GAHAR HANDBOOK FOR

HOSPITAL STANDARDS

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The General Authority for Healthcare Accreditation and Regulation

GAHAR Handbook for Hospital Standards

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following an independent assessment
against the Guidelines and Principles for the
Development of Health and Social Care Standards,
5th Edition

The period of Accreditation for these Standards
is from
February 2021 until **February 2025**

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Foreword

As an essential step towards implementing the comprehensive healthcare recovery in Egypt, here is the GAHAR Handbook for Hospital standards – Edition 2021 issued by the General Authority for Healthcare Accreditation and Regulation (GAHAR). This edition is a continuation of the efforts started in the last century for improving healthcare services in the country through standardization. The development of these standards is a valuable eventual product of collaborative efforts of representatives from the different health sectors in Egypt, including the Ministry of Health and Population, the private sector, university professors, and professional syndicates.

This book of standards handles healthcare delivery from two main perspectives, the patient-centered perspective and organization-centered perspective. Each of the two main sections of this book adopts one of these perspectives and discusses in detail the minimum requirement for accrediting organizations based on them. The first section discusses accreditation prerequisites and conditions. The second section discusses patient-centered standards and adopts Picker›s model for patient-centered care to ensure responsiveness of organizations to patients› needs. The third section discusses organization-centered standards, highlighting many aspects required for workplace suitability to provide safe and efficient healthcare. The third section adopts the HealthWISE concepts. The fourth sections discuss the additional requirements.

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

Introduction

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

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

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

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

Scope of this Handbook

These standards apply to hospitals as whole organizations seeking to be enrolled in the Universal Health Insurance program.

Inclusions

These standards are applicable to

- Ministry of Health and Population hospitals
- Military hospitals
- Police hospitals
- Sectorial hospitals
- Private hospitals
- Charity hospitals

Exclusions

These standards are not applicable to

- Day-care hospitals
- Long-term care facilities
- Mobile hospitals and medical caravans
- Non-allopathic systems of medicine
- Alternative medicine streams
- Wellness centers

Purpose

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

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

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

Use

Reading and Interpretation of the book

- The General Authority for Healthcare Accreditation and Regulations evaluates organization's structure, process, and/or outcome by setting standards that address these concepts.
- This book is divided into four sections, in addition to the foreword, introduction, Scope of this handbook, Purpose, Use, Acknowledgments, Acronyms, Survey activities and readiness, glossary and References.
- Each section is divided into chapters when applicable.
- Each chapter has:
  - an introduction that contains an overall intent.
  - implementation guiding documents that need to be checked in order to achieve good compliance with the standards.
  - purpose that details follow the introduction, and each one has a standard or more.
- A standard is a level of quality or achievement, especially a level that is thought to be acceptable; it is composed of a standard statement, keywords, intent, survey process guide, evidence of compliance, and liked standards paragraphs.

Standard Component

- Standard Statement
  - In this handbook, each standard is written as a standard statement preceded with a code.
  - Each standard is followed by a non-black-scripted statement that describes the essential quality dimension(s) addressed by the standard.
- Keywords
- Intent is meant to help organizations understand the most important element of standard statements, as these are words or concepts of great significance. It answers the question of WHAT the standard is intended to measure.
- Intent:
  - Standard intent is meant to help organizations understand the full meaning of the standard.
  - The intent is usually divided into two parts:
    - Normative: that describes the purpose and rationale of the standard provides an explanation of how the standard fits into the overall program. It answers the question of WHY the standard is required to be met.

Informative: is meant to help organizations identify the strategy to interpret and execute the standard. It answers the question of HOW .the standard is going to be met

  - Some standards require the implementation of minimum components of processes to be documented, implemented, recorded, and/or monitored. These components are usually preceded with the phrase “at least the following”, followed by a numbered/lettered list of requirements. Hence, these elements are considered essential, indivisible parts of compliance with the minimum acceptable standard.
- Evidence of compliance (EOCs):
  - Evidence of compliance 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.
- Survey process guide:
  - facilitates and assists the surveyors in the standard’s rating for the required EOCs.
- Related standards:

  As healthcare is a complex service, each standard measures a small part of it. To understand what each standard means in the overall context of healthcare standards, other standards need to be considered as well.
- Standards are categorized and grouped into three sets of groups:
  - Chapters, where standards are grouped as per uniform objective.
  - Quality dimensions, where each standard addresses a particular quality dimension, and strategic categorization of standards to analyze their quality characteristics.
  - Documentation requirements, where some standards require certain types of documents

Used Language and Themes

This handbook used certain themes and vocabulary to ensure uniformity and clarity; These are the most important ones that will help hospitals to interpret the standards:

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

- 'Process'
  A series of actions or steps taken in order to achieve a particular end.
- 'Documented Process'
  A document that describes the process and can be in the form of policy, procedure, program, plan, guideline, or protocol.
- Policy:
  - A principle of action adopted by an organization.
  - It usually answers the question of what the process is.
  - It is stricter than guidelines or protocols.
  - It does not include objectives that need to be met in a certain timeframe.
- Procedure:
  - An established or official way of doing something.
  - It usually answers the question of how the process happens.
  - It is stricter than guidelines or protocols.
  - It does not include objectives that need to be met in a certain timeframe.
- Plan:
  - A detailed proposal for doing or achieving something.
  - It usually answers the question of what is the goal, why, how it is going to be achieved, and when.
  - It includes objectives that need to be met in a certain timeframe.
- Guideline:
  - A general rule, principle, or piece of advice.
  - It usually answers the question of what the process is and how it should happen.
  - Usually, it is more narrative than protocol.
- Protocol:
  - A best practice protocol for managing a particular condition, which includes a treatment plan founded on evidence-based strategies and consensus statements.

- Usually, it has graphs, flow charts, mind maps, and thinking trees.

1. Document versus Record
   - Document:
   - Created by planning what needs to be done.
   - Record:
     Created when something is done.
2. Physician Versus Medical staff member
   - Physician:
     a professional who practices medicine
   - Medical Staff member:
     a professional who practices medicine, dentistry, and other independent practitioners.

Applying for a GAHAR survey

A hospital seeking GAHAR accreditation begins by:

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

Look back period

- Surveyors are required to review standards requirements and evaluate organization compliance to them over a look back period of time.
- Look back period: It is the period before the survey visit to which any hospital is obliged to comply with the GAHAR accreditation standards. Failure to comply with this rule affects the accreditation decision.
- Look back period varies from one hospital to another, depending on registration and accreditation status.
- A registered hospital seeking accreditation will:
  - Comply with the National Safety Requirements during the whole period between receiving the approval of registration and the actual accreditation survey visit.
  - Comply with the rest of the GAHAR Handbook for hospital standards for at least four months before the surveyor's visit.
- A hospital seeking re-accreditation:
  - For GAHAR accredited hospitals, compliance with the GAHAR Handbook for hospital standards from receiving the approval of the previous accreditation till the next accreditation survey visit.

Scoring Guide

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

These are mathematical rules that depend on summation and percentage calculation of scores of each applicable EOCs 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 applicabl**e when the surveyor determines that, the standard requirements are out of the organization scope (the score is deleted from the numerator and denominator)
- While most EOCs are independent, stand-alone units of measurement that represent the structure, process, and/or outcome, few EOCs are dependent on each other. Dependence means that compliance with one EOC cannot be achieved (or scored) without ensuring compliance with other EOCs.

Scoring of each 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%.

Scoring of each chapter

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

Accreditation Decision Rules

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

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

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

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

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

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

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

4th Decision: Rejection of Accreditation

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

Hospitals having status of accreditation or conditioned accreditation with elements of non-compliance are requested to:

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

Accreditation is valid for 3 years. Accreditation may me be suspended or withdrawn if:

- The Hospital fails to pass follow up surveys in case of conditioned accreditation,
- The Hospital fails to submit corrective action plans in case of presence of one not met EOC or more,
- The Hospital fails to pass unannounced survey,
- The Hospital fails to comply with GAHAR circulars when applicable.

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Acronyms

Code	Meaning
APC	Accreditation Prerequisites and Conditions
NSR	National Safety Requirements
PCC	Patient-Centeredness Culture
ACT	Access, Continuity, and Transition of Care
ICD	Integrated Care Delivery
DAS	Diagnostic and Ancillary Services
SAS	Surgery, Anesthesia, and Sedation
MMS	Medication Management and Safety
FMS	Facility Management and Safety
IPC	Infection Prevention and Control
OGM	Organization Governance and Management
CAI	Community Assessment and Involvement
WFM	Workforce Management
IMT	Information Management and Technology
QPI	Quality and Performance Improvement

SECTION 1

ACCREDITATION PREREQUISITES AND CONDITIONS

Section 1: Accreditation Prerequisites and Conditions

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

Compliance with GAHAR accreditation prerequisites

APC.01 The hospital sustains, ensures and monitors compliance with registration requirements.

Safety

Keywords:
Sustaining registration requirements.

Intent:
Registration requirements are considered the minimum level of quality, safety, and compliance for any hospital aiming at being enrolled in the Universal Health Insurance system. When the hospital is registered, it is expected that the hospital sustains or improve the same level of quality scored during the registration visit.

Survey process guide:
During the GAHAR survey, the surveyors may assess compliance with the standard's requirements.

Evidence of compliance:
1. The hospital establishes a process of frequent assessment of compliance with registration requirements.
2. The hospital acts on all feedback and reports received from GAHAR during the registration period.
3. The hospital reacts to all GAHAR requirements and reports in a timely manner.
4. The hospital demonstrates using approved monitoring tools to measure the compliance with National Safety Requirements.
5. When a gap is identified, the hospital takes all necessary measures to improve performance and sustain compliance.

