GAHAR Handbook for

HOSPITAL PROVISIONAL ACCREDITATION STANDARDS

2025 Edition

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Introduction

The ultimate goal of healthcare is to provide high-quality healthcare services to all who need them in a suitable manner and at the appropriate time. The quality of healthcare depends on the level of value that healthcare facilities provide to all their stakeholders within the scope of their services. The provisional accreditation requirements for hospitals in 2025 come as part of a set of publications by the General Authority for Healthcare Accreditation and Regulation, as part of affirming the efforts of all state agencies and institutions to move forward towards achieving Egypt's Vision 2030 and its goals, especially the advancement of the quality of life of the Egyptian citizen and achieving justice in rights and opportunities. This is achieved by achieving an acceptable level of quality in healthcare and human safety in all hospitals in Egypt. The provisional accreditation requirements for hospitals in 2025 rely on four main axes: basic requirements, GAHAR safety requirements, Essential quality requirements, and The operating manual. It also relies in its reference primarily on the relevant laws and regulations in Egypt's Vision 2030, as well as the standards of the General Authority for Healthcare Accreditation and Regulation for Hospitals 2025, accredited by the International Society for Quality in Healthcare (ISQua) in December 2024. It should be noted that obtaining provisional accreditation according to these requirements is the main step towards reaching the larger and more important stage in achieving the quality of healthcare, which is obtaining accreditation according to Hospital standards 2025

Provisional Accreditation program for Healthcare Facilities

Based on Law No. 2 of 2018 regarding the comprehensive health insurance system issued in January 2018 and its executive regulations issued by a decision of the Council of Ministers in May 2018 and Decision No. 2040 of 2018 forming the Board of Directors of the General Authority for Healthcare Accreditation and Regulation.

***Note:* The definition of medical facilities as stated in Law No. 2 of 2018**

Within the framework of the successive and continuous steps taken towards organizing the health sector to ensure its safety, stability, and improvement of its quality, and to affirm confidence in the quality of healthcare outputs in the Arab Republic of Egypt at all local, regional, and international levels; the Board of Directors of the General Authority for Healthcare Accreditation and Regulation has decided the following:

First: Setting the rules and conditions for the provisional accreditation of healthcare facilities as a prelude to their accreditation by the Authority, which includes, but is not limited to, the following:

a) Achieving the basic requirements for healthcare facilities.
b) Achieving GAHAR safety requirements in healthcare facilities to ensure the safety of patients, companions, visitors, and employees of these facilities.
c) Achieving essential quality requirements to ensure the efficiency and effectiveness of healthcare services and the satisfaction of beneficiaries of the service.
d) Achieving the requirements of an operating manual for the healthcare facility to achieve a stable professional performance of the facility in all its departments and at all levels of service provision at all times and in all cases.

Second: Facilities that have obtained provisional accreditation from the Authority are committed to applying for the Authority's accreditation within a maximum period of three years from the date of the governorate's entry into the implementation of the universal health insurance law or three years from the date of provisional accreditation for facilities in governorates that have not entered the scope of the law's application, as of the date of provisional accreditation, otherwise the provisional accreditation shall be considered null and void.

Third: The duration of the provisional accreditation of the facility shall be one calendar year, renewable in accordance with the provisions of the previous paragraph.

Fourth: The General Authority for Healthcare Accreditation and Regulation shall define and raise awareness among the concerned parties about the procedures for the provisional accreditation of healthcare facilities according to a specific and comprehensive plan that does not in any way conflict with any of the rules governing the principles of transparency and avoiding conflicts of interest.

Fifth: Provisional accreditation requirements for hospitals:

a) Basic requirements.
b) GAHAR safety requirements.
c) Essential quality requirements.
d) Operating manual.

Sixth:
The provisional accreditation of the facility shall be according to the scope of services provided with the application for provisional accreditation. The authority must be notified in writing of any change in the scope of services provided (adding a new service, canceling an existing service, or increasing the volume of an existing service by more than 20 %) via email to reg@gahar.gov.eg at least **one month** before implementing this change.

Seventh:
In the Case of sentinel event, the General Administration for Registration and Accreditation of Healthcare Facilities must be notified within 48 hours of its occurrence or notification via email to Sentinel.Event@gahar.gov.eg. The General Administration for Registration and Accreditation must be provided with a root cause analysis of the reasons for the occurrence of the sentinel event within a maximum period of 45 days from the date of the occurrence of the sentinel event (as defined in standard QPI.11), attached to the corrective action plan to prevent/reduce its recurrence according to the nature of the event.

Eighth:
The facility is obligated to register at least 30% of the total number of medical professionals before the evaluation visit, and the remaining registration must be completed within three months from the date of provisional accreditation.

Ninth:
The provisional accreditation of the facility will **be suspended** for a period not exceeding six months in the following cases:

1. There were sentinel events related to the safety of patients, employees, or visitors that were not reported to GAHAR as stated in paragraph (Seventh).
2. Failure of the provisionally accredited facility to pass an unannounced evaluation visit in accordance with the decision-making rules.
3. Non-compliance with the data of the provisionally accredited facility in the provisional accreditation application and the current status of the facility during unannounced evaluation visits.
4. Failure to notify to GAHAR of any change in the scope of services provided (adding a new service, canceling an existing service, or increasing the volume of an existing service by more than 20 %) at least one month before implementing this change.
5. Incompliance with of the basic registration requirements.
6. Incompliance with the provisions of paragraph (Eighth).

Tenth:
Without violation of o the provisions of Law No. 2 of 2018, the provisional accreditation of the facility may be **cancelled** in the following cases:

1. Discovery of any tampering or forgery during or after the evaluation process or proof of the inaccuracy of the documents attached and submitted by the facility.
2. Obstruction by the facility of the work of Health regulation team, such as obstructing the obtaining of documents and data related to the field of health regulation work or access to places and services within the scope of auditing and inspection.
3. The facility's failure to pass the second chance visit in the case of conditional provisional accreditation.
4. Refusal of the provisionally accredited facility to receive the surveyors in announced/unannounced evaluation visits.
5. Cancellation of the facility's license or issuance of an administrative decision or court ruling to close it temporarily or permanently.

6. Transfer of the facility from its location stated in the provisional accreditation form or in the event of demolition or reconstruction of the facility.
7. Exceeding the specified period for suspending provisional accreditation as stated in paragraph (Ninth) without correcting the reasons for suspending provisional accreditation.

Steps for Provisional Accreditation of a Healthcare Facility at the General Authority for Healthcare Accreditation and Regulation:

1. The facility submits a provisional accreditation application to the authority by completing and submitting the designated form.
2. The General Authority for Healthcare Accreditation and Regulation reviews the application submitted by the facility and responds with a statement outlining the requirements and fees for the provisional accreditation of that facility.
3. The applicant facility pays the provisional accreditation fees and submits the necessary documents to the General Authority for Healthcare Accreditation and Regulation in accordance with the provisional accreditation requirements stated in the authority's response in the previous step.
4. the General Authority for Healthcare Accreditation and Regulation reviews the documents received from the facility, verifies their completeness, and contacts the facility to complete and correct any documents that the authority deems necessary to complete the provisional accreditation process.
5. After ensuring that all required documents in step (3) are complete, the General Authority for Healthcare Accreditation and Regulation schedules a visit to the facility to verify and audit the structure and processes related to the documents submitted by the facility.
6. A team of surveyors conducts an evaluation visit to the facility.

Provisional Accreditation Renewal:

- If the facility that has obtained provisional accreditation does not apply for accreditation within the first year from the date of acceptance of the provisional accreditation, it has the right to request a renewal of the provisional accreditation for another year, provided that the time period is calculated starting from the date of the provisional accreditation of the facility (if it was not from the governorates that entered the scope of applying the comprehensive health insurance system) or the date of entry of the governorate to which the facility belongs into the comprehensive health insurance system.
- According to Law No. 2 of 2018, facilities whose provisional accreditation with the authority has expired are evaluated for re-provisional accreditation for an additional period(s) of up to three years from the date of the governorate's entry into the scope of implementing the comprehensive health insurance law or from the date of the first provisional accreditation with the General Authority for Healthcare Accreditation and Regulation (whichever is earlier).

General Requirements:

1. The facility is committed to the accuracy of the documents and data submitted at all stages of the provisional accreditation process. If it is proven that the submitted documents are inaccurate at any stage of the visit, the facility is subject to cancellation of the evaluation visit.
2. The facility is committed to not using any certificate or logo of the authority in a misleading manner.
3. The facility is committed to not providing misleading data that harms the provisional accreditation certificate issued by the General Authority for Healthcare Accreditation and Regulation.

4. the General Authority for Healthcare Accreditation and Regulation is committed to informing the facility of the decision within a period not exceeding 15 working days from the date of completion of the evaluation work.
5. the General Authority for Healthcare Accreditation and Regulation has the right to inform the community of the results of the provisional accreditation, its suspension, or cancellation, as required by Law No. 2 of 2018.

Look Back Period

Surveyors are required to review the hospital's compliance with the Provisional Accreditation 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 Provisional Accreditation Requirements. Failure to comply with this rule shall affect the Provisional Accreditation decision.

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

Hospital seeking Re-Provisional Accreditation should comply with Provisional Accreditation requirements for the whole period from the initial Provisional Accreditation till the Re- Provisional Accreditation 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 Provisional Accreditation/ accreditation survey.

Scoring of GAHAR Safety Requirements (GSRs) and Essential Quality Requirements (EQRs).

During the survey visit, each GSR/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.

Example:
Evidences of compliance of GSR.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 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 GSRs 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:

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

Provisional Accreditation Decision Rules

1st Decision: Status of Provisional Accreditation 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 80f%, and
- No single GAHAR safety requirement (whole standard) is scored not met.

2nd Decision: Status of Provisional Accreditation that requires passing the 2nd survey visit within 9 months (Conditioned Provisional Accreditation)

- 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 GAHAR safety requirement (whole standard) is scored not met.

NB. The hospital can be Provisionally Accredited under terms and conditions of "conditioned Provisional Accreditation" only once.

3rd Decision: Status of Provisional Accreditation that requires passing the 2nd survey visit within 6 months (Conditioned Provisional Accreditation).

- 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 GAHAR safety requirements (whole standards) are scored not met.

NB. The hospital can be Provisionally Accredited under terms and conditions of "conditioned Provisional Accreditation" only once.

4th Decision: Denial of Provisional Accreditation

- 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 GAHAR 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 the goal is, 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.
- clinical care program:
  - A structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions according to clinical guidelines and protocols.
- 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.

► Reading and Interpretation of handbook

GAHAR 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 Provisional Accreditation process, hospitals have to show commitment to patient safety. This requires compliance with each of the GAHAR safety requirements (GSRs). During the Provisional Accreditation surveys, surveyors evaluate consistent implementation of each of the GSRs 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.

Section 1: Basic Requirements

Reading and Interpretation of Basic Requirements

- For an organization seeking GAHAR Provisional Accreditation/Re-Provisional Accreditation 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 Provisional Accreditation process as an initial step for GAHAR full accreditation.

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

Government Hospital

1. Hazardous Waste Handling License
2. Blood Bank License
3. Ionizing Radiation Equipment License
4. Laser Use License
5. Hemodialysis Unit License
6. Cardiac Catheterization Unit License
7. Radioactive Material Use License
8. Civil Defense Compliance Certificate
9. Elevator License
10. Electrical Generator License

Private Hospital or Hospital Affiliated with a Non-Governmental Entity

1. Hospital License
2. Hazardous Waste Handling License
3. Pharmacy License
4. Laboratory License
5. Blood Bank License
6. Ionizing Radiation Equipment License
7. Laser Use License
8. Hemodialysis Unit License
9. Cardiac Catheterization Unit License
10. Radioactive Material Use License
11. Physical Therapy Center License
12. Civil Defense Compliance Certificate
13. Elevator License
14. Electrical Generator License

Government or Private Hospital with a Psychiatry Department

Approval from the Regional Mental Health Council.

Section 2: GAHAR Safety Requirements

Chapter intent:

Patient safety, the reduction and mitigation of unsafe acts within the healthcare system, stands as an unwavering pillar of quality healthcare delivery. The intricate interaction between human factors, systems, and technology within healthcare settings creates a landscape prone to errors, some of which can have severe consequences. Although safeguards such as alarms, standardized procedures, and skilled professionals are in place, the inherent weaknesses in these layers of protection demand a continuous commitment to improvement. The focus on patient safety began to gain significant traction in the late 1990s, sparking a transformation in how healthcare organizations approach patient care. A culture of safety has since emerged, highlighting the importance of open communication, error reporting, and learning from mistakes. This change in mindset has fostered a more proactive and systematic approach to harm prevention. By setting clear expectations and conducting regular evaluations, accreditation bodies promote a culture of safety and accountability. Developing robust safety requirements for accreditation is essential in ensuring that patient safety remains a top priority across healthcare settings. To create effective safety requirements, a comprehensive understanding of the most critical areas of risk is necessary. Medication safety, infection prevention, communication, and patient identification are among the high-priority domains. These requirements should be grounded in evidence-based practices to ensure their effectiveness. As part of the GAHAR accreditation process, Hospitals have to show commitment to patient safety. This requires compliance with each of the GAHAR Safety Requirements (GSRs). During surveys, surveyors evaluate that safe and efficient implementation of each of the GSRs is maintained in all relevant practices. The application of the standards should be according to the applicable laws and regulations.

Chapter purpose:

1) **Provide** a comprehensive overview of GAHAR Safety Requirements.
2) **Outline** the essential components of an effective patient safety program.
3) **Support** organizational efforts to create a culture of safety.
4) **Enhance** patient outcomes by minimizing risks and adverse events.

GAHAR Safety Requirements

Code	Keyword	Standard Code
	GENERAL PATIENT SAFETY	
GSR.01	Patient identification	**ACT.03**
GSR.02	Verbal and telephone orders	**ICD.18**
GSR.03	Critical Results	**ICD.19**
GSR.04	Handover Communication.	**ACT.08**
GSR.05	Fall assessment and prevention	**ICD.10**
GSR.06	Pressure Ulcers Prevention	**ICD.11**
GSR.07	Venous Thromboembolism Prophylaxis	**ICD.12**
GSR.08	Critical Alarms	**CSS.02**
GSR.09	Catheter and tube misconnections	**CSS.03**
GSR.10	Recognition and response to clinical deterioration	**ICD.22**
GSR.11	Cardiopulmonary resuscitation	**CSS.05**
	DIAGNOSTIC AND ANCILLARY SERVICES	
GSR.12	Radiation Safety Program	**DAS.09**
GSR.13	Laboratory Safety Program	**DAS.23**
	SURGICAL AND INVASIVE PROCEDURAL SAFETY	
GSR.14	Surgical Site Marking	**SAS.05**
GSR.15	Pre-operative Checklist	**SAS.06**
GSR.16	Time-out/ sign out	**SAS.07**
GSR.17	Instrument Retention Prevention	**SAS.09**
	MEDICATION MANAGEMENT AND SAFETY	
GSR.18	Medication Reconciliation, best possible medication history (BPMH)	**MMS.10**
GSR.19	Medication storage and labelling	**MMS.04**
GSR.20	High-alert medications and concentrated electrolytes	**MMS.06**
GSR.21	Look-alike and Sound like medications.	**MMS.07**
	INFECTION PREVENTION AND CONTROL	
GSR.22	Hand Hygiene	**IPC.04**
	ENVIRONMENTAL AND FACILITY SAFETY	
GSR.23	Fire and smoke safety	**EFS.03**
GSR.24	Fire drills	**EFS.04**
GSR.25	Hazardous materials safety	**EFS.06**
GSR.26	Safety Management Plan	**EFS.07**
GSR.27	Medical Equipment Plan	**EFS.10**
GSR.28	Utilities Management Plan	**EFS.11**
	INFORMATION MANAGEMENT AND TECHNOLOGY	
GSR.29	Abbreviations	**IMT.04**

GENERAL PATIENT SAFETY

GSR.01 (ACT.03) 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 that may have grave consequences. Using two unique identifiers for each patient is the key to minimizing such preventable errors, which is especially important when administering high-alert medications or performing high-risk or invasive procedures.

The hospital shall develop and implement 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 include medications, clinical specimens, blood and blood products, and others.
d) Method to document identifiers such as wristbands, ID cards, and others.
e) The prohibited items for patient identification, such as the patient's bed and room numbers, and others.
f) Special situations when patient identification may not follow the same process, such as for newborn babies, unidentified patients, disasters, and others.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of patient identification.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the hospital policy and ensure their usage of at least two unique patient identifiers before procedures such as blood sampling, medications administration…etc.
- GAHAR surveyor may review a sample of medical records to check the presence of the two identifiers mentioned in the policy in each sheet.
- GAHAR surveyor may observe patient identification wristbands with the two unique identifiers and ensure compliance with the patient identification process before procedures or care.
- GAHAR surveyor may observe staff in special areas to check how they conduct patient identification, for example, pediatric or newborn identification at delivery and discharge ...etc.

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. Patient identification is conducted before performing diagnostic procedures, providing treatments, and performing any procedures.
4. The patient's identifiers are recorded in the patient's medical record.
5. The hospital monitors the reported data on patients' identification and takes actions to control or improve the process as appropriate.

GSR.02 (ICD.18) Verbal or telephone orders are communicated and documented according to the defined process.

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 shall develop and implement a policy and procedures for receiving verbal and telephone communication.
The policy addresses the process of reporting:

a) When verbal and telephone orders may be used.
b) Verbal orders and telephone orders are documented by the receiver.
c) Verbal orders and telephone orders are read back by the receiver.
d) Confirmed by the ordering physician.
e) Documentation and authentication requirements.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the communication of verbal and telephone orders.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to check verbal and telephone orders recording.

Evidence of compliance:

1. The hospital has an approved policy guiding the communication of verbal and telephone orders that addresses at least all elements mentioned in the intent from a) through e).
2. Healthcare professionals are aware of the elements of the policy.
3. All verbal and telephone orders are documented, then read back by the receiver, and confirmed by the ordering physician.
4. All verbal and telephone orders are recorded in the patient's medical record within a predefined timeframe.
5. The hospital monitors the reported data of verbal and telephone orders and takes actions to control or improve the process as appropriate.

GSR.03 (ICD.19) Critical results are communicated in time and documented according to the defined process.

Safety

Keywords:
Critical results

Intent:
Patient safety and quality of care can be compromised when there are delays in the completion of critical tests or in communicating the results of critical tests or critical test results to the requestor. Miscommunication is the most common root cause of adverse events. Writing down and reading back the results by the person receiving the information minimizes miscommunication and reduces errors 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 as 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.
The hospital shall develop and implement a policy and procedures to guide the process of identifying and reporting critical results. The policy addresses at least the following:

a) Lists of critical results and values.
b) Critical test results reporting process including timeframe and read-back by the recipient.
c) Process of recording.
    i. Date and time of notification.
    ii. Identification of the notifying responsible staff member.
    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.
d) Measures to be taken in case of critical results.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding critical results communications.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records and dedicated related registers, especially in the hospital's laboratory, medical imaging service departments, non-interventional cardiology laboratory, and point of care testing areas to check critical results recording.

Evidence of compliance:

1. The hospital has an approved policy to guide critical results communications that address 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 within a predefined timeframe, including all elements in the intent from i) through vii).
4. The hospital monitors the reported data on critical results and takes actions to control or improve the process as appropriate.

GSR.04 (ACT.08) A standardized approach to handover 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 clarification, which subsequently decreases medical errors.

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

a) Standardized methods of communication, such as SBAR, ISOBAR, I PASS the BATON and others.
b) Occasions when this method is used; this includes, but is not limited to, between different shifts (in the same department) and 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 a handover logbook, endorsement form, electronic Handover tool, and/or other methods, as evidence of implementation; this documentation is not required to be included in the patient's medical file.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of handover communication, 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 interview healthcare professionals to ensure their awareness of the hospital's policy.
- GAHAR surveyor may review medical records, handover logbooks, endorsement forms, electronic handover tools, and/or other methods as evidence of implementation.

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 communication conducted between different shifts and between different levels of care (different departments/ services).
4. Handover communications are documented using an established tool or format and are accessible as needed.
5. The hospital monitors the reported data on handover communication and takes actions to control or improve the process as appropriate.

GSR.05 (ICD.10) Patient's risk of falling is assessed, periodically reassessed, and managed.

Safety

Keywords:
Fall assessment 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 shall develop and implement a policy and procedures to guide the fall risk assessment and prevention process. The policy addresses at least the following:

a) Patient fall risk assessment on admission.
b) Assessment contents are based on guidelines.
c) Timeframe to complete fall assessment and frequency of reassessment.
d) The screening criteria for outpatient and ambulatory locations, situations, and conditions that may increase the risk of falls.
e) Fall risk prevention strategies for patients found at risk of falls.
f) General measures that are used to reduce the risk of falling, such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.
g) Tailored care plans based on individual patient fall risk assessment.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the assessment of the patient's risk for falls.
- GAHAR surveyor may interview Healthcare professionals to check their awareness of the hospital policy.
- GAHAR surveyors may interview families of patients at higher risk to assess their awareness of and involvement in prevention measures.
- GAHAR surveyor may review a sample of patients' medical records to check fall risk assessment and re-assessment tool and its documentation.
- GAHAR surveyor may review a sample of patients' medical records, to check general measures and tailored care plans recording.
- GAHAR surveyor may observe organization-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 the assessment of a patient's risk of fall that includes all elements in the intent from a) through g).
2. Healthcare professionals are aware of the elements of approved policy.
3. The hospital assesses and reassesses all inpatients for risk of fall using appropriate tools suitable for the patient population and documented in the patient's medical records.
4. Outpatients with certain conditions, situations, or locations will be screened for risk of falls.
5. The families of patients who are at higher risk of falling are aware of and involved in fall prevention measures.
6. General measures and tailored care plans are recorded in the patient's medical record.

GSR.06 (ICD.11) The Patient's risk of developing pressure ulcers is assessed, periodically reassessed and managed.

Safety

Keywords:
Pressure Ulcers Prevention

Intent:
The 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. The 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 shall develop and implement a policy and procedures to guide the pressure ulcer screening and prevention process. The policy addresses at least the following:

a) Pressure ulcer risk assessment is performed upon admission.
b) Contents of assessment based on guidelines.
c) Timeframe to complete pressure ulcer assessment.
d) Frequency of reassessment of risk of pressure ulcer development.
e) General measures are used to reduce the risk of pressure ulcers, such as pressure relieving devices and mattresses.
f) Tailored care plans based on individual patient pressure ulcer assessment.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding pressure ulcer risk assessment.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the pressure ulcer risk assessment elements and prevention measures.
- GAHAR surveyor may interview patients' families at higher risk to assess their awareness of and involvement in prevention measures.
- GAHAR surveyor may review a sample of the patient's medical records to check pressure ulcer risk assessment tools and tailored care plan documentation.
- GAHAR surveyor may observe the hospital's general measures to reduce the risk of pressure ulcers, such as pressure-relieving devices and mattresses.

Evidence of compliance:

1. The hospital has an approved policy to guide pressure ulcer risk assessment that addresses all elements mentioned in the intent from a) through f).
2. Healthcare professionals are aware of the elements of the pressure ulcer risk assessment and of prevention measures.
3. The hospital assesses upon admission and reassesses each patient's risk for developing a pressure ulcer using appropriate tools suitable for the patient population.
4. The families of patients at higher risk of pressure ulceration are aware of and involved in prevention measures.
5. General measures and tailored care plans are recorded in the patient's medical record.

GSR.07 (ICD.12) Patient's risk of developing venous thromboembolism (deep venous thrombosis and pulmonary embolism) is assessed, periodically reassessed and managed.

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 shall adopt and implement a guideline for VTE prophylaxis. The guideline addresses at least the following:

a) Patient risk assessment on admission.
b) Contents and timeframe to complete VTE assessment.
c) Reassessment of risk of VTE.
d) Appropriate prophylaxis such as mechanical, pharmacological, or both according to risk severity.
e) Tailored care plans based on individual patient VTE risk assessment.

Survey process guide:

- GAHAR surveyor may review the hospital's adopted VTE risk assessment and management guidelines.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the VTE risk assessment process elements and prevention measures.
- GAHAR surveyor may interview patients with a higher level of VTE risk and their families to assess their awareness of and involvement in the prevention measures.
- GAHAR surveyor may review a sample of the patient's medical records to check VTE risk assessment and tailored care plan documentation.
- GAHAR surveyor may observe compliance with the hospital's VTE guidelines.

