ongoing training to the healthcare professionals involved in management and use of LASA.
4. LASA medications are stored, segregated, and labeled safely and uniformly in all locations.
5. LASA medication are checked properly upon dispensing.
6. The hospital tracks, collects, analyzes, and reports data on management of LASA. Identified improvement opportunities identified are acted upon.

Surgery, Anesthesia and Sedation

NSR.17 Precise site where a surgery or invasive procedure shall be performed is clearly marked by the physician with patient's involvement.

Safety

Keywords:

Surgical site marking

Intent:

Performing the right surgery on the right patient and on the right side without any retained instrument is the mainstay objective of surgical safety.
Establishing related policies and procedures, otherwise known as the universal protocol, is the initial step for offering safe surgery.
Visible and clear site marking is an error reduction strategy that should be performed by the physician who will perform the surgery and invasive procedure with the involvement of the patient if the patient is an adult and fully conscious or patient's family in other situations.
The site marking in each organization should be unified, detectable, and placed on the

nearest site to the surgical site.
The hospital develops and implements a policy and procedures for site marking with the indication and exempted surgeries and procedures from site marking, apply the process before the call for surgery and invasive procedure and continuously monitor the compliance with the process.

Survey process guide:
GAHAR surveyor may review the hospital policy to ensure the presence of all required components in the policy followed by observing a patient going for surgery and invasive procedure for the presence of a clear, approved, non-washable mark on the surgery or invasive procedure site (when applicable) and interviewing staff about policy orientation and implementation.

Evidence of compliance:
1. The hospital has an approved policy for site marking in the hospital.
2. Staff are trained on the implementation of site marking.
3. Site marking is a unified mark all over the hospital and performed by the responsible physician for the surgery and invasive procedure.
4. Site marking is performed before the patient enters the operation room.
5. The hospital tracks, collects, analyzes and reports data on site marking process.
6. The hospital acts on improvement opportunities identified in its site marking process.

NSR.18 Documents and equipment needed for procedures and anesthesia or sedation are verified to be on hand, correct, and properly functioning before calling for the patient.

Safety

Keywords:
Pre-operative checklist

Intent:
Ensuring the availability of all needed items as blood booking, results of the requested investigation or special prosthesis should be done as a preoperative verification process to ensure patient safety and appropriateness of care.
Ensuring the availability and functioning of needed equipment minimizes the risk of errors by preventing the use of malfunctioning equipment or cancellation of surgery and invasive procedure after the patient went to the operating rooms or invasive procedure unit. Implementing regular checkups is a quality improvement process that should be guided by designed checklists performed by trained staff.
The hospital is required to ensure the availability and functioning of equipment needed for the surgery and invasive procedure before calling for the patient. This equipment and tools could be differed according to the type of surgery and invasive procedure or the use of anesthesia and sedation.

Also, the hospital is required to develop a process for preoperative verification of the availability of all needed or requested documents and other items before the patient going for the surgery or invasive procedure.

Survey process guide:

GAHAR surveyor may review the hospital policy followed by tracing a patient underwent or going for surgery and invasive procedure to ensure the correct verification process for needed documents and other requested orders as blood booking or investigations. The surveyor will observe patient endorsement to the operating room or other invasive procedure unit and review the document of endorsement. Also, the checklist showing the availability and functioning of needed equipment shall be reviewed.

Evidence of compliance:

1. The hospital has an approved policy for preoperative verification of all needed documents and equipment.
2. There is recorded evidence of preoperative verification of all needed documents and equipment before each surgery and invasive procedure.
3. The hospital tracks, collects, analyzes and reports data on preoperative verification process.
4. The hospital acts on improvement opportunities identified in its preoperative verification process.

NSR.19 Correct patient, procedure, and body part is confirmed preoperatively and just before starting a surgical or invasive procedure (time out).

Safety

Keywords:

Timeout

Intent:

Time out for verification of the correct patient, correct surgery or invasive procedure, and correct site and side of surgery or invasive procedure is a single process that has been proved to reduce wrong-site surgery.

When performing a surgery or invasive procedure, healthcare professionals should verify the right patient, the right type of surgery, right site, right side, and the patient received the prophylactic antibiotic if applicable.

The hospital develops and implements a policy and procedures to ensure correct patient, correct surgery or invasive procedure and correct site and side of surgery or invasive procedure and apply the time out process just before the start of the surgery or invasive procedure (after induction of anesthesia).

Survey process guide:

GAHAR surveyor may review the policy and procedure for preventing the wrong patient, wrong site/side, and wrong surgery/invasive procedure and ensure that it supports patient,

procedure, as well as part of body verification just before start of the procedure, regardless whether the patient is anesthetized, sedated or awake (Time Out). This is followed by observing a case during the time-out process and review the document used to record this process. Document review of the open and closed medical record will also be performed in addition to staff interviews on how to perform the process and its special circumstances.

Evidence of compliance:

1. The hospital has an approved policy to ensure the correct patient, procedure, and body part.
2. Time out is implemented before all surgery and invasive procedures immediately before the start of surgery or invasive procedure.
3. The surgery or invasive procedure team is involved in the time out process, including the performing physician, the nurse, and the anesthesiologist when applicable.
4. The hospital tracks, collects, analyzes and reports data on time out process.
5. The hospital acts on improvement opportunities identified in time out process.

NSR.20 Accurate counting of sponges, needles, and instruments pre and post-procedure is verified.

Safety

Keywords:

Instrument retention prevention

Intent:

Missing sponges, needles, towels, or instruments inside the patient body act as a foreign body and causes serious morbidity in the form of pain, organ injury and sepsis, which necessitate to reopen the patient and could reach up to mortality.

The hospital is required to spend every effort by the surgical team to prevent missing any foreign body during surgery/invasive procedure by meticulous counting of any used item before, during the closure of each body space, and after the closure of the skin.

Survey process guide:

GAHAR surveyor may review the policy and procedure to ensure that it covers the role of nurses and surgeons, pre and postoperative count double verification, as well as steps to be taken in case of discrepancy between pre and postoperative counts. The surveyor could observe a case during or after surgery or invasive procedure or review the count sheet in the closed or open medical record. A surgical or procedure team interview will also be done.

Evidence of compliance:

1. Counting of sponges, needles, towels, or instruments is done pre, during, and after the surgery or invasive procedure by two staff as the second one is acting as a witness for the first one.
2. There is a record for the preoperative, intraoperative and postoperative count of sponges, needles, towels, or instruments.

3. The performing physician confirmed the process and signed the count sheet.
4. The hospital tracks, collects, analyzes and reports data on the counting process.
5. The hospital acts on improvement opportunities identified in the counting process.

Environmental and Facility Safety

NSR.21 Fire and smoke safety plan addresses prevention, early detection, response, and safe evacuation in case of fire and/or other internal emergencies.

Safety

Keywords:

Fire and smoke safety

Intent:

One of the critical considerations in the safety design for hospitals is the prevention of fire, particularly with respect to 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 working knowledge of how to use the equipment and to avoid panic.

The last resort, failing the ability to completely suppress the fire, is to evacuate the hospital. Moving all patients, visitors, and staff out of dangerous and/or damaged facilities as safely as possible is always the goal of an evacuation.

It is important to recognize that people's attention to detail and processes will not be optimal in an evacuation scenario. To that end, understanding key principles will help staff members make good decisions during a chaotic event.

The hospital develops a fire and smoke safety plan that addresses at least the following:

An ongoing risk assessment that will have the following features:

a. Assesses compliance with Civil Defense regulations.
    i. Assesses compliance with fire and building codes.
    ii. Includes fire and smoke separation, areas under construction and other high-risk areas for example stores, fuel tanks, kitchens including hoods, generators, laundry, oxygen supply, medical gases rooms, 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, for example, dangerous gas leakage.
    v. A special risk assessment is performed during renovation and construction.
b. Early detection of fire and smoke system, including the central control panel connected to all areas in hospitals according to its functionality, and ensure continuous monitoring 24/7.

c. Fire suppression system such as water system, automated or manual fire extinguisher.
d. Listing of firefighting and alarm systems includes maintenance testing, inspection schedule.
e. Availability of safe, unobstructed fire exits, with clear signage to assembly areas and emergency light, in addition to other related signage like how to activate the fire alarm using a fire extinguisher and hose reel.
f. Inspection of all firefighting and alarm systems should be in place, and results are recorded with needed corrective actions.
g. Safe storage and handling of highly flammable materials.
h. The hospital should perform proper annual training and orientation of all staff in a practical manner to make sure that everyone in the hospital can:
    i. Demonstrate RACE and PASS.
    ii. Define who is responsible for medical gas valves shut off, with alternative oxygen sources in case of fire.
    iii. Safely evacuate all occupants.
    iv. Provide specific training for the evacuation of high-risk patients like (Operating theatres, Intensive care units).
    v. Hospital evacuation pathway, gathering areas, and assembly points.
i. Documentation of all results in a proper way and repetition according to the training plan.
j. The plan is evaluated annually and, if needed, according to related performance measures results or major incidents.

Survey process guide:

- GAHAR surveyor may review the fire safety plan, facility fire safety inspections, and fire system maintenance.
- GAHAR surveyor may check that fire alarm; firefighting and smoke containment systems are working effectively and complying with civil defense requirements.
- GAHAR surveyor may review plan of testing (drills) and staff training (all staff should be trained on fire safety).

Evidence of compliance:

1. The hospital has an approved fire and smoke safety plan that includes all elements from a) through j) in the intent.
2. The hospital fire alarm, firefighting and smoke containment system are available, functioning and comply with civil defense requirements.
3. Inspection, testing and maintenance of fire alarm, firefighting and smoke containment systems are performed and recorded.
4. The hospital provides education for fire response and evacuation to all staff at least once annually.
5. The hospital guarantees safe evacuation processes for all occupants in case of fire and/

or other internal emergencies.

6. The fire and smoke safety plan is evaluated annually and, whenever indicated, with aggregation and analysis of necessary data.

NSR.22 Fire drills are performed in different clinical and non-clinical areas, including at least one unannounced drill annually.

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 hospital staff should 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 hospital records fire drills details including, but are 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.

Interviewing staff to check the awareness of fire safety plans and basic procedures in such cases as RACE and PASS.

Survey process guide:

- GAHAR surveyor may review the records of fire and evacuation drills with dates, timings, staff who participated, the involved areas in the hospital and corrective action plan based on the drill evaluation.
- GAHAR surveyor may Interview staff to check the awareness of fire safety plan and basic procedures in such cases like (Rescue, Alarm, Confine, Extinguish/Evacuate and Pull, Aim, Squeeze, Sweep).

Evidence of compliance:

1. Fire drills are performed based on a predefined time interval.
2. Staff members participate in fire drills at least once annually.
3. Fire drill results are recorded from a) through e) in the intent.
4. Fire drill results evaluation is performed after performing each drill.
5. The hospital plans a corrective action, whenever indicated.

NSR.23 The hospital plans safe handling, storage, usage and transportation of hazardous materials and waste disposal.

Safety

Keywords:

Hazardous materials safety

Intent:

Hazardous materials are chemical 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, flammable and combustible substances, poisons, and radioactive materials. 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 hospitals to plan their safe use and establish a safe working environment.

Hospital waste is Any waste which is generated in the diagnosis, treatment or immunization of human beings or in research in a hospital.

Healthcare waste includes infectious, chemical, expired pharmaceutical and radioactive items and sharps. These items can be pathogenic and environmentally adverse. 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.

Hospital Waste Management means the management of waste produced by hospitals using such techniques that will help to check the spread of diseases.

The hospital should identify and control hazardous material and waste all over the hospital to ensure that staff, patients, relatives, vendors, and the environment are safe.

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 plan includes, but is not limited to, the following:

a. A current and updated inventory of hazardous materials used in the hospital, the inventory should include the material name, hazard type, location, usage, consumption rate, and responsibility.

b. Material safety data sheet (MSDS) should be available and includes information such as physical data, hazardous material type (flammable, cytotoxic, corrosive, carcinogenic, etc.), safe storage, handling, spill management and 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 spill and exposure.
h. Compliance with local laws and regulations, availability of required licenses, and/or permits.
i. Staff training and orientation.
j. The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review the hazardous material and waste management program to make sure that it covers all safety requirements of hazardous materials, safe storage, handling, spills, required protective equipment and waste disposal according to local laws and regulations.
- GAHAR surveyor may review the hazardous material and waste disposal plan, hazardous material, and waste inventories, as well as Material Safety Data Sheet (MSDS) during document review session or during hospital tours and tracers.
- GAHAR surveyor may inspect hazardous material labeling and storage in addition to waste collection segregation storage and final disposal.

Evidence of compliance:

1. The hospital develops hazardous material and waste management plan that addresses all elements from a) through j) in the intent.
2. The hospital ensures staff safety when handling hazardous materials/or waste.
3. Waste disposal occurs according to laws and regulations.
4. The hospital ensures safe usage, handling, storage, and labeling of hazardous materials.
5. The hospital has an approved document for spill management, Investigation, and recording of different incidents related to hazardous materials.
6. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

NSR.24 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 from inappropriate behavior such as violence and aggression.

The hospital develops 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 includes at least the following:

a. Proactive risk assessment.
b. Effective planning to prevent accidents and injuries and minimize potential risks, to maintain safe conditions for all occupants to reduce and to control risks.
c. Processes for pest and rodent control.
d. The hospital identifies potential risks because of system failure and/or staff 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.
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 depending on job hazard analysis.

Survey process guide:

- GAHAR surveyor may review safety plan/s to make sure that they include suitable risk assessment surveillance.
- GAHAR surveyor may review surveillance rounds plan. Checklist, different observations, and proper corrective actions when applicable.
- GAHAR surveyor may inspect workers in different areas like workshops and waste collection areas to check usage of suitable personal protective equipment (PPE).

Evidence of compliance:

1. The hospital has an approved plan to ensure a safe work environment that includes all elements from a) through g) in the intent.
2. Staff are aware of safety measure pertinent to their job.
3. Safety measures are implemented in all areas.
4. Safety instructions are posted in all high-risk areas.
5. Safety management plan is evaluated and updated annually with aggregation and analysis of necessary data.

NSR.25 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 disposal of radioactive materials and radiological equipment; develops policies by which radiological equipment are used safely; ensures compliance with regulations; and provides emergency response assistance.
The hospital environment, staff, patients, relatives and vendors should be safe from radiation hazards, as medical Imaging services are provided on-site, the hospital has a radiation safety program that shall address all components of the hospital medical Imaging services.
The hospital develops and implements a program to guide the process of radiation safety to ensure that hospital environment, staff, patients, families, and vendors are safe from radiation hazards that address at least the following:

a. Compliance to laws, regulations, and guidelines.
b. All ionizing and non- ionizing radiation equipment are maintained and calibrated.
c. Protocols to identify maximum dose of radiation for each type of examinations.
d. Staff self-monitoring tools.
e. Appropriate and safe waste disposal for radioactive materials.
f. Staff suitable personal protective equipment.
g. Patients' safety precautions.
h. MRI safety plan.

Survey process guide:

- GAHAR surveyor may review the radiation safety program to check approved level of exposure according to local laws and regulations, shielding methods and safety requirements for both staff members and patients.
- GAHAR surveyor may review environmental radiation measures, Thermo Luminescent Dosimeter (TLD) and/or badge films of the staff results, CBC results, lead aprons inspection.
- GAHAR surveyor may interview staff to check their awareness.
- GAHAR surveyor may observe medical imaging services inside medical imaging area or outside it to check compliance with radiation safety precautions.

Evidence of compliance:

1. The hospital has an approved radiation safety program for patients and staff that addresses potential safety risks and hazards encountered in the hospital in addition to all elements mentioned in the intent from a) through h).
2. Identified radiation safety risks are mitigated through processes and safety protective devices, for both staff and patients.

3. Staff members involved in medical imaging are aware of radiation safety precautions and receive on-going education and training for new procedures and equipment.
4. Radiation doses measured and monitored for patients and does not exceed approved maximum level.
5. Radiation doses for patients in all radiology areas are recorded in the patient's medical record.
6. The radiation safety program is part of the hospital environment and facility safety program.

NSR.26 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 member 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. Incidents 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:

- GAHAR surveyor may review laboratory safety program that should include at least: list of chemicals and hazardous materials, dealing with spills, safety requirements, suitable PPE, maintenance and calibration of medical equipment, and staff orientation, and proper waste disposal.

- GAHAR surveyor 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 available and includes the items in the intent from a) to i).
2. Laboratory staff is trained on the safety program.
3. Laboratory risk assessment is performed and safety reports are issued at least semi-annually to the 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 hospital tracks, collects, analyzes and reports data on laboratory safety program and it acts on identified improvement opportunities.

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 most hospitals, a trained biomedical and engineering team manages the entire medical inventory, and is responsible for dealing with medical equipment hazards. Being responsible for such an extensive array of devices can be cumbersome, especially when the stakes are so high.

Not only does lazy monitoring and management lead to inefficiency, but it can also seriously harm patient outcomes. As an example, poor maintenance increases the chances of downtime, and inadequate servicing and sterilization can be harmful to both doctors and patients.