6. The hospital reports to GAHAR any challenges that affect compliance with registration requirements.

Related standards:

ICD.03 Prehospital care, ambulance care, emergency medical care during disasters; SAS.01 Surgery and invasive procedure services; IPC.01 Infection prevention and control (IPC) team.

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

Safety

Keywords:

Registration of staff

Intent:

Healthcare Professionals registration process aims at ensuring the competence of healthcare professionals by matching their qualifications and experience to registered or accredited hospital scope of medical services. In return, this process will improve the quality of healthcare services provided to the community. The hospital is expected to register 100% of all members of the following healthcare professions:

a) Physicians
b) Dentists
c) Pharmacists
d) Physiotherapists
e) Nurses
f) Nursing technicians
g) Health technicians
h) Chemists and physicists
i) Veterinary doctors (working in kitchen, hospital research lab or other areas)
j) The hospital created a process to register all applicable newly hired staff members within 1-3 months.

Survey process guide:

During the GAHAR survey, the surveyor assesses the compliance with the standard's requirements

Evidence of compliance:

The hospital has an approved process for registering all members of the required medical professionals.

1. The hospital assigns a taskforce to ensure complete registration and Identify those who are not registered within a defined timeframe.
2. The process covers all full-time, part-time, visiting, or other types of contracts/ agreements.
3. The hospital reports to GAHAR, healthcare authority, and professional syndicates of any finding that can affect patient safety such as, fake, or misrepresented credentials.

Related standards:

WFM.01 Workforce Laws and regulations; WFM.03 Recruitment; WFM.05 Verifying credentials.

Transparent and ethical relationships

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

Effectiveness

Keywords:

Accurate and complete information

Intent:

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

Survey process guide:

Before and during the course of the GAHAR survey, surveyors will expect transparency

of sharing information, reports, or concerns related to registration, accreditation, licensure, inspection, audits, legal affairs, reportable sentinel events, and reportable measures.

Evidence of compliance:

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

Related standards:

CAI.06 Promoting quality of care.

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

Safety

Keywords:

Accreditation process value

Intent:

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

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

Survey process guide:

During the GAHAR survey, surveyors will expect transparency of sharing information, reports, or concerns related to safety issues. GAHAR surveyors will expect to see announcements to inform staff and patients on mechanisms to report safety issues to GAHAR.

Evidence of compliance:

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

Related standards:

CAI.06 Promoting quality of care; QPI.11 Incident reporting system.

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

Equity

Keywords:

Professional standards during surveys

Intent:

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

a) Integrity
b) Objectivity
c) Professional competence

d) Confidentiality
e) Respect

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

Survey process guide:

During the GAHAR survey, surveyors expects that safety, security, confidentiality, privacy, respect, integrity, objectivity, and professional competence values are going to be cherished at all times.

Evidence of compliance:

1. During surveys, the hospital reports any conflict of interest to GAHAR with evidence.
2. During surveys, the hospital maintains professional standards on dealing with surveyors.
3. During surveys, the hospital ensures that the environment does not pose any safety or security risks to surveyors.
4. During surveys, the hospital avoids media or social media releases without GAHAR's approval.

Related standards:

CAI.06 Promoting quality of care; EFS.09 Security plan; EFS.10 Medical equipment plan; EFS.12 Disaster plan; IMT.02 Information management plan; QPI.02 Quality plan

SECTION 2

PATIENT-CENTERED STANDARDS

Section 2: Patient-Centered Standards

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

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

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

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

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

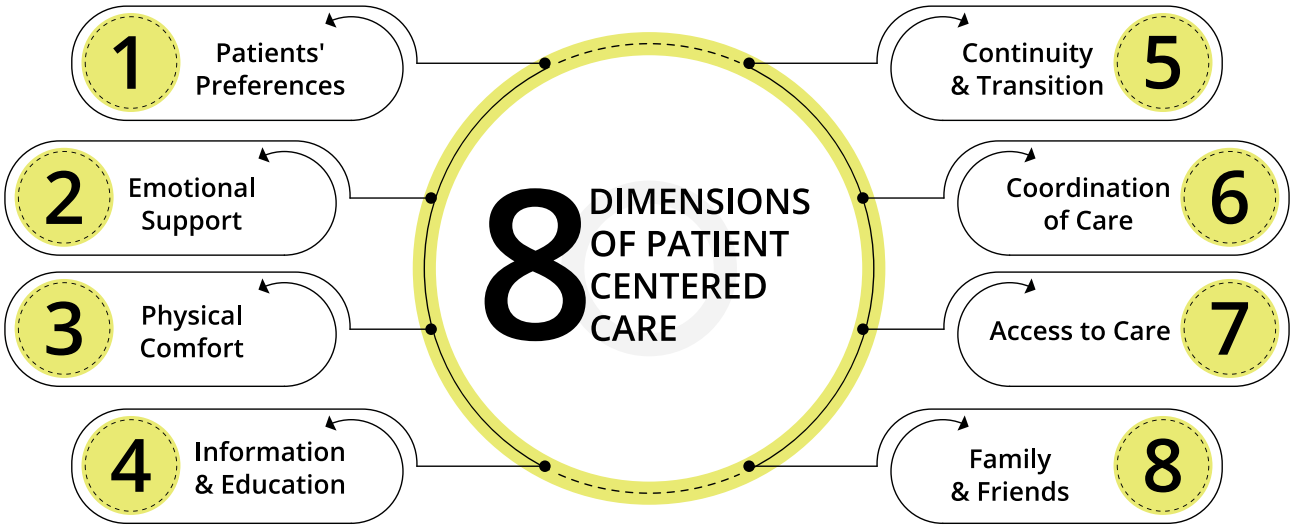
According to Charmel and Frampton, the IOM report reinforces patient-centered care not only as a way of creating a more appealing patient experience but also as a fundamental practice for providing high-quality care in the US.

Practically, many Egyptian hospitals could readily put patient's medical record and

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

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

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



1. **Patients' Preferences**

   At every step, patients should be given the needed information to make thoughtful decisions about their care. Those preferences should always be considered when determining the best course of action for that patient. The expertise and authority of healthcare professionals should complement and enhance the patient perspective. Assessment and care should be in a way that maintains patients' dignity and demonstrates sensitivity to their cultural values healthcare professionals need

to focus on the person's quality of life, which may be affected by their illness and treatment. Everyone involved is always on the same team, working toward the same goal.

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

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

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

5. **Continuity and Transition**
   A transition from one phase of care to the next should be as seamless as possible. Patients should be well informed about what to expect. Treatment regimens, especially medication regiments, should be clearly defined and understood. And everyone involved should be able to plan and understand what warning signs (and positive indicators) to look out for.

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

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

8. **Involvement of Family and Friends**
   Patient-centered care encourages keeping patients involved and integrated with their families, their communities, and their everyday lives by:
   - Accommodating the individuals who provide the person with support during care.
   - Respecting the role of the person's advocate in decision making.
   - Supporting family members and friends as caregivers, and recognizing their needs.

National Safety Requirements

Chapter intent:

The World Health Organization (WHO) defines patient safety as the reduction and mitigation of unsafe acts within the healthcare system, as well as through the use of best practices shown to lead to optimal patient outcomes. Healthcare is a complex environment where errors can injure or kill. Usually, the safeguards work. However, each layer of defenses such as alarms, standardized procedures, and trained health professionals has weak spots.

Advances and commitment to patient safety worldwide have grown since the late 1990s, which leads to a remarkable transformation in the way patient safety is viewed.

When multiple system failures occur, mistakes that would usually be caught slip through, the price we pay when such situations occur is often high, on both a human and a health-system level.

Measuring patient safety initiatives and adverse events is essential when monitoring the progress of these strategies, tracking success, and helping to flag issues or identify potential areas for improvement.

As part of the GAHAR registration process, Hospitals have to show commitment to patient safety. This requires compliance with each of the National Safety Requirements (NSRs). During surveys, surveyors evaluate that safe and efficient implementation of each of the NSRs is maintained in all relevant practices. The application of the standards should be according to the applicable Egyptian laws and regulations.

Chapter purpose:

The main objective is to ensure that organizations provide and maintain a patient safety program effectively. To achieve this effectiveness, the chapter addresses all the National Safety Requirements. Some requirements were placed into other chapters for convenience.

Implementation guiding documents:

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

1. Egyptian Constitution
2. Egyptian code of medical ethics 238/2003
3. Egyptian code of nursing ethics
4. Jeddah Declaration on Patient Safety 2019

5. WHO Patient Safety Assessment Manual
6. WHO Surgical Safety Checklist
7. WHO Patient Safety Friendly Initiatives

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

Code	NSR Keyword	Code in this book
	GENERAL PATIENT SAFETY	
NSR.01	Patient Identification	ACT.03
NSR.02	Verbal and telephone orders	ICD.18
NSR.03	Hand Hygiene	IPC.05
NSR.04	Catheter and tube misconnections	ICD.35
NSR.05	Fall screening and prevention	ICD.11
NSR.06	Pressure Ulcer Prevention	ICD.12
NSR.07	Handover Communication	ACT.09
NSR.08	Critical Alarms	ICD.34
NSR.09	Recognition of and response to clinical deterioration	ICD.37
NSR.10	Venous Thromboembolism Reduction	ICD.13
NSR.11	Critical Results	ICD.30
	MEDICATION MANAGEMENT AND SAFETY	
NSR.12	Abbreviations	IMT 04
NSR.13	Medication Reconciliation	MMS.10
NSR.14	Medication storage and labelling	MMS.04
NSR.15	High alert medications and concentrated electrolytes	MMS.06
NSR.16	Look-Alike and Sound-Alike Medication	MMS.07
	SURGICAL, ANESTHESIA AND SEDATION	
NSR.17	Surgical Site Marking	SAS.05
NSR.18	Preoperative Checklist	SAS.06
NSR.19	Time-out	SAS.07
NSR.20	Instrument Retention Prevention	SAS.09
	ENVIRONMENTAL AND FACILITY SAFETY	
NSR.21	Fire Safety	EFS.03
NSR.22	Fire Drill	EFS.05
NSR.23	Hazardous Material Safety	EFS.06
NSR.24	Safety Management Plan	EFS.07
NSR.25	Radiation Safety Program	DAS.09
NSR.26	Laboratory Safety Program	DAS.24
NSR.27	Medical Equipment Safety	EFS.10
NSR.28	Utilities Safety	EFS.11

Patient-Centeredness Culture

Chapter intent:

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

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

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

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

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

Practically, Hospitals need to ensure infrastructure for uniform patient-centered care

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

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

Chapter purpose:

- This chapter is written and arranged in a logical order that first describes the infrastructure and culture needed to comply with the chapter requirements.
- It describes basic patient rights and responsibilities.
- It touches on those techniques and cultural changes that organizations need to address while building a patient-centered culture.