Evidence of compliance:

1. The hospital has an approved guideline for assessment and management of patient's VTE risk that addresses all elements mentioned in the intent from a) through e).
2. Healthcare professionals are aware of the elements of the VTE assessment process and of prevention measures.
3. VTE risk assessments are completed and recorded within an approved timeframe.
4. The families of patients at higher risk for VTE are aware of and involved in prevention measures.
5. Tailored care plans based on individual patient VTE risk assessments are conducted and recorded in the patient files.

GSR.08 (CSS.02) The hospital has an approved policy and procedures for managing critical medical 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 an 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 with critical alarming systems. The hospital shall develop and implement 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) Critical alarms are tested and activated with appropriate settings.
c) Priorities for competing alarms, staff members authorization for disabling alarms or changing their settings and monitoring of response to alarm activation.
d) Staff members' responsibility, control measures, and remedial action.
e) Alarms are sufficiently audible with respect to distances and competing for noise within the unit.
f) Documentation required, including evidence of responsible staff members, responsible company, schedule, agreed settings, evidence of function.
g) Reporting malfunction and remedial action.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the safe management and use of critical alarms and also review the inventory of all devices with critical alarms, including setting guidelines.
- GAHAR surveyor may review the schedules of alarm tests and documentation of the currently active settings at different care areas.
- GAHAR surveyor may interview staff around devices with critical alarms to check their knowledge of critical alarm settings and response to their activation, and also interview maintenance staff to check their knowledge of critical alarm settings.
- GAHAR surveyors may observe (listen) or activate critical alarms to check the suitability of the alarm volume for the working space.
- GAHAR surveyor may review maintenance records for evidence of responsible staff, a responsible company, a schedule, agreed-upon settings, evidence of function, reporting of malfunction, and remedial action.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. Competent individuals are responsible for the management and use of critical alarms.
3. Management and the use of critical alarms are done according to the approved policy.
4. Management and use of critical alarms are recorded according to policy.
5. Alarm events and malfunctions are reported, and actions are taken to maintain the safety of clinical alarms.

GSR.09 (CSS.03) A system is in place 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, or drainage). During care, these tubes and catheters may be misconnected, leading to the administration of the wrong material via the wrong route, resulting in grave consequences.
When purchasing new catheters and tubing, the hospital has documented acceptance testing and risk assessment to identify the potential for misconnections.
The hospital shall develop and implement a policy and procedures guiding the prevention of catheter and tubing misconnections.
The policy addresses at least the following:

a) Non-clinical staff members, families, or visitors should not be responsible for connecting and disconnecting tubes.
b) Labelling of high-risk catheters (e.g., arterial, epidural, intrathecal) and avoidance of using catheters with injection ports for these applications.
c) 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.
d) Standardized line reconciliation, rechecking process, and catheter maps as part of handover communications.
e) Acceptance testing and risk assessment to identify potential misconnections when purchasing new catheters and tubing.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding catheter and tubing misconnection prevention.
- GAHAR surveyor may interview responsible staff members to describe the catheter and tubing connection processes.
- GAHAR surveyor may review a sample of patients' medical records to check the management and use of tubes and catheters records and the safe tube connection use monitoring record presence.
- GAHAR surveyor may review a sample of responsible staff files to check their competency assessment.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. Competent individuals are responsible for the management and use of tubes and catheters.
3. Management and use of tubes and catheters are done as per the hospital policy.
4. Management and use of tubes and catheters are recorded in patient medical records.

GSR.10 (ICD.22) The hospital has a hospital-wide process for recognition of and response to clinical deterioration.

Effectiveness

Keywords:
Recognition 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 shall develop and implement 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 for 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:

- GAHAR surveyor may review the hospital policy guiding the safe process of recognition of and response to clinical deterioration.
- GAHAR surveyor may interview involved staff members in direct patient care to ensure their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to check recording observations such as respiratory rate, oxygen saturation, blood pressure, heart rate, temperature, consciousness level, etc. for recognition of clinical deterioration and to check response records.
- GAHAR surveyor may review a sample of staff members' files for those involved in direct patient care to check their training records.

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 trained on recognition of and response to clinical deterioration.
3. Recognition and response to clinical deterioration are done as per the hospital policy, using age specific criteria.
4. Recognition and response to clinical deterioration are recorded in the patient’s medical record.

GSR.11 (CSS.05) Response to cardio-pulmonary arrest in the hospital is managed for both adult and pediatric patients.

Effectiveness

Keywords:
Cardiopulmonary resuscitation

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 and ready to respond to any emerging situation. All the time, availability of adequate and functioning equipment and supplies is also a cornerstone for resuscitating patients in emergency conditions.
The hospital shall develop and implement a policy and procedures to ensure safe management of cardio-pulmonary arrests.
The policy addresses at least the following:

a) Defined criteria for recognition of cardio-pulmonary arrest, including adults and pediatrics.
b) The required qualifications and advanced life support training of the hospital code teams.
c) Education of staff members on the defined criteria.
d) Identification of involved staff members who will respond.
e) Mechanisms for calling staff members to respond, including code(s) that may be used for calling an emergency.
f) The time frame of response.
g) The response is uniform 24 hours a day and seven days a week.
h) Recording of response and management.
i) Management of emergency equipment and supplies, including:
    i. Identification of required emergency equipment and supplies list according to laws, regulations, and standards of practice.
    ii. Emergency equipment and supplies are available throughout the hospital and checked daily for readiness.
    iii. Emergency equipment and supplies are age-appropriate.
    iv. Emergency equipment and supplies are replaced immediately after use or when expired or damaged.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the safe management of cardio-pulmonary arrests and interview involved staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may review a sample of patients' medical records to check cardio-pulmonary arrest management records.
- GAHAR surveyor may review the files of involved staff members to check their qualifications and training records.
- GAHAR surveyors may assess the availability and functionality of age-appropriate emergency equipment, medications, and supplies throughout the hospital.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through i).

2. All staff members involved in cardiopulmonary resuscitation are aware of the hospital policy.
3. Staff with basic life support start the process immediately, while those with advanced life support will start within a maximum of 5 minutes.
4. Age-appropriate emergency equipment, medications, and supplies are available throughout the hospital.
5. Emergency equipment and supplies are checked daily and replaced after use.
6. Management of cardio-pulmonary arrests is recorded in the patient's medical record

DIAGNOSTIC AND ANCILLARY SERVICES

GSR.12 (DAS.09) Radiation safety program is developed and implemented.

Safety

Keywords:
Radiation Safety Program.

Intent:
Radiation safety program ensures all activities with ionizing and non-ionizing radiation are conducted in a safe manner and in compliance with the law and regulations, and applicable standards and guidelines.
The program is administered by the Radiation Safety Officer and is designed to protect staff, patients, and the public from potential exposure to radiation from radioactive sources and radiation-emitting devices. Furthermore, the radiation safety program controls the release of radioactive materials into the environment. The program shall maintain that all radiological equipment is used safely.
The hospital monitors staff health by performing regular biannual CBC analysis and collecting their thermos-luminescent dosimeter (TLD) and/or badge film reports. When CBC results exceed the borderline further investigations are ordered.
The hospital shall develop and implement a radiation safety program that addresses all components of the radiological services. it should be properly communicated to all staff, implemented, reviewed, and updated annually. The program shall include at least the following:

a) Availability and applicability of the staff self-monitoring tools.
b) Availability and applicability of the suitable personal protective equipment.
c) Patients' radiation safety precautions.
d) Methods to ensure that patients who receive ionizing radiation doses (e.g. CT or in catheter units) are not exceeding the international references of the International Atomic Energy Agency (IAEA).
e) All ionizing and non- ionizing radiation equipment are maintained and calibrated.
f) MRI safety program, which includes pre-exposure screening for metals, metallic implants, devices, and use of MRI compatible devices.
g) Nuclear medicine and PET CT radiation protection and safety measures:
    i. Safe waste disposal and isolated sewage for radioactive materials according to national law and regulations.
    ii. Safe hot lab for radioisotope processing.
    iii. Isolated waiting area for injected patients.
    iv. Each area in the nuclear medicine unit is labelled and isolated.
    v. The Survey meter and dose calibrator must be calibrated.
h) Laser safety measures:
    I. Laser safety PPEs
    II. Non-refractive surface in the installed room

III. Laser warning signs

Survey process guide:

- GAHAR surveyor may review the radiation safety program to check the approved level of exposure according to local laws and regulations, shielding methods, and safety requirements.
- GAHAR surveyor may review environmental radiation measures, thermos-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 the implemented radiation safety measures.

Evidence of Compliance:

1. The hospital has a written, updated, and approved radiation safety program that addresses all elements mentioned in the intent from a) through h).
2. Staff members involved in medical imaging are aware of the radiation safety program.
3. The hospital ensures that exposed patients do not exceed the approved maximum level.
4. Environmental radiation safety measures, personal monitoring devices results, and the regular CBC results are available and documented.
5. Nuclear medicine safety measures are implemented by addressing the elements from i) through v) in the intent.
6. Laser safety measures are implemented by addressing the elements from I) to III) in the intent.

GSR.13 (DAS.23) A comprehensive documented laboratory safety program is implemented.

Safety

Keywords:
Laboratory Safety Program

Intent:
The laboratory environment can be a hazardous place to work.
Laboratory staff members are exposed to numerous potential hazards including chemical, biological, physical and radioactive hazards, as well as musculoskeletal stresses.
Laboratory safety is governed by numerous regulations and best practices. Over the years, multiple guides were published to make laboratories increasingly safe for staff members.
Laboratory management should design a safety program that maintains a safe environment for all laboratory staff, patients, and families.
The laboratory should have a documented program that describes the safety measures for laboratory facilities according to the national requirements.
This program should be properly communicated to all staff, implemented, reviewed, and updated annually. 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) List of laboratory chemicals and hazardous materials.
e) Incidents handling and corrective action are taken when needed.
f) Proper Disposal of Laboratory Waste.
g) Safety Data Sheets (SDS) Requirements.
h) Handling Chemical Spills/Spill Clean Up.

i) Instructions for the use of personal protective equipment.
j) 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, Laboratory risk assessment, (SDS) requirements, 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, labelling and waste disposal process.
- GAHAR surveyor may interview laboratory staff to inquire about their experience regarding Safety Program.

Evidence of compliance:

1. A written updated program that describes safety measures for laboratory services and facilities is documented and includes the items in the intent from a) to j).
2. Laboratory staff are 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 monitors the reported data on laboratory safety program and takes actions to control or improve the process as appropriate.

SURGICAL AND INVASIVE PROCEDUREL SAFETY

GSR.14 (SAS.05) The precise site where surgery or invasive procedure shall be performed is clearly marked by the physician, along with the patient and/or family involvement.

Safety

Keywords:

Surgical Site Marking

Intent:

Performing the right surgery on the right patient and the right side without any retained instrument is the main objective of surgical safety. Surgical Site Marking is an error reduction strategy. Establishing related policies and procedures, known as the universal protocol, is the initial step for offering safe surgery. The hospital shall develop and implement a policy and procedures for the site marking process that includes at least the following:

a) Unified mark on the nearest surgical site.
b) Indication of site marking.
c) The physician who will perform the surgery / invasive procedure is responsible for site marking.
d) Involvement of the patient.
e) Surgeries and procedures exempted from site marking.
f) Appropriate time for surgical site marking before surgery.
g) Monitoring compliance with the process.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the site marking process.
- GAHAR surveyor may interview involved staff members to check their awareness of the hospital policy.
- GAHAR surveyor may observe to check the presence of a clear, approved, non-washable mark on the surgery / invasive procedure site (when applicable)

Evidence of compliance:

1. The hospital has an approved policy guiding the site marking process that includes at least elements from a) through g) mentioned in the intent.
2. Involved staff are aware of the implementation of site marking.
3. Site marking is a unified mark throughout the hospital and is performed by the physician responsible for the surgery or invasive procedure.
4. Site marking is performed before sending the patient to the operating room, involving the patient and the patient's family.
5. The hospital monitors the reported data regarding the site marking process and takes actions to control or improve the process as appropriate.

GSR.15 (SAS.06) Documents and equipment needed for procedures, 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, such as blood booking, the results of the requested investigation, or a 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 the cancellation of surgery and invasive procedures after the patient goes to the operating rooms or invasive procedure unit. Implementing regular checkups is a quality improvement process that should be guided by designed checklists and 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 differ according to the type of surgery and invasive procedure or the use of anesthesia and sedation.

Also, the hospital is required to have a process for preoperative verification of the availability of all needed or requested documents and other items before the patient goes for surgery or an invasive procedure. The preoperative verification process shall include the following:

- The identification of the patient and the planned procedure with the involvement of the patient/family.
- The availability and functioning of needed equipment.
- Informed consent and related education to the patient
- Precise site marking
- Results of requested investigations and diagnostic imaging
- Blood booking and ensuring blood availability.
- Implantable devices and special prostheses.

- Special precautions for infection control preparation.

Survey process guide:

- GAHAR surveyor may interview involved staff to check their awareness of the hospital preoperative verification process, followed by tracing the patient who underwent or is going to undergo surgery / invasive procedure to ensure the correct verification process for needed documents and other requested orders, such as blood booking or investigations.
- GAHAR surveyor may observe patient endorsement to the operating room or other invasive procedure unit.
- GAHAR surveyor may review the document of endorsement and the checklist showing the availability and functioning of needed equipment.

Evidence of compliance:

1. The hospital has a process for preoperative verification of all needed documents and equipment.
2. The staff involved are trained on the hospital process for preoperative verification.
3. Recorded evidence of preoperative verification of all items mentioned in the intent before each surgery or invasive procedure exists.
4. The hospital monitors the reported data on the preoperative verification process and takes actions to control or improve the process as appropriate.

GSR.16 (SAS.07) Time-out is conducted before starting surgical and invasive procedures, and sign-out is done before leaving the procedure location.

Safety

Keywords:

Time-out/sign-out

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 proven to reduce wrong-site surgery.
The surgery or invasive procedure team, including the performing physician, the nurse, and the anesthesiologist, when applicable, is involved in the time-out process.
When performing a surgery or invasive procedure, healthcare professionals should verify the right patient, the right type of surgery, the right site, the right side, and the patient receiving prophylactic antibiotics if applicable.
The team shall not start the surgical or invasive procedure before resolving any conflict or confusion the team members could raise.
The hospital shall develop and implement a policy and procedures to ensure the correct patient, the correct surgery or invasive procedure, and the correct site and side of the surgery or invasive procedure.
The time-out process shall be applied just before the start of the surgery or invasive procedure (after induction of anesthesia).
According to WHO, sign-out is a part of the safe surgery checklist in which the operating team shall review all the processes so far before leaving the operating location, including the procedure name, ensuring completion of the counting process, verifying the extracted specimen against its label as well as raising any other concerns and problems during the procedure.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the time-out process and interview involved staff members to ensure their awareness.
- GAHAR surveyor may observe a case during the time-out process and ensure process conduction before starting surgical or invasive procedure (if applicable).
- GAHAR surveyor may review a sample of patients' medical records for those who underwent surgery/invasive procedure and related documents to check time-out process/sign-out process documentation.

Evidence of compliance:

1. The hospital has an approved policy to ensure the correct patient, procedure, and body part before surgical or invasive procedures.
2. Time out is done immediately before surgery or invasive procedure starts.
3. Sign-out is conducted at the end of all surgical and invasive procedures and before leaving the operating location.
4. The hospital monitors the reported data on time-out and sign-out processes and takes actions to control or improve the process as appropriate.

GSR.17 (SAS.09) The accuracy of counting sponges, needles, and instruments pre- and post-procedure is verified.

Safety

Keywords:

Instrument Retention Prevention

Intent:

Missing sponges, suture reels, needles, blades, towels, or instruments inside the patient's body act as a foreign body and cause serious morbidity in the form of pain, organ injury and sepsis, which necessitate reopening the patient and could reach up to mortality.
The surgical team should spend all efforts to prevent missing any foreign body during surgery/invasive procedure by meticulously counting any item used before, during the closure of each body space, and after the closure of the skin.
Once a miscount is identified, the team shall conduct re-counting, check the missing item, make provisions using imaging studies, and report the miscount.

Survey process guide:

- GAHAR surveyor may review the hospital process guiding accurate counting of sponges, needles, and instruments pre- and post-procedure, followed by interviewing involved staff members to check their awareness, and may inquire about the actions to be taken in case of an identified miscount.
- GAHAR surveyor may observe a case during or after surgery or an invasive procedure (if applicable).

Evidence of compliance:

1. The hospital has a process to manage surgical counts.
2. Two staff members count sponges, needles, towels, or instruments before, during, and after the surgery or invasive procedure, as the second one acts as a witness for the first one.
3. The preoperative, intraoperative, and postoperative counts are recorded, and the performing physician signs the record.

4. There is a process to manage and deal with miscounts once identified.
5. The hospital monitors the reported data on the counting process and takes actions to control or improve the process as appropriate.

MEDICATION MANGEMENT AND SAFETY

GSR.18 (MMS.10) 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 transition in care (hospital admission, transfer from one unit to another during hospitalization, discharge from the hospital, or during receiving ambulatory care services).

As a result, the new medication regimen prescribed at 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 requires developing a list of current medications and medications to be prescribed, comparing the medications on the two lists, and making clinical decisions based on the comparison.
The medication reconciliation process is a multidisciplinary activity with responsibilities shared among physicians, nurses, pharmacists, and other clinicians involved in the patient's care.

The hospital shall develop and implement 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) before ordering any new medication.
   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 prescribed before and during the episode of care).
   iv. During ambulatory care services (if it involves medication) before prescribing.
b) Identify the responsibility of performing medication reconciliation.
c) Patients and family involvement.
d) Steps of the medication reconciliation process such as collecting the list of both prescribed and non-prescribed medications (e.g., vitamins, nutritional supplements, over-the-counter drugs, and vaccines) used by patients, clarification whether these medications and their dosages are appropriate, matching with a new list of medication and recording changes.

Survey process guide:

- GAHAR surveyor may review the hospital policy and interview medical staff members, pharmacists, and nurses to inquire about the medication reconciliation process.
- GAHAR surveyors may review a sample of patients' medical records to assess the recording of current medications upon admission.

- GAHAR surveyor may interview an appropriate number of patients to inquire about medication history assessment.
- GAHAR surveyor may check whether the patient's own medications match 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 d).
2. Staff responsible for reconciling medications are trained to take the best possible medication history (BPMH) and reconcile medications.
3. Medication reconciliation occurs in situations mentioned in the intent from i) to iv) within a defined timeframe.
4. Medication prescribers compare the list of current medications with the list of medications tobe prescribed and make clinical decisions based on the comparison.
5. Reconciled medications are clearly recorded, and related information is clearly communicatedto healthcare professionals involved in the patient's medication prescribing.

GSR.19 (MMS.04) Medications are stored in a manner that maintains the security and quality of the medications and is according to the applicable laws and regulations.

Safety

Keywords:
Medication storage and labeling

Intent:
Appropriate storage of medications can reduce waste, incorrect medication dispensing and handling, and the incidence of missed doses. Medications are usually stored in pharmacies, storage areas, or patient care areas in the hospital according to the manufacturer's recommendation and according to the applicable laws and regulations.

The stability/effectiveness of some medications depends on storing them in the correct conditions,such as light, humidity, and temperature. The hospital shall maintain appropriate storage conditions in medication storage areas to protect the stability of medications (temperature, light, humidity) 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.

Labeling 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 drugs. Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original containers and placed into unlabeled containers. This unsafe practice neglects the basic principles of safe medication management, yet it is routine in many hospitals.

Medications, medication containers, other solutions, and the components used in their preparation are clearly labeled (if not clearly shown in the original packages or boxes) with the name, concentration/ strength, expiration date, batch number, and any applicable warnings.

Survey process guide:

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

GSR.20 (MMS.06) 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 and concentrated electrolytes

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

Concentrated electrolytes include, but are not limited to, potassium chloride [equal to or greater than two mEq/mL concentration], potassium phosphate [equal to or greater than three mmol/mL 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 one method to minimize the risk of death or injury associated with these medications.

The hospital shall develop and implement a policy and procedures to guide the process of safe use of high-alert medications and concentrated electrolytes that address at least the following:

a) Lists of high-alert medications and concentrated electrolytes based on the hospital's own data and both national and internationally recognized organizations (e.g., Institute of Safe Medication Practice (ISMP) and the World Health Organization (WHO).
b) Strategies are in place to prevent the inadvertent use of these medications.
c) A uniform process for the safe storage and administration of high-alert medications and concentrated electrolytes

Survey process guide:

- GAHAR surveyor may review the hospital policy that guides the process of safe use of high-alert medications.
- GAHAR surveyor may observe patient care areas and assess measures to ensure the safe storage of high-alert medications (such as being labeled) and concentrated electrolytes (such as being removed whenever possible, labeled with a warning reminder, or separated in secure areas).
- GAHAR surveyor may interview pharmacists/nurses at different patient care areas to assess their understanding of preventive strategies for managing these medications and concentrated electrolytes.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements from a) through c) in the intent
2. The hospital has an approved and annually updated list(s) of high-alert medications and concentrated electrolytes.
3. The hospital implements process(es) to prevent inadvertent use of high-alert medications and concentrated electrolytes.
4. The hospital trains healthcare professionals involved in the management and use of high-alert medications and concentrated electrolytes.
5. The hospital monitors the reported data on the management of high-alert medications and concentrated electrolytes and takes actions to control or improve the process as appropriate.

GSR.21 (MMS.07) 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 like medications.

Intent:
Look-alike sound-alike (LASA) medications are those visually similar in physical appearance or packaging and names of medications with 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 non-proprietary names, dosage forms, strengths, directions, and the indication for use to help differentiate LASA medication names. If LASA medications have different indications, associating an indication with a medication may help differentiate it from another 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 “tall man” (mixed case) lettering (e.g., DOPamine versus DoBUTamine) to emphasize drug name differences.
The hospital develops a risk management strategy to minimize adverse events with LASA medications and enhance patient safety.
The hospital shall develop and implement a policy and procedure to ensure the 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 that guides the process of safe use of LASA medications.
- GAHAR surveyor may review the hospital's updated list of look-alike and sound-alike medications.
- GAHAR surveyor may Interview pharmacists and nurses to inquire about processes to minimize the risk of using look-alike sound-alike medications.
- GAHAR surveyor may observe the pharmacy, medication carts, medication storage, and medication preparation areas to check the labeling of LASA medications.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements from a) to d) in the intent.
2. There is an approved list of LASA medications that is updated at least annually.
3. The hospital provides training to the healthcare professionals involved in the management and use of LASA.
4. LASA medications are stored, segregated, and labeled safely and uniformly in all locations.
5. The hospital monitors the reported data on the management of LASA and takes actions to control or improve the process as appropriate.

INFECTION PREVENTION AND CONTROL

GSR.22 (IPC.04) professional 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 and includes:

- Handwashing: washing hands with plain or antimicrobial soap and water
- Hygienic hand rub: treatment of hands with an antiseptic hand rub to reduce the transient flora without necessarily affecting the resident skin flora. These preparations are broad-spectrum and fast-acting, and persistent activity is not necessary.
- Surgical hand antisepsis/surgical hand preparation/ presurgical hand preparation: antiseptic handwash or antiseptic hand rub performed preoperatively by the surgical team to eliminate transient flora and reduce resident skin flora. Such antiseptics often have persistent antimicrobial activity.

Choosing the type of hand hygiene based on the type of procedure and risk assessment. Functional Hand hygiene stations (sinks, clean single-use towels, hand hygiene posters, general waste basket and appropriate detergent) must be present in appropriate numbers and places, according to national building codes. Alcohol-based hand rubs may replace hand wash in healthcare facilities unless hands are visibly soiled to overcome the shortage in sinks.

The hospital shall develop and implement a hand hygiene policy that includes at least the following:

a) Hand hygiene techniques.
b) Indications for hand Hygiene.
c) Personal protective equipment (PPE).
d) Accessibility of hand hygiene facilities.
e) Nail Care and Jewellery.
f) Hand hygiene education and training.
g) Monitoring the compliance.

Survey process guide:

- GAHAR surveyor may review the policy of hand hygiene and hand hygiene guidelines.
- GAHAR surveyor may interview hospital staff to ask about hand hygiene techniques, and WHO's five moments of hand hygiene.
- GAHAR surveyor may review healthcare professionals' training records.
- GAHAR surveyor may observe hand washing facilities at each patient care area and check the availability of supplies (soap, tissue paper, alcohol hand rub, etc.) and hand hygiene posters.
- GAHAR surveyor may observe the compliance of healthcare professionals with hand hygiene technique and WHO five moments of hand hygiene with WHO observation audit tool

Evidence of compliance:

1. The hospital has approved Hand Hygiene policies and procedures based on current professional guidelines that address all the elements mentioned in the intent from a) to g).
2. Healthcare professionals are trained on these policies and procedures.
3. Hand hygiene is implemented according to the policy.
4. Hand hygiene posters are displayed in required areas.
5. Hand hygiene facilities are present in the required numbers and places.
6. The hospital monitors the reported data on the hand hygiene process and takes actions to control or improve the process as appropriate.