This is why it is crucial to establish some basic equipment safety and service guidelines.

The hospital develops a plan for medical equipment management that address at least the Following:

a. Developing criteria for selecting new medical equipment.
b. Inspection and testing of new medical equipment upon procurement and on a predefined interval basis.
c. Training of staff on safe usage of medical equipment upon hiring upon installation of new equipment, and on a predefined regular basis by a qualified person.
d. Inventory of medical equipment including availability, criticality, and functionality.
e. Identification of critical medical equipment that should be available for the operator even through provision of back-up such as life-saving equipment, ventilator, DC shock.

f. Specialized and critical equipment(s) lists are identified.
g. 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.
h. Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.
i. Malfunction and repair of medical equipment.
j. Dealing with equipment adverse incidents, including actions taken, backup system, and reporting.
k. Updating, retiring and/or replacing for medical equipment in a planned and systematic way.

Survey process guide:

- GAHAR surveyor may review the medical equipment maintenance program to ensure availability of all required documents, inventory of medical equipment, preventive maintenance schedule, calibration schedule and staff training records.
- During the GAHAR survey, surveyor may check medical equipment functionality and trace some medical equipment records.

Evidence of compliance:

1. The hospital has an approved medical equipment management plan that addresses all elements from a) through k) in the intent.
2. The hospital has qualified individuals to oversee medical equipment management.
3. Staff is educated on the medical equipment plan at least annually.
4. Records are maintained for medical equipment inventory, user training, equipment identification cards, and company emergency contact, testing on installation, periodic preventive maintenance, calibration and malfunction history.
5. The hospital ensures that only trained and competent people handles the specialized equipment(s).
6. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

NSR.28 Essential utilities plan addresses regular inspection, maintenance, testing and repair.

Safety

Keywords:

Utilities management

Intent:

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 hospital develops a utility management plan to ensure efficiency and effectiveness of all utilities that includes at least the following:

a. Inventory of all utility key systems, for example, electricity, water supply, medical gases, heating, ventilation and air conditioning, communication systems, sewage, fuel sources, fire alarm, and elevators.
b. 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 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:

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

Evidence of compliance:

1. There is a hospital approved plan for utility management that includes items a) through i) in the intent.
2. The hospital has qualified staff members to oversee utility systems.
3. Staff is educated on the utility systems plan at least annually.
4. Records are maintained for utility systems inventory, testing, periodic preventive maintenance and malfunction history.

5. Critical utility systems are identified and back up availability is ensured.
6. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

Section 3: Essential Quality Requirements

► Reading and Interpretation of Essential Quality Requirements (EQRs):

- Each standard of essential quality requirements standards is composed of a standard statement, keywords, intent, survey process guide, and evidence of compliance.
- Standard statement:
- 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:
- The standard keywords are meant to help hospitals understand the most important element(s) of standard statements, as these are words or concepts of great significance. Keywords answer the question of what the standard is intended to measure.
- Intent:
- The intent is meant to help hospitals 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 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 hospitals 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.
- Survey process guide:
  Facilitates and assists the surveyors in the standards’ ratings for the required EOCs.
- Evidence of compliance (EOC):
  - The EOC of a standard indicates what is reviewed and assigned a score during the on-site survey process.
  - The EOCs for each standard identify the requirements for full compliance with the standard as scoring is done in relation to met EOCs.

◊ Essential Quality Requirements

EQR	Keyword
PCC.04	Patient and family rights
PCC.15	Waiting spaces
PCC.21	Complaints and suggestions
01.ACT	Granting access
ACT.14	Special care units' access
ICD.14	Plan of care
ICD.38	Cardiopulmonary resuscitation and medical emergencies
DAS.05	Medical imaging quality assurance and control
DAS.19	Laboratory internal quality assessment
DAS.28	Blood procurement
SAS.08	Operative report
SAS.18	Physiological assessment by anesthesia
MMS.03	Medication procurement, formulary
MMS.05	Emergency medications
IPC.12	Isolation precautions
IPC.14	Disinfection, sterilization
IPC.21	Food services
OGM.01	Governing body structure
OGM.02	Mission statement
OGM.06	Committee structure
OGM.14	Billing system
OGM.20	Staff health
WFM.02	Staffing plan
WFM.06	Staff files
WFM.07	Orientation program
WFM.09	Staff performance evaluation
IMT.06	Integrity of data and information
IMT.08	Patient's medical record management
IMT.11	Downtime of data systems
QPI.11	Incident reporting system
QPI.12	Significant events
QPI.13	Sentinel events
Additional standard for organizations with academic, research or organ/ tissue transplantation services	
ADD.07	Research patient rights

PCC.04 Patient and family rights are protected and informed to patients and families.

Patient-centeredness

Keywords:

Patient and family rights

Intent:

Seeking and receiving care and treatment at a hospital can be overwhelming for patients, making it difficult for them to act on 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 hospital is committed to helping him/her to gain knowledge of his/her rights. The hospital provides direction to staff regarding their role in protecting the rights of patients and families. The hospital develops and implements a policy and procedures to ensure that all staff members are aware of and respond to patient and family rights issues when they interact with and care for patients throughout the hospital that addresses at least the following:

a. Patient and family rights as defined by laws and regulations, and the ethical code of healthcare professionals' syndicates.
b. Patient and family right to access care if provided by the hospital.
c. Patient and family right to know the name of the treating, supervising, and/or responsible medical staff member.
d. Patient and family rights to care that respects the patient's personal values and beliefs.
e. Patient and family rights to be informed and participate in making decisions related to their care.
f. Patient and family rights to refuse care and discontinue treatment.
g. Patient and family rights to security, personal privacy, confidentiality, and dignity.
h. Patient and family rights to have pain assessed and treated.
i. Patient and family rights to make a complaint or suggestion without fear of retribution.
j. Patient and family rights to know the price of services and procedures.
k. Patient and family rights to seek a second opinion either internally or externally.

Survey process guide:

- The GAHAR surveyor may review patient rights policy and interview staff members to check their awareness.
- The GAHAR surveyor may observe patient rights statements posted in the 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 hospital has an approved policy guiding the process of defining patient and family rights, as mentioned in the intent from a) through k).
2. All staff members are aware of patients' and families' rights.
3. An approved statement on patient rights is posted in all public areas in the hospital in a

way that makes it visible to staff, patients, and families.
4. Patient and family rights are protected in all areas and at all times.
5. Information about patient rights is provided in writing or in another manner, the patient's and their families understand.

PCC.15 Patient-centered waiting spaces are available for various services.

Patient-centeredness

Keywords:
Waiting spaces

Intent:
Waiting spaces are a major pain point in the patient experience. Not only emotions such as anxiety, fear, confusion, frustration, annoyance are high when a patient is waiting for a medical service, but it is more frustrating to be combined that with uncomfortable seating, lacking basic human needs, and overcrowding. The hospital ensures that waiting spaces are comfortable and suitable for patient's and family's needs.

Survey process guide:
During the GAHAR survey, the surveyor may visit waiting spaces meant to accommodate patients or their families.
Visits may include waiting areas in outpatient clinics, emergency room, admission office, registration office, cafeteria, or other areas.

Evidence of compliance:
1. Waiting spaces are lit, ventilated, clean, and safe.
2. Waiting spaces are planned to accommodate the expected number of patients and families.
3. Waiting spaces provide access to satisfy basic human needs such as toilets, potable water, and food.
4. Patients receive information on how long they may wait.

PCC.21 Patients and families are able to make oral or written complaints or suggestions through a defined process.

Patient-centeredness

Keywords:
Complaints and suggestions

Intent:
While hospitals are able to proactively measure and use patient'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 develops and implements a policy and procedures to create a uniform system for dealing with different complaints and suggestions from patients and/or their families to make it

easy to follow up, monitor, and learn from practices. The hospital policy address at least the following:

a. Mechanisms to inform patients and families of communication channels to voice their complaints and suggestions.
b. Tracking processes for patients' and families' complaints and suggestions.
c. Responsibility for responding to patients' complaints and suggestions.
d. Timeframe for giving feedback to patients and families about voiced complaints or suggestions.

Survey process guide:

- The GAHAR surveyor may review the policy of managing patient complaints and suggestions.
- The GAHAR surveyor may assess the process of managing patient suggestions and complaints during tracer activities, leadership interview sessions, or during quality program review sessions.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of managing patients' complaints and suggestions as mentioned in the intent from a) through d).
2. The hospital allows the complaining process to be publically available.
3. Patients and families are allowed to provide suggestions and complaints.
4. Complaints and suggestions are investigated and analyzed by the hospital.
5. Patients and families receive feedback about their complaints or suggestions within approved timeframes.

ACT.01 The hospital grants patients access to its services according to applicable laws and regulations and pre-set eligibility criteria.

Patient-centeredness

Keywords:

Granting access (before patient's registration)

Intent:

While World Health Organization member countries embraced the concept of universal coverage as early as 2005, few have yet achieved the objective. This is mainly due to numerous barriers that hinder access to needed health services. If services are available and there is a continuous supply of services, then the opportunity to obtain healthcare exists, and a population may 'have access' to services. The extent to which a population' gains access' also depends on the financial, hospital, and social or cultural barriers that limit the utilization of services. Thus, access measured in terms of utilization is dependent on the affordability, physical accessibility, and acceptability of services and not merely adequacy of supply. Services available Shall be relevant and effective if the population is 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, such as not hindering women by offering female healthcare professionals when and where it is relevant. The process of patient registration – covered in the next standards- usually includes a review of the patient's eligibility to receive certain services. These eligibility criteria are usually pre-set by healthcare payers and guided by laws, regulations, and hospital policies. Pre-set criteria need to be available for those responsible for granting access to patients. In order to improve accessibility to the hospital services, patients and families should be well informed about the available services.
The hospital develops and implements a policy and procedures to guide the process of granting access. The policy addresses at least the following:

a. The process to screen patients to determine that the hospital scope of services can meet their healthcare needs.
b. Access through emergency areas is safe and appropriate for patients' conditions.
c. Access through ambulatory areas include a clearly defined scheduling and queuing process for patients that ensures appropriate identification, clear sufficient information exchange, safety, and comfort.

Survey process guide:

- The GAHAR surveyor may review documents describing the approved hospital process then followed by a visit to the point of the first contact in the hospital such as service desks, receptions, call centers, emergency rooms, and outpatient areas. A visit may be part of another survey activity, such as a tour or a tracer.
- The GAHAR surveyor may observe these areas for information given to patients such as brochures, posters, digital, verbal messages, or other types of information and may interview patients to assess their awareness.

Evidence of compliance:

1. The hospital has an approved policy granting access to patients that addresses all elements mentioned in the intent from a) through c).
2. Patients are made aware of available services, including operating hours, types of services, cost of each service (when relevant), and access path.
3. The hospital defines a system for informing patients and families about services that is suitable for different literacy levels and is available at points of contact and public areas.
4. Patients are referred and/or transferred to other healthcare organizations when healthcare needs are not matching hospital scope of service.

ACT.14 The hospital grants access to intensive care and specialized care units and discharge from these units based on clear criteria.

Equity

Keywords:

Special care units' access

Intent:

Specialized care units refer to inpatient units that are specifically designed, staffed, and equipped for the continuous observation and treatment of critically ill or complex patients, including all types of intensive care units, as well as intermediate care or step-down units. Critical care units and specialized care units are subject to increasing demand, decreasing supply, decrease quality of care, and increase administrative costs of healthcare provision. Hospitals should preserve the availability of needed and necessary critical and specialized care services are to titrate demand-to-need at its most sensitive level; this can be maintained by:

a. Defined physiologic based admission criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.
b. Defined discharge physiologic based criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.

Survey process guide:

- GAHAR surveyor may learn about the hospital special units during the review of hospital application to GAHAR, during the opening conference or during the course of the GAHAR survey.
- GAHAR surveyor may review a document describing the approved hospital process for admission and discharge from critical care and special care areas.
- GAHAR surveyor may visit critical care units, dialysis units, burn units, infectious diseases units, or other units where special resources, such as beds, equipment, or expertise, need to be allocated wisely. During the visit, an open file review for the patient's medical record may be performed.
- GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through b).
2. All staff members involved in the admission and discharge of patients from specialized and critical care units as aware of the approved criteria.
3. Only competent staff members are allowed to admit and discharge patients from critical and specialized care units.
4. Admission and discharge of patients from critical and specialized care units occur when criteria are met.

ICD.14 An individualized plan of care is developed for every patient.

Patient-centeredness

Keywords:
Plan of care

Intent:
A plan of care provides direction on the type of healthcare the patient/family/community may need. The focus of a plan is to facilitate standardized, evidence-based, and holistic care. Recording a plan of care ensures medical staff members, nurses, and other healthcare professionals integrate their findings and work together with a common understanding of the best approach towards 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. Based on assessments of the patient performed by the various healthcare disciplines and healthcare professionals.
c. Developed with the involvement of the patient and/or family through shared decision making, with discussion of benefits and risks that may involve decision aids.
d. Includes identified needs, interventions, and desired outcomes with timeframes.
e. Updated as appropriate based on the reassessment of the patient.
f. Goals or desired results of the treatment or care
g. The progress of patient/service user in achieving the goals or desired results of treatment, care or service is monitored.

Survey process guide:

- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. There is evidence that plan of care is developed by all relevant disciplines based on their assessments that addresses all the elements mentioned in the intent from a) through g).
2. There is evidence that plan of care is developed with the participation of patient and/or family in decision making.
3. Plan of care is changed / updated based on a reassessment of patient changing condition.

ICD.38 Response to medical emergencies and cardio-pulmonary arrests in the hospital is managed for both adult and pediatric patients.

Safety

Keywords:
Cardiopulmonary resuscitation and medical emergencies

Intent:
Any patient receiving care within a hospital is liable to suffer from a medical emergency

requiring a rapid and efficient response. Time and 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 emerging situation. The hospital develops and implements a policy and procedures to ensure 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 and pediatrics.
b. Education of staff members on the defined criteria.
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.
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.

Survey process guide:

- The GAHAR surveyor may review the policies for medical emergencies and cardio=-pulmonary arrest.
- The GAHAR surveyor may review the process to build medical emergency teams and to ensure regular rehearsals including reviewing minutes of meetings of the concerned committee (such as Code Blue or Medical Emergencies committee) as evidence of regular monitoring of the processes.
- The GAHAR surveyor may review the process to measure and recording observations such as respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc.
- The GAHAR surveyor may check evidence of staff training concerning recognition and communication of medical emergencies or cardio-pulmonary arrest.
- The GAHAR surveyor may observe compliance with policies for medical emergencies and cardio-pulmonary arrest.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. All staff members involved in medical emergencies and cardiopulmonary resuscitation are aware of the hospital policy.
3. Competent individuals are responsible for the management of medical emergencies and cardio-pulmonary arrests.
4. Management of medical emergencies and cardio-pulmonary arrests occurs safely.
5. Management of medical emergencies and cardio-pulmonary arrests are recorded in the patient's medical record.

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

Effectiveness

Keywords:

Medical imaging quality assurance and control

Intent:

Management of the routine quality control (QC) of medical imaging equipment is a major responsibility of the 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 not identified by quality control systems and help the medical imaging service to determine accuracy of images.

Management of routine quality control includes developing the QC protocols, implementation of the program, oversight of the program, and responsibility 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, analysis, followed up and preventive actions are taken and recorded before major problems arise.

The medical imaging service develops and implements a procedure for quality control that include at least the following:

a. Elements of the internal quality control performed according to risk assessment for each study/modality.
b. The frequency for quality control testing is determined by the 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 should 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 a regular interval (at least monthly).
g. Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

Survey process guide:

- GAHAR surveyor may visit areas were medical imaging services are provided including radiology department or other departments where portable medical imaging services are provided to check quality control procedures and records.

- GAHAR surveyor may interview medical imaging service staff members and other healthcare professionals to check their awareness on quality control performance.

Evidence of compliance:

1. The hospital has an approved procedure describing 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 quality control procedure.
4. All quality control processes are recorded.
5. Responsible authorized staff member reviews quality control and function check data at least monthly.
6. Corrective action is taken whenever targets are unmet.

DAS.19 An individualized internal quality control program is developed and implemented for all tests.

Effectiveness

Keywords:

Laboratory internal quality assessment

Intent:

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. Elements of the internal quality control performed according to risk assessment for each test method.
b. The frequency for quality control testing is determined by the hospital according to guidelines and manufacturer instructions whichever is more stringent.
c. Quality control materials to be used. They shall be handled and tested in the same manner and by the same laboratory staff member testing patient samples.
d. 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.

e. Acceptance-rejection rules for internal quality control results.
f. The internal quality control program is approved by the designee prior to implementation.
g. Quality Control data is reviewed at a regular interval (at least monthly) by responsible authorized staff member.
h. Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

Survey process guide:

- GAHAR surveyor may visit laboratory to check quality control procedures and records.
- GAHAR surveyor may interview laboratory staff members to check their awareness on quality control performance.