Implementation guiding documents:

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

1. The Egyptian Constitution
2. The Universal Declaration on Human Rights, 1964
3. Cairo Declaration on Human Rights in Islam, 1990
4. Law 126/2008 on the Egyptian child
5. Law 10/2018 on the rights of handicapped
6. Drafted Egyptian law for Elderly care
7. Law 181/2018 on Egyptian Consumer Protection
8. Law 206/2017 on advertisement for healthcare services
9. Egyptian code of medical ethics 238/2003
10. Egyptian code of nursing ethics (Nursing Syndicate Publications)
11. Code of ethics and behavior for civil service staff,2019, if applicable
12. Egyptian Criminal code 58/1937
13. Egyptian consent laws
14. MOH Ministerial decree 186/2000, Management of emergency cases
15. MOHP Ministerial decree 216/1982, Healthcare facilities organization
16. MOHP Ministerial 186/2001, A patient's right to know the expected cost of care

Planning and protecting the patient-centeredness culture

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

Patient-centeredness

Keywords:
Hospital advertisement

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

Survey process guide:
GAHAR surveyors may check hospital website, social media, or other forms of advertisement at any time from the receiving of application and assigning of surveyors until sending the survey report. Advertisements may be matched with the application information and with survey visit observations.

Evidence of compliance:
1. The hospital has an approved policy guiding the process of providing clear, updated, and accurate advertisements of services.
2. Advertisements are done in compliance with laws, regulations, and ethical codes of healthcare professionals' syndicates.
3. Patients and their families receive clear, updated, and accurate information about the hospital's services, healthcare professionals, and working hours.
4. Patients and their families are informed of expected costs in a manner and a language they understand.

Related standards:

PCC.09 Patient education materials; ACT.01 Granting access; CAI.05 Community suggestions and complaints.

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

Patient-centeredness

Keywords:

Interdisciplinary patient-centeredness

Intent:

Patient-centered culture development and maintenance require careful planning, agile implementation, and close monitoring. A journey of changing/improving a hospital culture requires collaborative teamwork from multiple disciplines. A site-based interdisciplinary committee is established to oversee and assist with the implementation and maintenance of person-centered culture. The committee has terms of references that include at least the following:

a) Work to plan and assist with the implementation and maintenance of patient-centred practices.
b) Membership includes a multidisciplinary team of nurses, medical staff members, administrative and management staff and patient representatives.

Active membership of this committee includes at least patients and family members (could be a patient who visits the hospital frequently or for a long period of time), a mix of junior administrative and management staff members, and a combination of clinical and non-clinical. This team creates a vision of establishing a patient-centered culture with clear steps to achieve it, communicate this vision to multiple stakeholders and staff members, identify potential obstacles and resistance, then work to remove these obstacles and ease down resistance.

Survey process guide:

The GAHAR surveyor may receive information about the patient-centered culture support during the opening presentation. Terms of references and meeting notes may be reviewed during the document review session or during the leadership interview session. Questions may be posed to explore the mechanisms taken to plan, assist, and maintain patient-centered practices.

Evidence of compliance:

1. The interdisciplinary committee has approved terms of reference.
2. The committee meets at predefined intervals multiple times a year.
3. The committee meetings are recorded.

Related standards:

QPI.01 Quality committees; ICD.02 Collaborative care; ACT.12 Multidisciplinary management.

PCC.03 Patient-centered initiatives are supported by the hospital staff and leadership.

Patient-centeredness

Keywords:

Patient centeredness support

Intent:

Patient centeredness culture sustainability requires informing and engaging staff on how to be patient-centered. Healthcare professional-patient relationships, communication courses, and discussion among medical staff members emphasize this culture. Education can be in the form of lectures, demonstrations, courses, workshops, role-plays, and other mechanisms. The hospital leadership can develop patient-centered initiatives, but it requires staff adoption and implementation to ensure implementation. The hospital should be able to measure compliance with patient-centered initiatives and evaluate staff performance accordingly.

Survey process guide:

The GAHAR surveyor may receive information about patient-centered initiatives during the opening presentation session.

The GAHAR surveyor may check staff files to assess how patient-centeredness are reflected in the staff member's performance evaluations.

The GAHAR surveyor may inquire about leadership support and encouragement of patient-centeredness initiatives during the leadership interview session.

During hospital tours and tracers, staff may be interviewed and asked about patient-centered initiatives.

Evidence of compliance:

1. Staff is oriented, educated, and trained on patient-centered initiatives.
2. The hospital developed mechanisms to evaluate the patient-centeredness

performance of staff; these mechanisms may include patient education activities, patient engagement in making care decisions, and/or providing emotional support.
3. When a staff member or a group of staff demonstrates a patient-centered initiative, there is a mechanism to use the lessons from this initiative to improve hospital-wide performance.
4. Hospital leadership takes action to encourage staff participation in patient-centeredness initiatives.

Related standards:
PCC.16 Comfortable stay; PCC.17 Patient needs; PCC.10 Patient and family education process; PCC.21 Patient and family feedback; ICD.02 Collaborative care

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

Patient-centeredness

Keywords:
Patient and family rights.

Intent:
Seeking and receiving care and treatment at a hospital can be overwhelming for patients, making it difficult for them to act on their rights and understand their responsibilities in the care process. Patients should be able to understand their rights and know how to use them. If for any reason, a patient does not understand his/her right, the hospital is committed to helping him/her to gain knowledge of his/her rights. The hospital provides direction to staff regarding their role in protecting the rights of patients and families. The hospital develops and implements a policy and procedures to ensure that all staff members are aware of and respond to patient and family rights issues when they interact with and care for patients throughout the hospital that addresses at least the following:

a) Patient and family rights as defined by laws and regulations, and the ethical code of healthcare professionals' syndicates.
b) Patient and family right to access care if provided by the hospital.
c) Patient and family right to know the name of the treating, supervising, and/or responsible medical staff member.
d) Patient and family rights to care that respects the patient's personal values and beliefs.
e) Patient and family rights to be informed and participate in making decisions related

to their care.
f) Patient and family rights to refuse care and discontinue treatment.
g) Patient and family rights to security, personal privacy, confidentiality, and dignity.
h) Patient and family rights to have pain assessed and treated.
i) Patient and family rights to make a complaint or suggestion without fear of retribution.
j) Patient and family rights to know the price of services and procedures.
k) Patient and family rights to seek a second opinion either internally or externally.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy guiding the process of defining patient and family rights, as mentioned in the intent from a) through k).
2. All staff members are aware of patients' and families' rights.
3. An approved statement on patient rights is posted in all public areas in the hospital in a way that makes it visible to staff, patients, and families.
4. Patient and family rights are protected in all areas and at all times.
5. Information about patient rights is provided in writing or in another manner, the patient's and their families understand.

Related standards:

PCC.11 Informed consent; PCC.13 Informed refusal; PCC.19 Patient dignity, privacy, and confidentiality; ACT.10 Second opinion; ACT.08 Patient care responsibility

PCC.05 Patients and families are empowered to assume their responsibilities.

Equity

Keywords:

Patient and family responsibilities.

Intent:

Patients and their families should be able to assume responsibilities related to the care process.

If, for any reason, a patient/family does not understand his/her responsibilities, the

hospital is committed to helping him to gain relevant knowledge. The inability to assume these responsibilities might affect the care or the management processes of the patients themselves, of their families, of other patients or of staff members. The hospital is responsible for making the patients' responsibilities visible to patients and staff members at all times. The hospital develops and implements a policy and procedures to ensure that patients are aware of their responsibilities.

The policy addresses at least the following:

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

Survey process guide:

- GAHAR surveyor may review patient responsibilities policy and interview staff members to check their awareness.
- During the GAHAR survey, the surveyor may observe patient responsibility statements posted in the hospital. The surveyor may also observe how patients receive information about their responsibilities.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of defining patient and family responsibilities as mentioned in the intent from a) through e).
2. All staff members are aware of patients' and families' responsibilities.
3. An approved statement on patient and family responsibilities is posted in all public areas in the hospital in a way that makes it visible to staff members, patients, and families.
4. Information about patient responsibilities is provided in writing or in another manner that the patient understands.

Related standards:
ACT.08 Patient care responsibility; PCC.07 Admission consent; PCC.10 Patient education; PCC.09 Patient and family education materials.

PCC.06 Violations against patients' and families' rights and responsibilities are managed.

Patient-centeredness

Keywords:
Reporting violations

Intent:
Sustaining a patient-centeredness culture requires continuous monitoring of compliance and identifying opportunities for improvement. Empowered staff members, patients, and families are able to report violations for any patient's or family's rights and responsibilities.