ENVIRONMENTAL AND FACILITY SAFETY

GSR.23 (EFS.03) 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 critical consideration for the hospitals' safety design is the prevention of fire, particularly with respect to the combustibility of construction and furnishing materials and the spread of fire and smoke.
Fire alarm systems and suppression equipment need to be readily accessible to combat accidental or malicious fires. Hospital staff must be knowledgeable about equipment usage, remain calm, and communicate effectively based on previous arrangements and training.
If all attempts to fully suppress the fire fail, the hospital evacuates. The main goal of hospital evacuation is moving all patients, visitors, and staff out of dangerous and/or damaged areas as safely as possible.
Priorities and respect should be taken into consideration during hospital evacuation. Independent cases then dependent cases using simple and available tools like mattresses, bed sheets, trolleys, wheelchairs, or other tools.

Proactive periodical environmental safety risk assessments for hospitals should be performed, with required risk mitigation measures for different hospital areas.
During an evacuation scenario, paying attention to detail and processes will not be optimal. Understanding key principles is sufficient for helping staff members make good decisions during a chaotic event.

The hospital shall develop and implement a fire, smoke, and non-fire safety plan based on environmental safety risk assessment that addresses at least the following:

a) Preventive measures:
   - Safe storage and handling of highly flammable materials.
   - Assesses compliance with Civil Defence requirements or recommendations.
   - Fire and smoke separation, areas under construction, and other high-risk areas, such as stores, fuel tanks, kitchens including hoods, generators, laundry, oxygen supply, medical gases rooms, electrical control panels, medical records room, garbage room, etc., with risk mitigation measures.

b) Fire alarm and smoke detection 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 systems, such as water systems and automated or manual fire extinguishers, and their distribution in the hospital. There should be signs explaining how to activate the fire alarm and use a fire extinguisher and hose reel.

d) Safe evacuation through a continuous and unobstructed path of travel from any occupied part of the building to a safe area outside the building (assembly areas). This path must be clearly marked with exit signs and free from obstructions.

e) An annual training plan for all staff, ensuring everyone can proficiently demonstrate RACE, PASS, and other activities that ensure the safety of everyone during fire and non-fire emergencies, with documentation of all results regularly according to the training plan.

f) The fire and smoke safety plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the fire safety plan and related documents, such as facility fire safety inspections, fire system maintenance, and staff training (all staff should be trained on fire safety).
- GAHAR surveyors may observe to check the availability, accessibility, and effectiveness of fire alarm, firefighting, and smoke containment systems and compliance with civil defense requirements.
- GAHAR surveyor may review the plan of testing (drills).

Evidence of compliance:

1. The hospital has an approved and updated fire and smoke safety plan that includes all elements from a) through f) in the intent.
2. The hospital provides training on fire safety and evacuation for all staff at least annually.
3. The hospital fire alarm and smoke containment system is available, accessible and functioning.
4. The hospital fire firefighting systems are available, accessible and functioning.
5. Inspection, maintenance and testing of fire alarms, firefighting, and smoke containment systems are performed and recorded.
6. The evacuation path is clearly marked with exit signs and free from obstructions.

GSR.24 (EFS.04) Fire drills are performed in different clinical and non-clinical areas.

Safety

Keywords:
Fire drills

Intent:
A fire drill is designed to ensure staff readiness in case of fire and/or other internal emergencies. It provides staff members with the necessary knowledge and comprehension of the fire safety plan by consistently conducting training sessions and simulations to respond promptly, safely, and appropriately. Periodical drills make the staff self-confident and able to fulfill their responsibilities in the event of a fire.
Fire drills in hospitals should be performed at least quarterly, including one unannounced drill annually, and the hospital should record the details of the drill, including, but not limited to, the following:

a) Dates and timings.
b) Staff who participated in the drill.
c) Involved areas.
d) Shifts.

Survey process guide:

- GAHAR surveyor may review fire and evacuation drill records, including dates, timings, participating staff, and the hospital's involved areas.
- GAHAR surveyor may review the hospital's corrective action plan, which is based on the drill evaluation.
- GAHAR surveyor may interview staff members to check their awareness of the fire safety plan and basic procedures in such cases as RACE and PASS (Rescue, Alarm, Confine, Extinguish/Evacuate and Pull, Aim, Squeeze, Sweep).

Evidence of compliance:

1. Fire drills are performed at least quarterly, including one unannounced drill annually.
2. All staff members participate in fire drills at least once annually.
3. Fire drill results are recorded, including items from a) through d) that are mentioned in the intent.
4. Fire drill evaluation is performed after performing each drill with a corrective action plan when indicated.
5. The hospital staff guarantees a safe evacuation for patients, staff, and visitors.

GSR.25 (EFS.06) The hospital plans safe handling, storage, usage, and transportation of hazardous materials and waste management.

Safety

Keywords:
Hazardous materials safety and waste management

Intent:
Hazardous materials are substances that, if released or misused, can threaten the environment, life, or health. These chemicals are used in industry, agriculture, medicine, research, and consumer goods.
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. As the effects of hazardous materials can be extensive and

catastrophic, it is crucial for hospitals to carefully plan and create a safe working environment for the use of such materials.

Hospital waste refers to any waste produced during the diagnosis, treatment, or immunization of humans or in research within a hospital facility.
According to the World Health Organization (WHO) classification, hospital waste is categorized into the following categories:

- Infectious
- Pathological and anatomical
- Pharmaceutical
- Chemical
- Heavy metals
- Pressurized containers
- Sharps
- Genotoxic/cytotoxic
- Radioactive

These items/ categories can be pathogenic and adversely affect the hospital environment.
Other non-hazardous waste items generated in hospitals as a result of healthcare service provision include medication boxes, packaging for medical items and food, leftover food, and office waste.
To ensure the safety of staff, patients, relatives, vendors, and the environment, it is crucial for the hospital to identify and manage hazardous materials and waste present throughout its premises. This involves using techniques to properly handle and dispose of waste produced by hospitals in order to prevent the spread of diseases.

The hospital shall develop and implement a hazardous material and waste management plan that 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) A safety data sheet (SDS) should be available and include 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, and storage of hazardous materials.
e) Appropriate segregation, labeling, handling, storage, transportation, and disposal of all categories of hazardous waste.
f) Availability of required protective equipment and spill kits.
g) Investigation and documentation of different incidents, such as spills and exposure.
h) Compliance with local laws and regulations.
i) Availability of required licenses and/or permits.
j) Staff training and orientation.
k) The plan is updated annually based on evaluation.

<u>Survey process guide:</u>

- GAHAR surveyor may review the hospital's hazardous materials and waste management plan to ensure that it covers all safety requirements for hazardous materials, safe storage, handling, spills, required protective equipment, and waste disposal according to local laws and regulations.
- GAHAR surveyor may review hazardous material, waste inventories, and Safety Data Sheets (SDS).

- GAHAR surveyor may observe to check hazardous material labeling and storage in addition to waste collection segregation storage and final disposal.

Evidence of compliance:

1. The hospital has an approved and updated hazardous material and waste management plan that addresses all elements from a) through k) in the intent.
2. The hospital ensures the availability of the hospital SDS.
3. Staff is trained on hazardous material and waste management plans.
4. The hospital ensures the safe use, handling, storage, and labeling of hazardous materials.
5. The hospital ensures that waste handling, storage, and labeling are according to laws and regulations.
6. The hospital has an approved document for spill management, Investigation, and recording of different incidents related to hazardous materials.

GSR.26 (EFS.07) A safe work environment plan addresses high-risk areas, procedures, risk mitigation requirements, tools, and responsibilities.

Safety

Keywords:
Safety Management Plan

Intent:
Health services are committed to providing a safe environment for patients, staff, and visitors. Hospital safety arrangements keep patients, staff, and visitors safe from inappropriate risks such as electricity and inappropriate behavior such as violence and aggression.
The hospital shall develop and implement a safety plan to cover the building, property, medical equipment, and systems to ensure a safe physical environment for patients, families, staff, visitors, and vendors. The safety plan shall include at least the following:

a) Proactive risk assessment.
b) Safety measures are based on risk assessment, such as exposure to infectious agents, electric and radioactive hazards, vibration, and noise.
c) Identify 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).
d) Processes for pest and rodent control.
e) Regular inspection with documentation of results, performing corrective actions, and appropriate follow-up.
f) Responsibilities according to laws and regulations.
g) Safety training depending on job hazard analysis.
h) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital safety plan to ensure that suitable risk assessment is included.
- GAHAR surveyor may review surveillance rounds plan, checklist, different observations, and proper corrective actions when applicable.

- GAHAR surveyor may observe the safety measures implementation in all areas and safety instructions posters in all high-risk areas.
- GAHAR surveyor may observe to check availability and ensure staff compliance with suitable personal protective equipment (PPE) in different areas like workshops and waste collection areas.

Evidence of compliance:

1. The hospital has an approved and updated plan to ensure a safe work environment, including all elements from a) through h) in the intent.
2. Safety instructions are posted in all high-risk areas.
3. Staff are aware of safety measures based on their job hazards.
4. PPEs are available and used whenever indicated.
5. Safety measures are implemented in all areas.

GSR.27 (EFS.10) Medical equipment plan ensures selection, inspection, testing, maintenance, and safe use of medical equipment.

Safety

Keywords:
Medical Equipment Plan

Intent:
The management of medical equipment is crucial for the accurate diagnosis and effective treatment of patients. Within hospitals, a trained team of biomedical engineers oversees the entire medical equipment inventory and assumes responsibility for addressing and dealing with hazards associated with this equipment.
Managing such a large number of equipment can be challenging, especially when the stakes are so high. Neglecting proper monitoring and management not only results in inefficiency but also poses a serious risk to patient outcomes. For instance, neglecting maintenance raises the likelihood of equipment downtime, and inadequate servicing can have detrimental effects on both medical professionals and patients. This emphasizes the importance of implementing safety and service guidelines for medical equipment.
The hospital shall develop and implement a plan for medical equipment management that contains at least the following:

a) Selection, inspection, and testing of medical equipment:
   i. Developing criteria for selecting new medical equipment.
   ii. Inspection and testing of new medical equipment upon procurement and on a predefined interval basis.
   iii. 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.
   iv. Inventory of medical equipment, including availability and functionality.
   v. Identification of critical medical equipment that should be available for the operator even through the provision of backup such as life-saving equipment, ventilator, and DC shock.

b) Maintenance and safe use of medical equipment:
   I. 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.

II. Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.
III. Malfunction and repair of medical equipment.
IV. Dealing with adverse incidents involving equipment, including actions taken, backup system, and reporting.
V. Updating, retiring, and/or replacing medical equipment in a planned and systematic way.

c) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital medical equipment management plan and related documents, e.g. (inventory of medical equipment, preventive maintenance schedule, calibration schedule, and staff training records).
- GAHAR surveyor may observe the medical equipment functionality.

Evidence of compliance:

1. The hospital has an approved and updated medical equipment management plan that addresses all elements from a) through c) in the intent.
2. The hospital has a qualified individual to oversee medical equipment management.
3. The hospital ensures that only trained and competent staff handles the specialized equipment(s).
4. Records are maintained for medical equipment inventory, user training, equipment identification cards, company emergency contact, and testing on installation.
5. Records are maintained for medical equipment, periodic preventive maintenance, calibration, and malfunction history.
6. Equipment adverse incidents are reported, and actions are taken.

GSR.28 (EFS.11) Essential utility plan addresses regular inspection, maintenance, testing, and repair.

Safety

Keywords:
Utility Management

Intent:
As hospital's utility systems form the operational infrastructure that enables the provision of safe patient care, it is crucial for hospitals to plan and implement effective response and recovery activities in the event of a failure in their utility systems.
Some of the essential utilities include mechanical systems (e.g., heating, ventilation, and cooling); electrical systems (e.g., 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 systems; fuel systems; access control, duress alarm, and surveillance systems; medical gases, air and vacuum systems; and pneumatic tube systems.
The hospital shall have a utility management plan to ensure the efficiency and effectiveness of all utilities. The plan shall include at least the following:

a) Inventory of all essential utility systems, for example, electricity, water supply, medical gases, heating, ventilation and air conditioning, communication systems, sewage, fuel sources, fire alarms, and elevators.
b) Layout of the utility systems.

c) Staff training on utility plan.
d) Regular inspection, testing, and corrective maintenance of utilities.
e) Regular testing of alarms (refrigerators, nursing call alarms, medical gases, others).
f) Testing of the electric generator with and without a load on a regular basis.
g) Providing fuel required to operate the generator in case of an emergency.
h) Cleaning and disinfecting water tanks and testing 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.
i) Preventive maintenance plan, according to the manufacturer's recommendations.
j) Identification of critical utility systems and ensuring backup availability.
k) The hospital performs regular, accurate data aggregation and analysis (for example, frequency of failure, preventive maintenance, compliance with proper monitoring, updating, and improvement of the different systems).
l) The plan is updated annually based on evaluation.

Survey process guide:

- GAHAR surveyor may review the hospital utility management plan to ensure coverage of all required measures, e.g., regular inspection, maintenance, and backup for all essential utility systems management.
- GAHAR surveyor may review inspection records, preventive maintenance schedule, contracts, as well as testing results of generators, tanks, and/or other essential utility systems to make sure of facility coverage 24/7.

Evidence of compliance:

1. The hospital has an approved and updated plan for utility management that includes items a) through l) in the intent.
2. The hospital has trained staff members to oversee utility management.
3. The hospital utility management plan is implemented.
4. Records are maintained for utility systems inventory, testing, periodic preventive maintenance, and malfunction history.
5. Critical utility systems are identified, and backup availability is ensured.

INFORMATION MANGEMENT AND TECHNOLOGY

GSR.29 (IMT.04) The hospital defines standardized symbols and abbreviations.

Efficiency

Keywords:
Abbreviations

Intent:
Usually, codes, symbols, and abbreviations are used 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 shall develop a policy and procedures for approved and non-approved 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) The list of not-to-use symbols/abbreviations is guided by reliable references, such as the Institute for Safe Medication Practices (ISMP) list.
c) Non-English abbreviations 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 a sample of medical records to check for the used symbols/abbreviations with medication orders and inpatient medical records.
- GAHAR surveyor may interview medical staff to check their awareness about symbols/abbreviations requirements.

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 record in the patient's medical record are aware of the policy requirements.
3. Symbols and abbreviations, including the approved list, are used according to the policy.
4. Violation of the list of not-to-use symbols/abbreviations is monitored, and corrective actions are taken.

Section 3: Essential Quality Requirements

Chapter intent:

Essential quality requirements, the foundation of exceptional healthcare, hinges on a commitment to continuous improvement and a patient-centered approach. The complex interactions between patients, staff, processes, and technology in healthcare demand a strong system to guarantee safe, effective, and fair care. While skilled professionals and established protocols are crucial, the inherent risks within the healthcare system demand a proactive and systematic approach to quality enhancement. The focus on essential quality has evolved significantly, emphasizing the importance of patient involvement, data-driven decision-making, and a culture of continuous learning. Accreditation bodies play a pivotal role in promoting these principles by establishing clear expectations and conducting regular evaluations. Developing robust EQRs is paramount to driving quality improvement across all healthcare settings.

To create effective EQRs, a comprehensive understanding of the critical areas impacting quality is necessary. These include patient rights, access to care, medication safety, infection prevention, workforce management, and information management, among others. These requirements must be grounded in evidence-based practices and aligned with national and international quality standards. As part of the GAHAR accreditation process, Hospitals must demonstrate their commitment to essential quality requirements. This necessitates compliance with each of the GAHAR Essential Quality Requirements (EQRs).

Chapter purpose:

1. Provide a comprehensive overview of GAHAR Essential Quality Requirements.
2. Outline the essential components of an effective quality management system.
3. Support organizational efforts to create a culture of continuous quality improvement.
4. Enhance patient outcomes by minimizing risks and maximizing the value of healthcare services.

Essential Quality Requirements

Code	Keyword	Standard code
Patient-Centeredness Culture		
EQR.01	Patient and family rights	**PCC.02**
EQR.02	Patient and family education process	**PCC.07**
EQR.03	Informed consent	**PCC.08**
EQR.04	Complaints and suggestions	**PCC.16**
Access, Continuity, and Transition of Care		
EQR.05	Granting access (before patient's registration)	**ACT.01**
EQR.06	Special care units' access	**ACT.13**
Integrated Care Delivery		
EQR.07	Emergency Services	**ICD.03**
EQR.08	Plan of care	**ICD.15**
EQR.09	Transfusion of blood and blood products	**ICD.21**
Critical and Special Care Services		
EQR.10	Critical care	**CSS.01**
EQR.11	Restraint and seclusion	**CSS.12**
Diagnostic and Ancillary Services		
EQR.12	Medical imaging quality assurance and control	**DAS.05**
EQR.13	Laboratory internal quality assessment	**DAS.18**
EQR.14	Blood procurement	**DAS.27**
Surgery, Anesthesia, and Sedation		
EQR.15	Operative report	**SAS.08**
EQR.16	Physiological assessment by anesthesia	**SAS.17**
Medication Management and Safety		
EQR.17	Medication procurement, formulary	**MMS.03**
EQR.18	Emergency medications	**MMS.05**
Infection Prevention and Control		
EQR.19	IPC committee meetings	**IPC.03**
EQR.20	Safe injection practices	**IPC.08**
EQR.21	Care bundles	**IPC.11**
EQR.22	Transmission based precautions	**IPC.12**
EQR.23	Sterilization/disinfection	**IPC.14**
EQR.24	Food services	**IPC.20**
Organization Governance and Management		
EQR.25	Governing body Structure and responsibilities	**OGM.01**
EQR.26	Mission statement	**OGM.02**
EQR.27	Committee structure	**OGM.05**
EQR.28	Billing system	**OGM.12**

EQR.29	Staff health program	**OGM.17**
Workforce Management		
EQR.30	Staffing plan	**WFM.02**
EQR.31	Staff files	**WFM.06**
EQR.32	Orientation program	**WFM.07**
EQR.33	Staff performance evaluation	**WFM.09**
Information Management and Technology		
EQR.34	Integrity of data and information	**IMT.06**
EQR.35	Patient's medical record management	**IMT.08**
EQR.36	Downtime of data systems	**IMT.11**
Quality and Performance Improvement		
EQR.37	Quality Committee (s)	**QPI.01**
EQR.38	Incident reporting system	**QPI.10**
EQR.39	Sentinel events	**QPI.11**
Academic and Teaching Hospitals		
EQR.40	Patient rights during bedside teaching	**ATH.04**
EQR.41	Research patient rights	**ATH.09**

EQR.01 (PCC.02) Patient and family rights are protected and informed to patients and families.

Patient-centeredness

Keywords:
Patient and family rights

Intent:
It is crucial for patients to understand and effectively exercise their rights. When patients lack this understanding, the hospital is committed to helping them gain the necessary knowledge. Additionally, the hospital ensures its staff is well-guided in their responsibility to safeguard the rights of patients and their families.
Patient and family rights shall be defined according to laws and regulations, as well as the ethical code of healthcare professionals' syndicates.
The hospital shall develop and implement a policy and procedures that ensure all staff members are informed about and appropriately address patient and family rights issues during their interactions with patients throughout the hospital. This policy shall address at least the following:

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

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding patient and family rights.
- GAHAR surveyor may interview staff members to ensure their awareness of the hospital policy.
- GAHAR surveyor may observe that patient rights statements are visibly displayed in the hospital.
- GAHAR surveyor may observe how patients receive information about their rights.
- GAHAR surveyor may observe 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, including items mentioned in the intent from a) through j).
2. All staff members are aware of patients' and families' rights.
3. Patients' rights are posted and visible to patients, families, and staff.
4. Patient and family rights are protected in all areas and at all times.
5. Patients are informed of their rights in a manner they can understand.

EQR.02 (PCC.07) Patients' and families' education is provided.

Patient-centeredness

Keywords:
Patient and family education process

Intent:

Patient and family education helps to understand the care process and empowers patients and families to make informed decisions. Multiple disciplines contribute to the process of educating patients and families during care processes.

The Hospital shall develop and implement a policy and procedures to define the process of patient and family education. The policy addresses at least the following:

a) Identify patient and family needs that may vary from one patient to another. However, at least the following needs are to be addressed for all patients:
    i. Diagnosis and condition of the patient.
    ii. Care plan, expected outcome of care and alternative to the plan of care.
    iii. Discharge instructions.
b) Multidisciplinary responsibility of patient and family education process
c) The method of education is provided according to patient and family values and level of learning, as well as in a language and format that they understand.
d) Documentation of patient education activities, including information and education provided, how the information and education were delivered (e.g., in writing, verbally, by demonstration, etc.), and confirmation that the patient and/or family understood the information and education provided.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding the patient and family education process.
- GAHAR surveyor may interview staff members to ensure their awareness of patients' and families' education process and recording.
- GAHAR surveyor may review a sample of patients' medical records to check the completion of patient and family education records.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of patient and family education that includes at least the points mentioned in the intent from a) through d).
2. All staff members are aware of patients' and families' education process and recording.
3. Patients receive education relevant to their condition.
4. Patient education activities are recorded in the patient's medical record.

EQR.03 (PCC.08) The hospital has a defined process to obtain informed consent for certain medical processes.

Patient-centeredness

Keywords:
Informed consent

Intent:

One of the main pillars of ensuring patients' involvement in their care decisions is obtaining informed consent. Informed consent is a process for getting permission before performing a healthcare

intervention on a person or disclosing personal information. To give consent, a patient should be informed of many factors related to the planned care. These factors are required to make an informed decision. The hospital shall develop and implement a policy and procedures to describe how and where informed consent is used and documented as required by applicable laws and regulations. The policy includes at least the following:

a) The list of medical processes when informed consent is needed; this list includes:
   i. Surgery and invasive procedures.
   ii. Anaesthesia, moderate and deep sedation.
   iii. Use of blood and donation of blood.
   iv. High-risk procedures or treatments (including but not limited to electroconvulsive treatment, radiation therapy, and chemotherapy).
   v. Research.
   vi. Photographic and promotional activities, for which the consent could be for a specific time or purpose.
b) The likelihood of success and the risk of not doing the procedure or intervention, as well as the benefits and alternatives to performing that particular medical process.
c) Certain situations when consent can be given by someone other than the patient, as well as mechanisms for obtaining and recording it according to applicable laws and regulations and approved hospital policies.
d) Consent forms available in all applicable locations.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding the process of obtaining informed patient consent.
- GAHAR surveyor may review the list of medical processes when informed consent is needed.
- GAHAR surveyor may review a sample of patients' medical records to check informed patient consent completion.
- GAHAR surveyor may observe the distribution and availability of informed consent forms by visiting areas where they are most needed, such as the operating room, dental clinic, endoscopy unit, and others.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of informed consent that includes all elements mentioned in the intent from a) through d).
2. Informed consent is obtained in a manner and language that the patient understands and does not contain abbreviations.
3. The responsible physician obtaining the informed consent signs the form with the patient.
4. Informed consent given by someone other than the patient complies with applicable laws and regulations.

EQR.04 (PCC.16) 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 shall be 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 shall develop and implement 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 addresses 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.
e) Monitor the reported data on patients' complaints and take actions to control or improve the process.

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 e).
2. Staff is aware of complaints and suggestion policy.
3. The hospital allows the complaining process to be publicly available.
4. Complaints and suggestions are investigated, analyzed by the hospital, and resolved in an approved timeframe.
5. Patients and families receive feedback about their complaints or suggestions within approved timeframes.

EQR.05 (ACT.01) The hospital grants patients access to its services according to applicable laws and regulations.

Patient-centeredness

Keywords:
Granting access (before patient's registration)

Intent:

Access to healthcare means timely use of personal health services to achieve the best health outcomes. The hospital shall establish a systematic and transparent process for granting patients access to the services provided, promoting efficiency and consistency in the admission process and ultimately enhancing the quality of care provided in the facility.
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.

Implementing pre-set eligibility criteria will facilitate the prioritization of individuals whose needs align with the facility's services. These pre-set criteria need to be available for those responsible for granting access

to patients. The hospital will conduct a pre-admission screening to determine if the individual is eligible for admission and if the hospital can meet their care needs.
This screening may involve reviewing medical records, conducting an in-patient assessment, and interviewing the individual and their family. Patients with the same needs may vary in terms of age, abilities, language, and cultural context, or they may present other barriers that make the process of accessing and receiving care difficult.
Accessible infrastructure for patients with special needs should also be considered. This may include handicapped parking, wheelchair-accessible entrances, toilets for disabled patients, walking rails, etc.