Evidence of compliance:

1. The hospital has an approved procedure describing the internal quality control process of all laboratory tests addressing all elements in the intent from a) through h).
2. Laboratory staff members involved in internal quality control are competent in internal quality control performance.
3. All quality control processes are performed according to the internal quality control procedure.
4. All quality control processes are recorded.
5. Responsible authorized staff member reviews quality control and function check data at least monthly.
6. Corrective action is taken when indicated.

DAS.28 Processes of collection, handling, testing of blood, and blood components are performed safely and effectively.

Safety

Keywords:

Blood procurement

Intent:

Blood collection has been practiced for centuries and is still an invasive procedure in healthcare.

Each step in the process of blood procurement (collection, handling and testing) affects the specimen quality, thus it is important for preventing specimen laboratory error, subsequent patient injury or even death.

For example, the touch of a finger to verify the location of a vein before insertion of the needle increases the chance that a specimen will be contaminated. This can cause prolong hospitalization, delay diagnosis and cause unnecessary use of antibiotics.

The hospital develops and implements a policy for management of blood and blood

components.

The policy addresses at least the following:

a. Collection
    i. Donation of blood: Donor area cleanliness and convenience, donor reaction and outdoor blood donation campaigns.
    ii. Infection control precautions.
b. Handling
    i. Identification of blood/blood components bags and tubes.
    ii. Temperature controls.
    iii. Transportation of blood.
c. Testing
    i. Determination of ABO group
    ii. Determination of Rh(d) type previous records
    iii. Laboratory tests for infectious diseases
    iv. Quarantine storage
d. Preparation
    i. Sterility
    ii. Seal
    iii. Blood components preparation instructions and protocols

Survey process guide:

- GAHAR surveyor may review blood transfusion services policy during document review session.
- GAHAR surveyor may perform a tracer session on a person donating blood unit or on the donation process to review assessment, collection, handling, testing and preparation steps
- GAHAR surveyor may interview blood transfusion services healthcare professionals to check their awareness on requirements.
- GAHAR surveyor may visit areas were blood collection occurs to check compliance with requirements.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through d) and based on national guidelines.
2. Blood bank staff is aware of the hospital's policy.
3. Blood and/or blood components are collected and handled as elements from a) through b) and based on national guidelines.
4. Blood and/or blood components are tested and prepared as elements from c) through d) and based on national guidelines.

SAS.08 Procedure details are recorded immediately after the procedure.

Safety

Keywords:
Operative report

Intent:
Immediate reporting of the procedure has a significant role in the continuity of care.
Planning for postoperative care depends on findings and special events that occurred during the procedure, as failure to report these events markedly compromises patient care.
The hospital is requested to immediately report the procedure details before the patient leaving the procedural unit.
Recording the names of all staff involved in the procedure has a medico-legal aspect and communication aspect and any similarity or discrepancy in the patient diagnoses before and after the procedure should be documented and clarified.
Details of the procedure should be clearly stated, including the incision site, if applicable, step by step of the surgical technique, and ended by how the skin closure or ending the procedure is done.
Use of any prosthesis or implantable devices should be stated in the report, including any special precautions when dealing with or to remove it.
Occurrence of complications during the procedure should be recorded with the action taken to manage.
Any specimen removed from the body should also be stated clearly in the procedure report.
That addresses at least the following:

a. Time of start and time of the end of the procedure.
b. Name of all staff involved in the procedure, including anesthesia.
c. Pre-procedure and post-procedure diagnoses.
d. The procedure performed with details.
e. The details of any used implantable device or prosthesis including the batch number
f. The occurrence of complications or not.
g. Any removed specimen or not.
h. Signature of the performing physician.

Survey process guide:
GAHAR surveyor may perform a closed and open medical record review to check the completeness of all components needed in the procedure report.

Evidence of compliance:
1. The procedure report is readily available for all patients who underwent a procedure before leaving the procedural unit.
2. The report includes at least a) through h) in the intent.
3. The report is kept in the patient's medical record.

SAS.18 A competent anesthesiologist performs continuous monitoring of the patient's physiological status before and during anesthesia.

Safety

Keywords:
Physiological assessment by anesthesia

Intent:
Administering anesthesia and performing surgeries and invasive procedures 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 patient condition, which is used in determining the patient criteria of discharge from the post-anesthesia care unit.
The type of monitoring is determined according to the patient's condition, age, type of anesthesia, type, and duration of surgery based on the clinical practice guidelines.
Continuous monitoring allows the anesthesiologist for on-time intervention for any changes in the patient's condition.

Survey process guide:
GAHAR surveyor may observe a patient while receiving the anesthesia service to evaluate the process of patient monitoring and the staff involved in this process, this is followed by medical record review for open and closed patients' records received anesthesia.

Evidence of compliance:
1. The patient physiologic status is monitored before and during anesthesia based on hospital approved clinical practice guidelines.
2. The monitoring of patient physiologic status is performed by a qualified anesthesiologist.
3. The results of the monitoring are recorded in the patient's medical record regularly according to the approved hospital clinical guidelines/protocols.

MMS.03 Hospital medications are selected, listed, and procured based on approved criteria.

Efficiency

Keywords:
Medication procurement, formulary

Intent:
Medication selection and procurement is an interdisciplinary process, and it involves (if not being done through higher authority outside the hospital) efforts to quantify medications requirements, selecting appropriate procurement methods, prequalifying suppliers, and products. It also involves managing tenders, establishing contract terms, assuring medications quality, obtaining the best prices, and is performed based on a clear process according to applicable laws and regulations.
The hospital shall develop a list (known as a formulary) of all the medications it stocks.

A formulary is selected based on disease prevalence, evidence of efficacy, safety, and comparative cost-effectiveness. Laws and regulations may determine the medications on the list. The formulary shall include (but not limited to):

a. Names of medications,
b. Strengths/concentrations of medication(s),
c. Dosage forms of the medication(s),
d. Indications for use,
e. Risks/side effects of the medications, and
f. Cost of the medications

Updating the medication list is guided by criteria (e.g., indications for use, effectiveness, drug interactions, adverse drug events, sentinel events, population(s) served (e.g., pediatrics, geriatrics), and costs. The hospital develops and implements a process to evaluate the medication use in the hospital to monitor and update the medication list (e.g., ABC analysis, vital/essential/nonessential and (VEN) analysis). Evaluation of medications, with a view to add or delete them from the formulary, is an important criterion for formulary update and maintenance.

Survey process guide:

During the patient journey tracer and medication management review session, GAHAR surveyor may trace the prescription of a medication or group of medications and follow the process steps for selecting, listing, procuring, and monitoring. GAHAR surveyor may interview those involved in medication selection process to learn about the process and its variants such as procuring a medication that is not listed in the formulary, procuring a medication for temporary period or for one patient.

Evidence of compliance:

1. The hospital (represented by the drug and therapeutic committee) has a hospital's approved process for appropriate selection and procurement of medications according to the applicable laws and regulations, hospital mission, patient needs and safety, and services provided to ensure uninterrupted availability of medication supply.
2. The hospital has an approved list of the approved medications (often referred to as a formulary), which includes at least items from a) to f) in the intent.
3. A controlled printed and/or electronic formulary copy of the approved medications shall be readily available and accessible to all those involved in medication management.
4. Medication list (formulary) is monitored, maintained, and updated.
5. The hospital has an approved process to guide the addition/deletion of medication to/ from the medication list (formulary).
6. The hospital has an approved process on proper communication about medication shortage and outage to prescribers and other healthcare professionals.

MMS.05 Emergency medications are available, accessible, and secured at all times.

Safety

Keywords:

Emergency medications

Intent:

In situations when a patient emergency occurs, quick access to emergency medications is critical and may be lifesaving.

The hospital develops and implements a policy and procedures to ensure the availability of emergency medications in patient care areas that addresses at least the following:

a. Emergency medications shall be readily accessible and uniformly stored to facilitate quick access to the right medication to meet emergency needs. For example, in each emergency cart in the hospital, emergency medications are in the same drawer and laid out in the same manner within the drawer of each cart.
b. Prevention of abuse, loss, or theft of emergency medications to ensure their availability when needed.
c. Replacement of emergency medication at the most appropriate time when used, damaged, or outdated.

Survey process guide:

During GAHAR survey, Surveyor may observe emergency medication storage areas; surveyor may interview staff members who are responsible for emergency medication storage to inquire about storage conditions, accessibility, storage security and replacement of medications when needed. Surveyor may repeat this activity in multiple units/departments to assess uniformity of performance.

Evidence of compliance:

1. The hospital has an approved policy to guide emergency medications availability that addresses at least all elements mentioned in the intent from a) through c).
2. Emergency medications are uniformly stored in all locations.
3. Emergency medications are appropriately available and accessible to the clinical areas when required.
4. Emergency medications are replaced within a predefined timeframe when used, damaged, or outdated.

IPC.12 Patients with clinically suspected and/or confirmed communicable diseases follow isolation precautions according to probable mode(s) of transmission.

Safety

Keywords:

Isolation precautions

Intent:

Isolation precautions create barriers between people and microorganisms that help in

preventing the spread of germs in the hospital.
If the patient is determined to be at an increased risk for transmission of microorganisms, the patient is placed in the hospital's standardized isolation room.
The hospital must have one or more standardized isolation room(s)
When the standardized isolation room(s) is not currently available, the patient should be separated in separate assigned areas/room.
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 hospital must develop protocols 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 room the patient is in, contacting staff must always wear appropriate respiratory protection (as N95 respirator).
Environmental measures: Routine cleaning of high touch surfaces is standard.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- During GAHAR Survey, the surveyor may observe at least one standardized isolation room(s) and assigned areas for patient placing according to the hospital capacity
- During GAHAR Survey, the surveyor may interview healthcare professionals to inquire about use of PPE and performance of hand hygiene according to the type of isolation, this can be observed as well.

Evidence of compliance:

1. The hospital has an approved policy to guide transmission-based precautions.
2. Healthcare professionals are trained and educated on approved policies.
3. The hospital has one or more standardized isolation room(s) according to laws and regulations.
4. Patients with suspected/ confirmed clinical communicable diseases are identified and separated in separate assigned areas/room.
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.

IPC.14 Patient care equipment are 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 hospital.

In clinical procedures that involve contact with medical/surgical equipment, it is crucial that healthcare professionals follow standard practices and guidelines to clean and disinfect or sterilize.

Cleaning process is a mandatory step in processing of patient care equipment.

Cleaning, disinfection, and sterilization can take place in a centralized processing area. Assigned processing area shall have workflow direction.

The hospital develops and implements 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 and laryngoscopes etc. Chemical disinfectants approved for high-level disinfection include glutaraldehyde, orthophtaldehyde 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 touching 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:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals.
- During the hospital tours and tracers, the surveyor may observe the number of functioning pre-vacuum class B sterilizers, the presence of physically separated areas according to

the standard with unidirectional airflow, and the presence of storage areas that meet the standard criteria.
- GAHAR surveyor may check the ability of the staff to perform the sterilization process properly.

Evidence of compliance:
1. The hospital has an approved policy to guide the process of disinfection and sterilization that addresses all element in the intent from a) through g).
2. Healthcare professionals are trained on approved policy.
3. The hospital has at least one functioning pre-vacuum class B sterilizer.
4. The laws and regulations, Spaulding classification, and manufacturer's requirements and recommendations guide sterilization or disinfection.

IPC.21 Food services are safe and effective.

Safety

Keywords:
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 develops and implements a policy and procedures to guide safe food services that address at least the following:
a. Food receiving process.
b. A safe storage process including 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. Food transportation process.

Survey process guide:
- GAHAR surveyor may review hospital policy during document review session, followed by interviewing staff to check their awareness.
- GAHAR surveyor may observe the measures for prevention of cross contamination as presence of separate cutting boards for different type of food, separated areas for receiving, storage, and preparation of food and nutritional products.

- GAHAR surveyor may review recorded food storage temperatures.
- GAHAR surveyor may observe the sanitary food storage, preparation and distribution.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. Staff members involved in food services are aware of approved policy.
3. There are separate areas for receiving, storage, and preparation of food and nutritional products.
4. There are measures to prevent the risk of cross-contamination.
5. The hospital prepares and distributes food using proper sanitation and temperatures.

OGM.01 The hospital has a defined governing body structure.

Effectiveness

Keywords:

Governing body structure

Intent:

The governing body is responsible for defining the hospital's direction and ensuring the alignment of its activity with its purpose. It is also responsible for monitoring its performance and future development. Therefore, defining the governing structure of a hospital ensures that it operate effectively and efficiently.

In a centralized system – such as the ministry of health and population - one governing body governs several subsidiary organizations.

In order to ensure the proper governance and efficient management of any organization, its structure has to be well defined. The definition should indicate the nature of the working relationship between its various components. Such relations, which are sometimes complex, can be illustrated through a hospital chart with arrows denoting lines of authority and accountability. Ideally, the structure should be simple and follow function with minimum unnecessary layers and tailored to the hospital's purpose.

Survey process guide:

GAHAR surveyor may observe the required information through the whole process of survey with special attention given to opening presentation, document review session and leadership interview session.

Evidence of compliance:

1. The governing body structure is represented in the hospital’s chart.
2. Members of the governing body are identified by title and name.
3. Governing body members are diverse and represent community interests and desired competencies.
4. The governing body meets on predefined intervals, and minutes of meetings are recorded.
5. The governing body evaluates its performance annually versus the strategic plan.

OGM.02 The governing body works with the hospital leaders to set the hospital mission statements.

Effectiveness

Keywords:
Mission statement

Intent:
Mission statement is a description of the hospital's core purpose. It is the ground element for establishing the strategic direction of a hospital leading to the formulation of its objectives and related strategies.
Defining the main purpose of the hospital in the form of a mission is one of the fundamental roles of the governing body, as the hospital's mission must be aligned with the national healthcare mission, communicated to the all relevant stakeholders, including staff, patients, and visitors.

Survey process guide:
GAHAR surveyor may observe the mission statement posters, brochures or documents focusing on its last update, approval, alignment and visibility.

Evidence of compliance:
1. The hospital has a mission statement approved by the governing body.
2. The mission statement is aligned with national healthcare initiatives and 2030 vision.
3. The mission statement is evaluated annually.
4. The mission statement is visible in public areas to staff, patients and visitors.

OGM.06 There is a clear process for coordination and communication among the hospital director, staff, and the hospital committees/ structures.

Effectiveness

Keywords:
Committee structure

Intent:
Accomplishing the hospital mission requires engagement and teamwork.
Such requirements are established through knowledge sharing and staff involvement in decision making.
Committees are tools for mixing distributed knowledge and abilities of various parts of the hospital in the format of one active and integrated unit that can have an effective role in decision- making.
A multidisciplinary selection of members of every committee and regular holding of committees can enhance its productivity.
The hospital leadership, medical staff, nursing staff, and other staff are involved in the relevant committees.
Each committee must have terms of references that include its membership, duties,

accountability/reporting, frequency of meeting, quorum, and baseline agenda.
The committee meetings are to be held regularly, and minutes of the meeting are documented.
The hospital has at least the following committees:

a. Environmental safety committee
b. Infection control committee
c. Pharmacy and therapeutic committee
d. Quality and patient safety committee
e. Mortality and Morbidity Committee

Survey process guide:

GAHAR surveyor may encounter many committee functions during the course of GAHAR survey, a clear committee structure with meeting agendas, minutes and staff appointment shall be checked.

Evidence of compliance:

1. The hospital has at least the committees mentioned in the intent a) through e).
2. Each committee had terms of reference.
3. Committees are meeting regularly.
4. Committees' minutes of the meetings are recorded and communicated to involved staff members.
5. There is an announced process of coordination and communication between the director and the staff and the hospital committees/ structures.

OGM.14 The hospital manages the patient billing system.

Efficiency

Keywords:

Billing system

Intent:

The billing process is a crucial component of hospital management.
Due to the complexity of the billing processes, billing errors may result in costly financial losses, for example, billing errors due to lack of or the inappropriate invoices of medical materials used by the missing barcode due to missing or inappropriate result reports.
The billing process includes that all the services and items provided to the patient are recorded to the patient's account, then all information and charges are processed for billing.
For third-party payer systems, the processed for billing is based on the requirements of insurance companies/agencies which generally have reimbursement rules.
The hospital develops a policy and procedures for the billing process that addresses at least the following:

a. Availability of an approved price list.
b. Patients are informed of any potential cost pertinent to the planned care.
c. A process to ensure accurate billing.
d. Use of accurate and approved codes for diagnoses, interventions, and diagnostics.

Survey process guide:

- GAHAR surveyor may review approved policy and price lists during the financial stewardship review session.
- GAHAR surveyor may interview some billing staff and some patients to match the actual performance against the approved policy.

Evidence of compliance:

1. The hospital has an approved policy for billing patients accurately.
2. There is an approved price list.
3. Patients are informed of any potential cost pertinent to the planned care.
4. The hospital uses accurate and approved codes for diagnoses, interventions, and diagnostics.
5. In the case of a third-party payer (or health insurance), the timeliness of approval processes is monitored.
6. Billing staff is oriented on various health insurance processes.