Survey process guide:
- The GAHAR surveyor may interview staff members to inquire about mechanisms to report violations.
- The GAHAR surveyor may also interview quality, risk management, or leadership staff to inquire about the process of reporting violations, its results, and improvement actions are taken based on these results.

Evidence of compliance:
1. The hospital is responsible for collecting, analyzing, interpreting, and evaluating violations for any patient's or family's rights and responsibilities.
2. Information about reporting violations to patient and family rights and responsibilities is provided to staff members, patients, and families in writing or in another understandable manner.
3. Periodical report on violations to patient and family rights and responsibilities is created and sent to the hospital director.
4. Actions are taken to improve patient centeredness practices based on those reports
5. When ethical dilemmas as conflicting decisions regarding the provision or withdrawal of treatment arise there is evidence of clear discussion and resolution of the situation

Related standards:
PCC.04 Patient and family rights; PCC.05 Patient and family responsibilities.

Empowerment and involvement of patients and their families

PCC.07 Admission consent is obtained from the patient or a legal representative before hospitalization after discussing the patient's needs and obligations.

Patient-centeredness

Keywords:
Admission consent.

Intent:
Admission consent represents a patient's or family's understanding and approval of the hospitalization process and its consequences. These consequences may include potential costs, hazards, and obligations that the patient may acquire during hospitalization. The hospital develops and implements a process to give patients and their families information about potential costs, hazards, and obligations in a language they understand.

Survey process guide:
- The GAHAR surveyor may visit the hospital admission point, such as the admission office, ER desk, Nurse stations, or others. During this visit, the surveyor may review the process with responsible staff and check the used templates or forms.
- The GAHAR surveyor may also perform an open or a closed file review to assess the completion of admission consent.

Evidence of compliance:
1. Admission consent is provided in writing in a language that the patient understands.
2. The patient's medical record includes a record of the patient's or legal representative's approval and consent to being hospitalized.
3. There is a process to address situations when neither a patient nor a legal representative can give admission consent.
4. Those responsible for obtaining admission consent are able to answer questions pertinent to potential costs, hazards, or obligations of hospitalization.

Related standards:
PCC.04 Patient and family rights; PCC.05 Patient and family responsibilities.

PCC.08 Patients and families have opportunities to meet with multiple members of the healthcare team (including the nurse and medical staff member).

Patient-centeredness

Keywords:
Meeting the healthcare team

Intent:
During all phases of care and especially during visiting hours, patients and their families may have questions about diagnosis, plan of care, expected outcome of care, length of stay, or other questions. Patients and families are encouraged to ask questions, and systems are in place to capture questions that arise when healthcare professionals are not present to answer them. The hospital provides opportunities to patients and their families to ask questions and to have answers in a manner that they understand. Tools such as "five moments of medication safety" or "Ask me if I washed my hands campaigns" are used to encourage patients to ask questions.

Survey process guide:
The GAHAR surveyor may interview patients or staff members to assess the availability and effectiveness of mechanisms of responding to patient and family inquiries.

Evidence of compliance:
1. A process is in place to allow patients and families to meet or to talk to healthcare professionals when needed.
2. A process is in place by which patients and families may request additional information on their diagnosis, treatment options, etc., and those requests are accommodated.
3. There is a clear process for patients and their families to place questions and get them answered even when the healthcare professionals are not present.
4. Tools are used to encourage patients to pose questions.

Related standards:
PCC.04 Patient and family rights.

PCC.09 Appropriate patient education materials are available.

Patient-centeredness

Keywords:
Patient and family education materials.

Intent:

Mass education may take the form of videos, social media posts, brochures, pamphlets, text messages, or other forms. Education materials need to be appropriate for the patient's condition, level of education, language, and culture as to support, maintain and improve their own health and wellbeing. This could include requirements relating to smoking cessation programs, stress management advice, diet and exercise guidance and substance abuse management.

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

Survey process guide:

- The GAHAR surveyor may be looking for a list of all potential topics, places, and/or timings of distributing patient education materials.
- The GAHAR surveyor may check patient education materials left for patients in waiting rooms, service desks, nurse stations, and others.

Evidence of compliance:

1. The hospital identifies the topics, places, and/or timings for distributing patients' education materials.
2. Patient education materials are readily available during the timings, in the places and for the topics identified by the hospital.
3. Patient education materials contain relevant and evidence-based information.
4. Patient education materials are appropriate for readers of varying literacy levels.
5. Patient education materials are translated into different languages for foreign patient groups, if applicable.

Related standards:

PCC.03 Patient centeredness support; ICD.10 Screening of healthcare needs; ICD.11 Fall screening & prevention; ICD.12 Pressure ulcers; ICD.14 Plan of care; ICD.17 Orders & requests; ICD.20 Patient's nutritional needs.

PCC.10 Patients' and families' education is provided clearly.

Patient-centeredness

Keywords:

Patient and family education process.

Intent:

Patient and family education helps to understand the care process and empower patients and families taking informed decisions. Multiple disciplines contribute to the process of educating patients and families during the course of care processes. The hospital develops and implements a policy and procedures to define the process of patient and family education. The policy addresses at least the following:

a) Identifying patient and family needs.
b) Multidisciplinary responsibility to identify educate patients and families.
c) Method for education is provided according to patient and family values and level of learning, and also in a language and format that they understand.

The multidisciplinary team identifies all the educational needs, which may vary from a patient to another; however, at least the following needs are to be addressed for all patients:

d) Diagnosis and condition.
e) Plan of care, expected outcome of care, and alternative to the planning of care.
f) Discharge instructions.

The education program is recorded.

Survey process guide:

- The GAHAR surveyor may review a policy describing the patient and family education process.
- During open or closed file reviews, the GAHAR surveyor may check patient and family education records to assess completion.

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 f).
2. All staff members are aware of patients' and families' education process and recording.
3. Patient education needs, the responsibility of providing education, and the method used are recorded in the patient's medical record.

4. Patients receive education relevant to their condition.
5. Patient education activities are recorded in the patient's medical record.

Related standards:

PCC.03 Patient centeredness support; PCC.09 Patient and family education process; ICD.10 Screening of healthcare needs; ICD.11 Fall screening & prevention; ICD.12 Pressure ulcers; ICD.14 Plan of care; ICD.17 Orders & requests; ICD.20 Patient's nutritional needs.

PCC.11 Recorded informed consent is obtained for certain medical processes as required by laws and regulations.

Patient-centeredness

Keywords:

Informed consent.

Intent:

One of the main pillars to ensure patients' involvement in their care decisions is by obtaining informed consent. To give consent, a patient should be informed of many factors related to the planned care. These factors are required to make an informed decision. Informed consent is a process for getting permission before performing a healthcare intervention on a person, or for disclosing personal information. The hospital develops and implements a policy and procedures to describe how and where informed consent is used. 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. Anesthesia, 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 in which the consent could be for specific time or purpose
b) The likelihood of success and the risk of not doing the procedure or intervention, benefits, and alternatives to performing that particular medical process.
c) Certain situations when consent can be given by someone other than the patient, and mechanisms for obtaining and recording it according to applicable laws and regulations and approved hospital policies.
d) Consent forms available in all applicable locations.

Survey process guide:

- The GAHAR surveyor may review a policy describing the patient consent process.
- During open or closed file reviews, the GAHAR surveyor may check patient consent to assess completion.
- During the GAHAR survey, the surveyor may check the distribution and availability of consent forms in areas where they are needed the most, such as 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. An informed consent form is available in all relevant areas.
3. Informed consent is obtained in a manner and language that the patient understands.
4. Informed consent is recorded and kept in the patient's medical record.
5. The most responsible physician obtaining the informed consent signs the form with the patient, with witnesses as legally required.
6. Informed consent given by someone other than the patient complies with laws and regulations.

Related standards:

PCC.04 Patient and family rights; PCC.12 Informed consent validity; SAS.06 Preoperative checklist, ICD.27 Psychiatric patient.

PCC.12 Informed consents validity is defined.

Timeliness

Keywords:

Informed consent validity.

Intent:

Informed consent should be valid during the time or procedure it is intended to cover. Sometimes, consents become invalid, in instances when:

a) A patient's health condition changes.
b) The plan of care changes.
c) Important additional information arises, that will carry different risks and hazards to the patient if they undergo the intended procedure.
d) A certain time period passes.
e) The patient's mental status is altered.

f) The medical staff member who was supposed to perform certain procedure changes.

The hospital should identify these situations when consent is no longer considered valid and the process for obtaining and recorded a new one.

Survey process guide:

The GAHAR surveyor may interview staff to inquire about consent validity.

Evidence of compliance:

1. The hospital defines validity requirements for informed consent.
2. The hospital defines a list of situations when a new consent is needed as relevant to the provided services.
3. All relevant staff members are aware of consent validity.
4. A new consent is obtained when the old consent expires or becomes invalid as mentioned in elements in the intent from a) to f).
5. A new consent is recorded in the patient's medical record when indicated.

Related standards:

PCC.04 Patient and family rights; PCC.11 Informed consent; SAS.06 Preoperative checklist.

PCC.13 Patients and families are informed about their rights and responsibilities related to refusing or discontinuing a step(s) in the medical care process such as a treatment, a diagnostic procedure, or an intervention.

Patient-centeredness

Keywords:

Informed refusal.

Intent:

Refusing or discontinuing medical care could be for a step(s) or taking the decision to be discharged against medical advice (DAMA).

Patients and families are given enough information, education, and documents about risks when his/her/their choices may result in patient harm. The hospital develops and implements a policy and procedures to hold the quality of life discussions to inform and educate patients on the risk(s)/benefit(s) when patient choice conflicts with the standards of care. The policy addresses at least the following:

a) How to inform the patient/family of the patient 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) How to follow up with the patient/family after leaving the hospital.