The hospital shall develop and implement a policy and procedures to guide the process of granting access. The policy shall address at least the following:

a) Identifying the hospital-wide scope of service.
b) How to provide complete information on the care provided and services access the hospital offers.
c) The process of screening patients to determine that the hospital's scope of services can meet their healthcare needs.
d) Access through emergency areas is safe and appropriate for patients' conditions.
e) Access through ambulatory areas includes a clearly defined patient scheduling and queuing process.
f) Actions to be taken if the patient's needs do not match the facility's scope of service.
g) Accessibility of hospital services for patients with various types of disabilities.

Survey process guide:

- GAHAR surveyor may review the hospital policy and related documents guiding the process of granting access.
- GAHAR surveyor may observe the process of granting access by visiting the point of first contact in the hospital, such as service desks, receptions, call centers, emergency rooms, and outpatient areas.
- GAHAR surveyor may interview patients to assess their awareness of the information given concerning available services, operating hours, the cost of each service, and the access path.

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 g).
2. The hospital provides complete information on the available services, including operating hours, types of services, cost of each service (when relevant), and access path.
3. When a patient's healthcare needs do not match the hospital's scope of service, the patient is referred and/or transferred to another healthcare organization or given assistance in locating the service.
4. Hospital services are accessible for patients with various types of disabilities.

EQR.06 (ACT.13) 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, decreasing quality of care, and rising administrative costs of healthcare provision. Hospitals should preserve the availability of needed and necessary critical and specialized care services 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 physiologic-based discharge 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 review the hospital application to GAHAR to be aware of special units in the hospital.
- 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 interview involved healthcare professionals to check their awareness of the process.
- GAHAR surveyor may review patients' open medical records when visiting critical care units, dialysis units, or other units with the team to check the special additional screening used to decide admission and discharge from intensive care and special care units.
- GAHAR surveyor may observe to ensure that special resources, such as beds, equipment, or expertise, are allocated wisely according to the patient's special needs, during visiting critical care units, dialysis units, or other units.

Evidence of compliance:

1. The hospital has approved admission and discharge criteria for intensive care and specialized units.
2. All staff members involved in the admission and discharge of patients from specialized and critical care units are 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.

EQR.07 (ICD.03) Urgent and emergency services are delivered according to applicable laws and regulations.

Effectiveness

Keywords:
Emergency Services.

Intent:
To ensure consistency and coordination of services with higher levels of care, emergency services offered to the community should be provided within the capabilities of the hospital as defined by law and regulations.

The hospital shall develop and implement a policy and procedures for emergency services. The policy addresses at least the following:

a) The staff qualifications required to provide emergency care around the clock, including ALS for medical staff.

b) Defined criteria are developed to determine the priority of care according to an evidence-based triage process.

c) The minimum requirements for medical and nurse emergency assessment and reassessment.

d) The care process follows approved clinical guidelines and protocols, including requesting investigations and consultations and holding patients for observations.

e) The medical records of emergency patients should include at least:

i) The triage assessment and level.
ii) The medical and nurses' assessment and reassessment.
iii) The care provided.
iv) The arrival time and departure time.
v) Patient disposition.
vi) Patient diagnosis or conclusion at termination of treatment.
vii) Patient condition at departure.
viii) Follow-up care instructions.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding emergency services.
- GAHAR surveyor may interview emergency staff members to check their awareness of the Hospital policy.
- GAHAR surveyor may review a sample of emergency staff members' files to check their competency assessment.
- GAHAR surveyor may review a sample of emergency patients' medical records to ensure compliance with hospital policy requirements.
- GAHAR surveyor may observe to ensure emergency patients prioritization based on the urgency of their condition, in compliance with the hospital's evidence-based triage criteria for different populations.

Evidence of compliance:

1. The hospital has an approved policy for emergency services as mentioned in the intent from a) to e).
2. Competent staff members provide emergency services according to the policy of emergency services.
3. Patients are prioritized based on the urgency of their condition using evidence-based triage criteria for different populations, such as adults and pediatrics, and/or according to the scope of service.
4. Emergency patients receive medical, and nurses' assessments based on their needs and conditions.

5. Medical records of emergency patients include Items from i) to viii) in the intent.

EQR.08 (ICD.15) 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.
A comprehensive care plan is developed for each patient, outlining the specific medical treatments, medications, and therapies required. Additionally, the plan considers psychosocial support, dietary needs, and rehabilitation services to address all aspects of the patient's health.
Effective communication is crucial for care coordination. Team members regularly exchange information about the patient's progress, treatment updates, and any changes in their condition.
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, including the result of diagnostic tests where relevant.
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) Developed and updated according to guidelines and patient needs and preferences.
e) Includes identified needs, interventions, and desired outcomes with timeframes.
f) Updated as appropriate based on the reassessment of the patient.
g) The progress of the patient in achieving the desired outcomes of care is monitored.

Survey process guide:

- GAHAR surveyor may review a sample of patients' medical records to check plan of care documentation in compliance with the standard requirements.
- GAHAR surveyor may interview patients and their families to ensure their participation in the decision-making of their plan of care development.
- GAHAR surveyor may observe to ensure compliance with the standard requirements.

Evidence of compliance:

1. The plan of care is developed by all relevant disciplines based on their assessments.
2. The plan of care addresses all the elements mentioned in the intent from a) to g) and is documented in the patient medical record.
3. The plan of care is developed with the participation of the patient and/or family in decision-making.
4. The plan of care is changed/updated, as appropriate, based on the reassessment of the patient.

EQR.09 (ICD.21) Blood and/or blood components are transfused according to professional practice guidelines.

Safety

Keywords:
Transfusion of blood and blood products

Intent:
Errors in transfusion of blood and/or blood components lead to significant risks for patients. Wrong blood administration incidents are mainly due to human error leading to misidentification of the patient and can lead to life threatening haemolytic transfusion reactions and other significant morbidities.
All blood transfusion reactions must be immediately reported to the Head of the Blood Bank and Quality Department for prompt investigation of the cause of the adverse reaction.
The hospital shall develop a policy and procedures for the transfusion of blood and/or blood components. The policy addresses at least the following:

a) Visually check the bag for integrity.
b) Blood transfusion in emergencies.
c) Conditions when the bag shall be discarded.
d) The rate for blood transfusion.
e) Recording the transfusion.
f) Monitoring and reporting any adverse event.
g) Special considerations for the use of blood components.
h) Management of transfusion complications.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding transfusion of blood and/or blood components.
- GAHAR surveyor may interview involved healthcare professionals especially in inpatient wards, emergency room and procedure areas, to ensure their awareness of hospital policy.
- GAHAR surveyor may observe the process of blood transfusion.
- GAHAR surveyor may review a sample of patients' medical records to check blood transfusion records.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through h).
2. Healthcare professionals involved in blood and/or blood component transfusion are aware of the hospital policy.
3. Blood or blood component bags are visually checked before transfusion.
4. Monitoring of the patient's condition during transfusion is recorded in the patient's medical record.
5. A system is implemented to prevent and manage transfusion complications.

EQR.10 (CSS.01) Critical care services are provided according to laws, regulations, and clinical guidelines.

Effectiveness

Keywords:

Critical care

Intent:

Critical care services address immediate life-threatening conditions where vital organs are at risk of collapse. Using advanced therapeutic, monitoring, and diagnostic technology, these services aim to maintain organ function and stabilize patients for further treatment. Specialized healthcare teams provide these essential services, making critical care units pivotal in acute care hospitals. Critical care services are both costly and limited. When overwhelmed by a sudden surge in patients, these units may lead to canceled surgeries and extended emergency department wait times.

The hospital may have more than one critical care unit, such as an intensive care unit (ICU), a coronary care unit (CCU), a neonatal intensive care unit (NICU), or a pediatric intensive care unit (PICU), depending on its scope and the population it serves.

A clinical care program refers to a structured and coordinated approach to providing healthcare services and managing the care of patients or individuals with specific medical conditions according to clinical guidelines and protocols. A clinical care program for intensive care units (ICUs) involves specialized care and management for critically ill patients requiring intensive monitoring and treatment that include the following:

a) Multidisciplinary team
b) Admission and discharge criteria
c) Initial assessment requirements, including circulation, respiration, and oxygenation.
d) Continuous monitoring and life support.
e) Care planning and goal setting
f) Clinical guidelines/protocols that address at least the following items:
    - Resuscitation and stabilization
    - Ventilatory and respiratory support
    - Invasive procedures and interventional techniques
    - Rehabilitation and early mobilization
g) Nutritional support
h) Psychosocial support and family engagement, as appropriate.

Survey process guide:

- GAHAR surveyor may review the hospital clinical care program for critical care units.
- GAHAR surveyor may interview the involved healthcare professionals to check their awareness of the hospital program.
- GAHAR surveyor may review a sample of patients' medical records to ensure assessment, plan of care, and monitoring of progress documentation.
- GAHAR surveyor may review critical care unit shift schedules and corresponding physicians' files to ensure the presence of at least one physician trained in advanced cardiac life support on each shift.
- GAHAR surveyor may review a sample of the involved healthcare professionals' files to check their competency assessment.

Evidence of compliance:

1. The hospital has a clinical care program for critical care units that addresses all the elements mentioned in the intent from a) through h).
2. The healthcare professionals involved in critical care are competent in handling the program.
3. At least one physician in each shift is trained in advanced cardiac life support.

4. Management and use of critical care services is done according to clinical guidelines.
5. Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.

EQR.11 (CSS.12) Restraint and seclusion are used according to defined criteria, laws, and regulations and in a manner that respects the patient's rights.

Patient-centeredness

Keywords:
Restraint and seclusion

Intent:

Coercion, defined as the use of intervention against a person's will, is a globally important issue. In psychiatry, coercive measures often involve limiting freedom of movement to contain aggressive behavior but are also used in other medical contexts. Coercion raises ethical and legal questions by limiting fundamental human rights such as liberty, autonomy, and physical integrity, thus requiring strict regulation.

Determining the clinical effects of coercion is challenging due to ethical, legal, and methodological concerns. Despite limited evidence of effectiveness, coercive measures are commonly used, particularly in psychiatry. These interventions should be a last resort, with patients' preferences considered. Enhancing the therapeutic relationship could improve the outcomes and perception of coercion.

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

a) The use of restraints or seclusion is according to defined criteria, laws, and regulations.
b) Requirements for clear physician order for the use of restraints and seclusion.
c) Safe and effective application and removal by qualified staff members.
d) The least restrictive methods are to be used as appropriate.
e) Protection of patient's rights, dignity, and well-being during use.
f) Monitoring and reassessment during use.
g) Renewal of the restraint order is based on continuing needs and according to laws and regulations.
h) Management and care for patient's needs during restraint and seclusion.
i) Termination of restraints and seclusion is according to defined criteria.

Survey process guide:

- GAHAR surveyor may review the hospital policy for appropriate and safe use of restraint and seclusion.
- GAHAR surveyor may interview involved staff members to ensure their awareness.
- GAHAR surveyor may review a sample of patients' medical records to check restraint and seclusion records.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment.
- GAHAR surveyor may observe to ensure compliance with the hospital policy.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through i).

2. All staff members involved in restraint and seclusion are aware of the hospital policy.
3. Competent individuals are responsible for the use of restraint and seclusion.
4. Restraint and seclusions are used as per the policy.
5. Restraints and seclusions are recorded in the patient's medical record.

EQR.12 (DAS.05) A medical imaging quality control program is developed.

Effectiveness

Keywords:
Medical imaging quality assurance and control

Intent:
Quality control measures are performed to monitor and ensure the reliability of study results produced by the medical imaging service. Quality controls can identify performance problems and helps the medical imaging service to determine accuracy of images.
Management of the routine quality control (QC) of medical imaging equipment is a major responsibility of the medical imaging professionals. 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 quality control performed according to guidelines, manufacturer instructions 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.

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 and recorded.
4. Responsible authorized staff member reviews quality control function and checks data at least monthly.
5. Corrective action is taken whenever targets are unmet.

EQR.13 (DAS.18) An internal quality control process 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.
Outliers or trends in examination performance, that may indicate problems in the examination system, should be analyzed, followed up and preventive actions should be taken and recorded before major problems arise.
The laboratory develops and implements a procedure for internal quality control that shall include at least the following:

a) Elements of the internal quality control.
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) Quality Control data is reviewed at a regular interval (at least monthly) by responsible authorized staff member.
g) 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, records, documented regular review of the quality control data and the action taken for Outliers or trends.
- 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 g).

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 process and checks data at least monthly, and corrective action is taken when indicated.

EQR.14 (DAS.27) Processes of collection, handling, testing of blood, and blood components are performed according to national/international requirements.

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 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 for handling of blood units.
- GAHAR surveyor may visit areas where 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 are 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.

EQR.15 (SAS.08) Surgical or invasive 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 leaves the procedural unit. Recording the names of all staff involved in the procedure has a medicolegal 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 of the procedure is done. The use of any prosthesis or implantable devices should be stated in the report, including any special precautions when dealing with or removing it.
Complications that occur during the procedure should be recorded, along with the actions taken to manage them. Any specimen removed from the body should also be stated clearly in the procedure report.
The report should address 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 and findings.
e) The details of any implantable device or prosthesis used, including the batch number.
f) The occurrence of complications or not.
g) Any removed specimen or not.

h) Estimated blood loss and/or transfused blood.
i) Signature of the performing physician.

Survey process guide:

- GAHAR surveyor may review a sample of patients' medical records for those who underwent surgeries/invasive procedures 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 items from a) to i) in the intent.
3. The report is kept in the patient's medical record.

EQR.16 (SAS.17) 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's physiologic status that could be very rapid. Accordingly, the patient's physiologic status is required to be continuously monitored starting from receiving the anesthesia to determine the baseline of the patient's condition, which is used in determining the patient's criteria for 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 to on-time intervention for any changes in the patient's condition.

Survey process guide:

- GAHAR surveyor may observe a patient while receiving anesthesia to evaluate the patient monitoring process and the staff involved in it.
- GAHAR surveyor may review a sample of patients' medical records for those who received anesthesia to ensure that the results of the patient monitoring during anesthesia are recorded in the patient's medical record regularly according to the approved professional practice guidelines/protocols.

Evidence of compliance:

1. The patient's physiologic status is monitored during anesthesia based on hospital-approved professional 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 professional practice guidelines/protocols.

EQR.17 (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 beingdone through higher authority outside the hospital) efforts to quantify medication requirements, select appropriate procurement methods, and prequalify suppliers and products. It also involvesmanaging tenders, establishing contract terms, assuring medication quality, and obtaining the bestprices. It is performed based on a transparent process according to applicable laws and regulations.

The hospital (represented by the drug and therapeutic committee) 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.

Updating the medication list is guided by criteria (e.g., indications for use, effectiveness, drug interactions, adverse drug events, sentinel events, and population(s) served (e.g., pediatrics, geriatrics). 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, intending to add or delete them from the formulary, is a necessary criterion for formulary update and maintenance.

Survey process guide:

- GAHAR surveyor may review the hospital formulary and check for its availability.
- GAHAR surveyor may interview the DTC members about the process of adding/deleting medication to/from the hospital formulary.
- GAHAR surveyor may ask about the action taken in case of medication shortage.

Evidence of compliance:

1. The hospital has a defined process for the appropriate selection and procurement of medications according to the applicable laws and regulations, hospital mission, patient needs, and services provided.
2. The hospital has an approved list of medications (formulary),which includes at least items from a) to e) 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. There is a process for overseeing medication use in the hospital to monitor, maintain, and update the medication list.
5. The hospital has a defined process to guide the addition/deletion of medication to/from the medication list (formulary).
6. The hospital has an approved process for properly communicating medication shortages and

outages to prescribers and other healthcare professionals.

EQR.18 (MMS.05) Emergency medications are available, accessible, and secured at all times.

Safety

Keywords:
Emergency Medications

Intent:
When a patient emergency occurs, quick access to emergency medications is critical and may be lifesaving. Emergency medications shall be readily accessible and uniformly stored to facilitate quick access to the proper 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.
The hospital shall develop and implement a policy and procedures to ensure the availability of emergency medications in patient care areas that address at least the following:

a) Emergency medications should be readily accessible and uniformly stored.
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:

- GAHAR surveyor may review the hospital policy for emergency medication management.
- GAHAR 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.
- GAHAR surveyor may observe emergency medication storage areas.

Evidence of compliance:

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

EQR.19 (IPC.03) The hospital establishes a functioning multidisciplinary IPC committee that meets at least monthly.

Effectiveness

Keywords:
IPC committee meetings

Intent:
IPC challenges continuously arise in the different hospital disciplines, which in turn provide input for the IPC team to evaluate the situation continuously. Stakeholders and process owners are then involved in the decision-making stage; thus, the presence of a multidisciplinary IPC committee is crucial in order to provide a continuous link between the upper managerial level, the IPC team, and all other hospital departments.

There is a structured infection control committee; all relevant disciplines should be represented in the committee, including (but not limited to) the medical department, nursing services, housekeeping, laboratory, pharmacy, and sterilization services, and the committee should have the right to summon whoever it deems appropriate.

The IPC committee is responsible for at least the following.

a) Setting criteria to define healthcare-associated infections (HAIS).
b) Surveillance methods and process
c) Strategies to prevent infection and control risks.
d) Reporting infection prevention and control activities
e) Reviewing and evaluating outbreaks or clusters of HAIS and recommending appropriate control measures.
f) Collaborating with relevant departments to ensure compliance with infection control standards and regulations.
g) Annual reviewing and evaluation of the program.

Survey process guide:

- GAHAR surveyor may review an approved IPC committee formation decision, recorded monthly meeting minutes (of the previous six months) and recommendations as well as records to prove follow-up

Evidence of compliance:

1. There are clear terms of reference for the infection control committee that include at least from a) to g) in the intent.
2. All relevant disciplines are represented in the committee.
3. The committee meets at least monthly.
4. The committee minutes are recorded.
5. Implementation of the decisions taken by the committee at the end of each meeting is followed up.

EQR.20 (IPC.08) The hospital ensures Safe injection practices.

Safety

Keywords:
Safe injection practices

Intent:
In the hospital, both inpatients and outpatients are continuously in need of injections, whether for diagnostic or therapeutic purposes; unfortunately, however, it carries an associated risk of infection for the patients. Vascular access devices, like cannula or other instruments used to obtain venous or arterial access, are one of the main causes of healthcare-associated infections. The risk of infection is greatly reduced by complying with the process for safe insertion and maintenance of the device and its removal as soon as it is no longer needed.

Moreover, needle stick injury among healthcare professionals is a common accident, so safe injection practices are crucial to ensure both patient and healthcare professionals' safety.

Healthcare professionals must always use a sterile, single-use disposable syringe or needle for each injection given and ensure that all injection equipment and medication vials remain free from contamination. Healthcare professionals must also consider that all ampoules, by default, are single-use, not all vials are multi-dose vials, and syringes should not be used as a container or storage of drugs.

Survey process guide:

- GAHAR surveyor may observe to check the availability of Intravenous bottles and ensure their proper use of single-dose vials and the proper use of multi-dose vials.
- GAHAR surveyor may observe to ensure the compliance of responsible healthcare professionals with safe insertion and maintenance of the vascular access device procedures.

Evidence of compliance:

1. The intravenous bottles/bags are not used interchangeably between patients.
2. Use of single-dose vials versus multi-dose vials follows regulations and hospital-approved clinical guidelines.
3. The hospital ensures single use of the fluid's infusion.
4. The hospital ensures sterility of any parenteral administration.

EQR.21 (IPC.11) The hospital ensures implementation of evidence-based and /or best practices care bundles.

Safety

Keywords:
Care bundles

Intent:
Care "bundles" are simple sets of evidence-based practices that, when implemented collectively, improve the reliability of their delivery and improve patient outcomes. A number of specific bundles are available that can be implemented at healthcare facilities in resource-limited settings. These packages of care contribute to infection prevention, reduce unnecessary antibiotic prescribing, and may limit the development of antibiotic resistance in healthcare facilities.
Bundles also help to create reliable and consistent care systems in hospital settings since they are simple (three to five elements), clear, and concise. In addition, the implementation of bundles also promotes multidisciplinary collaboration since they should be developed collaboratively, and consensus should be obtained with strong clinician engagement and endorsement.
In order for bundle implementation to be successful, each element of the bundle must be implemented collectively and consistently to achieve the most favourable outcomes ("all or none" approach).
The effective implementation of a care bundle requires that the measures be adapted to the local setting, appropriately followed, entrenched in the patient care culture, and recorded and evaluated to ensure compliance by all members of the healthcare team involved.
The hospital shall develop and implement a policy and procedures guiding evidence-based care bundles to address measures included in at least the following: -

a) Bundles for the prevention of central line-associated bloodstream infections (CLABSI)
b) Bundle for the prevention of catheter-associated urinary tract infections (CAUTI)
c) Bundle for the prevention of ventilator-associated pneumonia (VAP)
d) Bundle for the prevention of surgical site infection (SSI)

Survey process guide:

- The GAHAR surveyor may review the hospital policy guiding evidence-based care bundles and review the evidence-based selected measures for each bundle.
- The GAHAR surveyor may interview involved staff members to ensure their awareness of how to follow each bundle element for each patient.
- The GAHAR surveyor may review a sample of patients' medical records to check the bundles implementation and bundles implementation monitoring records.
- The GAHAR surveyor may observe the impact of bundled interventions on how they improve the "culture" of patient safety and promote teamwork.

Evidence of compliance:

1. The hospital has an approved process to collectively implement all elements of preventive care bundles.
2. Involved staff members are aware and educated on all elements of the bundles.
3. The hospital monitors implementation and compliance with bundles.

EQR.22 (IPC.12) Patients with clinically suspected and/or confirmed communicable diseases follow transmission-based precautions according to mode(s) of transmission.

Safety

Keywords:
Transmission based precautions.

Intent:
Transmission-based precautions (TBPs) are used in addition to standard precautions when standard precautions alone may be insufficient to prevent transmission of infection. TBPs are used for patients known or suspected to be infected or colonized with epidemiologically important or highly transmissible pathogens that can transmit or cause infection.
Transmission-based precautions create barriers between people and microorganisms that help prevent the spread of germs in the hospital. They also include appropriate patient placement and appropriate PPE selection, and use based on risk assessment.
There are three main categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions.
Once the patient is determined to be at an increased risk for transmission of microorganisms, the patient should be placed in the hospital's standardized isolation room. The hospital's standardized isolation room is a separate, well-ventilated room equipped with a hand-washing basin, a private bathroom, a self-contained door and extractors to extract air outside the facility. In addition, this room must be located far from the rest of the patient care areas, with no pressure specifications required for the ventilation system.
At least one standardized isolation room should be available in the ER for suspected infections.
When such standardized isolation room(s) is not currently available, the patient should be separated into separate assigned areas/rooms.
Concerning 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.
Patients with known or suspected airborne infections shall be identified. Such patients requiring airborne precautions are placed in a negative pressure room (AIIR). If a negative pressure room is occupied, place the patient in a room with a portable high-efficiency particulate air (HEPA) filter. If no portable HEPA filter is available, the hospital must ensure the patient's surgical mask is worn.
The hospital must have at least one negative pressure room (AIIR) for airborne infections.

Also, the hospital must have one or more standardized isolation rooms for other transmission-based precautions (droplet and contact).
Regardless of the type of the patient's isolation room, the contacting staff must wear appropriate respiratory protection (such as an N95 respirator) during all patient care time, and regular high-touch surface cleaning and disinfection is standard.

Empiric Precautions are isolation precautions while waiting for a clear diagnosis. Such precautions may be initiated while confirmatory tests are pending (e.g., laboratory cultures), including enteric contact precautions for patients with diarrhoea, airborne precautions for patients with symptoms consistent with tuberculosis, droplet precautions for patients with respiratory symptoms, and contact precautions for patients with wounds or a history of MRSA.
Expanded Precautions are isolation precautions to be used when dealing with highly transmissible or epidemiologically important pathogens that are Easily transmitted along with clusters of infected people (two or more individuals) in an area.

The hospital shall develop and implement a policy and procedures guiding Transmission-based precautions (TBPs) to address the three different categories: contact, droplet and airborne precautions.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding transmission-based precautions.
- GAHAR surveyor may assess to ensure the presence of at least one standardized isolation room(s) and assigned areas for patient placing according to the hospital capacity.
- GAHAR surveyor may interview healthcare professionals to inquire about the use of PPE and hand hygiene practices according to the type of isolation.
- GAHAR surveyor may observe staff compliance with the use of appropriate PPE and hand hygiene practices.