OGM.20 The hospital has an approved staff health program that is monitored and evaluated annually according to laws and regulations.

Safety

Keywords:

Staff health

Intent:

The 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 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
e. Staff education on the risks within the 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. A pre-employment medical examination is required for all employees' categories to evaluate their appropriateness for safe performance, and staff that is exposed to certain hazards as radiation should have periodic specific medical evaluation (tests and examinations). The 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.
i. 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.
j. All staff occupational health program-related results (medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulation

Survey process guide:

- GAHAR surveyor may meet staff members who are involved in developing and executing staff health program to check program structure, risks, education and orientation records
- GAHAR surveyor may review a sample of staff health records to ensure standard compliance

Evidence of compliance:

1. There is an approved hospital's staff health program according to local laws and regulations that cover a) through j) in the intent.
2. There is an occupational health risk assessment that defines occupational risks within the hospital.
3. Staff members are educated about the risks within the hospital environment, their specific job-related hazards, and periodic medical examination.
4. All staff members are subject to the Immunization program and to work restrictions according to laws and regulations and approved 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.

WFM.02 Hospital staffing plan identifies the number of staff and defines the desired skill mix, education, knowledge, and other requirements of staff members needed to meet the hospital mission, professional practice recommendations, and provide safe patient care.

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 successfully through matching up detailed staff data including skills, potential, aspirations, and location with business plans.
Shortage of competent healthcare professionals in multiple areas is an alarming sign, especially in critical care disciplines such as intensive care units and anesthesia.
The hospital must comply with laws, regulations and recommendations of professional practices that define desired education levels, skills, or other requirements of individual staff members including independent practitioner or that defines staffing numbers or mix of staff for the hospital.
The staffing plan is reviewed on a regular basis and updated as necessary by the leaders of each clinical or managerial area who defines the individual requirements of each staff position.
The hospital maintains a safe level of staff members including independent practitioner's numbers and skill level that matches at least 60% of its requirements specially in critical care areas.
Leaders consider the following factors to project staffing needs:

a. The hospital mission, strategic and operational plans
b. Complexity and severity mix of patients served by the hospital
c. Services provided by the hospital
d. Technology and equipment used in patient care

Survey process guide:
During the GAHAR survey, the surveyor may review the staff documents, observe workforce allocation and skills, or review staff including independent practitioner's files to check compliance of staffing plan to laws, regulations, and professional practices recommendations

Evidence of compliance:

1. Staffing plan matches the mission, strategic and operational plans.
2. Staffing plan complies with laws, regulations, and recommendations of professional practices.
3. Staffing plan identifies the estimated needed staff numbers including independent practitioners and skills with staff assignments to meet the hospital needs.

4. In critical care and anesthesia services, Competent staff members' number matches at least 60% of the required numbers in the staffing plan.
5. Staffing plan is monitored and reviewed at least annually.

WFM.06 A staff file is developed for each workforce member.

Efficiency

Keywords:
Staff files

Intent:
It is important for the hospital to maintain a staff files for each staff member including independent practitioners.
An accurate staff file provides recording about the staff's knowledge, skill, competency, and training required for carrying out job responsibilities.
In addition, the record shows evidence of staff performance and whether they are meeting job expectations.
Each staff member in the hospital including independent practitioners have a record(s) with information about his/ her qualifications; required health information, such as immunizations and evidence of immunity; evidence of participation in orientation as well as on-going in-service and continuing education; results of evaluations, including staff member performance of job responsibilities and competencies; and work history.
Records are standardized and kept currently according to the hospital policy.
Staff files including independent practitioners may contain sensitive information and that must be kept confidential.
The hospital developed a policy and procedures that guide management of staff files including independent practitioners that addresses at least the following:

a. Staff file initiation
b. Standard Contents such as; verified certification, license, Education, training and work history, Current job description, recorded evidence of orientation to the hospital, the assigned department, and the specific job, Evidence of initial evaluation of the staff member's ability to perform the assigned job, Ongoing In-service education received, Copies within three months evaluations and Copies of annual evaluations
c. Update of file contents
d. Storage
e. Retention time
f. Disposal

Survey process guide:

- GAHAR surveyor may check a sample of staff files to assess compliance to standard requirements
- GAHAR surveyor may visit the area where staff files are kept to assess storage conditions,

retention, confidentiality, and disposal mechanism
- GAHAR surveyor may interview staff involved in creation, use and storage of staff files to assess the process

Evidence of compliance:

1. The hospital has an approved policy that addresses at least elements from a) through f) in the intent.
2. Staff members who are involved in creation, storage and use of staff files, are aware of the policy requirements.
3. Staff files are confidential and protected.
4. Staff files include all the required records.
5. Staff files are disposed as per hospital policy.

WFM.07 Appointed, contracted, and outsourced staff undergo a formal orientation program.

Effectiveness

Keywords:

Orientation program

Intent:

The decision to appoint an individual to a hospital sets several processes in motion.

To perform well, 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 hospital mission.

This is accomplished through a general orientation to the hospital and his/ her role and a specific orientation to the job responsibilities of his/ her position

Staff orientation, especially when first employed, with the hospital policies, ensures alignment between hospital mission and staff activities.

It also helps to create a healthy hospital culture where all staff works with a shared mental model and towards agreed-upon objectives.

Staff orientation also facilitates the integration of new staff with the already available to rapidly form effective teams that offer safe and quality care.

The hospital builds a comprehensive orientation program that is provided to all staff members regardless of their terms of employment

Staff orientation occurs on three levels: General orientation, department orientation and job-specific orientation

General orientation program addresses at least:

a. Review of the hospital mission, vision, and values
b. Hospital structure
c. Hospital policies for the environment of care, infection control, performance improvement, patient safety and risk management

Department orientation program addresses at least:

d. Review of relevant policies and procedures
e. Operational processes,
f. Work relations.

Job Specific orientation:

g. High risk processes
h. Technology and equipment use
i. Staff safety and health

The hospital develops a staff manual that describe processes of staff appointment and reappointment, staff appraisal, staff complaints management, staff satisfaction measurement, code of ethics, disciplinary actions, and termination

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the process of orientation.
- GAHAR surveyor may check a sample of staff files to check evidence of attendance of general, departmental and job specific orientation

Evidence of compliance:

1. General orientation program is performed and it includes at least the elements from a) through c).
2. Department orientation program is performed and it includes at least the elements from d) through f).
3. Job specific orientation program is performed and it includes at least the elements from g) through i).
4. Any staff member attends orientation program regardless of employment terms.
5. Orientation completion is recorded in the staff file.

WFM.09 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 individual, team, hospital improvement when based on a defined transparent process with clear declared criteria relevant to the job functions.

Performance evaluation also promotes communication between employees and leaders,

enabling them to make informed decisions about staff planning, selection, incentives, training and education, and career planning.
Performance appraisal offers the chance to give feedback to staff about what they do well or poor in a confidential respectful manner, thus promoting a learning culture within the hospital.
The hospital uses a performance evaluation tool to ensure staff has the required criteria for doing jobs and achieving objectives.
Recorded process of employees' performance evaluation including performance review methods, tools, evaluation dimensions, criteria, time interval, appeal process, and responsible person for each staff category.

Survey process guide:

- GAHAR surveyor may interview department/service or hospital leaders and inquire about used tools for staff performance evaluation.
- GAHAR surveyor may check a sample of staff files to assess completion of performance evaluations.

Evidence of compliance:

1. Performance and competency evaluation is performed at least annually for each staff member.
2. Performance and competency evaluation is performed also when indicated by the findings of quality improvement activities and appropriate education and training provided.
3. There is evidence of employee feedback on performance and competency evaluation.
4. Actions are taken based on a performance review.
5. Performance and competency evaluation is recorded in staff members' files.

NB. Surveyors will consider this standard not applicable in the initial registration survey only.

IMT.06 Patient's medical record and information are protected from loss, destruction, tampering, and unauthorized access or use.

Safety

Keywords:
Integrity of data and information

Intent:
Data integrity is a critical aspect to the design, implementation and usage of any information system which stores, processes, or retrieves data as it reflects the maintenance of, and the assurance of the accuracy and consistency of data over its entire life cycle.
Any unintended changes to data as the result of a storage, retrieval or processing operation, including malicious intent, unexpected hardware failure, and human error, is failure of data integrity.
Patient's medical record and information are protected at all times and in all places.

Including protecting it from water, fire, or other damage, and unauthorized access. Keep security policies current, and decrease the likelihood and/or impact of electronic health information being accessed, used, disclosed, disrupted, modified, or destroyed in an unauthorized manner.
Medical records storage area must implement measures to ensure medical records protection, e.g., controlled access and the suitable type of fire extinguishers.

Survey process guide:

- GAHAR surveyor may interview staff to assess the process of information protection from loss, destruction, tampering, and unauthorized access or use.
- GAHAR surveyor may observe patient's medical records protection measures that include suitable type of fire extinguishers in archiving, storage area and in computers areas.

Evidence of compliance:

1. Medical records and information are secured and protected at all times.
2. Medical records and information are secured in all places, including patient care areas and the medical records department.
3. The medical records department storage area implements measures to ensure medical information integrity.
4. When an integrity issue is identified, Actions are taken to maintain integrity.

IMT.08 Patient's medical record is managed effectively.

Effectiveness

Keywords:
Patient's medical record management

Intent:
Without a unified structure of the patient's medical record, each healthcare professional will have his/her own solution, and the end result will be incompatibility of systems and the inability to share information.
Every patient evaluated or treated in the hospital has a medical record.
The file is assigned a number unique to the patient, used to link the patient with his or her health record.
A single file with a unique number enables the hospital to locate patient's medical record easily and document care of patient over time.
The patient's medical record must have uniform contents and order.
The main goal of developing a uniform structure of the patient's medical record is facilitating the accessibility of data and information to provide more effective and efficient patient care.
Patients' medical records are available to assist the healthcare professional in having quick access to patient information and to promote continuity of care and patient satisfaction.

The hospital developed a policy and procedures that addresses at least the following:

a. Medical record flow management: Initiation of a patient's medical record, unique identifiers generation, Tracking, Storing and Availability when needed to healthcare professionals
b. Medical record Contents and order uniformity
c. Medical record standardized use
d. Patient's medical record release
e. Management of voluminous patient's medical record

Survey process guide:

- GAHAR surveyor may review the policy followed by checking the implementation of the process
- GAHAR surveyor may check that each patient's medical record has a unique identifier for each patient, medical record contents, format and location of entries and medical records movement log-book.
- GAHAR surveyor may observe patient's medical record availability when needed by healthcare professional, contain up to date information within in an appropriate timeframe.
- GAHAR surveyor may interview staff to assess awareness about managing patient's medical record in the hospital

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through e).
2. All staff who are using patient's medical record are aware of the policy requirements.
3. A patient's medical record is initiated with a unique identifier for every patient evaluated or treated.
4. The patient's medical record contents, format, and location of entries are standardized.
5. The patient's medical record is available when needed by a healthcare professional.

IMT.11 Response to planned and unplanned downtime of data systems is tested and evaluated.

Efficiency

Keywords:

Downtime of data systems

Intent:

Downtime event is any event where a Health information technology system is unavailable or fails to perform as designed.

The downtime may be scheduled (planned) for purposes of maintenance or upgrading the system or unplanned due to unexpected failure.

These events may significantly threaten the safety of the care delivery and interruption of

organization operations in addition to the risk of data loss.
The hospital develops and implements a program to ensure continuity of safe patient care processes during planned and unplanned downtime include the alternative paper forms and other resources required.
The program includes the downtime recovery process to ensure data integrity.
All staff receives training about the transition into a downtime environment to respond to immediate patient care needs.

Survey process guide:

- GAHAR surveyor may perform a document review of the planned and unplanned downtime program, followed by checking the implementation of the process by review of the related documents, which include departmental workflow and work instructions for planned and unplanned downtime, stock of needed forms to be used during downtime and result of annual program testing.
- GAHAR surveyor may interview staff to assess awareness about the response to planned and unplanned downtime.

Evidence of compliance:

1. There is a program for response to planned and unplanned downtime.
2. The program includes downtime recovery process.
3. The staff is trained in response to the downtime program.
4. The hospital tests the program at least annually to ensure its effectiveness.

QPI.11 An 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 hospital injuries, patient complaints, medication errors, equipment failures, adverse reactions to drugs or treatments, or errors in patient care are to be included and reported.
The incidents reporting have an important influence on improving patient safety.
They can provide valuable insights into how and why patients can be harmed at the hospital level.
Incident reports help to detect, monitor, assess, mitigate, and prevent risks that include at least the following:

a. List of reportable incidents, near misses, adverse events, and sentinel events
b. Incident management process includes how, when, and by whom incidents are reported and investigated.

c. Incidents requiring immediate notification to the management
d. Incident classification, analysis, and results reporting
e. Indication for performing intensive analysis and its process

Survey process guide:

GAHAR surveyor may perform an interactive quality management program review session to check the hospital incident reporting, management system and review system activities in the hospital including identification, analysis, and correction of gaps to prevent future re-occurrence, then followed by an interactive discussion with staff during hospital tours and tracers to assess staff member's awareness.

Evidence of compliance:

1. The hospital has an approved policy defines an incident-type and reporting system that include a) through e).
2. All staff are aware of the incident-reporting system, including contracted and outsourced services.
3. Sentinel events are investigated and gaps in services are identified.
4. Hospital communicates with patient's/services users about adverse events they are affected by.
5. Corrective actions are taken to close gaps in services in a timely manner.

QPI.12 Significant events and/or near misses are analyzed and corrected.

Safety

Keywords:

Significant events

Intent:

Certain events require intensive analysis for identification of root causes using quality tools. Significant unexpected/near misses' events can happen even in the hospital, such as:

a. Confirmed transfusion reactions.
b. Significant anesthesia and sedation events that cause harm or have the potential to cause harm to a patient.
c. Significant differences between pre- and post-operative diagnoses, including surgical pathology findings.
d. Significant adverse drug reactions that cause harm or have the potential to cause harm to a patient.
e. Significant medication errors that cause harm or have the potential to cause harm to a patient.
f. Pulmonary Embolism or Deep Venous Thrombosis developed due to missing appropriate thrombo-prophylaxis treatment and improper VTE assessment risk.
g. Patient escape or attempted escape.

Such events need for immediate investigation and response.
The hospital has to perform a root cause analysis to identify actions that be taken to improve processes of care and prevent event reoccurring.

Survey process guide:
GAHAR surveyor may perform an interactive quality management program review session to check the hospital incident reporting results of significant incidents, analysis, and corrective actions, then followed by an interactive discussion to evaluate the awareness, selected measures, and implementation.

Evidence of compliance:
1. There is a document that defines criteria and process for intensive analysis when significant unexpected events occur and the time required completing the investigation and the time required to execute the action plan.
2. In case of significant/near miss incident, a committee is formed where the chairperson and relevant staff are trained on intensive analysis.
3. All significant unexpected /near misses events are timely investigated and analyzed.
4. Corrective actions are taken with clear time frame and responsible person(s).

QPI.13 The 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 involving death or serious physical or psychological injury. Serious injury specifically includes loss of limb or function A sentinel event signals an immediate investigation and response. The hospital developed a policy for sentinel event management that includes at least the following:

a. Definition of sentinel events such as:
    i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient' illness or underlying condition
    ii. Wrong patient, wrong site, wrong procedure events
    iii. Patient suicide, attempted suicide or violence leading to death or permanent loss of function
    iv. Unintended retention of a foreign object events in a patient after surgery or invasive procedure
    v. Wrong delivery of radiotherapy
    vi. Any peri-partum maternal death
    vii. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams

b. Internal reporting of sentinel events.
c. External reporting of sentinel events.
d. Team member's involvement.
e. Root cause analysis.
f. Corrective actions plans taken.

All sentinel events are communicated 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 in order 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 surveyor may perform an interactive quality management program review session to check the hospital's results of sentinel incidents reporting, definition and type of cases, and how the system identifies the gaps behind the sentinel event, reporting and time frame for investigation and action plan. Sentinel events reported to GAHAR may be followed up during the survey to check compliance with corrective actions.

Evidence of compliance:

1. The 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 by a root cause analysis in a time period specified by leadership that does not exceed 45 days from the date of the event or when made aware of the event.
3. All sentinel events are communicated 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.

Additional standard for organizations with academic, research or organ/tissue transplantation services

ADD.07 Patient rights are protected during research activities.

Patient-centeredness

Keywords:

Research patient rights

Intent:

In ethically acceptable research, risks have been minimized and are 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 might carry uncertainty and fear to participants. Also,

withdrawal from it might make the participants fearful of being discriminated against.
Invasions of privacy and breaches of confidentiality are disrespectful to participants 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 or housing.
The ethical foundation of informed consent is the principle of respect for persons. Competent individuals are entitled to choose freely whether to participate in research, and to make decisions based on an adequate understanding of what the research entails.
The hospital develops a research policy and procedures that includes at least:

a. Eligibility for enrollment in research projects or protocols
b. Patient rights during research enrollment
c. Confidentiality guarantees for photographs and patient information included in the research
d. Patient right to withdraw from research experiment without fear of retribution

No one should be deprived of its fair share of the benefits of research; these benefits include the direct benefits of participation (if any) as well as the new knowledge that the research is designed to yield.
Informed consents should be taken; decisions for children or adults who lack the mental capacity to provide informed consent should be made by an authorized surrogate decision-maker.