Survey process guide:

- The GAHAR surveyor may review a policy describing the informed refusal process.
- During open or closed file reviews, the GAHAR surveyor may check the patient's informed refusal form to assess completion.
- During the GAHAR survey, the surveyor may check the distribution and availability of informed refusal forms in areas where they are needed the most, such as emergency room, inpatient wards, and others.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of informed refusal.
2. Staff members receive education to focus on the strengths and empowerment of patients to make an informed choice.
3. Informed refusal form/DAMA form is available in all relevant areas.
4. Informed refusal form/DAMA form contains all required information in the intent from a) through d).
5. Informed refusal/DAMA form is recorded and kept in the patient's medical record.
6. Informed refusal/DAMA form given by someone other than the patient complies with laws and regulations.

Related standards:

PCC.04 Patient and family rights; PCC.09 Education material; PCC.10 Education process; ICD.14 Plan of care; ACT.08 Patient care responsibility.

PCC.14 Patients and families are informed and supported through the billing or other administrative processes.

Patient-centeredness

Keywords:

Patient and family education on administrative processes.

Intent:

Administrative processes, including billing processes, should be transparent, respectful, and responsive to the needs of patients and families. The hospital ensures that patients and families are able to understand and participate in administrative processes.

Survey process guide:

- GAHAR surveyor may visit patient accounts or patient billing departments (or other concerned departments) to assess the process of cost estimation, education of patients on the billing process.
- GAHAR surveyor may also inquire about other administrative processes such as obtaining pre-approval from insurance companies, providing reimbursement, paying deposits, and others.

Evidence of compliance:

1. Financial and/or patient relations staff members are available to assist patients and/or families in understanding and managing billing (or other administrative) processes.
2. Cost estimation documents and tools are available.
3. A process is in place to ensure periodic education and support of patients and families through the billing (or other administrative) process.
4. The hospital identifies patients whose conditions might require higher costs than expected and provides information to them periodically.

Related standards:

PCC.04 Patient and family rights; PCC.09 Educational material; PCC.10 Educational process; PCC.07 Admission consent; ACT.02 Registration process.

Ensuring patient's physical comfort

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

Patient-centeredness

Keywords:

Waiting spaces.

Intent:

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

Survey process guide:

- During the GAHAR survey, the surveyor may visit waiting spaces meant to accommodate patients or their families.

- Visits may include waiting areas in outpatient clinics, emergency room, admission office, registration office, cafeteria, or other areas.

Evidence of compliance:

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

Related standards:

ACT.05 Physical access and comfort; ACT.06 Wayfinding signage.

PCC.16 During hospitalization, the patient's stay is comfortable.

Patient-centeredness

Keywords:

Comfortable stay.

Intent:

Creating a comfortable place for patients to get well again is integral in ensuring that they will leave the hospital with a positive outlook. More than 600 studies have linked the hospital-built environment to factors such as patient satisfaction, stress, health outcomes, and overall healthcare quality, as quoted by the American Hospital Association. Overarching factors in the healthcare hospital environment include noise levels, patient and pain management, and environmental factors inhibiting or facilitating communication; these factors all tie together. When an environment is too noisy, patients may have a hard time getting sleep or being comfortable, inhibiting their abilities to recover. This may also limit communication. Cleanliness of the hospital is crucial for keeping patients comfortable and at ease during their stay, and cleanliness creates a calmer atmosphere. The hospital ensures that the patient's stay is comfortable and suitable for the patient's and family's needs.

Survey process guide:

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

Evidence of compliance:

1. Patients are allowed to control the environment of their space, such as ventilation, temperature, lighting, and noise.
2. Comfortable spaces and equipment are available for patient use.
3. Healthy food is available for patients and their companions 24 hours a day and seven days a week.
4. Visiting hours are convenient for patients and their families.

Related standards:

PCC.15 Physical access and comfort

Protecting patient's belongings, privacy, and confidentiality

PCC.17 The hospital identifies, communicates, and honors patient emotional, religious, spiritual needs, and other preferences.

Patient-centeredness

Keywords:

Patient's needs.

Intent:

Research has indicated communication during medical interactions can influence patients' emotional experiences, and potentially have positive impacts on psychosocial health outcomes. More research needs to focus on the processes through which clinical staff members move through recognizing a patient's emotional needs to ultimately providing therapeutic resources as needed. Structures that give frontline staff members autonomy over the decision-making processes that affect their work are in place.

Survey process guide:

The GAHAR surveyor may interview staff or patients to inquire about emotional, religious, and spiritual needs and how some routine functions may be adjusted based on these needs.

Evidence of compliance:

1. Clinical staff members assess and reassess patients' emotional, religious, and spiritual needs and this is documented in the file.
2. Plans of care are modified to honor emotional, religious, and spiritual needs.
3. Cleaning, food, and other services assess and reassess patient and family preferences.
4. Traditional schedules are modified to honor patient preferences.

Related standards:
PCC.03 Patient-centeredness support; PCC.04 Patient and family rights.

PCC.18 Patient's dignity, privacy, and confidentiality are protected during all medical care processes, such as screening, assessments, care, and treatments.

Patient-centeredness

Keywords:
Patient's dignity, privacy, and confidentiality

Intent:
One of the most important human needs is the desire for respect and dignity. The patient has the right to care that is respectful and considerate at all times, in all circumstances, and recognizes the personal worth and self-dignity of the patient. Patient's privacy, particularly during clinical interviews, examinations, procedures/treatments, and transport, is important. Patients may desire privacy from other staff members, from other patients or even from accompanying family members. The hospital must treat the patient's information as confidential and must implement processes to protect such information from leakage, loss, or misuse.

Survey process guide:
During the GAHAR survey, the surveyor may observe situations such as patient's examination and assess if privacy and confidentiality were maintained.

Evidence of compliance:
Patient's privacy is respected for all clinical interviews, examinations, procedures/ treatments, and transport.
Confidentiality of patient information is maintained according to laws and regulations.
Patients are allowed to decide who can attend their screening, assessment, or care processes.

Related standards:
PCC.04 Patient and family rights.

PCC.19 The hospital's responsibility towards the patient's belongings is defined.

Patient-centeredness

Keywords:
Patient's belongings.

Intent:

Patient's belongings may include clothing, dentures, hearing aids, eyeglasses or contact lenses, or valuables such as jewelry, electronic devices, cash, and credit/debit cards. The hospital develops and implements a policy and procedures to accept custody of patients' belongings or not. Hospitals may accept custody of patient's belongings for the patient's best interests; and if acceptance is not likely to disrupt or compromise hospital operations, patient or employee safety; and if the patient is not capable of being responsible for the belongings and family or designee is unavailable to take custody of the belongings. Hospital policies addresses at least the following:

a) Who is responsible for securing patient belongings?
b) When responsibility for these belongings begin?
c) How belongings be protected? For how long? What will happen after that?
d) How patients and families are informed about the hospital's responsibility for belongings.
e) How the hospital will manage lost and found situations.

Survey process guide:

- The GAHAR surveyor may review a document that guides hospital responsibilities for patient's belonging.
- The GAHAR surveyor may interview staff members to assess their awareness of hospital policy.
- During the GAHAR survey, the surveyor may observe posters, brochures, or other means of communication that inform patients about hospital responsibility.
- The GAHAR surveyor may review security records, other records, and cabinets where patient belongings are kept and recorded.

Evidence of compliance:

1. The hospital has an approved policy guiding hospital responsibilities for patient's belongings as mentioned in the intent from a) through e).
2. Staff members are aware of the hospital's policy.
3. Information about the hospital's responsibility for belongings is given to the patient or family, as applicable.
4. The patient's belongings are protected and returned.
5. Lost and found items are recorded, protected, and returned when possible; the hospital defines a process to follow when items are not returned within a defined timeframe.

Related standards:
PCC.04 Patient and family rights.

Responsiveness to patients' and families' voices

PCC.20 The hospital improves provided services based on measured patients' and families' feedback.

Patient-centeredness

Keywords:
Patient and family feedback.

Intent:
Patient feedback could include concerns, compliments and formal complaint or through surveys, that may help hospitals to identify ways of improving clinical and non-clinical performance. Ultimately, that translates into better care and happier patients. Hospitals can solicit feedback from patients in a variety of ways: phone surveys, written surveys, focus groups, or personal interviews. Many hospitals use written surveys, which tend to be the most cost-effective and reliable approach. The hospital develops and implements a policy and procedures to guide the process of managing patient feedback. Hospital policy addresses at least the following:

a) Measuring feedback for hospitalized patients.
b) Measuring feedback for ambulatory patients.
c) Measuring feedback for emergency patients.

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

Survey process guide:

- The GAHAR surveyor may review the policy of patient and family feedback.
- The GAHAR surveyor may assess the process of use of patient and family feedback for performance improvement during leadership interview sessions or during quality program review sessions.

Evidence of compliance:

1. The hospital has an approved policy guiding the process of patient and family feedback measurement and use as mentioned in the intent from a) through c).
2. There is evidence that the hospital has received, analyzed, and interpreted feedbacks from patients and families.
3. There is evidence that interpreted feedbacks have been shared with concerned staff members and planned for improvement.
4. There is evidence that patients' and families' feedback is used to improving the quality of service.

Related standards:

PCC.04 Patient and family rights; PCC.22 Complaints and suggestions

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

Patient-centeredness

Keywords:

Complaints and suggestions.