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 the hospital capacity and at least one AIIR.
4. Required transmission-based precautions are implemented according to national and international guidelines during hospital stay and during transfer.
5. Patients with suspected/ confirmed communicable diseases are identified and separated in labelled assigned areas/rooms.
6. 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.

EQR.23 (IPC.14) Patient care equipment is disinfected/sterilized based on evidence-based guidelines and manufacturer recommendations.

Safety

Keywords:
Sterilization/disinfection

Intent:
The processing of reusable patient care equipment is a critical process in 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.

The cleaning process is a mandatory step in the processing of patient care equipment. Cleaning, disinfection, and sterilization can take place in a centralized sterile processing department. The assigned processing area shall have workflow direction.

The hospital shall develop and implement a policy and procedures to guide the process of sterilization/disinfection that addresses at least the following:

a) Receiving and cleaning of used items.
b) Preparation and processing.
    i. The processing method is to be chosen according to the 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 itemsthat come in contact with mucous membranes or non-intact skin, such as gastrointestinal endoscopes, respiratory and anaesthesia 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 somesemi-critical items, most non-critical reusable items may be decontaminated where theyare used and do not need to be transported to a central processing area.
c) labelling 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 review hospital policy guiding the process of sterilization/disinfection.
- GAHAR surveyor may observe to check 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 assess the ability of involved Healthcare professionals 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 elements in the intent from a) through g).
2. Healthcare professionals involved in sterilization are competent.
3. The hospital has at least one functioning pre-vacuum class B sterilizer.
4. The laws and regulations, Spaulding classification, and manufacturer's instructions (operating manual) guide sterilization or disinfection.
5. There are at least three physically separated areas for cleaning, packaging, and/or sterilization and storage.
6. Clean and sterile supplies are properly stored in designated storage areas that are clean, dry, and protected from dust, moisture, and temperature extremes.

EQR.24 (IPC.20) The hospital has a process to ensure safe food services.

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 shall develop and implement 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 a food rotation system that is consistent with first-in-first-out principles.
c) Monitoring of temperature during preparation and storage.
d) Functioning washing facility in the kitchen
e) Prevention of cross-contamination of food, whether directly from raw to cooked food or indirectly through contaminated hands, working surfaces, cutting boards, utensils, etc.
f) Food transportation process.
g) Preparation, storage, and administration of feeding tube nutritional therapy.
h) Safe handling and storage of expressed breast milk and formula.

Survey process guide:

- GAHAR surveyor may review hospital policy guiding safe food services.
- GAHAR surveyor may interview involved staff members to check their awareness.
- GAHAR surveyor may assess compliance with the measures for prevention of cross-contamination, such as the presence of separate cutting boards for different types of food and separate 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 guiding safe food services that addresses all the elements mentioned in the intent from a) through h), and involved staff members are aware of the approved policy.
2. There are separate areas for receiving, storage, and preparation of food and nutritional products.
3. The hospital prepares and distributes food using proper sanitation and temperatures.
4. Expressed breast milk and formula are handled according to guidelines and hospital policy.
5. Administration of feeding tube nutritional therapy is performed according to policy and procedure.

EQR.25 (OGM.01) The hospital has a defined governing body structure, responsibilities, and accountabilities.

Effectiveness

Keywords:
Governing body structure and responsibilities

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.
In order to ensure the proper governance and efficient management of any organization, its structure has to be well-defined**,** and members of the governing body are identified by title and name. The governing entity is represented or displayed in an organizational chart that clearly defines lines of authority and accountability. A governing body should be diverse, reflect the community's interests and desired competencies, and evaluate its performance annually. The governing body meets at set intervals, with meeting minutes recorded.
It should consider that in a centralized system, such as university hospitals, one governing body governs several subsidiary organizations. On the other hand, a governing body can be a board of directors, committee, or a single owner in the case of the private sector.

The governing body of a hospital has several responsibilities and accountabilities to ensure the hospital operates effectively, ethically, and in accordance with its mission. These responsibilities include:

a) Strategic oversight including defining and upholding the hospital's mission, vision, and values, developing, and approving strategic plans, and ensuring long-term sustainability and growth.
b) Financial stewardship including approving budgets, monitoring financial performance, ensuring appropriate allocation of resources to support the hospital's priorities and objectives, and supporting fundraising efforts and capital campaigns.
c) CEO selection and evaluation and ensure effective succession planning and leadership development.
d) Quality and safety including establishment and monitoring of quality improvement initiatives, ensuring the hospital complies with all relevant laws, regulations, and accreditation standards.
e) Ethical and legal responsibilities that include ensuring compliance with healthcare laws, regulations, and standards, promoting ethical behavior and decision-making within the hospital, and risk management to protect the hospital from potential liabilities.
f) Community engagement to promote positive relationships with the community, ensure the hospital addresses community health needs, and advocate for policies and initiatives that support the hospital's mission and the health of the community.
g) Accountability including reviewing and assessing the hospital's performance in meeting its goals and objectives, and ensuring transparency and accountability in reporting to stakeholders, including patients, staff, and the community.

By fulfilling these responsibilities, the governing body ensures the hospital operates efficiently, provides high-quality care, and meets its commitments to patients, staff, and the community.

To ensure effective governance, the governing body should evaluate its performance annually and provide ongoing education and development opportunities for board members to stay informed about healthcare trends and governance practices.

Survey process guide:

- GAHAR surveyor may review the documents that describe the structure and responsibilities of the governing body.
- GAHAR surveyor may review the recorded minutes of meetings.

Evidence of compliance:

1. The governing body structure is represented in the hospital's organizational chart.
2. Members of the governing body are diverse and identified by title and name.
3. The governing body meets at predefined intervals, and minutes of meetings are recorded.
4. The governing body evaluates its performance annually.
5. The responsibilities and accountabilities of the governing body are defined and include items from a) to g) in the intent.
6. The governing body approves the strategic plan, operational plans, quality improvement and patient safety plan, and community assessment and involvement program.

EQR.26 (OGM.02) The governing body works with the hospital leaders to set the hospital mission statement.

Effectiveness

Keywords:
Mission Statement

Intent:
The 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 e.g., scope of service, specialty, population served, and level of care in the form of a mission is one of the fundamental roles of the governing body. The hospital's mission must be aligned with the national healthcare mission and communicated to 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 reviewed annually.
3. The mission statement is visible in public areas to staff, patients, and visitors.

EQR.27 (OGM.05) The hospital develops the required committees by laws and regulations.

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 team 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 reference that include its membership, duties, accountability/reporting, frequency of meetings, quorum, and baseline agenda.
The committee meetings are to be held regularly, and the 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 review the terms of reference of each committee.
- GAHAR surveyor may review a sample of meeting minutes of each committee.
- GAHAR surveyor may review the annual evaluation of committees.

Evidence of compliance:

1. The hospital has at least the committees mentioned in the intent a) through e).
2. Each committee has terms of reference.
3. Committees meet regularly.
4. Committees' minutes of meetings are recorded and communicated to involved staff members.
5. The performance of committees is reviewed annually.

EQR.28 (OGM.12) 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 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 in 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 ensures that patients and families are able to understand and participate in administrative processes such as obtaining pre-approval from insurance companies, providing reimbursement, paying deposits, and others. The hospital, on the other hand, should monitor the timeliness of third-party approval.
The hospital shall develop and implement a policy and procedures for the billing process that addresses at least the following:

a) Availability of an approved price list.
b) A process to ensure accurate billing.

c) Use of accurate and approved codes for diagnoses and procedures.
d) Patients/families are informed of any potential cost pertinent to the planned care.
e) Patients/families are assisted to understand and manage administrative processes of pilling.
f) Identifying patients whose conditions might require higher costs than expected and providing information to them periodically.

Survey process guide:

- GAHAR surveyor may review the hospital policy and price lists.
- GAHAR surveyor may interview some billing staff and some patients to check their awareness of the policy and the different payment methods.
- GAHAR surveyor may observe the presence of the price list for all provided services in its related areas.

Evidence of compliance:

1. The hospital has an approved policy for billing patients that addresses at least items from a) to f) in the intent.
2. There is an approved price list for healthcare services provided in the hospital.
3. Patients are informed of any potential cost pertinent to the planned care.
4. The hospital uses approved codes for diagnoses and procedures.
5. Billing staff is oriented on various health insurance processes.

EQR.29 (OGM.17) The hospital has an approved staff health program that is monitored and evaluated annually according to laws and regulations.

Safety

Keywords:
Staff Health program

Intent:
The hospital shall implement a staff health program to ensure the safety of the staff according to workplace exposures.

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 evaluations (tests and examinations). A situational examination may be required in case of exposure to specific substances.
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-risk areas and processes.
The program scope covers all staff and addresses 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 bloodborne 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) Results of the medical evaluation are documented in staff health records, and action is taken when there is a positive result, including employee awareness of these results and provision of counseling and interventions as might be needed.
h) Recording and management of staff incidents (e.g., injuries or illnesses), taking corrective actions and setting measures in place to prevent recurrences.
i) Infection control staff is 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 (eg., medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulations.

Survey process guide:

- GAHAR surveyor may interview staff members who are involved in developing and executing staff health programs 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 aware of the risks within the hospital environment, their specific job-related hazards, and periodic medical examinations.
4. All staff members are subject to the immunization program and 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 that actions are taken, and employees are informed, in case of positive results.

EQR.30 (WFM.02) The hospital develops a staffing plan to ensure that the provided services are consistent with patient needs, hospital mission, and professional practice recommendations.

Efficiency

Keywords:
Staffing Plan

Intent:
Staff planning is the process of ensuring that a hospital has the right people to carry out the work needed for business successfully by matching detailed staff data, including skills, potential, aspirations, and location, with business plans.
The shortage of competent healthcare professionals in multiple areas is an alarming sign, especially in critical care disciplines such as 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 practitioners, or that define staffing numbers or a 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 define the individual requirements of each staff position. The hospital maintains a safe level of staff members, including independent practitioners' numbers and skill level, that matches at least 60% of its requirements, especially 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) Workload during working hours and different shifts.
e) Technology and equipment used in patient care.

Survey process guide:

- GAHAR surveyor may review the hospital staffing plan, observe workforce allocation and skills, or review staff files, including independent practitioners, to check compliance of the staffing plan to laws, regulations, and professional practices recommendations.

Evidence of compliance:

1. The staffing plan matches the mission, strategic, and operational plans.
2. Staffing plan complies with laws, regulations, and recommendations of professional practices.
3. The staffing plan identifies the estimated needed staff numbers, including independent practitioners, skills, and qualifications required to meet the hospital's specific needs.
4. The staffing plan is monitored and reviewed at least annually.

EQR.31 (WFM.06) A staff file is developed for each workforce member.

Efficiency

Keywords:
Staff Files

Intent:
It is essential for the hospital to maintain a staff file for each staff member, including independent practitioners.
An accurate staff file provides a recording of 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 hospital staff member, including independent practitioners, has a record(s) with information about their qualifications; required health information, such as immunizations and evidence of immunity; proof of participation in orientation as well as ongoing in-service and continuing education; evaluation results, including staff member performance of job responsibilities and competencies; and work history.
Records are standardized and are kept currently according to hospital policy.
Staff files, including independent practitioners, may contain sensitive information that must be kept confidential.
The hospital shall develop and implement a policy and procedures that guide the management of staff files, including independent practitioners, that address at least the following:

a) Staff file initiation.
b) Standardized Contents such as:
    i Qualifications, including education, training, licensure, and registration, as applicable.
    ii Work history.

iii Documentation of credentials evaluation and primary source verification.
iv Current job description.
v Recorded evidence of newly hired general, departmental, and job-specific orientation.
vi Ongoing hospital and professional education received.
vii Copies of provisional and annual performance evaluations.

c) Update of file contents.
d) Storage.
e) Retention time.
f) Disposal.

Survey process guide:

- GAHAR surveyor may review the hospital policy guiding staff file management.
- GAHAR surveyor may interview staff involved in creating, using, and storing staff files to assess their awareness.
- GAHAR surveyor may check a sample of staff files to assess the standardized contents.
- GAHAR surveyor may visit the area where staff files are kept, assessing storage conditions, retention, confidentiality, and disposal mechanism.

Evidence of compliance:

1. The hospital has an approved policy to maintain and standardize staff files that address at least elements from a) through f) in the intent.
2. Staff members involved in creating, storing, and using staff files are aware of the policy requirements.
3. Staff files are confidential and protected.
4. Staff files include all the required records from i) through vii), as mentioned in the intent.
5. Former staff files are retained for a specific time as per hospital policy, and the hospital maintains confidentiality during the disposal of files.

EQR.32 (WFM.07) Newly Appointed, contracted, and outsourced staff undergo a formal orientation program.

Effectiveness

Keywords:
Orientation Program

Intent:
Regardless of employment experience, any new staff member needs to understand the entire hospital structure and how their specific clinical or nonclinical responsibilities contribute to the hospital's mission.

This is accomplished through a general orientation to the hospital and their role and a specific orientation to the job responsibilities of their position. Staff orientation, especially when first employed, with the hospital policies, ensures alignment between the hospital mission and staff activities. It also helps to create a healthy hospital culture where all staff work with a shared mental model and towards agreed-upon objectives. Staff orientation also facilitates the integration of new staff with the already available to form effective teams that offer safe and quality care rapidly.

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.

The general orientation program addresses at least the following:

a) The hospital mission, vision, values, and hospital structure.
b) Hospital policies for Environmental and Facility Safety.
c) General information about infection control policies and procedures.
d) Hospital policies for performance improvement, patient safety, and risk management.
e) Ethical framework and code of conduct.
f) Patient and family rights.

The department orientation program addresses at least the following:

g) Review of relevant policies and procedures**.**
h) Operational processes.
i) Work relations.

The job-specific orientation program addresses at least the following:

j) Job-specific duties and responsibilities as per the job description.
k) Technology and equipment use.
l) High-risk processes.
m) Staff safety and health.

The hospital is encouraged to develop a staff manual that describes the processes of staff appointment and reappointment, appraisal, complaint management, satisfaction measurement, code of ethics, disciplinary actions, and termination.

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the orientation process.
- 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. A general orientation program is performed, and it includes at least the elements from a) through f).
2. A department orientation program is performed, and it includes at least the elements from g) through i).
3. A job-specific orientation program is performed, and it includes at least the elements from j) through m).
4. All New staff members, including contracted and outsourced staff, attend the orientation program regardless of employment terms.
5. There is evidence that each staff member has completed the orientation program, which is recorded in their file.

EQR.33 (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.
The hospital uses a performance evaluation tool to ensure staff have the required criteria for doing jobs and achieving objectives. 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.

Competency is the process of determining the ability of staff to fulfill the primary responsibilities of the position for which they were hired. Observing and measuring competency for every position in the hospital is one of the most important duties of the department leaders. They must also ensure that each staff member understands the expectations, responsibilities, activities, and competencies required for their position.
Competency shall be done after the probationary period (initial competency assessment), then on an ongoing basis at least annually for at least the following (the nursing staff, staff who provide medical imaging services, laboratory services, procedural services, POCT services, and staff who are handling critical medical equipment).

The hospital should have a documented process for employees' performance evaluation, including performance review methods, tools, evaluation dimensions, criteria, time interval, appeal process, and responsible person for each staff category, and the effective management of underperformance.

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. The employee's department carries out performance and competency evaluations.
3. Performance and competency evaluation is based on the job description.
4. There is evidence of employee feedback on performance and competency evaluation.
5. Actions are taken based on a performance review.

EQR.34 (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 of the design, implementation, and usage of any information system that stores, processes, or retrieves data as it reflects the maintenance, assurance, 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 the failure of data integrity.
Patient's medical records and information are protected at all times and in all places, including protecting it from water, fire, or other damage, as well as 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.
Ensure that the spaces where medical records and data are kept secure and only accessible to those who need them. Medical records and server storage areas must implement measures to ensure protection, e.g., controlled access and suitable types 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 the patient's medical records protection measures (including the suitable type of fire extinguishers, water protection, controlled access, etc.) in archiving, storage, computer areas, or other places, including medical records.

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 that handle medical records, including patient care areas and the medical records department.
3. The medical records department and server storage area implement measures to ensure medical information integrity.
4. When an integrity issue is identified, actions are taken to maintain integrity.

EQR.35 (IMT.08) The Patient's medical record is managed to ensure effectiveness.

Effectiveness

Keywords:
Patient's Medical Record Management

Intent:
Patient 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.

Every patient evaluated or treated in the hospital has a medical record. The file is assigned a number unique to the patient and is used to link the patient with their health record. A single file with a unique number enables the hospital to easily locate a patient's medical record and document the patient's care 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 to facilitate the accessibility of data and information to provide more effective and efficient patient care.

The hospital shall develop and implement a policy and procedures for medical record management 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 records.

Survey process guide:

- GAHAR surveyor may review the hospital policy for medical record management.
- 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 logbook.
- GAHAR surveyor may observe patient's medical record availability when needed by healthcare professionals and contain up-to-date information within an appropriate timeframe.
- GAHAR surveyor may interview staff to assess awareness about managing patients' medical records in the hospital.

Evidence of compliance:

1. The hospital has an approved policy for medical record management that includes all the items in the intent from a) through e).
2. All staff using patients' medical records 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.

EQR.36 (IMT.11) Response to planned and unplanned downtime of data systems is tested and evaluated.

Efficiency

Keywords:
Downtime of Data Systems

Intent:
A 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 care delivery and the interruption of organizational operations, in addition to the risk of data loss.

The hospital shall develop and implement a program to ensure the continuity of safe patient care processes during planned and unplanned downtime, including the alternative paper forms and other

resources required. The program includes the downtime recovery process to ensure data integrity. Unplanned events are documented and investigated to determine corrective actions. All staff receive 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 reviewing 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 the result of annual program testing.
- GAHAR surveyor may review documented events for unplanned downtime events and action taken.
- 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 a 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.

EQR.37 (QPI.01) The quality improvement activities are governed by a multidisciplinary performance improvement, patient safety, and risk management committee(s).

Efficiency

Keywords:

Quality Committee (s)

Intent:

Performance improvement, patient safety, and risk management committee(s) are responsible for providing oversight and making recommendations to the governing body concerning matters pertaining to the effectiveness, efficiency, and appropriateness of quality, safety, and risk management of health services provided across the hospital. Oversight aims to improve performance, governance, and hospital effectiveness and ensure the plan will be directed and managed daily.

The hospital shall establish a multidisciplinary committee(s) for performance improvement, patient safety, and risk management, with a membership of top leaders as committee chairpersons. The committee(s) shapes the quality culture of the facility through terms of references that include at least:

a) Ensuring that all designated care areas participate in quality improvement activities.
b) Establishing organization-wide priorities for improvement.
c) Ensuring that all required measurements are monitored, including the frequency of data collection.
d) Reviewing adverse events, near-misses, and root cause analyses to prevent recurrences.
e) Developing and implementing strategies to enhance patient safety and minimize risks.
f) Monitoring compliance with regulatory and accreditation standards related to quality and safety.
g) Reviewing patient satisfaction data and identifying opportunities to enhance patient experience.
h) Reporting information about performance data and quality improvement activities to the governing body, hospital leaders, and appropriate staff members.
i) Evaluating the performance of the committee on an annual base.

The periodic meeting provides the required information and feedback about plans and activities. It also improves collaboration, provides an opportunity to evolve as a team, and helps comply with laws and regulatory requirements.

Survey process guide:

- GAHAR surveyor may review the terms of reference of the multidisciplinary performance improvement, patient safety, and risk management committee.
- GAHAR surveyor may review the committee's meeting minutes and check that all recommendations are communicated to all involved staff members.
- GAHAR surveyor may interview the designated committee(s) chairperson and committee members to inquire about the hospital's quality and patient safety activities.

Evidence of compliance:

1. There is a multidisciplinary performance improvement, patient safety, and risk management committee(s) in compliance with relevant laws and regulations, including items from (a) to (i) in the intent.
2. There is an official assignment document for the designated committee(s) chairperson who leads and actively participates in the committee(s) meetings.
3. The committee(s) meets at predefined intervals.
4. Committees' minutes of meetings are recorded and communicated to involved staff members.
5. The committee(s) evaluates its performance on an annual basis.

EQR.38 (QPI.10) The hospital has an incident-reporting system.

Safety

Keywords:

Incident Reporting System

Intent:

Robust risk management is supported by effective incident reporting systems. An incident is defined as any event that affects the safety of a patient, staff member, or visitor. In most hospital injuries, patient complaints, medication errors, equipment failure, adverse reactions to drugs or treatments, or errors in patient care are to be included and reported.
Incident reporting has a significant influence on improving patient safety and can provide valuable insights into how and why patients can be harmed at the hospital level. Incident reporting helps detect, monitor, assess, mitigate, and prevent patient, staff, and visitor risks. The incident-reporting system includes 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) Staff training on incident management process
d) Incidents that require immediate notification to management
e) Incident classification, analysis, and results reporting
f) Indication for performing intensive analysis and its process

Adverse events can have significant negative consequences for both patients and staff. The hospital should understand the emotional and psychological impact of such incidents and should be dedicated to

offering comprehensive support to those affected, including both immediate and ongoing assistance. Transparent communication and thorough follow-up are ensured to address any concerns, fostering a culture of safety and trust.

Survey process guide:

- GAHAR surveyor may review the incident reporting list, review a sample of reported incidents, and assess the corrective actions taken.
- GAHAR surveyor may interview staff to check their awareness of the incident-reporting system.

Evidence of compliance:

1. The hospital has an approved incident-reporting system that includes items from a) through f) in the intent.
2. All staff are aware of the incident-reporting system, including contracted and outsourced services.
3. All reported incidents are investigated, and service gaps are identified.
4. Corrective and/or preventive actions are taken to close gaps in services in a timely manner.
5. The hospital communicates with patients/service users about adverse events they are affected by and provides both immediate and ongoing assistance.

EQR.39 (QPI.11) The hospital defines, reports, investigates sentinel events, and takes corrective and preventive actions.

Safety

Keywords:

Sentinel events

Intent:

According to the World Health Organization, an adverse event is an injury related to medical management, in contrast to disease complications. Adverse events may be preventable or non-preventable. A preventable adverse event is an adverse event caused by an error relevant to medical management. Medical management includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care.
“Near-miss” or “close call” is a serious error or mishap that can potentially cause an adverse event but fails to do so because of chance or because it is intercepted. Also called a potential adverse event.
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. While both adverse events and sentinel events involve harm to patients, sentinel events are a subset of adverse events that are particularly severe and demand immediate attention and investigation to prevent recurrence and improve patient safety. Thus, a sentinel event signals an immediate investigation and response. Root cause analysis is also indicated in potential sentinel events (near-miss).
The hospital shall develop a policy for sentinel event management that includes at least the following:

a) Definitions of adverse event, near miss and sentinel event. Sentinel events include, but not limited to:
    i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient’s illness or underlying condition.
    ii. Wrong patient, wrong site, or 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 peripartum maternal death.
vii. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
viii. Major haemolytic transfusion reaction.
ix. Rape.
x. Fire.
xi. Infant abduction.

b) Internal reporting of sentinel events.
c) External reporting of sentinel events.
d) Team member's involvement.
e) Root cause analysis.
f) The taken corrective and preventive action plans.
g) Procedures for managing adverse events consequences, including the first and second victims affected.

All sentinel events are communicated to GAHAR within two working days of the event or of becoming aware of it. All events that meet the definition must have a root cause analysis to clearly understand the contributing factors behind the system gaps. The analysis and action must be completed within 45 days of the event or becoming aware of it.

Survey process guide:

- GAHAR surveyor may review the hospital policy for management of sentinel events and may interview hospital leaders to check their awareness.
- GAHAR surveyor may review a sample of reported sentinel events and assess the investigation, root cause analysis, and the corrective actions that were taken.

Evidence of compliance:

1. The hospital has a sentinel events management policy that includes items in the intent from a) through g), and leaders are aware of the policy requirements.
2. All sentinel events are investigated thoroughly and communicated by root cause analysis in a 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 from i) through xi) in the intent are communicated to GAHAR within two working days of the event or becoming aware of the event.
4. Leaders take corrective and preventive action based on identified root cause analysis.
5. Results of root cause analysis with related actions are reported to the hospital governing body and GAHAR.

EQR.40 (ATH.04) Patient rights and autonomy are respected and upheld during bedside clinical teaching activities.