Survey process guide:

- GAHAR surveyor may assess research activities during leadership interview session followed by interviewing some committee members either through a focused session or during hospital tours and tracers.
- GAHAR surveyor may interview patients who are enrolled in research activities to check compliance to the standard

Evidence of compliance:

1. The hospital has an approved program that includes all the points in the intent from a) through d).
2. Researchers are aware of the policy requirements.
3. Signed patient consent for participation in research is placed in the research file and in the patient's medical record.
4. When patient safety issues are identified during research, patients are informed and actions are taken to ensure patient safety.

Section 4: Operating Manual

► Reading and Interpretation of the Operating Manual

The operating manual outlines all the documents required in GAHAR Handbook of Hospital Accreditation Standards (policies, procedures, plans, programs, lists, etc.).
All of these documents should be available for the purpose of reviewing by GAHAR's surveyors during the registration survey.
The survey process regarding the operating manual section will be conducted through interviews with the hospital leaders regarding their related documents and how they developed them including their plans for implementation.
The required list of documents is categorized according to GAHAR Handbook of Hospital Accreditation Standards chapters as follow:

- Patient centeredness culture
- Access, continuity, and transition of care
- Integrated care delivery
- Diagnostic and ancillary services
- Surgery, anesthesia and sedation
- Medication management and safety
- Environmental and facility safety
- Infection prevention and control
- Organization governance and management
- Community assessment and involvement
- Workforce management
- Information management and technology
- Quality and performance improvement
- Additional requirements

NB. More than one requirement can be included in one document.

► Operating Manual Items/Components:

1. Patient Centeredness Culture:

a. Policy guiding clear, updated, and accurate advertisements of services (Policy) PCC.01
b. Patient & family rights. (Policy) PCC.04
   Minimum contents:
   - Patient and family rights as defined by laws and regulations, and the ethical code of healthcare professionals' syndicates.
   - Patient and family right to access care if provided by the hospital.
   - Patient and family right to know the name of the treating, supervising, and/or responsible medical staff member.
   - Patient and family rights to care that respects the patient's personal values and beliefs.
   - Patient and family rights to be informed and participate in making decisions related to their care.
   - Patient and family rights to refuse care and discontinue treatment.
   - Patient and family rights to security, personal privacy, confidentiality, and dignity.
   - Patient and family rights to have pain assessed and treated.
   - Patient and family rights to make a complaint or suggestion without fear of retribution.
   - Patient and family rights to know the price of services and procedures.
   - Patient and family rights to seek a second opinion either internally or externally.
c. Patient & family responsibilities (Policy) PCC.05
   Minimum contents:
   - Patients and their families have the responsibility to provide clear and accurate information on the disease/condition current and past medical history.
   - Patients and their families have the responsibility to comply with the policies and procedures of the hospital.
   - Patients and their families have the responsibility to comply with financial obligations according to laws and regulations and hospital policy.
   - Patients and their families have the responsibility to show respect to other patients and healthcare professionals.
   - Patients and their families have the responsibility to follow the recommended treatment plan.
d. Patient and family education process. (Policy) PCC.10
   Minimum contents:
   - Identifying patient and family needs.
   - Multidisciplinary responsibility to identify educate patients and families.

- Method for education is provided according to patient and family values and level of learning, and also in a language and format that they understand.

e. Informed consent. (Policy) PCC.11
Minimum contents:
- The list of medical processes when informed consent is needed, this list includes:
  - Surgery and invasive procedures.
  - Anesthesia, moderate and deep sedation.
  - Use of blood and donation of blood.
  - High-risk procedures or treatments (including but not limited to, electroconvulsive treatment, radiation, therapy, and chemotherapy).
  - Research.
  - Photographic and promotional activities, for in which the consent could be for specific time or purpose.
- The likelihood of success and the risk of not doing the procedure or intervention, benefits, and alternatives to performing that particular medical process.
- 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 and approved hospital policies.
- Consent forms available in all applicable locations.

f. Informed refusal. (Policy) PCC.13
Minimum contents:
- How to inform the patient/family of the patient current medical condition.
- How to inform the patient/family of the consequences of their decision.
- How to record patient and/or family refusal of the medical care process step.
- How to follow up with the patient/family after leaving the hospital.

g. The hospital responsibilities towards patient's belongings. (Policy) PCC.19
Minimum contents:
- Who is responsible for securing patient belongings.
- When responsibility for these belongings begin.
- How belongings be protected? For how long? What will happen after that.
- How patients and families are informed about the hospital's responsibility for belongings.
- How the hospital will manage lost and found situations.

h. Patient and family feedback. (Policy) PCC.20
Minimum contents:
- Measuring feedback for hospitalized patients.
- Measuring feedback for ambulatory patients.
- Measuring feedback for emergency patients.

i. Patient complaints and suggestions. (Policy) PCC.21
Minimum contents:
- Mechanisms to inform patients and families of communication channels to voice their complaints and suggestions.
- Tracking processes for patients' and families' complaints and suggestions.
- Responsibility for responding to patients' complaints and suggestions.
- Timeframe for giving feedback to patients and families about voiced complaints or suggestions.

2. Access, Continuity, and Transition of Care

Related NSRs:
NSR.01: Patient identification
NSR.07: Handover communication

a. Granting patient access to the hospital (before registration). (Policy) ACT.01
Minimum contents:
- The process to screen patients to determine that the hospital scope of services can meet their healthcare needs.
- Access through emergency areas is safe and appropriate for patients' conditions.
- Access through ambulatory areas include a clearly defined scheduling and queuing process for patients that ensures appropriate identification, clear sufficient information exchange, safety, and comfort.

b. Registration process. (Policy) ACT.02
Minimum contents:
- Establishing of a hospital-wide scope of service.
- A competent staff member performs an initial screening process.
- A screening process is used to determine the priority of the patient's medical and nursing care needs in an emergency, ambulatory, interventional units, and referral to the hospital.

c. Hospital scope of services. (approved document) ACT.02

d. Hospitalization process. (Policy) ACT.04

Minimum contents:
- Hospitalization procedures of patients, including those coming from the outpatient area, emergency areas, and other hospitalization routes.
- A defined care plan and time frame for the hospitalization process.
- Information to be given to the patient and family at the time of hospitalization.
- Management of patients when the bed is not available.
- Management of patients whose care needs cannot be met by the hospital, including care at emergency rooms, outpatient clinics, or inpatient services.

e. Risk assessment and management plan for patient flow. (Plan) ACT.07
f. Policy guiding the process of assigning patient's care responsibility. (Policy) ACT.08
   Minimum contents:
   - Each hospitalized patient is assigned to one Most Responsible Physician (MRP) as relevant to a patient's clinical condition.
   - Conditions to request and grant transfer of care responsibility.
   - How information about assessment and care plan, including pending steps, can be transferred from the first most responsible physician to the next one.
   - The process to ensure clear identification of responsibility between transfer of responsibility parties.
g. Second opinion. (Policy) ACT.10
   Minimum contents:
   - Defined criteria for getting the second opinion for patients.
   - A clear process of communicating second opinion requests to concerned healthcare professionals.
   - A clear process of communicating essential information to the second opinion healthcare professionals.
   - Timeframe to respond to second opinion requests.
   - Response details to ensure safe and appropriate care planning.
   - Actions to be taken when a second opinion can't be provided by the hospital
h. Consultation process. (Policy) ACT.11
   Minimum contents:
   - Defined criteria for getting a consultation for patients.
   - Expected outcome and urgency of consultation.
   - A clear process of communicating consultation requests to concerned healthcare professionals.
   - Timeframe to respond to consultation requests.
   - Response details to ensure safe and appropriate care planning.
i. Multidisciplinary management. (Policy) ACT.12
   Minimum contents:
   - Defined criteria for getting multidisciplinary opinions.
   - Clear responsibilities among the treating team.
   - Recording details of communication, assessment, and care.
j. Patient transportation. (Policy) ACT.13
   Minimum contents:
   - Safe patient handling to and from examination bed, trolley, wheelchair, and other transportation means.
   - Staff safety while lifting and handling patients.
   - Coordination mechanism to ensure safe transportation within the approved timeframe.

- Competence of responsible staff members for the transportation of patients.
- Defined criteria to determine the appropriateness of transportation within the hospital.

k. Special care units' access and discharge. (Policy) ACT.14
Minimum contents:
- Defined physiologic based admission criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.
- Defined discharge physiologic based criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.

l. Patient flow out: transfer, referral, temporary discharge and discharge. (Policy) ACT.15
Minimum contents:
- Planning for discharge, temporary discharge, referral, and/or transfer out begins once diagnosis or assessment is settled and, when appropriate, includes the patient and family.
- A responsible staff member for ordering and executing the discharge, referral, and/or transfer out of patients.
- Defined criteria determine the appropriateness of referrals and transfers-out are based on the approved scope of service and patient's needs for continuing care.
- Coordination with transfer/ referral agencies, if applicable, other levels of health service and other organizations.

3. Integrated Care Delivery:

Related NSRs:
NSR.02: Verbal and telephone orders
NSR.04: Catheter and tube misconnection
NSR.05: Fall screening and prevention
NSR.06: Pressure ulcer prevention
NSR.08: Critical alarms
NSR.09: Recognition and response to clinical deterioration
NSR.10: Venous thromboembolism prophylaxis
NSR.11: Critical results

a. Collaborative care. (Policy) ICD.02
Minimum contents:
- Identifying the scope of work, tasks, and treatments for each healthcare professional category.
- Identify areas of overlap and clarify responsibilities.
- A mechanism to ensure that all healthcare professionals are aware of care plans

developed by other team members in response to each patient's needs.
- Clear guidance on who will perform screening of special patient needs and how assessment and care will be provided when needed.
- A mechanism to resolve conflicts between professionals regarding assessment and care plans in a defined timeframe.
- A mechanism for involving medical and allied healthcare professionals in concertation with the patient and the patient's family in the evaluation of treatment options and treatment planning.

b. Prehospital care, ambulance care, emergency medical care during disasters. (Policy) ICD.03

Minimum contents:

- Provision, operation, or sourcing of ambulance services.
- Continuous readiness.
- The time frame for receiving calls, dispatching of vehicles, and reaching patients.
- Screening, assessment, and reassessment of patients.
- Care protocols for patients at the scene and during transfer.

c. Emergency services (Policy). ICD.04

Minimum contents:

- Qualified staff members are available during working hours.
- Defined criteria are developed to determine the priority of care according to a recognized triage process.
- Assessment, reassessment, and care management follow approved clinical guidelines and protocols.

d. Emergency care guidelines. ICD.05

Minimum clinical guidelines/protocols:

- Emergency stabilization and treatment of chest pain.
- Emergency stabilization and treatment of shock.
- Emergency stabilization and treatment of poly-trauma.
- Emergency stabilization and treatment of altered level of consciousness.
- Emergency stabilization and treatment of obstructed labor.

e. Outpatient services. (Policy) ICD.07

Minimum contents:

- Scope and content of the initial assessment, including history and physical examination.
- The time frame for completing and recording the initial assessment for each discipline.
- Responsibility for completion of assessments.
- Frequency of reassessments and follow-ups of patients whenever applicable.
- Recording of care plans.

f. Medical patient assessment and reassessment. (Policy) ICD.08
Minimum contents:
- Chief complaint.
- Details of the present illness.
- Previous hospital admissions, surgery, and invasive procedures.
- Allergies.
- Adverse drug reactions.
- Medications history.
- Social, emotional, and behavioral history.
- Family history.
- The required elements of the comprehensive physical examination.
- Elements of history and examination related to the specialty.

g. Nursing patient assessment and reassessment. (Policy) ICD.09
Minimum contents:
- Vital signs
- Pain
- Additional measurements such as height, weight
- Risk assessments. e.g., fall, bedsores e) Airway, breathing, circulation, disability, skin, and hydration.
- Outputs (as relevant)
- A detailed nursing assessment of a specific body system(s) relating to the presenting problem or other current concern(s) required.

h. Screening of healthcare needs. (Policy) ICD.10
Minimum contents:
- Qualified healthcare professionals define screening criteria for assessing the following patients' risks and needs.
- Timeframe to complete healthcare needs screening.
- Process for identifying the need for further assessment by the specific service when defined criteria are met.
- Screening occurs for at least the following:
  - Nutritional status
  - Functional status
  - Psychosocial status
  - Discharge needs
  - Victims of abuse and neglect

i. Clinical practice guidelines adaptation and adoption. (Policy) ICD.15
Minimum contents
- How clinical practice guidelines/protocols are adopted and reinforced, reviewed, evaluated, updated, and adopted based on evidence-based literature.

- The hospital should adapt and adopt guidelines or protocol for the most common/ high risk three diagnoses managed in the hospital annually.
- Clinical practice guidelines adapted/adopted by the hospital are evaluated at least annually or when needed.

j. Orders and requests (Policy) ICD.17
Minimum contents:
- Name of the ordering medical staff members.
- Date and time of order.
- Patient identification, age, sex.
- Clinical reason for ordering and requesting a service.
- Preparation requirements.
- Precautions to be taken.
- Site and laterality for medical imaging studies.
- Prompt authentication by the ordering medical staff members.

k. Pain screening, assessment, reassessment and management. (Policy) ICD.19
Minimum contents:
- Pain screening tool.
- Complete pain assessment elements that includes nature, site, and severity.
- Frequency of pain reassessments.
- Pain management protocols.

l. Assessment and management of patient's nutritional needs. (Policy) ICD.20
Minimum contents:
- Availability of competent individuals for assessment and management of patient's nutritional needs.
- Defined criteria for the involvement of nutritional services into the patient care process.
- Components of nutritional assessment.
- Management and care for patient's nutritional needs:
  - A list of all special diets is available and accommodated.
  - Ordering of food is appropriate to the patient's clinical condition.
  - Ordering for food or other nutrients is recorded in the medical record.
  - Scheduling for meals and timings of distribution of meals complies with patient's preferences.
- Management and storage of food brought in by family members.

m. Assessment and management patient psychosocial needs. (Policy) ICD.21
Minimum contents:
- Availability of competent individuals for assessment and management of patient's psychosocial needs.
- Defined criteria for the involvement of psychosocial services into the patient care process.

- Components of psychosocial assessment that includes at least stress, anxiety, depression, social isolation, and poor relationships.
- Management and care of patient's psychosocial needs:
  - A list of community resources for health promotion and vulnerability support is available.
  - Education of patients and/or their families on available community resources when needed.
- Management and support in case of a patient's disability, infectiousness, and inability to afford the payment of care costs.

n. Assessment and management patient's functional needs. (Policy) ICD.22
Minimum contents:
- Availability of competent individual for assessment and management of patient's functional needs.
- Components of functional assessment.
- Management and care for patient's functional needs through an individualized plan of care that addresses at least the following:
  - Management, care, and support for independent activities of daily life such as eating, drinking, walking, and moving.
  - Management, care, and support for communication for those with limited hearing, vision, cognitive or intellectual abilities.
  - Empowerment and support for families and others who may observe, assist, and react to the patient's daily life activity needs, functional needs, and transportation.
- Defined criteria for the involvement of rehabilitative services into the patient care process.

o. Identification, screening and assessment of special-needs patient populations. (Policy) ICD.23
Minimum contents:
- Identification of special-needs patient populations that visit the hospital which should include at least the following:
  - Adolescents
  - Elderly
  - Disabled
  - Immunocompromised
  - Patients with communicable diseases
  - Patients with chronic pain
  - Victims of abuse and neglect
- Availability of competent individuals for assessment and management of special patient populations needs.

- Required modifications for regular patient assessment methods to match special patient populations needs.
- Management and care for special patient populations needs through an individualized plan of care.

p. Safe childbirth process. (Policy) ICD.24
q. Assessment and management of the pediatric population. (Policy) ICD.25
   Minimum contents:
   - Immunization status.
   - Nutritional assessment and care.
   - Cognitive abilities assessment and care.
   - Congenital diseases screening and care.
   - Social assessment and care according to national child law and regulation.
   - Growth charts.
r. Care of terminally ill and dying patients. (Policy) ICD.26
   Minimum contents:
   - The preparation of patients and their families for death.
   - Clinical decisions should be individualized, and includes a shared approach for decision making with the involvement of the patient and/or family.
   - Management of symptoms, including pain and depression.
   - Provision of patient and family support for psychosocial, emotional, cultural and spiritual needs.
s. Care of psychiatric patients. (Policy) ICD.27
   Minimum contents:
   - Compulsory treatment.
   - Informed consent.
   - Restraints usage.
   - Overnight visits.
   - Monitoring and follow-up of non-returning patients.
   - Electroconvulsive therapy.
   - Vocational and recreational activities.
t. Care of patients on restraint and seclusion. (Policy) ICD.28
   Minimum contents:
   - The use of restraints or seclusion is according to defined criteria, laws, and regulations.
   - Requirements for clear physician order for the use of restraints and seclusion.
   - Safe and effective application and removal by qualified staff members.
   - The least restrictive methods are to be used as appropriate.
   - Protection of patient's rights, dignity, and well-being during use.
   - Monitoring and reassessment during use.