Intent:

While hospitals are 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 develops and implements a policy and procedures to create a uniform system for dealing with different complaints and suggestions from patients and/or their families to make it easy to follow up, monitor, and learn from practices. The hospital policy address at least the following:

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

Survey process guide:

- The GAHAR surveyor may review the policy of managing patient complaints and suggestions.

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

Evidence of compliance:

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

Related standards:

PCC.04 Patient and family rights. PCC.21 Patient and family feedback.

Access, Continuity, and Transition of Care

Chapter intent:

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

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

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

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

Locally, the Egyptian constitution focuses on the importance of granting access to healthcare services to all Egyptians, with a special emphasis on providing emergency life-saving care. Egyptian laws for establishing hospitals defined the minimum requirements for licensure and for access pathways. The medical code of ethics defined the framework of doctors' responsibilities towards patients. Currently, a new law for medical accountability is under discussion, where a clear direction on physician care responsibility is expected. In addition, the Egyptian government has announced a major initiative to transform the healthcare industry in Egypt, where payers and healthcare professionals shall be separated, and a body of accreditation shall measure the quality of provided services. All this shall be under the umbrella of the Universal Health Insurance, where eligibility criteria are set for patient access, and referral mechanisms shall be established.

Practically, Hospitals need to consider all the accesses to services, even on the pre-hospital level, when applicable. Building a Most Responsible Physician culture is important as well. Establishing organization policies on patient flows and studying the

flow bottlenecks help organizations to better use available resources and safely handle patient journeys.

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

Chapter purpose:

- The main objective is to ensure that organizations provide and maintains equitable, effective access to patient care services in a safe, efficient way.
- The patient may start accessing healthcare services through the emergency room, outpatient department, admission office, dialysis unit, daycare unit, or registration/ admission offices.
- Upon hospitalization and all through the patient journey, someone shall be responsible for the patient's plan of care, even if the patient is lying on a board waiting for transfer from the emergency room to a patient room.
- Sometimes, care plans change, and another doctor needs to be called in for a consultation or even become completely responsible for patient care. These situations also need to be addressed by the hospitals, and clear processes need to be established.
- Sometimes, patients need to be physically transported from one place to another; this process entails a risk of mishandling and missing some information, organizations need to develop a process to avoid these risks.
- Finally, upon discharge, transfer, or referral to a service outside the hospital, clear information needs to be documented.

Implementation guiding documents:

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

1. Egyptian constitution
2. Universal Health Insurance Law 2/2018
3. Prime Minister decree, 1063/2014 Management of Emergency cases
4. Ministerial decree 186 / 2001 Management of emergency cases
5. The transition of care, WHO, 2016
6. Law 10/2018 on the rights of handicapped
7. Egyptian code of building for handicapped

8. Nursing Syndicate Publications – Nursing Guidelines
9. MOHP Ministerial decree number 216 / 1982 Healthcare facilities organization
10. MOHP Ministerial decree 254/2001 Discharge summary requirements
11. Publications of Central Administration of Emergency and Critical Care, the Egyptian ministry of health and population

Effective and safe patient flow-in the hospital

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

Patient-centeredness

Keywords:

Granting access (before patient's registration).

Intent:

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

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

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ACT.05 Physical access and comfort, ACT.06 Wayfinding signage; PCC.15 Waiting spaces; ACT.13 Patient transportation; ACT.14 Special care unit process; ICD22 patient functional needs

ACT.02 The hospital ensures a safe, effective and comfortable registration process.

Patient-centeredness

Keywords:

Registration process.

Intent:

Patient registration is a starting point for community members to benefit from the healthcare system services. Usually, it is a complex process that requires a considerable amount of preliminary patient data input, including a collection of patient demographic information such as personal and contact information, Patient referral or appointment scheduling, collection of patient health history, and Checking of health payer coverage. If handled incorrectly, this series of initial touch-points can lead to a number of ongoing

issues, including overwhelmed patients who may decide not to pursue their care at a hospital that is disorganized. The hospital develops and implements a policy and procedures to guide the registration process. The policy includes at least the following:

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

Survey process guide:

- GAHAR surveyor may review document describing the approved hospital process for registration then followed by a visit to the patient registration areas in the hospital such as service desks, receptions, call centers, registration office, admission office, nurse stations, emergency rooms, or outpatient areas. A visit may be part of another survey activity, such as a tour or a tracer.
- GAHAR surveyor may observe these areas for information given to patients such as brochures, posters, digital, verbal messages, or other types of information.
- GAHAR surveyor may also trace different patients to ensure that their patient registration processes are uniform, especially in life-threatening conditions.

Evidence of compliance:

1. The hospital has an approved policy for matching patient healthcare needs to hospital scope of service that addresses all elements mentioned in the intent from a) through c).
2. All staff members involved in patient registration and flow pathway are aware of the hospital policy.
3. The registration process and patient flow information are available and visible to patients and families at the point of the first contact and in public areas.
4. Patient registration and flow processes are uniform to all patients.

Related standards:

ACT.05 Physical access and comfort, ACT.06 Wayfinding signage; PCC.15 Waiting spaces; ACT.13 Patient transportation; DAS.02 Medical imaging service evaluation

ACT.03 NSR.01 Accurate patient identification through at least two identifiers to identify the patient and other elements associated with his/her plan of care.

Safety

Keywords:

Patient identification.

Intent:

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

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

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy and procedure for patient identification that addresses all elements mentioned in the intent from a) through f).
2. All healthcare professionals are aware of hospital policy.

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

Related standards:

ACT.16 Referral and transfer sheet; DAS.08 Medical imaging results; DAS.15 Pre-examination process; ICD.17 Order and request; SAS.07 Time-out.

ACT.04 The hospital ensures a safe, effective and comfortable hospitalization process.

Patient-centeredness

Keywords:

Hospitalization process.

Intent:

Hospital admission involves staying at a hospital for at least one night or more. The hospital develops and implements a policy and procedures in order to clarify and simplify the hospitalization process. The policy addresses at least the following:

a) Hospitalization procedures of patients, including those coming from the outpatient area, emergency areas, and other hospitalization routes.
b) A defined care plan and time frame for the hospitalization process.
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.

Survey process guide:

- The GAHAR surveyor may review documents describing the approved hospital process for hospitalization then followed by a visit to the hospitalization areas in the hospital such as admission office, nurse stations, emergency rooms, or outpatient areas. A visit may be part of another survey activity, such as a tour or a tracer.
- The GAHAR surveyor may trace a patient to check the time interval taken between the time when a decision of admission was taken and the time when the patient actually became on the bed. This period may be looked at thoroughly to learn about how the hospital responded to patient needs.

Evidence of compliance:

1. The hospital has an approved policy and procedure for hospitalization procedures that addresses all elements mentioned in the intent a) through e).
2. All staff members involved in patient registration and flow pathway are aware of the policy.
3. When patient care is required during the hospitalization process, a defined care plan is recorded in the patient's medical record.
4. When a patient bed is not available, the patient stays in a safe and comfortable way according to their medical needs.

Related standards:

PCC.17 Patient needs, ICD.14 Plan of CareICD.09 Nursing patient assessments, ICD.08 Medical patient assessments, ICD.10 Screening of healthcare needs.

ACT.05 The hospital works in collaboration with other community stakeholders to provide physical comfort and easy physical access.

Equity

Keywords:

Physical access and comfort

Intent:

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

Survey process guide:

During the first day of the GAHAR survey, the surveyor may observe the hospital access on the way to the hospital, identifying potential blockages of access such as the absence of nearby public transportation, presence of a physical barrier like a canal or even absence of clear signs to direct patients in. These observations may be discussed with hospital leaders in the leadership interview session.

Evidence of compliance:

1. A needs assessment analysis is performed to identify patient needs for easy physical access and comfort.
2. The hospital ensures safe access through multiple means of transportation, either private, public, or both.
3. The hospital's services are accessible for patients with various types of disabilities.

Related standards:

PCC.15 Waiting spaces; ACT.07 Patient flow risks; ACT.13 Patient transportation; ICD.22 Patient functional needs; DAS.02 Medical imaging service evaluation

ACT.06 Appropriate and clear wayfinding signage are used to help patients and families to reach their destination inside the hospital.

Effectiveness

Keywords:

Wayfinding signage.

Intent:

Healthcare hospitals present a unique set of navigational challenges. Often, these environments have developed over time and include multiple buildings or structures. This makes navigation these hospitals a complex process. In addition, patients and families who visit healthcare campuses are often under stress. Wayfinding systems can help reduce their stress by providing easy-to-follow signage and legible directions to their destinations. A key issue for the design and creation of wayfinding signage is the need to create it such that you are helping every possible user type. People need to find their way, and lighting is very important when it comes to signage. Signage needs to be readable in different lighting conditions and in different weathers (if the signage is used outdoors). In some settings, reliance on text-based messaging is minimized, and systems rely heavily on non-text cues such as colors and symbols.

Survey process guide:

During the GAHAR survey, the surveyor may observe wayfinding signs readability, clarity, and acceptability. Wayfinding signs may include all those signs encountered by patients during their journey in the hospital.

Evidence of compliance:

1. All hospital areas are identified with signs.
2. Wayfinding signs are used in all relevant places to reduce patient and family confusion.

3. When color-coded signage is used, clear instructions on what each color means should be available.
4. Signs are visible and lit during all operating times.

Related standards:

PCC.15 Waiting spaces; ACT.13 Patient transportation; DAS.02 Medical imaging service evaluation.

Effective and safe patients flow within the hospital.

ACT.07 The hospital has an approved risk assessment and management plan for patient flow.

Efficiency

Keywords:

Patient's flow risks.