Patient centeredness

Keywords:
Patient rights during bedside teaching

Intent:
Academic/teaching hospital that provides bedside teaching shall develop a policy and procedures to ensure patient rights during bedside teaching that address at least the following:

a) Obtain verbal or written consent and ensure that patients fully understand the purpose, nature, and potential impact of their participation in teaching sessions. They also have the right to refuse or withdraw consent at any time without any negative consequences on their care.
b) Safeguard privacy and confidentiality and take necessary measures, such as using private areas, obtaining verbal consent for learners' involvement, and refraining from discussing sensitive or identifiable patient information in public or non-confidential settings.
c) Promote a culture of professionalism and respect among healthcare providers, learners, and patients. Educate learners about appropriate behavior, respect for patient boundaries, and the importance of maintaining a professional and ethical approach during all interactions.
d) Prioritize patients' physical and emotional comfort and safety during bedside teaching. Take appropriate measures to minimize potential discomfort or harm to the patient, including avoiding unnecessary procedures or examinations solely for teaching purposes.
e) Encourage feedback from patients regarding their experiences with bedside teaching. Provide a mechanism for patients to express any concerns, complaints, or suggestions related to their participation in teaching activities and ensure that these are addressed promptly and appropriately.

Survey process guide:

- GAHAR surveyor may review the hospital policy and procedures guiding patient rights during bedside teaching.
- GAHAR surveyor may interview the staff involved in bedside teaching to ensure their awareness of the hospital policy.
- GAHAR surveyor may interview patients subjected to bedside teaching to ensure that patient rights are respected.

Evidence of compliance:

1. The hospital has a policy that addresses all the items from a) to e) in the Intent.
2. The staff involved in bedside teaching are aware of the contents of the policy.
3. Verbal or written consent is obtained from patients before involvement in bedside teaching.
4. Privacy and confidentiality are safeguarded during bedside teaching.

EQR.41 (ATH.09) 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. Enrolment in 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 study entails**.**
The hospital shall develop and implement a research policy and procedures that includes at least:

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

No one should be deprived of their 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 study is designed to yield.
Informed consent 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 interview hospital leaders and some committee members to inquire about research activities.
- GAHAR surveyor may interview patients enrolled in research activities to ensure their rights are respected during research enrolment.
- GAHAR surveyor may interview researchers to check their awareness of research activities requirements.
- GAHAR surveyors may review the research file and the medical records of patients who participated in research activities to check for signed patient consent.

Evidence of compliance:

1. The hospital has an approved policy 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 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 for 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 Provisional Accreditation 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 for Hospital Accreditation Standards chapters as follow:

- Patient centeredness culture
- Access, continuity, and transition of care
- Integrated care delivery
- Critical and special care services
- 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
- Academic and Teaching Hospitals

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

Standard Code & Keyword	Kind of document	Components
1- Patient centeredness culture:		
PPC.01 Multidisciplinary patient-centeredness	**Approved document**	The committee has defined responsibilities that include at least the following: a) Create a vision of establishing a patient-centered culture with the required approaches to achieve it. b) Communicate this vision to multiple stakeholders and staff members. c) Education and training of the staff to ensure that they understand and can implement patient-centered care practices including empowerment of patients to make an informed choice/decision. d) Identify potential obstacles and resistance. e) Work to remove these obstacles and ease down resistance.
PCC.02 Patient and family rights	**Policy**	a) Patient and family's right to access care if provided by the hospital. b) Patient and family's right to know the name of the treating, supervising, and/or responsible medical staff member. c) Patient and family rights to care that respects the patient's personal values and beliefs. d) Patient and family rights to be informed and participate in making decisions related to their care. e) Patient and family rights to refuse care and discontinue treatment. f) Patient and family rights to security, personal privacy, confidentiality, and dignity. g) Patient and family rights to have pain assessed and treated. h) Patient and family rights to make a complaint or suggestion without fear of retribution. i) Patient and family rights to know the price of services and procedures. j) Patient and family rights to seek a second opinion either internally or externally.
PCC.03 Patient and family responsibilities	**Policy**	a) Patients and their families are responsible for providing clear and accurate information on the disease/condition's current and past medical history. b) Patients and their families are responsible for complying with the hospital's policies and procedures. c) Patients and their families are responsible for complying with financial obligations according to laws, regulations, and hospital policy. d) Patients and their families are responsible for showing respect to other patients and healthcare professionals.

Standard Code & Keyword	Kind of document	Components
		e) Patients and their families are responsible for following the recommended treatment plan.
PCC.07 Patient and family education process	**Policy**	a) Identify patient and family needs that may vary from one patient to another. However, at least the following needs are to be addressed for all patients: iv. Diagnosis and condition of the patient. v. Care plan, expected outcome of care and alternative to the plan of care. vi. Discharge instructions. b) Multidisciplinary responsibility of patient and family education process c) The method of education is provided according to patient and family values and level of learning, as well as in a language and format that they understand. d) Documentation of patient education activities, including information and education provided, how the information and education were delivered (e.g., in writing, verbally, by demonstration, etc.), and confirmation that the patient and/or family understood the information and education provided.
PCC.08 Informed consent	**Policy**	a) The list of medical processes when informed consent is needed; this list includes: vii. Surgery and invasive procedures. viii. Anaesthesia, moderate and deep sedation. ix. Use of blood and donation of blood. x. High-risk procedures or treatments (including but not limited to electroconvulsive treatment, radiation therapy, and chemotherapy). xi. Research. xii. Photographic and promotional activities, for which the consent could be for a specific time or purpose. b) The likelihood of success and the risk of not doing the procedure or intervention, as well as the benefits and alternatives to performing that particular medical process. c) Certain situations when consent can be given by someone other than the patient, as well as mechanisms for obtaining and recording it according to applicable laws and regulations and approved hospital policies. d) Consent forms available in all applicable locations.

Standard Code & Keyword	Kind of document	Components
PCC.10 Informed refusal	**Policy**	a) How to inform the patient/family of the patient's current medical condition. b) How to inform the patient/family of the consequences of their decision. c) How to record patient and/or family refusal of the medical care process step. d) Patients are informed about available care and treatment alternatives.
PCC.14 Patient's belongings	**Policy**	a) Determine the facility's level of responsibility for patient belongings. b) How patients and families are informed about the hospital's responsibility for belongings. c) Staff who are responsible for managing patient belongings. d) The process in place to manage patient's property including, how are the belongings recorded and protected? for how long? how and when patient' property is returned? e) How the hospital will manage lost and found situations. The hospital shall define a clear process to follow when items are not returned within a defined timeframe.
PCC.15 Patient and family feedback	**Policy**	a) Measuring feedback for hospitalized patients. b) Measuring feedback for ambulatory patients. c) Measuring feedback for emergency patients.
PCC.16 Complaints and suggestions	**Policy**	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. e) Monitor the reported data on patients' complaints and take actions to control or improve the process.
2- Access, continuity, and transition of care:		
Related GSRs: **GSR.01: Patient identification** **GSR.04:Handover communication**		

Standard Code & Keyword	Kind of document	Components
ACT.01 Granting access (before patient's registration)	**Policy**	a) Identifying the hospital-wide scope of service. b) How to provide complete information on the care provided and services access the hospital offers. c) The process of screening patients to determine that the hospital's scope of services can meet their healthcare needs. d) Access through emergency areas is safe and appropriate for patients' conditions. e) Access through ambulatory areas includes a clearly defined patient scheduling and queuing process. f) Actions to be taken if the patient's needs do not match the facility's scope of service. g) Accessibility of hospital services for patients with various types of disabilities.
ACT.01 Granting access (before patient's registration)	**Approved document**	Hospital scope of services
ACT.02 Registration process	**Policy**	a) Minimum information needed to register the patient. b) Coordinating patient flow between necessary hospital services c) Minimum information needed for the registration process and flow of patients are visible to patients and families at the point of the first contact and in public areas.
ACT.04 Hospitalization process.	**Policy**	a) Hospitalization procedures of patients, including those coming from the outpatient area, emergency areas, and other hospitalization routes. b) The hospital plan for bed, time frame for hospitalization, medical equipment, supplies, and medication to support patient care. c) Information to be given to the patient and family at the time of hospitalization. d) Management of patients when the bed is not available. e) Management of patients whose care needs cannot be met by the hospital, including care at emergency rooms, outpatient clinics, or inpatient services.
ACT.06 Patient's flow risks.	**risk assessment document**	Risk assessment for patient flow

Standard Code & Keyword	Kind of document	Components
ACT.07 Patient's care responsibility	**Policy**	a) Each hospitalized patient is assigned to one of the Most Responsible Physicians (MRP) as relevant to a patient's clinical condition. b) Conditions to request and grant transfer of care responsibility. c) How information about assessment and care plan, including pending steps can be transferred from the first most responsible physician to the next one. d) The process to ensure clear identification of responsibility between the transfer of responsibility parties.
ACT.09 Second opinion	**Policy**	a) Defined criteria for getting a second opinion for patients. b) A clear process of communicating second opinion requests to concerned healthcare professionals. c) A clear process of communicating essential information to the second opinion healthcare professionals. d) Timeframe to respond to second opinion requests. e) Response details to ensure safe and appropriate care planning. f) Actions to be taken when the hospital can't provide a second opinion.
ACT.10 Consultation process	**Policy**	a) Requirements/criteria for getting a consultation for patients. b) Expected outcome and urgency of consultation. c) A clear process of communicating consultation requests to concerned healthcare professionals. d) Timeframe to respond to consultation requests. e) Response details to ensure safe and appropriate care planning.
ACT.11 Multidisciplinary Management	**Policy**	a) Defined criteria for getting multidisciplinary opinions. b) Clear responsibilities among the treating team. c) Recording details of communication, assessment, and care.
ACT.12 Patient's Transportation	**Policy**	a) Safe patient handling to and from the examination bed, trolley, wheelchair, and other transportation means. b) A coordination mechanism is needed to ensure safe transportation within the approved timeframe. c) Competence of staff responsible for handling and transportation of patients. d) Staff safety while lifting and handling patients. e) Defined criteria to determine the appropriateness of transportation within the hospital.

Standard Code & Keyword	Kind of document	Components
ACT.13 Special care units' access	**approved document for admission and discharge criteria**	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 physiologic-based discharge criteria for the intensive care and specialized units and/or specific conditions defined by appropriate healthcare professionals in the hospital.
ACT.14 Patient's referral, transfer, temporary discharge, and discharge.	**Policy**	a) 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) A qualified individual is responsible for ordering and executing the patient discharge, referral, and/or transfer out. b) Defined criteria determine the appropriateness of referrals and transfers-out based on the approved scope of service and patient's needs for continuing care. c) Coordination with transfer/ referral agencies, if applicable, other levels of health service and other organizations. d) Referral/transfer sheets are complete and include at least the following: i. Patient identification ii. Reason for referral/transfer. iii. Collected information through assessments and care. iv. Medications and provided treatments. v. Transportation means and monitoring required. vi. Condition on referral/transfer. vii. Destination on referral/transfer. viii. Name of the medical staff member who decided the patient referral/transfer.
ACT.16 Telemedicine	**Program**	a) Define the scope of services and the technological modalities used. b) The appropriate telemedicine platforms, mobile or internet–based applications, and other peripheral devices should be in accordance with recommended industry guidelines. c) The resources required to sustain the planned telemedicine clinical services based on program goals. d) The training required for employees, participating providers, and other technical personnel specific to the telemedicine industry. e) The process of overseeing outsourced telemedicine services or functions. f) The hospital provides a clear method for the patient to initiate an encounter for telemedicine services.

Standard Code & Keyword	Kind of document	Components
		g) The process of verifying and documenting patient/provider identities and physical locations for each telemedicine encounter. h) Adheres to generally accepted evidence-based guidelines relevant to the clinical services used for patient encounters. i) The process of triaging patients to determine their eligibility for the available telemedicine services. j) The process of ensuring the privacy and cybersecurity of protected health information (PHI) in accordance with applicable laws and regulations. k) The fees for telemedicine services, insurance coverage, and the billing process associated with the delivery and utilization of telemedicine services. l) Periodical evaluation of telemedicine services based on quality indicators, including access, effectiveness, and satisfaction.
3- Integrated care delivery:		
Related GSRs: **GSR.02: Verbal and telephone orders** **GSR.03: Critical results** **GSR.05: Fall assessment and prevention** **GSR.06: Pressure ulcers prevention** **GSR.07: Venous thromboembolism prophylaxes** **GSR.10: Recognition and response to clinical deterioration**		
ICD.01 **Uniform Care**	**Policy**	a) Hospitals shall develop a policy that specifies what constitutes uniform care, what practices can be followed to ensure that patients are not discriminated against based on their background or category of accommodation, and how to report and investigate potential discrimination events.
ICD.02 **Prehospital care, ambulance care, and emergency medical care during disasters**	**Policy**	a) Provision, operation, or sourcing of ambulance services. b) Continuous readiness. c) The time frame for receiving calls, dispatching vehicles, and reaching patients. d) Screening, assessment, and reassessment of patients. e) Care protocols for patients at the scene and during transfer. f) Conducting drills to ensure continuous readiness.

Standard Code & Keyword	Kind of document	Components
ICD.03 Emergency Services	**Policy**	a) The staff qualifications required to provide emergency care around the clock, including ALS for medical staff. b) Defined criteria are developed to determine the priority of care according to an evidence-based triage process. c) The minimum requirements for medical and nurse emergency assessment and reassessment. d) The care process follows approved clinical guidelines and protocols, including requesting investigations and consultations and holding patients for observations. e) The medical records of emergency patients should include at least: ix) The triage assessment and level. x) The medical and nurses' assessment and reassessment. xi) The care provided. xii) The arrival time and departure time. xiii) Patient disposition. xiv) Patient diagnosis or conclusion at termination of treatment. xv) Patient condition at departure. xvi) Follow-up care instructions.
ICD.04 Emergency Care Guidelines	**Policy**	a) Emergency stabilization and treatment of chest pain. b) Emergency stabilization and treatment of shock. c) Emergency stabilization and treatment of poly-trauma. d) Emergency stabilization and treatment of altered level of consciousness. e) Emergency stabilization and treatment of asthma f) Emergency stabilization and treatment of stroke g) Other emergencies selected based on the hospital's scope of services.
ICD.05 Outpatient Services	**Policy**	a) Scope and content of the patient screening required to determine the priority of the patient's medical and nursing care needs in the outpatient department. b) A competent staff member performs an initial screening process. c) Scope and content of the initial assessment, including history and physical examination. d) Responsibility for the completion of assessments. e) Recording of care plans. f) Frequency of reassessments through subsequent visits or follow-ups, whenever applicable.

Standard Code & Keyword	Kind of document	Components
		g) Documentation of patient and family education and follow-up instructions.
ICD.06 Medical patient assessments	**Policy**	The hospital shall develop and implement a policy and procedures to define the minimum acceptable contents and frequency of clinical assessment and reassessments. The initial assessment includes at least the following: a) Chief complaint. b) Details of the present illness. c) Past medical and surgical history. d) Allergies and adverse drug reactions. e) Medications history. f) Social, emotional, and behavioral history. g) Family history. h) The required elements of the comprehensive physical examination. i) Specialized assessment is performed per specialty or patient category. j) Provisional diagnosis.
ICD.07 Nursing patient assessments	**Policy**	The hospital shall develop and implement a process to define the minimum acceptable contents and frequency of nursing clinical assessments and reassessments. Initial nursing assessment record includes at least the following: a) Vital signs and additional measurements such as height and weight. b) Fall assessment. c) Required screening, e.g., for pain, bedsores, functional, nutritional, psychosocial, etc., as per the hospital policies. d) Airway, breathing, circulation, disability, skin, and hydration. e) Outputs (as relevant). f) A detailed nursing assessment of a specific body system(s) relating to the presenting problem or other current concern(s) required.
ICD.08 Screening for further assessment needs	**Policy**	a) The screening criteria for each of the following healthcare needs. i. Nutritional status ii. Functional status iii. Psychosocial status iv. Discharge needs. v. Victims of abuse and neglect

Standard Code & Keyword	Kind of document	Components
		b) The qualified individuals responsible for setting the criteria for screening patients for each healthcare need from i) to v). c) Timeframe to complete healthcare needs screening. d) Process for identifying the need for further assessment by the specific service when defined criteria are met. e) The documentation requirements of the screening from i) to v) and the referral process as applied.
ICD.09 Pain screening, assessment, reassessment, and management	**Policy**	a) Pain screening tools suitable for different patient populations as per the hospital scope, i.e., tools for adults, pediatrics, neonates, and cognitively impaired patients. b) Complete pain assessment elements that include pain intensity, character, location, frequency, and duration. c) Frequency of pain reassessments. d) Pain management protocols. e) Competent staff responsible for pain management.
ICD.13 Patient nutritional needs	**Policy**	a) Availability of competent individuals for assessment and management of patient's nutritional needs. b) Defined criteria for the involvement of nutritional services in the patient care process. c) Components of nutritional assessment. d) Management of patient's nutritional needs: I. A list of all special diets is available and accommodated. II. Ordering of food is appropriate to the patient's clinical condition. III. Ordering for food or other nutrients is recorded in the medical record. IV. Scheduling for meals and timings of distribution of meals complies with patient's preferences. e) Process to ensure the safety of food brought by the family.
ICD.14 Special-needs patient populations	**Policy**	a) Identification of special-needs patient populations that visit the hospital and need to modify the general assessment form, which should include at least the following: I. Neonates. II. Pediatrics. III. Adolescents IV. Elderly V. Immunocompromised VI. Patients with communicable diseases VII. Patients with special psychosocial needs VIII. Victims of abuse and neglect

Standard Code & Keyword	Kind of document	Components
		b) Availability of competent individuals for assessment and management of special patient populations needs. c) Required modifications for regular patient assessment methods to match special patient populations' needs. d) Management and care for special patient populations needs through an individualized plan of care.
ICD.16 Clinical practice guidelines adaptation and adoption	**Policy**	a) Procedures guided adoption and adaptation of clinical practice guidelines/protocols such as: i. Guideline selection criteria such as indication and need, evidence-based, and relevance to the hospital's scope of work and capabilities. ii. Expert panel formation. iii. Initial assessment, adaptation, and customization. iv. Local review by hospital leadership and other relevant hospital bodies to ensure that the guideline aligns with the hospital's overall strategic goals and maintains clinical quality. v. Development of implementation plan. b) The hospital should adapt and adopt guidelines or protocol for at least the most common/high risk three diagnoses managed in the hospital annually. c) Feedback, monitoring, and evaluation during and after the implementation. The hospital continually monitors the impact of the adapted guideline on patient outcomes and adherence rates. This data helps identify successes and areas needing improvement. d) The hospital plans to implement approved national clinical practice guidelines whenever they are available. e) The adopted/adapted CPGs should be reviewed and updated at least every 2 years and as appropriate.
ICD.20 Ordering of blood and blood products	**Policy**	a) Assessment of the patient's clinical need for blood. b) Education of patient and family about proposed transfusion and recording in the patient's medical record. c) Selecting blood product and quantity required and completing the request form accurately and legibly. d) Recording the reason for the transfusion so that the blood bank can check that the product ordered is suitable for diagnosis. e) Clearly communicate whether the blood is emergently or routinely needed. f) Sending the blood request form with the blood sample to the blood bank. g) When recipient's blood sample is received, a qualified member of the staff should confirm, if the information on the label and on

Standard Code & Keyword	Kind of document	Components
		the transfusion request form are identical. In case of any discrepancy or doubt, a new sample should be obtained.
ICD.21 Transfusion of blood and blood products	**Policy**	a) Visually check the bag for integrity. b) Blood transfusion in emergencies. c) Conditions when the bag shall be discarded. d) The rate for blood transfusion. e) Recording the transfusion. f) Monitoring and reporting any adverse event. g) Special considerations for the use of blood components. h) Management of transfusion complications.
4- Critical and special care services:		
Related GSRs: **GSR.08: Critical Alarms** **GSR.09: Catheter and tube misconnections** **GSR.11: Cardiopulmonary resuscitation**		
CSS.01 Critical care	**Program**	a) Multidisciplinary team b) Admission and discharge criteria c) Initial assessment requirements, including circulation, respiration, and oxygenation. d) Continuous monitoring and life support. e) Care planning and goal setting f) Clinical guidelines/protocols that address at least the following items: i) Resuscitation and stabilization ii) Ventilatory and respiratory support iii) Invasive procedures and interventional techniques iv) Rehabilitation and early mobilization g) Nutritional support h) Psychosocial support and family engagement, as appropriate.
CSS.04 Terminally ill patients	**Policy**	a) Principles of palliative and end-of-life care. b) Patient-centered care tailored to individual needs, preferences, values, and goals.

Standard Code & Keyword	Kind of document	Components
		c) Shared decision-making with the involvement of the patient and/or family. d) Pain management of end-of-life care. e) Provision of patient and family counselling and support for psychosocial, emotional, cultural, and spiritual needs. f) The multidisciplinary team approach, including healthcare professionals, caregivers, and patients and their families.
CSS.06 Dialysis services	**Program**	a) Pre-dialysis assessment b) National/ international clinical guidelines defining: i. Dialysis modality selection based on the assessment of an individual's condition. ii. The timing of initiation of dialysis is based on clinical manifestations and lab workup. iii. Vascular access management to ensure optimal dialysis delivery. iv. Prevention and management of dialysis-induced complications. v. Cardiopulmonary collapse and urgent medical conditions during dialysis. vi. Infection control precautions. vii. Patient immunization according to laws and regulations. c) Close monitoring of the patient during dialysis sessions. d) Medication management to control chronic complications of end-stage renal disease and dialysis. e) Periodic laboratory testing and clinical assessment to optimize dialysis prescription. f) Patient education and support, including dietary and fluid management.
CSS.07 Chemotherapy	**Program**	a) The treatment plan is based on a comprehensive evaluation of the patient's medical history, imaging studies, pathology reports, and staging information. b) Chemotherapy administration following established protocols and guidelines. c) Procedures for safe preparation and handling of chemotherapy drugs. d) Pre-treatment evaluation prior to each chemotherapy session to assess their overall health and suitability for treatment. e) Patient education about the chemotherapy regimen, including precautions to take during and after treatment. f) Proactive management of chemotherapy-related symptoms to minimize their impact and improve patient comfort. g) Monitoring and follow-up throughout the treatment course.

Standard Code & Keyword	Kind of document	Components
CSS.08 Radiotherapy	**Program**	a) Treatment planning based on a comprehensive evaluation of the patient's medical history, imaging studies (such as CT scans or MRI), and pathology reports. b) Simulation and imaging prior to treatment, during which precise imaging techniques are used to map the treatment area. c) Radiation treatment delivery, including external and internal radiation therapy. d) Processes to verify the accuracy of treatment plans, radiation doses, and treatment delivery and adherence to strict safety protocols. e) Accurate patient positioning and immobilization techniques are critical for precise radiation delivery. Immobilization devices, such as molds, masks, or customized cradles, may be used to minimize patient movement. f) Optimization measures needed to achieve the required therapeutic effect using the effective radiation dose to the targeted organ with fewer radiation hazards. g) Provision of all possible safety measures for releasing patients after radionuclide therapy, particularly for family members and the general public. h) Proactive management of side effects to minimize their impact and maximize patient comfort. i) Patient and/or family education and support. j) Regular monitoring and assessment to evaluate treatment response and adjust the treatment plan if necessary.
CSS.09 Childbirth	**Program**	a) Assessment and re-assessment of women in labor, b) Use of cardiotocography and partogram for women in labor. c) Clinical guidelines/protocol that address the following items: i. Management of premature rupture of membranes. ii. Management of Antepartum hemorrhage. iii. Management of fetal distress. iv. Induction of labor. v. Episiotomy. vi. Instrumental vaginal delivery. vii. Caesarean section (CS), repeated CS, and emergency hysterectomy. viii. Management of multiple births. ix. Management of post-partum hemorrhage. d) Management of pain in women in labor. e) The immediate postpartum care. f) Providing support for breastfeeding and newborn care.

Standard Code & Keyword	Kind of document	Components
CSS.10 Rehabilitation	**Policy**	a) The types of rehabilitation programs and services offered within the hospital, including inpatient, outpatient, and long-term hospital rehabilitation. b) Qualified staff is responsible for overseeing the provision of each rehabilitation service according to patient needs. c) The use of professional standards of practices to guide the rehabilitation interventions that include at least: i. Assessment and evaluation of the individual's condition, abilities, and goals. This involves medical evaluations by the physiatrist, physical and functional assessments, and psychological evaluations. ii. Plan of care, based on the medical and functional assessment, to address the individual's specific needs and goals. iii. Multidisciplinary team of healthcare professionals who collaborate to provide comprehensive care. iv. Designing a patient-oriented treatment program with clear medical problem lists and the goals of the rehabilitation program. v. Education and counseling to help individuals and their families understand the condition, cope with the challenges, and make informed decisions regarding their care. vi. Regular monitoring of the individual's progress. d) Rehabilitation equipment and resources to facilitate the rehabilitation process, such as exercise machines, assistive devices, mobility aids, and adaptive technologies. e) Discharge planning and follow-up care to ensure a smooth transition from the program to a suitable setting. This may involve arranging for home modifications, recommending community resources and support services, and coordinating with other healthcare providers to ensure continuity of care. f) Medical records documentation requirements for each module.
CSS.11 Psychiatric disorders	**Program**	a) Assessment and evaluation of the individual's mental health condition. b) Screening, assessment, and management of patient's risk of imminent harm to self and others c) Safe and appropriate use of behavioral restraint and seclusion. d) A personalized treatment plan that may include various modalities and care coordination for complex cases that need multiple treatment providers.