- Renewal of the restraint order based on continuing need and according to laws and regulations.
- Management and care for patients needs during restraint and seclusion.
- Termination of restraints and seclusion is according to defined criteria.

u. Care of victims of drug abuse and addiction. (Policy) ICD.29
Minimum contents:
- Assessment of history of drug use, including the age of onset, duration, intensity, patterns of use, used drugs, consequences, and complications.
- Types of previous treatment and responses to the treatment.
- History of mental, emotional, and behavioral problems.
- Features of the environment that promote compliance and wellness or obstacles to recovery:
  - Financial status.
  - Current living situation and family circumstances.
  - Need for family participation in the patient's care.
  - Treatment acceptance or the motivation for treatment.

v. Care of patient receiving chemotherapy and radiotherapy. (Policy) ICD.31
Minimum contents:
- Identification of special-needs patient populations that visit the hospital.
- Availability of competent individuals for assessment and management of special patient populations needs.
- Required modifications for regular patient assessment methods to match these patients' needs.
  - Before the first administration of a new regimen, such as pathologic confirmation or verification of initial diagnosis, Initial cancer stage, or current cancer status, the treatment plan, including, at a minimum, the patient diagnosis, drugs, doses, duration of treatment, and goals of therapy.
  - On each clinical encounter or day of treatment, healthcare professionals perform and record patients' assessments that includes at least the following elements, and takes appropriate action: weight, height, treatment toxicities and adverse effects.
- Management and care for patients undergoing chemotherapy and/or radiotherapy needs through an individualized plan of care including management of complications such as extravasation, anaphylaxis, and neutropenia.

w. Care of dialysis patients. (Policy) ICD.32
Minimum contents:
- Initial assessment requirements.
- Reassessment requirements.
- Periodic laboratory testing.

- Clinical guidelines/protocols for at least the following:
  - Care of arteriovenous access (AVE access).
  - Anticoagulation usage.
  - Dialysis-induced complications.
  - Cardiopulmonary collapse and urgent medical conditions during dialysis.

x. Critical care services. (Policy) ICD.33
Minimum contents:
- Minimum resources required for each bed, such as: space, skills, and equipment.
- Initial assessment requirements including circulation, respiration, and oxygenation.
- Reassessment requirements.
- Monitoring of equipment.
- Management of critical care procedures such as; tracheostomy, intubation, prone positioning, and delirium screening.

y. Emergency equipment and supplies. (Policy) ICD.36
Minimum contents:
- Identification of required emergency equipment and supplies list according to laws, regulations, and standards of practice.
- Emergency equipment and supplies are available all over the hospital.
- Emergency equipment and supplies are age-appropriate.
- Emergency equipment and supplies are replaced immediately after use or when expired or damaged.
- Emergency equipment and supplies are checked daily for their availability and readiness.

z. Cardiopulmonary resuscitation and medical emergencies (Policy) ICD.38
Minimum contents:
- Defined criteria of recognition of emergencies and cardio-pulmonary arrest including adults and pediatrics.
- Education of staff members on the defined criteria.
- Identification of involved staff members to respond.
- Mechanisms to call staff members to respond; including code(s) that may be used for calling emergency.
- The time frame of response.
- The response is uniform 24 hours a day and seven days a week.
- Recording of response and management.

Required documents include: Basic and advanced life support certifications (BLS/ACLS or as related) from a recognized relevant professional organization. The hospital approves single certification body to standardize the resuscitation services according to the hospital approved protocols.

4. Diagnostic and Ancillary Services

Related NSRs:
NSR.25: Radiation safety program
NSR.26: Laboratory safety program

a. Medical imaging service planning (licenses, permits, guidelines and list of services) DAS.01
b. Performance and competency assessment of medical imaging staff (policy) DAS.02
   Minimum contents:
   - Direct observation of routine work processes and procedures, including all applicable safety practices.
   - Direct observation of equipment maintenance, function checks; and monitoring recording and reporting of examination results.
   - Review of imaging professionals' human resources records.
   - Assessment of problem-solving skills.
   - Training on special modalities, equipment, and studies.
c. Procedure manual for each medical imaging study type. DAS.03
   Minimum contents:
   - Scope and general overview
   - Equipment description
   - Maintenance procedures
   - Quality control
   - Safety procedures
   - Critical findings
d. Medical imaging pre-examination process. (policy) DAS.04
   Minimum contents:
   - Proper completion of request form to include: patient identification (Full patient name, date of birth, gender, patient contact, and location), name of the ordering physician, studies requested, date and time of study, clinical information, special marking for urgent tests request.
   - Patient preparations including specific risks.
   - Description of study techniques.
   - Pre-study review of requests to ensure that the requested examination is appropriate to the needs of the referrer and the patient.
   - Actions to be taken when a request is incomplete, illegible, or not clinically relevant, or when the patient is not prepared.
   - Recording informed approvals from patients and referrers when an additional or substituted examination is called for.

e. Medical imaging quality control program. DAS.05
Minimum contents:
- Elements of the internal quality control performed according to risk assessment for each study/modality.
- The frequency for quality control testing is determined by the hospital according to guidelines and manufacturer instructions whichever is more stringent.
- Quality control methods to be used. It can be handled and tested in the same manner and by the same medical imaging staff member.
- Quality control performance expectations and acceptable results should be defined and readily available to staff so that they will recognize unacceptable results in order to respond appropriately.
- The quality control program is approved by the designee prior to implementation.
- Responsible authorized staff member reviews quality control data at a regular interval (at least monthly).
- Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

f. Medical imaging examination protocols. DAS.06
Minimum contents:
- Radiographic factors
- Positioning
- Sterile tray set-up
- Aftercare

g. Medical imaging investigations reporting within approved timeframe. (policy) DAS.07
Minimum contents:
- Time frames for reporting various types of images to healthcare professional and to patients.
- Emergency and routine reports.
- Accountabilities on the medical Imaging services across the hospital.
- Qualified licensed medical staff member is responsible for interpretation and reporting.

h. Laboratory services planning (scope of services and plan for services) DAS.10

i. Performance and competency assessment of laboratory staff (Policy) DAS.11
Minimum contents:
- Direct observation of routine work processes and procedures, including all applicable safety practices.
- Direct observation of equipment maintenance, function checks; and monitoring recording and reporting of examination results.
- Review of work records.
- Assessment of problem-solving skills.

- Examination of specially provided samples, such as previously examined samples, inter-laboratory comparison materials, or split samples.

j. Reagents' management. (Policy) DAS.12
Minimum contents:
- Criteria for inspection, acceptance, and rejection of provided reagent.
- Methods of identification, enlisting and labeling of all reagents present in the laboratory.
- Method to ensure reagents quality before use for testing.
- Measures to ensure that the laboratory does not use expired materials.
- Define safety limits for the reordering of the laboratory materials according to the laboratory needs.
- Requesting, issuing and dispatching reagent and supplies as well as identifying responsible person.

k. Selection and evaluation of referral laboratory. (Policy) DAS.13
Minimum contents:
- Selection: selection should be based primarily on quality of performance. Whenever possible, referral specimens are sent to a national or international accredited laboratory.
- Evaluation: The laboratory should implement an evaluation process either before starting contracting, during the contract, or upon renewal of the contract for the referral laboratory through monitoring the quality of performance, turnaround time, and result reporting.
- Requirements: A signed document specifying the expectations of the two parties involved should be readily available for quick referral. The document includes at least the following:
  - Scope of service
  - Agreement conditions (including accreditation status).
  - Sample requirements
  - Turnaround time (TAT)
  - Result reporting
  - Release of information to the third party
  - Mean of solving disputes
  - The validity of the agreement and review schedule.

l. Minimal retesting intervals for laboratory investigations. (Policy) DAS.14
Minimum contents:
- Frequency of repeating a test should be based on a number of criteria:
  - The physiological properties affecting the analyte
  - Biological half-life
  - Analytical aspects

        - Treatment and monitoring requirements
        - Established guidelines
    - Education of requesters, so that appropriate tests are requested at the right time and for the right patient.
    - Information in the laboratory service manual regarding indications for repeating a test.
    - Implementation of logic rules in the laboratory to remove or restrict requests based on previous patient data.
    - Delivery of prompts to remind the requester at point of requesting via remote/ ward requesting software that a request is either too soon or inappropriate, with the facility to review previous results or ask questions. There is also be an option to record the reason for overriding a minimal retesting interval.
    - Limiting a test's use is also achieved by restricting the requesting of a repeat test to a particular grade or level of staff, so that only those of an appropriate level may have access to a particular test.

m. Laboratory pre-examination process (Policy) DAS.15

Minimum contents:

- Proper completion of request form to include: patient identification (Full patient name, 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.
- Patient preparations including instructions for dietary requirements (e.g., fasting and special diets).
- Description of specimen type collection techniques.
- Proper specimen labeling.
- Criteria for safe disposal of materials used in the collection.
- Proper handling and transportation of specimens.
- Turnaround time of tests
- Minimal retesting interval

n. Specimen reception, tracking, and storage processes. (Policy) DAS.16

Minimum contents:

- Setting criteria for acceptance or rejection of specimens.
- Evaluation of received specimens by authorized staff member to ensure that they meet the acceptance criteria relevant for the requested examination(s).
    - 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.

        - 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.
        - 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.
    - Traceability of all portions of the primary specimen to the original primary sample.
    - Process of recording all specimens referred to other laboratories for testing.
    - Instructions for proper sample storage in the pre-examination phase.

o. Verification/Validation of laboratory test methods. (Policy) DAS.17
   Minimum contents:
    - Measurement of trueness.
    - Measurement of precision.
    - Measurement of linearity (detection and quantification limits).
    - Validation the examination procedures when:
        - Using a non-standard method.
        - The standard method used outside its intended scope.
        - The validated method with modification.

p. Laboratory examination procedures: written procedure for each analytical test. DAS.18
   Minimum contents:
    - Principle and clinical significance of the test.
    - Requirements for patient preparation and specimen type, collection, and storage. Criteria for acceptability and rejection of the sample.
    - Reagents and equipment used.
    - Verification/validation of examination procedures.
    - The test procedure, including test calculations and interpretation of results.
    - Calibration and control procedures and corrective actions to take when calibration or control results fail to meet the laboratory's criteria for acceptability.
    - Verified/Validated biological reference intervals/clinical decision values.
    - Critical test results.
    - Analytical measurement range and instructions for determining results when it is not within the measurement interval.
    - Limitations in methodologies including interfering substances.
    - References.

q. Laboratory quality control program. DAS.19
   Minimum contents:
    - Elements of the internal quality control performed according to risk assessment for each test method.
    - The frequency for quality control testing is determined by the hospital according

to guidelines and manufacturer instructions whichever is more stringent.
- Quality control materials to be used. They shall be handled and tested in the same manner and by the same laboratory staff member testing patient samples.
- 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.
- Acceptance-rejection rules for internal quality control results.
- The internal quality control program is approved by the designee prior to implementation.
- Quality control data is reviewed at a regular interval (at least monthly) by responsible authorized staff member.
- Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

r. Laboratory post-examination process. (Policy) DAS.21
Minimum contents:
- Final report data fulfillment including at least: identity of the laboratory, patient identification, tests performed, ordering clinician, date and time of specimen collection and the source of specimen, reporting date and time, test results and reference interval, identification of the verifying individual (Approver), interpretation of results, where appropriate, advisory, or explanatory comment when needed.
- Reviewing, verifying, and reporting of results by authorized staff member.
- Criteria for specimen storage.
- The defined retention time of laboratory results.
- The defined retention time of patient samples.

s. Laboratory turnaround time. (Policy) DAS.22
t. Laboratory results reporting within identified turnaround time (STAT). (Policy) DAS.23
u. Quality control procedures manual of point of care tests. DAS.25
v. Blood transfusion services quality manual. DAS.26
Minimum contents:
- Organization and management
- Resources, equipment and supplies
- Customer needs
- Process control
- Documents and records
- Deviations, nonconformance and complications
- Donor assessments
- Blood screening
- Process improvements
- Facilities and safety

w. Safe blood donation. (Policy) DAS.27

Minimum contents:

- Donor screening based on:
  - Donor's history of surgeries, vaccination, receiving blood and donation interval.
  - Donor's physical examination including general appearance, height and weight and vital signs.
  - Blood bag laboratory testing, including specified communicable diseases, blood grouping and RH typing.
- Mechanisms to ensure voluntary non-remunerated blood donation.
- Pre-donation counselling by trained staff that include risk behaviors and self-exclusion for patient safety, tests carried out on donated blood and potential side effects. (questionnaires may be used)
- Donor safety and privacy.

x. Management of blood, and blood components. (Policy) DAS.28

Minimum contents:

- Collection:
  - Donation of blood: donor area cleanliness and convenience, donor reaction and outdoor blood donation campaigns.
  - Infection control precautions.
- Handling:
  - Identification of blood/blood components bags and tubes.
  - Temperature controls.
  - Transportation of blood.
- Testing:
  - Determination of ABO group
  - Determination of Rh(d) type previous records
  - Laboratory tests for infectious diseases
  - Quarantine storage
- Preparation
  - Sterility
  - Seal
  - Blood components preparation instructions and protocols

y. Contracted blood banks. (Policy) DAS.30

Minimum contents:

- Selection:
  - Selection should be based primarily on quality of performance.
  - Whenever possible, blood and blood components are obtained from an accredited laboratory.

- Evaluation:
  - The blood bank should implement an evaluation process before starting relationship by assessing blood bank accreditation status, inspection reports, performing an on-site visit to the blood bank, or by other means of evaluation.
  - The blood bank should implement an evaluation process during the relationship with the outside blood bank by monitoring and evaluating certain quality measures.
- Requirements:
  A signed document specifying the expectations of the two parties involved should be readily available for quick referral. The document includes at least the following:
  - Scope of Service.
  - Agreement conditions (including accreditation status).
  - Agreement on safe storage and transportation conditions.
  - Role of the involved parties in look back and transfusion transmitted diseases investigation.
  - Predefined acceptance criteria for each blood component received.
  - Release of blood, blood components or information to the third party.
  - Mean of solving disputes.
  - Validity of the agreement and review schedule.
- Inspection:
  - Checking for meeting predefined acceptance criteria for each blood component received.
  - Evaluation and verification of units' identification information including unit numbers, ABO/Rh-D and Expiration dates.
  - Conformation of ABO/Rh-D for RBC components.
  - Actions taken for unsatisfactory blood or blood component units.
  - Evaluation and verification of the transportation condition of each blood component.

z. Ordering of blood and blood products. (Policy) DAS.31
   Minimum contents:
   - Assessment of patient's clinical need for blood.
   - Education of patient and family about proposed transfusion and recording in the patient's medical record.
   - Selecting blood product and quantity required and completing the request form accurately and legibly.
   - Recording the reason for transfusion, so that the blood bank can check that the product ordered is suitable for diagnosis.
   - Clearly communicate whether the blood is emergently or routinely needed.
   - Sending the blood request form with blood sample to the blood bank.

- When recipient's blood sample is received, a qualified member of the staff should confirm, if the information on the label and on the transfusion request form are identical. In case of any discrepancy or doubt, a new sample should be obtained.

aa. Distribution of blood and blood components. (Policy) DAS.32

Minimum contents:

- Blood compatibility testing of all whole blood and red cells transfused.
- The cross-matching report form should have patient's first name with surname, age, sex, identification number, ABO and Rh(D) type.
- The form should have donor unit identification number, segment number, ABO and Rh(D) type and expiry date of the blood.
- Interpretation of cross matching report and the name of the person performing the test and issuing the blood should be recorded.
- Each unit of blood should be visually inspected before distribution. It should not be distributed if there is any evidence of leakage, hemolysis or suspicion of microbial contamination such as unusual turbidity, or change of color.
- Special situations such as:
  - Conditions for reissuance of blood: when blood and/or blood components are returned to blood bank to be reused/reordered.
  - Urgent requirement of blood.
  - Actions to be taken when required blood type is not available

ab. Transfusion of blood and blood products. (Policy) DAS.33

Minimum contents:

- Visually checking the bag for integrity.
- Blood transfusion in emergencies.
- Conditions when the bag shall be discarded.
- The rate for blood transfusion.
- Recording the transfusion.
- Monitoring and reporting any adverse event.
- Special considerations for use of blood components.
- Management of transfusion complications.