Intent:

Patient flow is defined as the movement of patients, information, or equipment between departments, staff groups, or hospitals as part of a patient care pathway. Designing healthcare systems with effective patient flow is critical to the delivery of safe, effective patient care. Poor flow can lead to increased costs, poor quality, and poor patient experience. The goal of seamless patient flow across care settings is often blocked by a lack of integration both within the hospital and between hospitals. Increasing demand and capacity issues in the healthcare systems have led to bottlenecks in hospitals for scheduled and unscheduled care. When this is combined with suboptimal coordination between various departments and services, efficient patient flow is prevented. Usually, risk assessment is a term used to describe the overall process or method where hazards are identified; the risk is analyzed, evaluated, and controlled. In this case, it also addresses the better use of resources. A proper risk assessment for patient flow addresses locations, timings, and conditions that lead to peak occupancies and peak flows. Hospitals perform a risk assessment to identify areas in the hospital where bottlenecks exist then to develops a strategic, whole system, standardized and shared approach for improving patient flow placing the needs and views of the patients at the center of care plans; supporting optimal use of resources, avoiding unnecessary delays in care and facilitating seamless coordination of care across multiple settings. Improvements in patient flow will be achieved through targeted work streams to redesign processes of care, support access to care in an approved timeframe, and optimize the use of healthcare resources. The risk management plan addresses multiple scenarios

of patient flow, identified bottlenecks, and crowding areas. And improvement actions/ projects to achieve more efficient patient flow.

Survey process guide:

- The GAHAR surveyor may perform an interactive quality management program review session to assess hospital performance improvement processes. During this session, the GAHAR surveyor may be evaluating opportunities for improvement in patient flow and actions taken by the hospital to address these opportunities.
- The GAHAR surveyor may notice the existence of some bottlenecks or crowding places during different hospital tours and tracers. These notices may be matched with the hospital risk assessment to evaluate its comprehensiveness.

Evidence of compliance:

1. There is a risk assessment for patient flow that addresses all hospital areas.
2. Relevant stakeholders participate in performing the risk assessment.
3. Bottlenecks and crowded places are identified.
4. Actions are taken to improve patient flow.

Related standards:

ACT.05 Patient access and comfort; PCC.15 Waiting spaces; ACT.13 Patient transportation; ACT.14 Special care unit process; ICD.22 Patient functional needs; DAS.02 Medical imaging service evaluation.

ACT.08 The hospital ensures safe, effective and clear responsibilities for patient care.

Safety

Keywords:

Patient's care responsibility.

Intent:

Patients often require concurrent care from more than one healthcare professional in hospitals and healthcare institutions. Patients of large clinics or other healthcare facilities may also be cared for by more than one physician. The term most responsible physician (MRP) generally refers to the physician who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time. Misunderstandings about who among the healthcare team is responsible for a patient's care may compromise that care and may result in an adverse event and increased medico-legal risk. Such protocols should address:

i. Identifying the most responsible physician and properly managing handovers of care can improve patient safety and reduce the medico-legal risk for physicians by preventing potential breakdowns in the chain of communication both among healthcare team members and with the patient, and thereby help ensure that inconsistency or redundancy in care is avoided.
ii. The identity of who will act as MRP for a patient should be determined early and based on the particular circumstances of each case. It should be clear in the patient's medical record, which the physician is designated as the MRP. While typically the attending or admitting physician will be the MRP, this may not always be the case.

The hospital develops and implements a policy and procedures to guide the process of assigning patient care responsibility. The policy addresses at least the following:

a) Each hospitalized patient is assigned to one Most Responsible Physician (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 transfer of responsibility parties.

Survey process guide:

The GAHAR surveyor may review documents describing the approved hospital process for assigning patient care responsibility, followed by an open or closed patient's medical record review to identify who is the most responsible physician for checked patients. Identified gaps may be assessed by interviewing other healthcare professionals to check the consistency.

Evidence of compliance:

The hospital has an approved policy and procedure for assigning care responsibility that address all elements mentioned in the intent from a) through d).
The patient's medical record identifies the physician responsible for care.
The clear handover process is performed in cases of transfer of care responsibility.

Related standards:

ICD.02 Collaborative care; ICD.17 Order and request; ACT.08 Handover communication; ACT.07 Patient flow risks; ACT.12 Multidisciplinary management; ACT.15 Patient flow out.

ACT.09 NSR.07 A standardized approach to hand over communications, including an opportunity to ask and respond to questions, is implemented.

Safety

Keywords:

Handover communication.

Intent:

The primary objective of a 'handover' is the direct transmission of accurate patient care information among staff members to ensure the continuity of care. Moreover, it provides a chance for clarifications, which subsequently decreases medical errors. The hospital develops and implements a policy and procedures to guide the process of handover communication. The policy addresses at least the following:

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

Survey process guide:

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

Evidence of compliance:

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

2. All healthcare professionals are aware of hospital policy.
3. Handover communications are recorded and available when required.
4. The hospital tracks, collects, analyzes, and reports data on the handover communication process.
5. The hospital acts on improvement opportunities identified in the handover communication process.

Related standards:

ICD.02 Collaborative care; ACT.12 Multidisciplinary management; ACT.16 Referral and transfer sheet.

ACT.10 Second opinion process is available, safe and effective.

Patient-centeredness

Keywords:

Second opinion.

Intent:

The second opinion is an independent professional review and assessment performed to confirm, add to, or revise the diagnoses and proposed treatment of another healthcare professional. A patient has the right to seek and undergo the same evaluation process with another medical staff member to determine if the first diagnosis is accurate and that the prescribed treatment plan is the most effective and efficient. Aside from a confirmation process, a second opinion can be sought if the patient is not satisfied with the initial diagnosis and treatment plan, and wish to explore other treatment approaches and another opinion. A second opinion on a surgical procedure may be recommended if the procedure is deemed as a non-emergency. While seeking second opinions is a patient right, some hospitals might not be able to provide second opinions because of a lack of expertise or unavailability of resources. In these cases, hospitals need to provide information to patients about available resources outside the hospital. The hospital develops and implements a policy and procedures to guide the process of providing a safe and effective second opinion process. The policy addresses at least the following:

a) Defined criteria for getting the 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 a second opinion can't be provided by the hospital

Survey process guide:

- The GAHAR surveyor may review documents describing the approved hospital process for a second opinion followed by an open or closed patient's medical record review to assess the process.
- The GAHAR surveyor may also interview healthcare professionals, patients, and families to check their awareness of the process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through f).
2. All medical staff members involved in a second opinion are aware of the hospital policy.
3. Second opinions are provided if possible.
4. When second opinions cannot be provided by the hospital, Patients and their families are notified of other alternatives.
5. The process of requesting, communicating, and responding to second opinion requests is recorded in the patient's medical record.

Related standards:

PCC.04 Patient and family rights; ICD.02 Collaborative care; ICD.14 Plan of care; ACT.09 Handover communication; ACT.11 Consultation process; ACT.12 Multidisciplinary management.

ACT.11 The consultation process is available, safe and effective.

Safety

Keywords:

Consultation process

Intent:

Consultation is the process of seeking an assessment by a medical staff member of a different discipline to suggest a diagnostic or treatment plan. Often, consultation leads to professional communication where clinicians share their opinions and knowledge with the aim of improving their ability to provide the best care to their patients. Such dialogue may be part of a clinician's overall efforts to maintain current scientific and professional knowledge or may arise in response to the needs of a particular patient.

Although consultation usually is requested in an efficient manner that expedites patient care, situations occur in which the relationship between healthcare professionals results in an inefficient, less-than-collegial consultative process that may not be in the best interest of the patient. For example, a patient and a consultant may be put at a serious disadvantage when consultation is requested late in the process of care or is not accompanied by sufficient background information, the reason for consultation is not clearly stated or late response to the consultation request. The hospital develops and implements a safe and appropriate consultation process.

The policy addresses at least the following:

a) Defined 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.

Survey process guide:

- The GAHAR surveyor may review the document describing the approved hospital process for a consultation followed by an open or closed patient's medical record review in any inpatient ward to assess the process implementation.
- The GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. Healthcare professionals who are involved in the consultation are aware of the hospital policy.
3. Consultations are obtained based on patient needs.
4. Consultations are obtained within a defined timeframe.
5. Information exchange between consultation requestor and responder to consultation requests is clear, descriptive of patient condition and important information, and recorded in the patient's medical record.

Related standards:

ICD.02 Collaborative care; ICD.14 Plan of care; ACT.09 Handover communication; ACT.10 Second opinion; ACT.12 Multidisciplinary management.

ACT.12 Multidisciplinary management process is safe, effective and appropriate to the patient's condition and needs.

Safety

Keywords:
Multidisciplinary Management

Intent:
A multidisciplinary management process usually occurs in the form of a meeting of a group of professionals from one or more clinical disciplines who together make decisions regarding the recommended treatment of individual patients. Multidisciplinary teams may specialize in certain conditions, such as cancer, diabetes, or other conditions. Clinical decisions are made based on reviews of clinical documentation such as case notes, test results, diagnostic imaging, etc. The patient may or may not be present during the multidisciplinary management meetings. Healthcare professionals defined multiple areas for improvement for Multidisciplinary management, including access to complete information and clarified roles for the different healthcare professionals. The hospital develops and implements a safe and appropriate multidisciplinary management process. The policy addresses at least the following:

a) Defined criteria for getting multidisciplinary opinions.
b) Clear responsibilities among the treating team.
c) Recording details of communication, assessment, and care.

Survey process guide:

- The GAHAR surveyor may review document describing the approved hospital process for multidisciplinary medical management followed by an open or closed patient's medical record review in any inpatient ward especially wards that admits patients with complex medical conditions such as internal medicine, oncology or critical care to assess the process implementation.
- The GAHAR surveyor may also interview medical staff members to check their awareness of the process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through c).
2. All medical staff members are aware of the hospital policy.
3. Multidisciplinary management meetings are obtained based on patient needs.
4. Multidisciplinary management meetings occur according to the policy.