Standard Code & Keyword	Kind of document	Components
		e) Psychotherapy and counseling, such as cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), psychodynamic therapy, or interpersonal therapy. f) Medication management, including appropriate prescribing, regular monitoring of medication effectiveness and side effects, and coordination between mental health providers and primary care physicians if necessary. g) Group therapy and support as an adjunct to individual therapy. h) Rapid tranquilization provision and administration guided by evidence-based practices and guidelines. i) Use of electroconvulsive therapy (ECT). j) Suicide prevention approaches k) Provisions for crisis intervention and psychiatric emergency services to ensure appropriate and timely responses to urgent situations. l) The involvement of family members or other support systems in the treatment process. m) Discharge planning includes transitioning individuals to lower levels of care, coordinating follow-up appointments, providing relapse prevention strategies, and ensuring appropriate community-based support services are in place. n) Performance measures to monitor, assess, and improve the program.
CSS.12 Restraint and seclusion	**Policy**	a) The use of restraints or seclusion is according to defined criteria, laws, and regulations. b) Requirements for clear physician order for the use of restraints and seclusion. c) Safe and effective application and removal by qualified staff members. d) The least restrictive methods are to be used as appropriate. e) Protection of patient's rights, dignity, and well-being during use. f) Monitoring and reassessment during use. g) Renewal of the restraint order is based on continuing needs and according to laws and regulations. h) Management and care for patient's needs during restraint and seclusion. i) Termination of restraints and seclusion is according to defined criteria.
CSS.13 Drug abuse	**Program**	a) Assessment and diagnosis. b) Medically supervised detoxification: this involves providing necessary medications, monitoring vital signs, and ensuring a supportive and safe environment during the withdrawal period.

Standard Code & Keyword	Kind of document	Components
		c) Counselling and psychotherapy: evidence-based therapies, such as cognitive-behavioral therapy (CBT), motivational interviewing, and contingency management, are often used. d) Medication-assisted treatment (MAT). e) Supportive Services: this may include case management, vocational support, educational assistance, housing support, peer support groups, and family therapy. f) Dual Diagnosis Treatment addressing both addiction and underlying mental health issues simultaneously through integrated care. g) Relapse prevention. h) Peer Support and Aftercare. i) Continuum of Care by providing resources for aftercare, follow-up appointments, and ongoing support services to maintain long-term recovery.
CSS.14 Organ/Tissue transplantation	**Program**	a) Criteria for selecting suitable organ and tissue transplant candidates, including medical, psychological, and social considerations. b) Comprehensive pre-transplant evaluation of recipients, including medical history, physical examinations, laboratory tests, and imaging studies. c) Clinical guidelines/protocol that address the following items: i. Protocols for identifying suitable donors, evaluating donor health and compatibility, and ensuring ethical organ and tissue procurement practices. ii. Transplant Surgery Procedures. iii. Immunosuppression and Anti-Rejection Strategies. iv. Management of complications that may arise during and after transplantation. v. Guidelines for post-operative care, including monitoring for complications, infections, and rejection. vi. Infection control measures to minimize the risk of post-transplant infections. d) Ethical and legal considerations, including informed consent and the donor-recipient relationship. Live donors should be informed in a complete and understandable fashion of the probable risks, benefits, and consequences of donation. e) Establish an ethics committee to review challenging cases and ethical dilemmas that may arise in the transplantation process. f) Psychosocial and social support for patients and their families throughout the transplantation process. g) Education and training for healthcare professionals involved in the transplant program.

Standard Code & Keyword	Kind of document	Components
		h) Address specific considerations for transplantation in children, elderly patients, and individuals with special medical conditions. i) Assess the success and outcomes of transplantation procedures, including graft survival rates and patient outcomes.
5-Diagnostic and ancillary services:		
Related GSRs: **GSR.12: Radiation Safety Program.** **GSR.13: Laboratory Safety Program**		
DAS.02 Provision of medical imaging service	**Policy**	a) Direct observation of routine work processes and procedures, including all applicable safety practices. b) Direct observation of equipment maintenance, function checks and monitoring recording and reporting of examination results c) Review of imaging professionals' human resources records. d) Assessment of problem-solving skills. e) Training on special modalities, equipment, and studies.
DAS.03 Technical standards (Practice Parameters)	**Procedure manual**	a) Scope and general overview b) Equipment description c) Maintenance procedures d) Quality control e) Safety procedures f) Critical findings
DAS.04 Pre-examination process	**Policy**	a) Proper completion of request form to include patient information (patient identification, date of birth, gender, and patient contact), name of the ordering physician, studies requested, date and time of study, clinical information, highlighting for urgent tests request. b) Patient preparations including specific risks. c) Pre-study review of requests to ensure that the requested examination is appropriate to the needs of the referrer and the patient. d) Actions to be taken when a request is incomplete, illegible, or not clinically relevant, or when the patient is not prepared. e) patients and referrers are informed when an additional or substituted examination is called for.
DAS.05 Medical imaging quality	**Procedure**	a) Elements of the quality control performed according to guidelines, manufacturer instructions for each study/modality.

Standard Code & Keyword	Kind of document	Components
assurance and control		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.
DAS.06 Medical imaging examination protocols	**Protocol**	a) Radiographic or examination factors b) Positioning, c) Aftercare according to the relevant examinations and/or modalities performed at the service. d) These protocols shall also address medical emergencies.
DAS.07 Medical imaging reports	**Policy**	a) Time frames for reporting various types of images to healthcare professional and to patients. b) Emergency and routine reports. c) Accountabilities on the medical Imaging reports across the hospital. d) Qualified licensed medical staff member is responsible for interpretation and reporting. e) The medical imaging service shall have an implemented process for notifying the referrer when a study or report is delayed.
DAS.11 Laboratory Staff	**Policy**	a. Direct observation of routine work processes and procedures, including all applicable safety practices. b. Direct observation of equipment maintenance, function checks; and monitoring recording and reporting of examination results. c. Review of work records. d. Assessment of problem-solving skills. e. Examination of specially provided samples, such as previously examined samples, interlaboratory comparison materials, or split samples.

Standard Code & Keyword	Kind of document	Components
DAS.12 Reagent Management	**Policy**	a) Criteria for inspection, acceptance, and rejection of provided reagent. b) Methods of identification, enlisting and labelling of all reagents present in the laboratory. c) Measures to ensure that the laboratory does not use expired materials. d) Define safety limits for the reordering of the laboratory materials according to the laboratory needs. e) Requesting, issuing, and dispatching reagent and supplies as well as identifying responsible person.
DAS.13 Outsourced laboratory services	**Approved document**	Written agreement between the two laboratories
DAS.13 Outsourced laboratory services	**Policy**	a) <u>Selection</u> Selection should be based primarily on quality of performance. Whenever possible, referral specimens are sent to a national or international accredited laboratory. b) <u>Evaluation:</u> The laboratory should implement an evaluation process either before starting to contract, during the contract, or upon renewal of the contract for the referral laboratory through monitoring the quality of performance, turnaround time, and result reporting. c) <u>Requirements</u>: 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: i. Scope of Service ii. Agreement conditions (including accreditation status). iii. Sample requirements iv. Turnaround Time (TAT) v. Result reporting vi. Release of information to the third party vii. Mean of solving disputes viii. The validity of the agreement and review schedule.
DAS.14 Pre-examination process	**Policy**	a) Proper completion of request form to include patient information (patient identification, date of birth, gender, and patient contact), 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.

Standard Code & Keyword	Kind of document	Components
		b) Patient preparations including instructions for dietary requirements (e.g., fasting, and special diets). c) Description of specimen type collection techniques. d) Proper specimen labelling. e) Criteria for safe disposal of materials used in the collection. f) Proper handling and transportation of specimens. g) Turnaround time of tests h) Minimal retesting Interval i) Individual test precaution
DAS.15 Specimen reception, tracking and storage.	**Policy**	a) Setting criteria for acceptance or rejection of specimens. b) Evaluation of received specimens by authorized staff member to ensure that they meet the acceptance criteria relevant for the requested examination(s). i. Acceptable specimen: Specimen recording process in an accession book, worksheet, computer, or another comparable system, recording includes the date and time of specimen's reception/registration and the identity of the person receiving the specimen. ii. Unacceptable specimen: Records of rejection are maintained, including the cause of rejection, time and date, name of rejecting person, and name of the notified individual. iii. Indications of acceptance of suboptimal specimen, taken measures, and recording that includes the date and time of specimen's reception/registration and the identity of the receiving person, c) Traceability of all portions of the primary specimen to the original primary sample. d) Process of recording all specimens referred to other laboratories for testing. e) Instructions for proper sample storage in the pre-examination phase.
DAS.16 Verified / Validated test methods.	**Policy**	a) Measurement of trueness. b) Measurement of precision. c) Measurement of linearity (detection and quantification limits). d) The laboratory shall validate the examination procedures when: e) Using a non-standard method. f) The standard method used outside its intended scope. g) The validated method with modification.

Standard Code & Keyword	Kind of document	Components
DAS.17 Examination procedures	**Procedure**	a) Principle and clinical significance of the test. b) Requirements for patient preparation and specimen type, collection, and storage. Criteria for acceptability and rejection of the sample. c) Reagents and equipment used. d) Verification/validation of examination procedures. e) The test procedure, including test calculations and interpretation of results. f) Calibration and control procedures and corrective actions to take when calibration or control results fail to meet the laboratory's criteria for acceptability. g) Biological reference intervals/clinical decision values. h) Critical test results. i) Analytical measurement range and instructions for determining results when it is not within the measurement interval. j) Limitations in methodologies including interfering substances. k) References.
DAS.18 Laboratory Internal quality assessment	**Procedure**	a) Elements of the internal quality control. 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) Quality Control data is reviewed at a regular interval (at least monthly) by responsible authorized staff member. g) Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.
DAS.19 Laboratory external quality assessment	**Protocol**	External quality control procedures
DAS.20 Post examination process	**Policy**	a) Final report data fulfilment including at least: i. Identity of the laboratory ii. Patient identification, iii. Tests performed, iv. Ordering clinician,

Standard Code & Keyword	Kind of document	Components
		v. Date and time of specimen collection and the source of specimen, vi. Reporting date and time, vii. Test results and reference interval, viii. Identification of the verifying individual (Approved) ix. Interpretation of results, where appropriate, advisory, or explanatory comment when needed. b) Reviewing, verifying, and reporting of results by authorized staff member c) Criteria for specimen storage. d) The defined retention time of laboratory results e) The defined retention time of patient samples f) Specimens' disposal.
DAS.21 Laboratory turnaround time	**Written process**	defining each laboratory test's total turnaround time and means of measuring it.
DAS.22 STAT results	**Written process**	ordering, collection, testing, and results reporting of urgent tests.
DAS.24 Point of care testing	**Procedure**	Quality control procedures manual for POCT
DAS.25 Blood Transfusion services management	**Policy**	a) Organization and Management. b) Resources, Equipment and Supplies c) Customer needs d) Process control e) Documents and records f) Deviations, nonconformance and complications g) Donor Assessments h) Blood screening i) Process improvements j) Facilities and safety k) Handling of shortage of blood
DAS.26 Safe blood donation	**Policy**	a) Screening based on: i. Donor's history of surgeries, vaccination, receiving blood and donation interval ii. Donor's physical examination including general appearance, height and weight and vital signs.

Standard Code & Keyword	Kind of document	Components
		iii. Blood bag laboratory testing, including specified communicable diseases, Blood grouping and RH typing. b) Mechanisms to ensure voluntary non-remunerated blood donation. c) Pre-donation counselling by trained staff that include risk behaviours and self-exclusion for patient safety, tests carried out on donated blood and potential side effects. (Questionnaires may be used) d) Maintain an up-to-date list of available donors of different groups. e) Donor safety and privacy
DAS.27 Blood Procurement	**Policy**	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. iv. Testing v. Determination of ABO group vi. Determination of Rh (d) type previous records vii. Laboratory tests for infectious diseases viii. Quarantine storage c) Preparation i. Sterility ii. Seal iii. Blood components preparation instructions and protocols
DAS.29 Contracted blood banks	**Policy**	a) Selection Selection should be based primarily on quality of performance. Whenever possible, blood and blood components are obtained from an accredited laboratory. b) 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.

Standard Code & Keyword	Kind of document	Components
		The blood bank should implement an evaluation process during the relationship with the outside blood bank by monitoring and evaluating certain quality measures c) 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: i. Scope of Service. ii. Agreement conditions (including accreditation status). iii. Agreement on safe storage and transportation conditions. iv. Role of the involved parties in look back and transfusion transmitted diseases investigation. v. Predefined acceptance criteria for each blood component received. vi. Release of blood, blood components or information to the third party. vii. Mean of solving disputes. viii. Validity of the agreement and review schedule. d) Inspection: ix. Checking for meeting predefined acceptance criteria for each blood component received. x. Evaluation and verification of units' identification information including unit numbers, ABO/Rh-D and Expiration dates. xi. Conformation of ABO/Rh-D for RBC components. xii. Actions taken for unsatisfactory blood or blood component units. xiii. Evaluation and verification of the transportation condition of each blood component.
DAS.29 Contracted blood bank	**document**	Written agreement between the two blood banks
DAS.30 distribution of blood and blood components	**Policy**	a) Blood compatibility testing of all whole blood and red cells transfused. b) The cross-matching report form should have patient's first name with surname, age, sex, identification number, ABO and Rh(D) type.

Standard Code & Keyword	Kind of document	Components
		c) The form should have donor unit identification number, segment number, ABO and Rh(D) type and expiry date of the blood. d) Interpretation of cross matching report and the name of the person performing the test and issuing the blood should be recorded. e) Each unit of blood should be visually inspected before distribution. It should not be distributed if there is any evidence of leakage, haemolysis, or suspicion of microbial contamination such as unusual turbidity or change of colour. Also, the policy shall include special situations such as f) Conditions for reissuance of blood: when blood and/or blood components are returned to blood bank to be reused/reordered. g) Urgent requirement of blood. h) Actions to be taken when required blood type is not available.
6-Surgical and Invasive Procedural safety		
Related GSRs: **GSR.14: Surgical Site Marking** **GSR.15: Pre-operative Checklist** **GSR.16: Time out – sign out** **GSR.17: Instrument retention prevention**		
SAS.01 Surgery and Invasive Procedure Services	**Approved document**	professional practice guidelines
SAS.02 Booking of surgeries and invasive procedures	**Policy**	a) Surgeries and invasive procedures are booked according to granted clinical privileges. b) The booking should specify the start time and end time for surgery based on the international surgery times. c) The hospital records surgeries and invasive procedures, whether they are scheduled, performed, or canceled. d) Clear and safe mechanism to identify patients in the records.

Standard Code & Keyword	Kind of document	Components
		e) A clear and safe mechanism to call patients for surgeries or invasive procedures.
SAS.10 Pathological Examination	**list**	list of exempted tissue from pathological examination
SAS.11 Implantable Devices	**Policy**	a) The selection process of implantable devices. b) Process for procurement and availability in the operating location. c) Technical staff qualification and competency from internal or external (company representative). d) Recording and documenting of implantable device in the patient's and OR records. e) Process and criteria of identifying and reporting adverse events related to implantable device. f) Tracking and recall of devices. g) Process of reporting malfunctions of implantable devices to authorities. h) Discharge instructions, including infection prevention requirements.
SAS.15 Anaesthesia Protocols	**Protocol**	anesthesia protocols and anesthesia emergencies and complications management protocols.
SAS.21 Sedation Protocol	**Policy**	a) The locations in which procedural sedation is allowed to be performed. b) The competencies and privileges required for staff involved in performing or monitoring procedural sedation. c) Situations in which procedural sedation must be conducted by an anesthesiologist only. d) Sedative agents used in procedural sedation for different patient categories and reverse agents. e) Emergencies are expected, and the needed requirements to manage such situations include the availability of critical equipment, supplies, and medications that cover all ages
SAS.21 Sedation Protocol	**PROTOCOL**	protocols for procedural sedation

Standard Code & Keyword	Kind of document	Components
7- Medication management and safety		
Related GSRs: **GSR.18: Medication reconciliation, best possible medication history (BPMH)** **GSR.19: Medication storage and labelling** **GSR.20: High-Alert medications and concentrated electrolytes** **GSR.21: Look-alike and sound-alike medications**		
MMS.01 Medication management	**Program**	a safe medication management program that addresses at least the following: a) Planning b) Selection and procurement c) Storage d) Ordering and prescribing e) Preparing and dispensing f) Administration g) Monitoring and evaluation
MMS.02 Antimicrobial Stewardship Program	**Program**	The antimicrobial stewardship program is a hospital priority with leadership commitment and support.
MMS.03 Medication Procurement, Formulary	**list**	The medication list (formulary) shall include (but not limited) 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.
MMS.05 Emergency Medications	**Policy**	Minimum contents: a) Emergency medications should be readily accessible and uniformly stored. 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.

Standard Code & Keyword	Kind of document	Components
MMS.08 Medication recall, expired, and outdated medication.	**Policy**	Minimum contents: a) Process to retrieve recalled medications. b) Labelling and separation of recalled medications. c) Patient notification (when applicable). d) Disposal or removal.
MMS.09 Radioactive medications, contrast, narcotics, and medication brought by patients.	**Policy**	Minimum contents: a) Receipt b) Identification and labeling c) Storage d) Administration
MMS.10 Medication Reconciliation, best possible medication history (BPMH)	**Policy**	Minimum contents: a) Situations where medication reconciliation is required: i. On admission (matching the current medication orders with the best possible medication history (BPMH) before ordering any new medication. 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 prescribed before and during the episode of care). iv. During ambulatory care services (if it involves medication) before prescribing. b) Identify the responsibility of performing medication reconciliation. c) Patients and family involvement. Steps of the medication reconciliation process such as collecting the list of both prescribed and non-prescribed medications (e.g., vitamins, nutritional supplements, over-the-counter drugs, and vaccines) used by patients, clarification whether these medications and their dosages are appropriate, matching with a new list of medication and recording changes
MMS.11 Ordering, prescribing, transcribing.	**Policy**	a) Identify who is authorized to prescribe which type of medications. b) Uniform location in the patient's medical record to order/prescribe medications. c) The limited situation(s) where the transcription process is necessary and cannot be avoided. d) The process of discontinuing medication order/prescription. e) The minimum required elements of complete medication prescriptions include:

Standard Code & Keyword	Kind of document	Components
		i. Patient identifications ii. Patient demographics include weight and height iii. Drug name iv. Dosage form v. Strength or concentration vi. Dosage, frequency, and duration vii. Route of administration viii. Rates of administration (when intravenous infusions are ordered) ix. Indications for use, maximum frequency, and maximum daily dose for PRN orders. x. Date and time of the order xi. Physician's identification f) The process to manage special types of orders, such as weight-based dosing, standing orders, emergency orders, or orders that need titration, tapering, or range doses orders. g) Process to manage medication orders that are incomplete, illegible, or unclear medication orders.
MMS.17 Medication errors, near misses, medication therapy problems	**Policy**	approved policy to guide the process of defining, reporting, analyzing, and acting on medication errors, near misses, and medication therapy problems based on national/international references.
8- Environmental and Facility Safety		
Related GSRs: **GSR.23: Fire and smoke safety** **GSR.24: Fire drills** **GSR.25: Hazardous materials safety and waste management** **GSR.26: Safety Management Plan** **GSR.27: Medical Equipment Plan** **GSR.28: Utility Management Plan**		
EFS.05 Smoking-Free Environment	**Policy**	The policy should include any exceptions, penalties, and the designated smoking area outside the building. All staff should be aware of the smoking-free environment policy.

Standard Code & Keyword	Kind of document	Components
EFS.09 Security Plan	**Plan**	a) a)Security risk assessment. b) b)Ensuring the identification of inpatients and staff in the hospital. c) c)Ensuring the identification of visitors and vendors/contractors with restrictions on their movement within the hospital. d) d)Identification of restricted areas. e) e)Vulnerable patients such as the elderly, infants, those with mental disorders, and handicapped should be protected from abuse and the above-mentioned harms. f) f)Children should be protected from abduction. g) g)Drill for child abduction should be performed at least biannually. h) h)monitoring of remote and isolated areas. i) i)Workplace violence management. j) j)Staff training and orientation. k) k)The plan is updated annually based on evaluation.
EFS.12 Water services	**Policy**	a) Routine maintenance and monitoring of water distribution and treatment systems. b) Continuing training and education of operators of water treatment systems. c) Monitoring of water at all stages (feed, product, and dialysis water). d) Methods and frequency of measuring microbiological and chemical contaminants. e) Maximum allowable concentrations of microbiological contaminants.
EFS.13 Disaster Plan	**Plan**	a) Risk assessment of potential emergencies, internal and external disasters, such as heavy rains, earthquakes, floods, hot weather, wars, bomb threats, terrorist attacks, traffic accidents, power failure, fire, and gas leakage. b) Risk assessment of potential epidemics and/or pandemics. c) Degree of preparedness according to the level of risk. d) Communication strategies: Internal communication may take the form of a clear call tree that includes staff titles and contact numbers, and external communication channels may include civil defense, ambulance centers, and police. e) Clear duties and responsibilities for hospital leaders and staff. f) Identification of required resources such as utilities, medical equipment, medical, and nonmedical supplies, including alternative resources. g) Business Continuity: i Triaging. ii Staff's main task is maintained in case of emergencies: management of clinical activities during a disaster, such as operating theatre and intensive care units. iii Alternative care sites and backup utilities. iv Safe patient transportation in case of emergency is arranged by the hospital.