5. Surgery, Anesthesia and Sedation:

Related NSRs:

NSR.17: Surgical site marking

NSR.18: Pre-operative checklist

NSR.19: Timeout

NSR.20: Instrument retention prevention

a. Booking of surgeries and invasive procedures. (Policy) SAS.02
   Minimum contents:
   - Surgeries and invasive procedures are booked according to granted clinical privileges.
   - The hospital records surgeries and invasive procedures, whether they are scheduled, performed, or canceled.
   - Clear and safe mechanism to identify patients in the records.
   - A clear and safe mechanism to call patients for surgeries or invasive procedures.

b. List of implantable devices used in the hospital. (list) SAS.11
c. Implantable devices tracking policy. (Policy) SAS.11
d. Organization chart of anesthesia department. SAS.14
e. Job description of anesthesia head of department. SAS.14
f. Anesthesia protocols. SAS.16
g. Sedation protocols. SAS.22

6. Medication Management and Use:

Related NSRs:
NSR.13: Medication reconciliation
NSR.14: Medication storage and labelling
NSR.15: High risk medication & concentrated electrolytes
NSR.16: Look-alike and sound-alike medications

a. Medication management program MMS.01
   Minimum contents:
   - Planning
   - Selection and procurement
   - Storage
   - Ordering and prescribing
   - Preparing and dispensing
   - Administration
   - Monitoring
   - Evaluation

b. Antibiotic stewardship program. MMS.02
c. Hospital medication formulary (Approved list). MMS.03
   Minimum contents:
   - Names of medications
   - Strengths/concentrations of medication(s)
   - Dosage forms of the medication(s)
   - Indications for use
   - Risks/side effects of the medications
   - Cost of the medications

d. Emergency medications. (Policy) MMS.05
Minimum contents:
   - Emergency medications shall be readily accessible and uniformly stored to facilitate quick access to the right medication to meet emergency needs. For example, in each emergency cart in the hospital, emergency medications are in the same drawer and laid out in the same manner within the drawer of each cart.
   - Prevention of abuse, loss, or theft of emergency medications to ensure their availability when needed.
   - Replacement of emergency medication at the most appropriate time when used, damaged, or outdated.

e. Medication recall. (Policy) MMS.08
Minimum contents:
   - Maintaining product integrity requirements
   - Process to retrieve recalled medications
   - Labelling and Separation of recalled medications
   - Patient notification (when applicable)
   - Disposal or removal
   - Regular monitoring of disposal of unused, unwanted, or expired medications

f. Safe management of medications that require special considerations (Radioactive medications, contrast, breast milk, medication brought by patients). (Policy) MMS.09
Minimum contents:
   - Receipt
   - Identification
   - Labeling
   - Storage
   - Administration
   - Monitoring

g. Ordering/prescribing and transcribing medications. (Policy) MMS.11, MMS.12
Minimum contents:
   - Who is authorized to prescribe which type of medications
   - Uniform location in the patient's medical record to order/prescribe/transcribe medications.
   - Transcription process and use during appropriate situations.
   - Listing of prescribed medications, their dosage and administration times.
   - Process of cancelation or discontinuation of a medication prescription

h. Medication errors and near misses defining, reporting, analyzing, and acting upon (Policy). MMS.18
Minimum contents:
   - Medication errors, near misses and medication therapy problems reporting to:

- Prescriber and/or another healthcare professional (as required)
- Drug and therapeutics committee
- Quality committee
- Leaders of the hospital
- Authorized institutions, according to national/international regulations.

7. Environmental and Facility Safety

Related NSRs:
NSR.21: Fire safety
NSR.22: Fire drill
NSR.23: Hazardous material safety
NSR.24: Safety management plan
NSR.27: Medical equipment safety
NSR.28: Utilities safety

a. Hospital design drawings, permits, licenses. EFS.01
b. Smoking-free environment. (Policy) EFS.04
c. Security plan. EFS.09
   Minimum contents:
   - Security risk assessment.
   - Ensuring the identification of patients, visitors, and staff in the hospital.
   - Identification of vendors/contractors with the restriction of their movement within the hospital.
   - Vulnerable patients such as the elderly, infants, those with mental disorders, and handicapped should be protected from the abuse and above-mentioned harms.
   - Children should be protected from abduction.
   - Drill for child abduction should be performed at least annually.
   - Monitoring of remote and isolated areas.
   - Staff training and orientation.
   - The plan is evaluated annually and, if needed, according to related performance measures results or major incidents.
d. Safe management of water services. (Policy) EFS.12
   Minimum contents:
   - Routine maintenance and monitoring of water distribution and treatment systems.
   - Continuing training and education of operators of water treatment systems.
   - Monitoring of water at all stages (feed, product and dialysis water).
   - Methods and frequency of measuring microbiological and chemical contaminants.
   - Maximum allowable concentrations of microbiological contaminants.

e. Disaster plan EFS.13
Minimum contents:
- Risk assessment of potential emergencies. internal and external disasters, such as heavy rains, earthquake, floods, hot weather, wars, bomb threats, terrorist attacks, traffic accidents, power failure, fire, gas leakage.
- Risk assessment of potential Epidemics and/or pandemics.
- Degree of preparedness according to the level of risk.
- Communication strategies: Internal communication may be in the form of clear call tree that includes staff titles and contact numbers, and external communication channels may include civil defense, ambulance center, police.
- Clear duties and responsibilities for hospital leaders and staff.
- Identification of required resources such as utilities, medical equipment, medical, and nonmedical supplies, including alternative resources.
- Business continuity:
  - Triaging.
  - Staff main task is maintained in case of emergencies: management of clinical activities during a disaster such as operating theatre and intensive care units.
  - Alternative care sites, and back-up utilities.
  - Safe patient transportation in case of emergency is arranged by the hospital.
- Drill schedule. The hospital must 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:
  - Scenario of the drill
  - Observations on: code announcement, timing, staff attendance, response, communication, triaging, and clinical management.
  - Clear corrective actions if needed.
  - Feedback to the environmental safety committee.
  - Debriefing.

8. Infection Prevention and Control:

Related NSR:
NSR.3: Hand hygiene

a. Infection control structure in the organization chart. IPC.01
b. Job description of infection control team. IPC.01
c. Infection prevention and control program. IPC.02
d. Safe injection guidelines. (Approved clinical guidelines) IPC.09
e. List of cleaning activities. IPC.10
Minimum contents:
- Activities to be done every day.

- Activities to be done every shift.
- Deep cleaning activities.

f. Sterile technique and aseptic technique guidelines. (Approved guidelines) IPC.11
g. Isolation precautions. (Policy) IPC.12
h. Disinfection and sterilization. (Policy) IPC.14
   Minimum contents:
   - Receiving and cleaning of used items.
   - Preparation and processing.
     - 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 and laryngoscopes etc. Chemical disinfectants approved for high-level disinfection include glutaraldehyde, orthophtaldehyde and hydrogen peroxide.
     - Sterilization must be used for all critical and heat-stable semi-critical items.
     - Low-level disinfection (for only non-critical items) are used for items such as stethoscopes and other equipment touching 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.
   - labeling of sterile packs.
   - 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.
   - Logbooks are used to record the sterilization process.
   - Inventory levels.
   - Expiration dates for sterilized items.
i. Disinfection/Sterilization quality control. (policy) IPC.15
   Minimum contents:
   - Quality control elements, method and frequency include:
     - Physical parameters (temperature, time and pressure), which are monitored every cycle.
     - Chemical parameters (internal chemical indicator inside the sterilization pack- external chemical indicator on the outside of the sterilization pack), which are monitored every pack.
     - Biological indicator which is done at least weekly.

- ¤ The test for adequate steam penetration and rapid air removal shall be done every day before starting to use the autoclave through the use of Class 2 internal chemical indicators and process challenge devices which is either porous challenge device or hollow challenge device.
- ¤ 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).
- ¤ 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.

- 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.
- The quality control program is approved by the designee prior to implementation.
- Responsible authorized staff member reviews quality control results at a regular interval.
- Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

j. laundry and healthcare textile services. (Policy) IPC.16
Minimum contents:
- Processes of collection and storage of contaminated textile.
- Cleaning of contaminated textile.
- Water temperature, detergents, and disinfectants usage.
- Processes of storage and distribution of clean textile.
- Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.

k. Infection risk assessment for areas under demolition, renovation, or construction. (Policy) IPC.17

l. Surveillance for healthcare associated infections. (Policy) IPC.18

m. Multi-drug resistant organisms control. (Policy) IPC.20

n. Safe food services. (Policy) IPC.21
Minimum contents:
- Food receiving process.
- A safe storage process including food rotation system that is consistent with first in first out principles.
- Monitoring of temperature during preparation and storage.
- Prevention of cross-contamination of food whether directly from raw to cooked food, or indirectly through contaminated hands, working surfaces, cutting boards, utensils, etc.

- Food transportation process.

o. Postmortem Care. (Policy) IPC.22
Minimum contents:
- Infection hazard assessments.
- Procedures to minimize these hazards.
- Use of appropriate engineering devices and personal protective equipment to minimize exposure.
- Sorting of waste.
- Record keeping.
- Environmental cleaning procedures.
- Reporting accidental exposures.

9. Organization Governance and Management

a. Organizational charts (Approved document) OGM.01
b. Governance structure. (Approved document) OGM.01
c. Governing body responsibilities and accountabilities. (Approved document) OGM.03
Minimum contents:
- Approval, receiving reports, and regular evaluation and update of at least the following:
- The hospital strategic plan.
- The operational plan and budget, capital investments.
- The quality improvement, patient safety, and risk management programs.
- Community assessment and involvement program.

d. Mission statement. (Approved document) OGM.02
e. Job description of hospital director. OGM.05
Minimum contents:
- Providing oversight of day-to-day operations.
- Ensuring clear and accurate posting of the hospital's services and hours of operation to the community.
- Ensuring that policies and procedures are developed, implemented by leaders, and approved by the governing body.
- Providing oversight of human, financial, and physical resources.
- Annual evaluation of the performance of the hospital's committees.
- Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation.
- Ensuring that there is a functional, organization-wide program for performance improvement, patient safety, and risk management with appropriate resources.

f. Hospital-wide committees' structures and functions. (Approved document) OGM.06
The required documents include terms of reference and at least one meeting minutes for each committee, follow up of actions, decisions and recommendations.

The hospital has at least the following committees:

- Environmental safety committee
- Infection control committee
- Pharmacy and therapeutic committee
- Quality and patient safety committee
- Mortality and morbidity committee

g. Strategic plan OGM.07

h. Operational plans. OGM.08

Minimum contents:

- Clear goals and objectives.
- Specific activities and tasks for implementation.
- Timetable for implementation.
- Assigned responsibilities.
- Sources of the required budget.

i. Job description of hospital leaders. OGM.09

Minimum contents:

- Sustaining firm hospital structure:
  - ¤ Planning for upgrading or replacing systems, buildings, or components needed for continued, safe, and effective operation.
  - ¤ Collaboratively developing a plan for staffing the hospital that identifies the numbers, types, and desired qualifications of staff.
  - ¤ Providing appropriate facilities and time for staff education and training.
  - ¤ Ensuring all required policies, procedures, and plans have been developed and implemented.
  - ¤ Providing adequate space, equipment, and other resources based on strategic and operational plans and needed services.
  - ¤ Selecting equipment and supplies based on defined criteria that include quality and cost-effectiveness.
- Running smooth directed operations:
  - ¤ Creating a safe and just culture for reporting errors, near misses, and complaints, and use the information to improve the safety of processes and systems.
  - ¤ Designing and implementing processes that support continuity, coordination of care, and risk reduction.
  - ¤ Ensuring that services are developed and delivered safely according to applicable laws and regulations and approved organization strategic plan with input from the users/staff.
- Continuous monitoring and evaluation:
  - ¤ Ensuring that all quality control monitoring is implemented, monitored, and

action is taken when necessary.
    - ¤ Ensuring the hospital meets the conditions of facility inspection reports or citations.
    - ¤ Annually assessing the operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle.
    - ¤ Annually reporting to the 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. The hospital data are reviewed, analyzed, and used by management for decision-making.
  - Continuous improvement

j. Job description of heads of departments. OGM.10
   Minimum contents:
   - Defining a written description of the services provided by the department (scope of service).
   - Recommending space, staffing, and other resources needed to fulfill the department's approved scope of service.
   - Recommending staff minimum number and qualifications required according to workload and approved scope of service.
   - Defining education, skills, and competencies needed by each category of staff.
   - Ensuring that there is a department specific orientation and continuing education program for the department's staff.
   - Ensuring coordination and integration of these services with other departments when relevant.
   - Ensuring that the department's/service's performance is monitored and reported annually to leadership.
   - Ensuring that the department is involved in the performance improvement, patient safety, and risk management program(s).

k. Supply chain management. (Policy) OGM.11
   Minimum contents:
   - Supplier's identification and selection process.
   - Suppliers are monitored and evaluated to ensure that the purchased supplies are provided from reliable sources that refrain from dealing with counterfeit, smuggled, or damaged supplies.
   - Suppliers are also evaluated based on their response upon request, quality of received materials, check for matching predefined acceptance criteria, lot number, and expiry date.
   - Supplies are monitored and evaluated to ensure that no recalled medications, samples, devices, medical supplies, or equipment are provided.
   - Transportation of supplies is monitored to ensure that it occurs according to

applicable laws and regulations, approved organization policy, and manufacturer's recommendations.

l. Stock management. (Policy) OGM.12
   Minimum contents:
   - Compliance of storage to laws, regulations, and organization policies.
   - Management of stocks safely and efficiently.
   - Inventory management and tracking the use of critical resources.
   - Stock items should at least have the following records (unless stated otherwise by laws and regulations)
     - Date received
     - Lot number and expiration date
     - Whether or not acceptance criteria were met and if any follow-up
     - Date placed in service or disposition, if not used.

m. Billing system. (Policy) OGM.14
   Minimum contents:
   - Availability of an approved price list.
   - Patients are informed of any potential cost pertinent to the planned care.
   - A process to ensure accurate billing.
   - Use of accurate and approved codes for diagnoses, interventions, and diagnostics.

n. Price list of services. (Approved list) OGM.14

o. List of all contracted services, including clinical and non-clinical services. (List) OGM.15

p. Selection and evaluation criteria for each contracted service. (Approved document) OGM.15

q. Positive workplace culture. (Policy) OGM.17
   Minimum contents:
   - Workplace cleanliness, safety and security measures.
   - Management of workplace violence, discrimination, and harassment.
   - Communication channels between staff and hospital leaders.
   - Staff feedback measurement.
   - Planning for staff development.

r. Code of ethics. (Policy) OGM.18
   Minimum contents:
   - Developing and implementing the code of ethics.
   - Developing and implementing of hospital values.
   - Handling medical errors and medico-legal cases.
   - Managing clinical research.
   - Identifying conflict of interest.
   - Gender equality

s. Staff health program. OGM.20
Minimum contents:
- Pre-employment medical evaluation of new staff.
- Periodic medical evaluation of staff members.
- Screening for exposure and/or immunity to infectious diseases.
- Exposure control and management to work-related hazards:
  - Ergonomic hazards that arise from the lifting and transfer of patients or equipment, strain, repetitive movements, and poor posture.
  - Physical hazards such as lighting, noise, ventilation, electrical and others.
  - Biological hazards from blood-borne and airborne pathogens and others.
- Staff education on the risks within the hospital environment as well as on their specific job related hazards.
- Staff preventive immunizations.
- Recording and management of staff incidents (e.g., injuries or illnesses, taking corrective actions, and setting measures in place to prevent recurrences).
- A pre-employment medical examination is required for all employees' categories to evaluate their appropriateness for safe performance, and staff that is exposed to certain hazards as radiation should have periodic specific medical evaluation (tests and examinations). The 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.
- 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.
- All staff occupational health program-related results (medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulation.

10. Community Assessment and Involvement

a. Plan for community involvement initiatives. CAI.01
Initiatives may include:
- Implementation of international baby-friendly initiatives.
- National initiatives of Universal Health Insurance, 100 Million Healthy Lives, Reduction of waiting lists for critical conditions or others.

b. Community assessment and involvement program. CAI.02
Minimum contents:
- Identification and description of the catchment area.