Standard Code & Keyword	Kind of document	Components
		h) Drill schedule: The hospital must schedule a drill for emergencies at least bi-annually and ensure staff attendance. Proper evaluation and recording of the drill include, but are not limited to: I. Scenario of the drill II. Observations on code announcement, timing, staff attendance, response, communication, triaging, and clinical management. III. Clear corrective actions if needed. IV. Feedback to the environmental safety committee. V. Debriefing. i) The plan is updated annually based on evaluation.
EFS.14 Environmental Sustainability, Green Healthcare	**Policy**	a) Leadership Commitment: Leaders demonstrate commitment to environmental sustainability by including it in policies. b) Employee Engagement: including activities to raise awareness, train staff on climate change and environmental practices, and encourage participation in eco-friendly initiatives. c) Waste Management: establish a comprehensive waste management system that prioritizes waste reduction and proper segregation. d) Green Infrastructure: considers opportunities for green infrastructure solutions through: i. Prioritizing natural lighting and avoid unnecessary outside lighting, ii. Efficient energy use through using LED bulbs, lighting with motion sensors, using an air conditioning system (24°C), and after-working hours' equipment shutdowns if applicable. iii. Water-saving fixtures further enhance sustainability. e) Monitoring through regular rounds to check the commitment to environmental Sustainability activities and evaluating the effectiveness of implemented strategies and activities.
9- Infection Prevention and Control		
Related GSRs: **GSR.22:Hand Hygiene**		

Standard Code & Keyword	Kind of document	Components
IPC.02 IPC program, risk assessment, guidelines	**Program**	a) Scope and objectives. b) Infection control policies and procedures. c) Risk assessment to identify departments and services with increased potential risk of infection and risk mitigation plan. d) Surveillance and monitoring system to monitor healthcare-associated infections (HAIs) and track infection rates within the hospital, e) Staff education and training on infection control principles and practices, f) Outbreak management g) Staff immunization, h) Antibiotic stewardship program to promote the appropriate use of antimicrobial agents, i) Continuously assess and improve infection control practices within the hospital.
IPC.05 PPE, guidelines, Physical Barriers	**Policy**	a) Different types of personal protective equipment (PPE). b) Standardized product specifications of Personal protective equipment (PPE). c) Personal protective equipment (PPE) use is based on the risk assessment. d) Staff education and training on the proper way and sequence of donning and doffing of various PPE. e) Monitoring the compliance.
IPC.09 Environmental cleaning, evidence-based guidelines	**Policy**	a) Identification of risk areas. b) High-touch environmental surfaces c) Frequency of environmental cleaning and disinfection d) Environmental detergents and disinfectants to be used. e) Method of cleaning and disinfection
IPC.10 Sterile technique, Aseptic technique	**Policy**	a) Identification of risk procedures, b) Types of aseptic techniques, c) Patient preparation.
IPC.11 Care bundles	**Policy**	a) Bundles for the prevention of central line-associated bloodstream infections (CLABSI) b) Bundle for the prevention of catheter-associated urinary tract infections (CAUTI) c) Bundle for the prevention of ventilator-associated pneumonia (VAP) d) Bundle for the prevention of surgical site infection (SSI)
IPC.12 Transmission based precautions.	**Policy**	policy and procedures guiding Transmission-based precautions (TBPs)

Standard Code & Keyword	Kind of document	Components
IPC.14 Sterilization/disinfection	**Policy**	a) Receiving and cleaning of used items. b) Preparation and processing. i. The processing method is to be chosen according to the 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 itemsthat come in contact with mucous membranes or non-intact skin, such as gastrointestinal endoscopes, respiratory and anaesthesia 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 somesemi-critical items, most non-critical reusable items may be decontaminated where theyare used and do not need to be transported to a central processing area. c) labelling 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.
IPC.15 Disinfection/Sterilization quality control program	**Policy**	a) Quality control elements, method and frequency include: i Cleaning monitor: Visual inspection with magnifying glasses (lighted magnifying glasses are preferred) should be done for each instrument after cleaning. ii Physical parameters (temperature, time and pressure) which are monitored every cycle. iii Chemical parameters (internal chemical indicator inside the sterilization pack- external chemical indicator on the outside of the sterilization pack), which are monitored for every pack. iv Biological indicator, which is done at least weekly. v The test for adequate steam penetration and rapid air removal shall be done every day before starting to use the autoclave,

Standard Code & Keyword	Kind of document	Components
		using Class 2 internal chemical indicators and process challenge devices, either porous or hollow. vi 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). vii Chemical test strips or liquid chemical monitors shall be used to determine whether an effective concentration of high-level disinfectants is present despite repeated use and dilution. The frequency of testing shall be based on how frequently these solutions are used. b) Quality control performance expectations and acceptable results shall be defined and readily available to staff so that they will recognize unacceptable results in order to respond appropriately. c) The quality control program is approved by the designee prior to implementation. d) Responsible authorized staff member reviews Quality Control results at regular intervals. e) Remedial actions were taken for deficiencies identified through quality control measures, and corrective actions were taken accordingly.
IPC.16 Laundry service, textile	**Policy**	a) Processes of collection and storage of contaminated textiles. b) Cleaning of contaminated textiles. c) Water temperature, detergents, and disinfectant usage. d) Processes of storage and distribution of clean textiles. e) Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.
IPC.17 Surveillance, Healthcare-associated infections.	**Policy**	The Hospital Shall develop and implement a policy and procedures guiding the surveillance process.
IPC.18 Outbreaks investigation	**Approved documented process**	The Hospital Shall develop and implement an approved process for outbreak investigations. The following 10-step approach to investigating an outbreak has been described in the literature: 1. Determine the existence of the outbreak, 2. Confirm the diagnosis, 3. Define a case, 4. Search for cases, 5. Generate hypotheses using descriptive findings, 6. Test hypotheses with an analytical study, 7. Draw conclusions,

Standard Code & Keyword	Kind of document	Components
		8. Compare the hypothesis with established facts, 9. Communicate findings, 10. Execute prevention measures.
IPC.19 Multi-Drug Resistant Organisms	**Policy**	a) The definition of Multi-Drug Resistant organisms. b) The most common micro-organisms of epidemiological importance. c) MDROs containment measures.
IPC.20 Food Services	**Policy**	a) Food receiving process. b) A safe storage process including a food rotation system that is consistent with first-in-first-out principles. c) Monitoring of temperature during preparation and storage. d) Functioning washing facility in the kitchen e) Prevention of cross-contamination of food, whether directly from raw to cooked food or indirectly through contaminated hands, working surfaces, cutting boards, utensils, etc. f) Food transportation process. g) Preparation, storage, and administration of feeding tube nutritional therapy. h) Safe handling and storage of expressed breast milk and formula.
IPC.21 Post-mortem care	**Policy**	a) Infection hazard assessments. b) Procedures to minimize these hazards. c) Use of appropriate engineering devices and personal protective equipment to minimize exposure. d) Sorting of waste. e) Record keeping. f) Environmental cleaning procedures. g) Reporting accidental exposures.
10- Organization Governance and Management		
OGM.01 Governing body structure and responsibilities	**Approved document**	hospital's organizational chart.
OGM.01 Governing body structure and responsibilities	**Approved document**	Governing body responsibilities and accountabilities

Standard Code & Keyword	Kind of document	Components
OGM.04 Hospital Director	**approved job description**	The job description covers at least the following: a) Providing oversight of day-to-day operations. b) Ensuring clear and accurate posting of the hospital's services and hours of operation to the community. c) Ensuring that policies and procedures are developed, implemented by leaders, and approved by the governing body. d) Providing oversight of human, financial, and physical resources. e) Annual evaluation of the performance of the hospital's committees. f) Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation. g) Ensuring that there is an organization-wide program for performance improvement, patient safety, and risk management with appropriate resources. h) Setting a framework to support coordination within and/or between departments or units, as well as a clear process of coordination with relevant external services. i) Regular reporting to the governing body on how legal requirements are being met.
OGM.05 Committee structure	**(Approved document)**	Term of reference for these 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
OGM.06 Strategic Planning	**plan**	Hospital strategic plan
OGM.08 Hospital leaders	**approved job description**	The hospital shall establish administrative authorities and responsibilities for hospital leaders that include the following: a) 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.

Standard Code & Keyword	Kind of document	Components
		- 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. b) Running smooth directed operations: - Creating a “Just Culture” for reporting errors, near misses, and complaints, and using 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. c) 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
OGM.09 Departmental management	**(Approved document) Job description of heads of departments.**	The responsibilities of the designated supervisor of each department and service are defined in writing and include at least the following: a) Defining a written description of the services provided by the department (scope of service). b) Recommending space, staffing, and other resources needed to fulfill the department's approved scope of service. c) Recommending staff minimum number and qualifications required according to workload and approved scope of service. d) Defining education, skills, and competencies needed by each category of staff. e) Ensuring that there is a department-specific orientation and continuing education program for the department's staff. f) Ensuring coordination and integration of these services with other departments when relevant. g) Ensuring that the department's/service's performance is monitored and reported at least quarterly to leadership.

Standard Code & Keyword	Kind of document	Components
		h) Ensuring that the department is involved in the performance improvement, patient safety, and risk management program(s).
OGM.10 Supply Chain Management	**Policy**	The hospital shall develop a policy and procedures for Supply Chain Management that addresses at least the following: a) Supplier's identification and selection process. b) 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. c) 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. d) Supplies are monitored and evaluated to ensure that no recalled medications, samples, devices, medical supplies, or equipment are provided. e) Transportation of supplies is monitored to ensure that it occurs according to applicable laws and regulations, approved organization policy, and manufacturer's recommendations.
OGM.11 Stock Management	**Policy**	The hospital shall develop a policy and procedures for managing storage, stock, and inventory addresses at least the following: a) Compliance of storage to laws, regulations, and organization policies. b) Management of stocks safely and efficiently. c) Inventory management and tracking of the use of critical resources. d) Recording stock items that should at least have the following (unless stated otherwise by laws and regulations): i. Date received ii. LOT number and expiration date iii. Whether acceptance criteria were met or not and if any follow-up required iv. Date placed in service or disposition, if not used
OGM.12 Billing System	**Policy**	a) Availability of an approved price list. b) A process to ensure accurate billing. c) Use of accurate and approved codes for diagnoses and procedures. d) Patients/families are informed of any potential cost pertinent to the planned care. e) Patients/families are assisted to understand and manage administrative processes of pilling.

Standard Code & Keyword	Kind of document	Components
		f) Identifying patients whose conditions might require higher costs than expected and providing information to them periodically.
OGM.12 Billing System	**(Approved list)**	approved price list for healthcare services provided in the hospital.
OGM.13 Contract Management	**(Approved list)**	a list of all contracted services, including clinical and non-clinical services
OGM.13 Contract Management	**Approved document)**	Selection and evaluation criteria for each contracted service.
OGM.15 Ethical Management	**Ethical committee with terms of reference**	a) Development of the hospital values and code of ethics. b) Awareness and training of the staff relevant to ethical practices and medicolegal issues. c) Management of medical ethical dilemmas. d) Identifying and disclosing conflict of interest. e) Management of discrimination, and harassment. f) Ensuring gender equality.
OGM.17 Staff Health program	**Program**	The program scope covers all staff and addresses 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 bloodborne 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) Results of the medical evaluation are documented in staff health records, and action is taken when there is a positive result, including employee awareness of these results and provision of counseling and interventions as might be needed.

Standard Code & Keyword	Kind of document	Components
		h) Recording and management of staff incidents (e.g., injuries or illnesses), taking corrective actions and setting measures in place to prevent recurrences. i) Infection control staff is 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 (eg., medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulations.
11- Community Assessment and Involvement		
CAI.01 Community involvement program	**Program**	a) Identification and description of the targeted population. b) Define the scope and objectives of the program. c) Identification of community partners d) Identify communication channels with community partners. e) Community needs assessment strategy. f) Community involvement activities, including health education. g) Collaborate with international, regional, and/or national community initiatives. h) Budget and resources. i) Evaluation of the program.
12- Workforce Management		
WFM.02 Staffing Plan	**Plan**	The hospital maintains a safe level of staff members, including independent practitioners' numbers and skill level, that matches at least 60% of its requirements, especially 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)Workload during working hours and different shifts. e)Technology and equipment used in patient care.

Standard Code & Keyword	Kind of document	Components
WFM.03 Recruitment process	**Policy**	a) Collaboration with service/department leaders to identify the need for a job, b) Communicating available vacancies to potential candidates, c) Announcing criteria of selection, d) Application process, e) Recruitment procedures.
WFM.05 Verifying credentials	**Approved document**	Approved document describing Verifying credentials
WFM.06 Staff Files	**Policy**	a) Staff file initiation. b) Standardized Contents such as: i. Qualifications, including education, training, licensure, and registration, as applicable. ii. Work history. iii. Documentation of credentials evaluation and primary source verification. iv. Current job description. v. Recorded evidence of newly hired general, departmental, and job-specific orientation. vi. Ongoing hospital and professional education received. vii. Copies of provisional and annual performance evaluations. c) Update of file contents. d) Storage. e) Retention time. f) Disposal**.**
WFM.07 Orientation Program	**Program**	The general orientation program addresses at least the following: a) The hospital mission, vision, values, and hospital structure. b) Hospital policies for Environmental and Facility Safety. c) General information about infection control policies and procedures. d) Hospital policies for performance improvement, patient safety, and risk management. e) Ethical framework and code of conduct. f) Patient and family rights. The department orientation program addresses at least the following: g) Review of relevant policies and procedures**.** h) Operational processes. i) Work relations.

Standard Code & Keyword	Kind of document	Components
		The job-specific orientation program addresses at least the following: j) Job-specific duties and responsibilities as per the job description. k) Technology and equipment use. l) High-risk processes. m) Staff safety and health.
WFM.08 Continuous Education Program	**Program**	a) Patient assessment. b) Infection control policy and procedures, needle stick injuries, and exposures. c) Environment safety plans. d) Occupational health hazards and safety procedures, including the use of personal protective equipment. e) Information management, including patient's medical record requirements as appropriate to responsibilities or job description. f) Pain assessment and treatment. g) Clinical guidelines used in the hospital. h) Basic cardiopulmonary resuscitation training at least every two years for all staff that provide direct patient care. i) Quality concept, performance improvement, patient safety, and risk management. j) Patient rights, patient satisfaction, and the complaint/ suggestion process. k) Provision of integrated care, shared decision-making, informed consent, interpersonal communication between patients and other staff, and cultural beliefs, needs, and activities of different groups served. l) Defined abuse and neglect criteria. m) Medical equipment and utility systems operations and maintenance.
WFM.09 Staff Performance Evaluation	**Approved document/ tool**	Approved document/ tools(criteria) for Staff Performance Evaluation
WFM.10 Medical Staff Structure	**Approved document for medical staff bylaws**	a) Entire medical staff structure. b) Medical staff committee structure and function. c) Medical staff categories and the specific qualifications necessary for each category (consultant, registrar, resident, etc.) d) Roles and responsibilities of each staff category, including employment status (full-time, part-time, locum, visitor, etc.) e) Credentialing, re-credentialing, appointment, and re-appointment processes, including primary source verification as applicable.

Standard Code & Keyword	Kind of document	Components
		f) The privileging and re-privileging (application, granting, revision, renewal), including temporary and emergency privileges. g) Ethics of good medical practice and conflict of interest. h) Defined criteria and process for suspension and other disciplinary actions, including the mechanism for a fair hearing and appeal process. i) Defined criteria and process for peer review
WFM.12 Clinical Privileges	**Policy**	a) Medical staff members and independent practitioners with clinical privileges are consistent with the medical staff bylaws. b) Privileges indicate whether medical staff can admit, consult, and treat patients. c) Privileges define the scope of patient care services and the types of procedures they may provide in the hospital. d) Privileges are determined based on documented evidence of competency (experience, qualifications, certifications, skills) that is reviewed and renewed at least every three years. e) Privileges are available in areas where medical staff provides services pertinent to granted privileges. f) Medical staff members with privileges do not practice outside the scope of their privileges. g) When medical staff are granted a privilege under supervision, clinical privileges address the accountable supervisors, mode, and frequency of supervision.
WFM.13 Medical Staff Performance Evaluation	**Approved document for Performance evaluation criteria**	1. Clinical care provision such as a) Compliance with evidence-based protocols for specific conditions or procedures. b) Completeness and timeliness of medical records documentation. c) Appropriate use of resources, e.g., medication use, blood and blood products, antibiotic usage, etc. d) Appropriateness of patient admissions. 2. Clinical outcomes such as: a) Rates of mortality and morbidity. b) Adverse events and procedure complication rate. c) Discrepancies between pre- and post-operative diagnoses. d) Sentinel events. 3. Attitude and behavior such as: a) Incidents related to ethical conduct. b) Disciplinary actions. c) Attendance pattern and absenteeism. d) Patient complaints.

Standard Code & Keyword	Kind of document	Components
		e) Staff Complaints.
WFM.14 Peer Review process.	**Policy**	a) Defined criteria for referring clinical cases for internal peer review. b) Defined criteria for referring clinical cases for external peer review. c) The data or information from peer review is used for re-appointment and re-privileging.
WFM.15 Nursing laws and regulations	**Approved Job description showing the nursing director's responsibilities**	a)Responsible for developing and implementing written nursing standards of practice and recording for nursing assessment, nursing care plan, nursing reassessment, and treatments. b)Responsible for evaluating the effectiveness of nursing treatments. c)Member of the senior leadership team of the hospital and attending the senior leadership staff meetings d)Ensuring that schedules and assigned tasks to the staff are completed.
WFM.17 Working Hours	**Policy**	a) Measures to avoid staff burnout. b) Planned rest times. c) Maternity protection and arrangements for breastfeeding.
13- Information Management and Technology		
Related GSRs: **GSR.29: Abbreviations**		
IMT.02 Information management plan	**Plan**	a) The identified information needs of clinical and managerial hospital leaders. b) The information needs and requirements of external authorities and agencies. c) The type and volume of services provided by the hospital. d) Clinical coding (diagnosis and procedure codes). e) The adequate timeframe required for the information dissemination process (internal or external dissemination). f) Education and training of staff according to their responsibilities, job descriptions, and data and information needs.

Standard Code & Keyword	Kind of document	Components
IMT.03 Document control system.	**Policy**	a) Standardized formatting b) Document control system for tracking issues and changes/modifications. c) 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 the issue and/or reviewed the document, and identification of changes of version. d) Required policies, procedures, plans, programs, and guidelines are available and disseminated to relevant staff. e) Staff understand how to access those documents relevant to their responsibilities. f) Retirement of documents.
IMT.05 Confidentiality and Security of data and information	**Policy**	a) Determination of who can access what type of data and information. b) The circumstances under which access is granted. c) Confidentiality agreements with all those who have access to patient data. d) Procedures to ensure privacy and cybersecurity of patient information. e) Procedures to secure the confidentiality of patient information that is communicated through e-mail or mobile devices. (e.g., implement end-to-end encryption for email and messaging services, use secure email platforms or services specifically designed for healthcare communication, use secure messaging apps that comply with healthcare privacy regulations, etc.) f) Staff training on the proper handling of patient information, the risks associated with insecure communication methods, and how to use secure communication tools effectively. g) Procedures to follow if confidentiality or security of information has been breached.
IMT.07 Retention of Data and Information	**Policy**	a) Retention time for each type of document. b) Information confidentiality must be maintained during the retention time. c) Retention conditions, archival rules, data formats, and permissible means of storage, access, and encryption. d) Data destruction procedures.
IMT.08 Patient's Medical record Management	**Policy**	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 records.

Standard Code & Keyword	Kind of document	Components
IMT.09 Medical Record Review	**Policy**	a) Random sampling and selecting approximately 5% of patient's medical records. b) Review of a representative sample of all services. c) Review of a representative sample of all disciplines/staff. d) Involvement of representatives of all disciplines who make entries. e) Review of the completeness and legibility of entries. f) Review occurs at least quarterly.
IMT.11 Downtime of Data Systems	**Program**	The program includes the downtime recovery process to ensure data integrity. Unplanned events are documented and investigated to determine corrective actions. All staff receive training about the transition into a downtime environment to respond to immediate patient care needs.
14- Quality and Performance Improvement		
QPI.01 Quality Committee (s)	**Performance improvement, patient safety and risk management committee(s) terms of references.**	a) Ensuring that all designated care areas participate in quality improvement activities. b) Establishing organization-wide priorities for improvement. c) Ensuring that all required measurements are monitored, including the frequency of data collection. d) Reviewing adverse events, near-misses, and root cause analyses to prevent recurrences. e) Developing and implementing strategies to enhance patient safety and minimize risks. f) Monitoring compliance with regulatory and accreditation standards related to quality and safety. g) Reviewing patient satisfaction data and identifying opportunities to enhance patient experience. h) Reporting information about performance data and quality improvement activities to the governing body, hospital leaders, and appropriate staff members. i) Evaluating the performance of the committee on an annual base.
QPI.02 Quality improvement Plan(s)	**Plan**	a) Quality policy and mission statement: The hospital's mission statement clearly defines its commitment to providing high-quality care and patient safety. b) The goal(s) and objectives (clinical and managerial) that fulfill the hospital mission. c) The role of leaders and defined responsibilities of improvement activities. d) Performance measures road map selection. e) Data collection, data analysis tools, and validation process.

Standard Code & Keyword	Kind of document	Components
		f) Information flow and reporting frequency. g) Defined criteria for prioritization and selection of performance improvement projects. h) Quality improvement model(s) used. i) Training on quality improvement and patient safety approaches. j) The plan(s) is updated annually based on evaluation.
QPI.03 Quality management team	**Approved Document**	Approved document Job description of quality management team
QPI.05 Performance Measures	**Approved list**	approved list of performance measures, a description of at least the following is needed: a) Definition. b) Defined data source. c) Specified frequency. d) Sampling techniques. e) Formula. f) Methodology of data collection and analysis. g) Target or benchmark the results.
QPI.08 Data aggregation, analysis, and validation.	**Approved document**	A written process for data review and validation: showing Data validation is required in the following situations: a) Starting a new measure in general and a clinical measure in specific b) Publishing the data to the community c) Any change in the data collection methodology d) Unexplained results without justification e) Change in the source of data f) Change in the scope of data collected
QPI.09 Risk Management Program	**Program**	a) Scope, objective, and criteria for assessing risks b) Risk management responsibilities and functions c) Policies and procedures support hospital risk management framework d) Staff training on risk management concepts and tools e) Risk identification, including updated risk register f) Risk prioritization and categorization (i.e., strategic, operational, reputational, financial, others) g) Risk reporting and communication with stakeholders and the governing body h) Risk Reduction plans and tools with priority given to high risks i) The risk management program/plan is updated annually

Standard Code & Keyword	Kind of document	Components
QPI.10 Incident Reporting System	**Approved document**	The incident-reporting system includes 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) Staff training on incident management process d) Incidents that require immediate notification to management e) Incident classification, analysis, and results reporting f) Indication for performing intensive analysis and its process
QPI.11 Sentinel events	**Policy**	a) Definitions of adverse event, near miss and sentinel event. Sentinel events include, but not limited to: i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient's illness or underlying condition. ii. Wrong patient, wrong site, or 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 peripartum maternal death. vii. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams. viii. Major haemolytic transfusion reaction. ix. Rape. x. Fire. xi. Infant abduction. b) Internal reporting of sentinel events. c) External reporting of sentinel events. d) Team member's involvement. e) Root cause analysis. f) The taken corrective and preventive action plans. g) Procedures for managing adverse events consequences, including the first and second victims affected.
QPI.12 Sustaining Improvement	**Approved document**	Approved document written methodology for improvement
15- Academic and Teaching Hospitals:		

Standard Code & Keyword	Kind of document	Components
ATH.02 Educational Governance	**Approved document**	Approved document showing accountability of medical education supervision
ATH.03 Curriculum development	**Approved document**	Approved document for curriculum development process.
ATH.04 Patient rights during bedside teaching	**Policy**	a) Obtain verbal or written consent and ensure that patients fully understand the purpose, nature, and potential impact of their participation in teaching sessions. They also have the right to refuse or withdraw consent at any time without any negative consequences to their care. b) Safeguard privacy and confidentiality and take necessary measures, such as using private areas, obtaining verbal consent for learners' involvement, and refraining from discussing sensitive or identifiable patient information in public or non-confidential settings. c) Promote a culture of professionalism and respect among healthcare providers, learners, and patients. Educate learners about appropriate behavior, respect for patient boundaries, and the importance of maintaining a professional and ethical approach during all interactions. d) Prioritize patients' physical and emotional comfort and safety during bedside teaching. Take appropriate measures to minimize potential discomfort or harm to the patient, including avoiding unnecessary procedures or examinations solely for teaching purposes. e) Encourage feedback from patients regarding their experiences with bedside teaching. Provide a mechanism for patients to express any concerns, complaints, or suggestions related to their participation in teaching activities and ensure that these are addressed promptly and appropriately.
ATH.06 Activities of house officers and residents	**Program**	a) Clinical rotations, including regular feedback and evaluation of each clinical rotation. b) Didactic education. c) Supervision and mentorship. d) Patient care responsibilities. e) Simulation training, if applicable. f) Assessment and evaluation. g) Providing education on hospital policies, procedures, plans, and other quality systems.

Standard Code & Keyword	Kind of document	Components
ATH.07 Training of Medical Students	**Program**	a) Clear curriculum and assessment requirements. b) An educational induction program to make sure that trainees understand their curriculum. c) Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum. d) The opportunity to work and learn with other members of medical staff to support interprofessional multidisciplinary working. e) Regular, useful meetings with clinical and educational supervisors
ATH.08 Research Ethical Framework	**Approved document**	The Research Ethics Committee
ATH.09 Research Patient Rights	**Policy**	a) Eligibility for enrolment in research projects or protocols. b) Patient rights during research enrolment. c) Confidentiality guarantees for photographs and patient information included in the research. d) The patient has the right to withdraw from the research experiment without fear of retribution.

ANNEX

المطلوب في الاشتراطات الأساسية	الجهة المعنية	المرجع القانوني
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 المنشات الطبية رقم ٥١ لسنة ١٩٨١ المعدل بالقانون ١٥٣ لسنة ٢٠٠٤
موافقة المجلس لإقليمي للصحة النفسية	المجلس الإقليمي 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 المنشاة	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 ٤ ١٩٥ 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 ١٥ لسنة ١٩٦١
ترخيص أجهزة الأشعة المؤينة	المكتب التنفيذى للوقاية من الأشعة المؤينة بالإدارة العامة للأشعة بوزارة الصحة والسكان	المادة ١ و٢ و٣ من القانون رقم ٥٩ لسنة ١٩٦٠ فى شأن تنظيم العمل بالإشعاعات المؤينة والوقاية من أخطارها وقرار وزير الصحة والسكان رقم ١٣٣م 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 كلوي	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 رقم٥٦٠ 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 طبيعي	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 و الوحدة المحلية التابعة لها المنشأة بحسب الأحوال	المادة ٢ والمادة ٣ من القانون رقم و لسنة ١٩٧٧ فى شأن إقامة وإدارة الآلات الحرارية والمراجل البخارية