- Gap analysis process involving at least the following:
  - Accessibility and timeliness of services
  - Risk assessment of the community hazards including environmental problems
  - Healthcare needs
  - Healthcare education needs
  - Healthcare expectation
- Planning for interventions
- Identifying potential solutions
- Announcing or posting selected solutions to the community
- Training tools and information provided for the community education program.

c. Community suggestions and complaints. (Policy) CAI.05
Minimum contents:
- Process for dealing with:
  - External business customers
  - Internal or external customer complaints
  - Situations to call police help, including aggressive behavior
  - Media

11. Workforce Management

a. Staffing plans (departmental and hospital-wide). WFM.02
Leaders consider the following factors to project staffing needs:
- The hospital mission, strategic and operational plans.
- Complexity and severity mix of patients served by the hospital.
- Services provided by the hospital.
- Technology and equipment used in patient care.

b. Recruitment process. (Policy) WFM.03
Minimum contents:
- Collaboration with service/department leaders to identify the need for a job.
- Communicating available vacancies to potential candidates.
- Announcing criteria of selection.
- Application process.
- Recruitment procedures.

c. Document describing the credential verification process. (Approved document) WFM.05

d. Staff files. (Policy) WFM.06
Minimum contents:
- Staff file initiation
- Standard contents such as; verified certification, license, education, training and work history, current job description, recorded evidence of orientation to the hospital, the assigned department, and the specific job, evidence of initial evaluation of the staff member's ability to perform the assigned job, ongoing in-

service education received, copies within three months evaluations and copies of annual evaluations.
- Update of file contents.
- Storage.
- Retention time.
- Disposal.

e. Orientation programs. WFM.07
Minimum contents:
- General orientation program
  - Review of the hospital mission, vision, and values
  - Hospital structure
  - Hospital policies for the environment of care, infection control, performance improvement, patient safety and risk management
- Departmental orientation program
  - Review of relevant policies and procedures
  - Operational processes
  - Work relations.
- Job specific orientation program
  - High risk processes
  - Technology and equipment use
  - Staff safety and health

f. Continuing education and training program. WFM.08
- May include the following:
  - Patient assessment.
  - Infection control policy and procedures, needle stick injuries and exposures.
  - Environment safety plans.
  - Occupational health hazards and safety procedures, including the use of personal protective equipment.
  - Information management, including patient's medical record requirements as appropriate to responsibilities or job description.
  - Pain assessment and treatment.
  - Clinical guidelines used in the hospital.
  - Basic cardiopulmonary resuscitation training at least every two years for all staff that provides direct patient care.
  - Quality concept, performance improvement, patient safety, and risk management.
  - Patient rights, Patient satisfaction, and the complaint/ suggestion process.
  - Provision of integrated care, shared decision making, informed consent, interpersonal communication between patients and other staff cultural

beliefs, needs and activities of different groups served.
- ¤ Defined abuse and neglect criteria.
- ¤ Medical equipment and utility systems operations and maintenance.

g. Staff performance evaluation (tools/criteria). (Approved document) WFM.09
h. Medical staff structure. (Approved document) WFM.10
i. Medical staff bylaws. WFM.11

Minimum contents:

- Entire medical staff structure.
- Medical staff committee structure and function.
- The appointment process including the process for validating required licensure, education, registration and/or certification of all medical staff and visiting consultants and professors.
- Medical staff members' education, license /registration, and other credentials required by law or regulation and by the hospital are verified and kept current.
- The medical staff bylaws are according to applicable laws and regulations, approved policies and approved by the hospital leader(s).
- The privileging (application, granting, revision, renewal).
- The hospital has a uniform process for gathering the credentials of medical staff members who are permitted to provide patient care without supervision.
- Defined criteria and process for suspension.
- The mechanism for a fair hearing and appeal process.
- Defined criteria and process for peer review

j. Clinical privileges. (Policy) WFM.13

Minimum contents:

- Medical staff members and independent practitioners with clinical privileges are subject to bylaws.
- Privileges indicate if the medical staff can admit, consult, and treat patients.
- Privileges define the scope of patient care services and types of procedures they may provide in the hospital.
- Privileges are determined based on documented evidence of competency (experience- qualifications – certifications-skills) that are reviewed and renewed at least every three years.
- Privileges are available in areas where medical staff provides services pertinent to granted privileges.
- Medical staff members with privileges do not practice outside the scope of their privileges.

k. Medical staff members' performance evaluation criteria. (Approved document) WFM.14

Minimum contents:

- Patient's medical record review for completeness and timeliness.

- Utilization practice and medication use.
- Compliance with approved clinical guideline.
- Complications, outcomes of care, mortality, and morbidity.
- Professional development

l. Peer review process. (Policy) WFM.15
Minimum contents:
- Defined criteria for referring clinical cases for peer review.
- Defined criteria for referring clinical cases for external peer review.
- The data and information from peer review are used for competence assessment and considered at the time of re-appointment and re-privileging.

m. Nursing structure. (Approved document) WFM.16

n. Job description for the nursing director. WFM.17
Minimum contents:
- Responsible for developing and implementing written nursing standards of practice and recording for nursing assessment, nursing care plan, nursing reassessment, and treatments.
- Responsible for evaluating the effectiveness of nursing treatments.
- Member of the senior leadership team of the hospital and attending the senior leadership staff meetings.
- Ensuring that schedules and assigned tasks to the staff are completed

12. Information Management and Technology

Related NSR:
NSR.12: Abbreviations

a. Information management plan IMT.02
Minimum contents:
- The identified information needs of clinical and managerial hospital leaders.
- The information needs and requirements of external authorities and agencies.
- The size and type of services provided by the hospital.

b. Quality management documentation system. (Policy) IMT.03
Minimum contents:
- Standardized formatting.
- Document control system for tracking of issues and tracking of changes.
- The system allows each 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.
- Required policies are available and disseminated to relevant staff.
- Staff understand how to access those policies relevant to their responsibilities.
- Retirement of documents.
- Policies revisions.

c. Confidentiality and security of data and information. (Policy) IMT.05
Minimum contents:
- Determination of who can access what type of data and information.
- The circumstances under which access is granted.
- Confidentiality agreements with all those who have access to patient data.
- Procedures to follow if confidentiality or security of information has been breached

d. Retention of data and information. (Policy) IMT.07
Minimum contents:
- Retention time for each type of documents.
- Information confidentiality must be maintained during the retention time.
- Retention conditions, archival rules, data formats and permissible means of storage, access, and encryption.
- Data destruction procedures.

e. Patient's medical record management. (Policy) IMT.08
Minimum contents:
- Medical record flow management: Initiation of a patient's medical record, unique identifiers generation, tracking, storing and availability when needed to healthcare professionals.
- Medical record contents and order uniformity.
- Medical record standardized use
- Patient's medical record release.
- Management of voluminous patient's medical record

f. Medical records review process. (Policy) IMT.09
Minimum contents:
- Review of a representative sample of all services.
- Review of a representative sample of all disciplines/staff.
- Involvement of representatives of all disciplines who make entries.
- Review of the completeness and legibility of entries.
- Review occurs at least quarterly.
- Random sampling and selecting approximately 5% of patient's medical record.

g. Electronic system downtime program. IMT.11

13. Quality and Performance Improvement:

a. Performance improvement, patient safety and risk management committee(s) terms of references. QPI.01
Minimum contents:
- Ensuring that all designated care areas participate.
- Establishing organization wide priorities for improvement.
- Ensuring that all required measurements are monitored including the frequency of data collection.

- Reviewing the analysis of aggregate data.
- Taking action in response to identified performance improvement or patient safety issues.
- Reporting information to governing body, hospital leaders and to appropriate staff members about the performance data and the quality improvement activities.
- Evaluating the performance of the committee in an annual base

b. Quality performance improvement and patient safety plan. QPI.02
   Minimum contents:
   - The goal(s) (clinical and operational goals) that fulfil the hospital mission.
   - Organization structure and improvement reporting channels.
   - Roles and responsibilities of leaders.
   - Define hospital priorities.
   - Performance measures road map selection.
   - Data collection, data analysis tools and validation process.
   - Defined criteria for prioritization and selection of performance improvement projects.
   - Quality improvement model(s) used.
   - Information flow and reporting frequency.
   - Training on quality improvement and risk management approaches.
   - Regular evaluation of the plan (at least annually).

c. Job description of quality management team. QPI.03

d. Approved documented work sheet (Data analysis report) for each selected performance measure. QPI.05
   Minimum contents:
   - Definition
   - Defined data source
   - Specified frequency
   - Sampling techniques
   - Formula
   - Methodology of data collection and analysis
   - Bench mark the results

e. Written process of data management includes the aggregation and analysis. (Approved document) QPI.08

f. Written process for data validation (Approved document). QPI.09
   Minimum contents:
   - Validity: data measure what it is supposed to measure.
   - Reliability: everyone defines, measures, and collects data uniformly.
   - Completeness: data include all the values needed to calculate performance measure.

- Precision: data have sufficient detail.
- Timeliness: data are up to date. Information is available on time.
- Integrity: data are true.

g. Risk management program. QPI.10
Minimum contents:
- Scope, objective, and criteria for assessing risks.
- Risk management responsibilities and functions.
- Staff training on risk management concepts and tools.
- Risk identification.
- Risk prioritization and categorization (i.e. strategic, operational, reputational, financial, other).
- Risk reporting and communication with stakeholders.
- Risk reduction plans and tools with priority given to high risks.

h. Incident reporting system (Policy). QPI.11
Minimum contents:
- List of reportable incidents, near misses, adverse events, and sentinel events.
- Incident management process includes how, when, and by whom incidents are reported and investigated.
- Incidents requiring immediate notification to the management.
- Incident classification, analysis, and results reporting.
- Indication for performing intensive analysis and its process

i. Written document defines criteria and process of investigations for significant events. (Approved document) QPI.12
Minimum contents:
- Confirmed transfusion reactions.
- Significant anesthesia and sedation events that cause harm or have the potential to cause harm to a patient.
- Significant differences between pre- and post-operative diagnoses, including surgical pathology findings.
- Significant adverse drug reactions that cause harm or have the potential to cause harm to a patient.
- Significant medication errors that cause harm or have the potential to cause harm to a patient.
- Pulmonary Embolism or Deep Venous Thrombosis developed due to missing appropriate thromboprophylaxis treatment and improper VTE assessment risk.
- Patient escape or attempted escape.

j. Sentinel events management (Policy). QPI.13
Minimum contents:
- Definition of sentinel events such as:

        - Unexpected mortality or major permanent loss of function not related to the natural course of the patient' illness or underlying condition.
        - Wrong patient, wrong site, wrong procedure events.
        - Patient suicide, attempted suicide or violence leading to death or permanent loss of function
        - Unintended retention of a foreign object events in a patient after surgery or invasive procedure.
        - Wrong delivery of radiotherapy.
        - Any peri-partum maternal death.
        - Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
    - Internal reporting of sentinel events.
    - External reporting of sentinel events.
    - Team members involvement.
    - Root cause analysis.
    - Corrective actions plans taken.
k. Written process or methodology for improvement (Approved document). QPI.14

Additional requirements for organizations with academic, research or organ/tissue transplantation services

14. Additional Requirements

a. Education program for house officers and residents. ADD.04
    - Establishing scope of house officer and resident assessment and treatment of patients.
    - Providing educational support.
    - Designing postgraduate curricula and assessments.
    - Providing education on hospital policies, procedures, plans and other systems.
    - Protected time 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.
b. Professional graduate education program. ADD.05
    - Clear curriculum and assessment requirements.
    - An educational induction program to make sure that trainees understand their curriculum.
    - Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum.
    - The opportunity to work and learn with other members of medical staff to support inter-professional multidisciplinary working.

- Regular, useful meetings with clinical and educational supervisors.

c. Research ethics committee structure documents, meeting agenda and meeting notes. ADD.06

d. Research patient rights (Policy). ADD.07
Minimum contents:
   - Eligibility for enrollment in research projects or protocols.
   - Patient rights during research enrollment.
   - Confidentiality guarantees for photographs and patient information included in the research.
   - Patient right to withdraw from research experiment without fear of retribution.

e. Organ/Tissue donation (Policy). ADD.08
Minimum contents:
   - Mechanism for notifying patients and their families of the option to donate or to decline to donate any organs or tissues as well as a mechanism for recording the decision.
   - Live donors should be informed of the probable risks, benefits, and consequences of donation in a complete and understandable fashion; they should be legally competent and capable of weighing the information; and they should be acting willingly, free of any undue influence or coercion.
   - Use of discretion and sensitivity, as appropriate, to the circumstances, beliefs, and desires of the families of potential donors.
   - Healthcare professionals should only proceed with the removal, intermediate management or implantation of cells, tissues, or organs when donations are unpaid and truly voluntary.
   - Tissues or organs may be removed from the body of a living minor for the purpose of transplantation according to law, regulations, and professional standards.
   - Pre-transplantation donor evaluation criteria that includes: initial screening, blood tests, physical and psychosocial assessments.

f. Organ/Tissue transplantation services (Policy). ADD.09
Minimum contents:
   - Criteria for identifying potential organ and tissue donors.
   - Pre-transplantation tissue/organ evaluation criteria that includes: initial screening, macro and microscopic tests when required and compatibility matching.
   - Post-Transplantation hospital stay, care plans, recovery plans and health instructions.

Annex

المطلوب في الإشتراطات الأساسية	الجهة المعنية	المرجع القانونى
ترخيص المستشفى	تصدر الإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان الموافقة المبدئية لإقامة مشروع مستشفى ثم شهادة توفير الجودة الشاملة ثم يصدر المحافظ المختص الترخيص النهائى عن طريق إدارة العلاج الحر التابع لها المستشفى	المادة ١ والبند الثانى من المادة ١٦ من قانون تنظيم المنشآت الطبية رقم ٥١ لسنة ١٩٨١ المعدل بالقانون ١٥٣ لسنة ٢٠٠٤
موافقة المجلس الإقليمى للصحة النفسية	المجلس الإقليمى للصحة النفسية	المادة ٢ والمادة ٣ من القانون رقم ٧١ لسنة ٢٠٠٩ بشأن رعاية المريض النفسى
ترخيص تداول النفايات الخطرة	الإدارة العامة لصحة البيئة بوزارة الصحة والسكان بعد تقديم تقييم الأثر البيئى وموافقة جهاز شئون البيئة	المادة ٢٩ من قانون البيئة رقم ٤ لسنة ١٩٩٤
ترخيص الصيدلية	إدارة الصيدلة بمديرية الشئون الصحية التابع لها المنشأة	مادة ٣٩ من قانون الصيدلة رقم ١٢٧ لسنة ١٩٥٥ المعدل بالقانون رقم ٢٥٣ لسنة ١٩٥٥ والقانون رقم ٧ لسنة ١٩٥٦ والقانون رقم ٦١ لسنة ١٩٥٩ ومادة ١ من قانون المحال العامة رقم ١٥٤ لسنة ٢٠١٩
ترخيص المعمل	الإدارة المركزية للمعامل بوزارة الصحة والسكان	مادة ١٠ ومادة ١٣ من القانون ٣٦٧ لسنة ١٩٥٤ فى شأن مزاولة مهن الكيمياء الطبية والبكتريولوجيا والباثولوجيا وتنظيم معامل التشخيص الطبى ومعامل الأبحاث العلمية
ترخيص بنك الدم	الإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان	الكتاب الدورى للإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان رقم ١٦ لسنة ٢٠١٨ وقرار وزير الصحة رقم ١٠٤ لسنة ١٩٨٥ وقرار وزير الصحة رقم ١٥٥ لسنة ١٩٦١
ترخيص أجهزة الأشعة المؤينة	المكتب التنفيذى للوقاية من الأشعة المؤينة بالإدارة العامة للأشعة بوزارةالصحة والسكان	المادة ١ و ٢ و٣ من القانون رقم ٥٩ لسنة ١٩٦٠ فى شأن تنظيم العمل بالإشعاعات المؤينة والوقاية من أخطارها وقرار وزير الصحة والسكان رقم ١٣٣ م لسنة ٢٠١٤
ترخيص استخدام الليزر	الإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان	الكتاب الدورى للإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان رقم ١٦ لسنة ٢٠١٨ وقرار وزير الصحة رقم ٣٨٥ لسنة ٢٠١٦
ترخيص وحدة غسيل كلوى	الإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان	الكتاب الدورى للإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان رقم ١٦ لسنة ٢٠١٨ وقرار وزير الصحة رقم ١٤١ لسنة ٢٠٠٩ وقرار وزير الصحة رقم ٥١٨ لسنة ٢٠١٢
ترخيص وحدة قسطرة قلب	الإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان	الكتاب الدورى للإدارة المركزية للمؤسسات العلاجية غير الحكومية والترخيص بوزارة الصحة والسكان رقم ١٦ لسنة ٢٠١٨ وقرار وزير الصحة رقم ٥٦٠ لسنة ٢٠١١

ترخيص استخدام المواد المشعة	هيئة الرقابة النووية والإشعاعية	المادة ١٢ والمادة ٢٥ من القانون رقم ٧ لسنة ٢٠١٠ لتنظيم الأنشطة النووية والإشعاعية
ترخيص مركز علاج طبيعى	المحافظ المختص بعد موافقة اللجنة الدائمة للعلاج الطبيعى بوزارة الصحة والسكان	المادة التاسعة من القانون رقم ٣ لسنة ١٩٨٥ فى شأن تنظيم مهنة العلاج الطبيعى
شهادة مطابقة اشتراطات الحماية المدنية	إدارة الحماية المدنية بالمحافظة التابع لها المنشأة	مادة ٣٩ من قانون البناء رقم ١١٩ لسنة ٢٠٠٨
ترخيص المصاعد	الوحدة المحلية التابعة لها المنشأة	المادة الخامسة من قانون إصدار قانون البناء رقم ١١٩ لسنة ٢٠٠٨
ترخيص المولدات الكهربية	وزارة الكهرباء والطاقة أو الوحدة المحلية التابعة لها المنشأة بحسب الأحوال	المادة ٢ والمادة ٣ من القانون رقم ٥٥ لسنة ١٩٧٧ فى شأن إقامة وإدارة الآلات الحرارية والمراجل البخارية



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