5. Information exchange between multidisciplinary management teams is clear, descriptive of patient condition and important findings, and recorded in the patient's medical record.

Related standards:

ICD.02 Collaborative care; ICD.14 ,Plan of care; ACT.09 Handover communication; ACT.10 Second opinion;

ACT.13 Transportation of patients is coordinated, safe, and in an approved timeframe.

Safety

Keywords:

Patient's Transportation

Intent:

Hospitals are busy places where staff face pressure to accommodate and treat a large number of patients on any given day. This pressure can lead to staff members improperly lifting, transporting, maneuvering, and positioning patients or using the wrong equipment for the job, which can, in turn, lead to injuries. Transportation in this standard refers to the act of lifting, maneuvering, positioning, and moving patients from one point to another point under the custody of hospital staff members.

Evidence-based research has shown that safe patient handling interventions can significantly reduce overexertion injuries by replacing manual patient handling with safer methods. The hospital should coordinate patient transportation between hospital departments and services. The hospital should be able to meet patient needs within an approved timeframe. Patient transportation should be facilitated and coordinated within the available services and resources. The hospital develops and implements a policy and procedures for managing patient transportation. The policy addresses at least the following:

a) Safe patient handling to and from examination bed, trolley, wheelchair, and other transportation means.
b) Staff safety while lifting and handling patients.
c) Coordination mechanism to ensure safe transportation within the approved timeframe.
d) Competence of responsible staff members for the transportation of patients.
e) Defined criteria to determine the appropriateness of transportation within the hospital.

Survey process guide:

- The GAHAR surveyor may review document describing the approved hospital process for patient transportation, followed by an open or closed patient's medical record review to assess the process implementation.
- GAHAR surveyor may observe the mechanisms of lifting, handling, and/or transporting patients during hospital tracers and tours.
- GAHAR surveyor may observe equipment used for lifting, handling, and/or transporting patients during hospital tracers and tours.
- GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. All staff members involved in the transportation of patients are aware of the hospital's policy.
3. Only competent staff members are allowed to lift, handle, and transport patients.
4. Transportation of patients occurs in a safe, appropriate manner and within an approved timeframe.
5. Requirements for transporting patients in critical conditions are identified, used, and recorded in the patient's medical record.

Related standards:

ICD.11 Fall screening and prevention; ACT.09 Handover communication.

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

Equity

Keywords:

Special care units' access

Intent:

Specialized care units refer to inpatient units that are specifically designed, staffed, and equipped for the continuous observation and treatment of critically ill or complex patients, including all types of intensive care units, as well as intermediate care or step-down units. Critical care units and specialized care units are subject to increasing demand, decreasing supply, decrease quality of care, and increase administrative

costs of healthcare provision. Hospitals should preserve the availability of needed and necessary critical and specialized care services is to titrate demand-to-need at its most sensitive level; this can be maintained by :

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ACT.08 Patient care responsibility; PCC.07 Admission consent; ACT.08 Handover communication; ICD.02 Collaborative care; ICD.14 Plan of care; ACT.10 Second opinion; ACT.09 Handover communication; ACT.12 Multidisciplinary management; ACT.15 Patient flow out; ACT.16 Referral and transfer sheet.

Effective and safe patients flow-out of the hospital

ACT.15 Processes of transfer outside the hospital, referral, temporary discharge and discharge of patients are defined.

Safety

Keywords:

Patient's flow out (transfer, referral, temporary discharge and discharge)

Intent:

Discharge from the hospital is the point at which the patient leaves the hospital and returns home.

Temporary discharge is when a patient may require a brief time off unit absence during their admission due to clinical needs, cultural needs, preferences, and expectations of the patients and families. A referral is when the patient leaves the hospital to seek additional medical care temporarily in another organization. A transfer is when the patient leaves the hospital and gets transferred to another organization, such as a tertiary care organization, to a rehabilitation organization, or to a nursing home. Discharge, referral, and transfer involve the medical instructions that the patient will need to fully recover. For hospitals, an effective patient referral system is an integral way of ensuring that patients receive optimal care at the right time and at the appropriate level, as well as cementing professional relationships throughout the healthcare community. Recording and responding to referral feedback ensures continuity of care and completes the cycle of referral. The hospital develops and implements a policy and procedures to guarantee the appropriate and patient referral within an approved timeframe, which is based on the identified patient's needs and guided by clinical guidelines/protocols.

The policy addresses at least the following:

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.
b) A responsible staff member for ordering and executing the discharge, referral, and/or transfer out of patients.
c) Defined criteria determine the appropriateness of referrals and transfers-out are based on the approved scope of service and patient's needs for continuing care.
d) Coordination with transfer/ referral agencies, if applicable, other levels of health service and other organizations.

Survey process guide:

The GAHAR surveyor may review a document describing the approved hospital processes for referrals, transfers, temporary discharge and discharges.

The GAHAR surveyor may visit inpatient wards to assess staff knowledge of the process and may also perform a closed file review for the patient's medical record of patients who were transferred, referred, or discharged.

The GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through d).
2. All staff members involved in discharge, temporary discharge, referral, or transfer of patients are aware of the hospital policy.
3. The discharge, temporary discharge, referral, and/or transfer out order is clearly recorded in the patient's medical record.
4. The reason for the discharge, temporary discharge, referral, and/or transfer out is recorded in the patient's medical record.
5. The referral and/or transfer feedback is reviewed, signed, and recorded in the patient's medical record.

Related standards:

ACT.08 Patient care responsibility; ACT.09 Handover communication; ACT.12 Multidisciplinary management; ACT.13 Patient transportation; ACT.16 Discharge summary; ACT.16 Referral and transfer sheet; PCC.18 Patient needs; ICD.08 Medical assessment; ICD.14 Plan of care.

ACT.16 Discharge summaries are complete.

Safety

Keywords:

Discharge summary

Intent:

Discharging patients from a hospital is a complex task. An essential part of this process is the documentation of a discharge summary. A discharge summary is a clinical report prepared by a healthcare professional at the conclusion of a stay in the hospital or series of treatments. It is often the primary mode of communication between the hospital

care team and after healthcare professionals. It is considered a legal document, and it has the potential to jeopardize the patient's care if errors are made. Delays in the completion of the discharge summary are associated with higher rates of readmission, highlighting the importance of successful transmission of this record in an approved timeframe. The discharge summary includes at least the following:

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

Survey process guide:

- The GAHAR surveyor may perform a closed file review for the patient's medical record of a patient who was discharged to assess completeness and compliance.
- The GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. All staff members involved in the discharge of patients are aware of the mechanism to obtain a discharge summary.
2. There is evidence of identification and provision of required support to ensure safe patient discharge.
3. Discharge summaries are recorded using all the required elements from a) through i).
4. A copy of the discharge summary is kept in the patient's medical record.

Related standards:

ACT.14 Special care unit access; ACT.15 Patient flow out; ICD.20 Patient nutritional needs; PCC.09 Patient and family education material.

ACT.17 Referral/transfer sheets are complete.

Safety

Keywords:
Referral/transfer sheet

Intent:
As an important part of the patient care, a copy of the referral/transfer sheet should be retained in the patient's medical record of each referred/transferred patient. The content of the referral/transfer sheet should be comprehensive and detailed to achieve the following: support handoff process by the required information, promote continuity of care, and comply with requirements of law and regulations. The referral/transfer sheet includes at least the following:

a) Reason for referral/transfer.
b) Collected information through assessments and care.
c) Medications and provided treatments.
d) Transportation means and required monitoring.
e) Condition on referral/transfer.
f) Destination on referral/transfer.
g) Name of the medical staff member who decided the patient referral/transfer.

Survey process guide:

- GAHAR surveyor may perform a closed file review for the patient's medical record of a patient who was referred/transferred to assess completeness and compliance.
- GAHAR surveyor may also interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. All staff members involved in the referral/transfer of patients are aware of the process.
2. There is evidence of identification and provision of required support to ensure safe patient referral.
3. Referral/transfer sheets are recorded using all the required elements from a) through g).
4. A copy of the referral/transfer sheet is kept in the patient's medical record.

Related standards:

ACT.08 Patient care responsibility; ACT.09 Handover communication; ACT.12 Multidisciplinary management; ACT.13 Patient transportation; ACT.14 Special care units needs; ACT.15 Patient flow out; PCC.17 Patient needs; ICD.08 Medical assessment; DAS.09 Medical image results.

Integrated Care Delivery

Chapter intent:

Optimal health and personal care require following universally acknowledged methods to identify and to address complex issues. There are multiple ways to categorize these methods. In this handbook, they are defined into the screening, assessment, reassessment, referral, and consultation, then care plans are developed that might be in the form of surgery, an invasive procedure, a medication, an intervention, or any other form of care.

Usually, patients are screened whenever full assessments are not required. Screening is a strategy used in a population to identify the possible presence of an as-yet-undiagnosed disease in patients without signs or symptoms by performing a high-level evaluation of patients to determine whether a further deeper assessment is required. It is a crucial step to save resources and time.

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

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

The assessment and management of certain categories of patients may differ in their content and scope from the regular processes. Hospitals shall be clearly identifying, assessing, and managing these categories of patients accordingly. Provision of

equitable and effective care to infants and children is one of the nation's visions, and it is addressed in a separate standard. In response to fighting drug abuse and addiction, specific assessment is required to ensure a proper plan of care is in place that individually assists victims in their journey to social and psychological well-being.
The Egyptian government has announced a major initiative to transform the healthcare industry in Egypt, where payers and providers shall be separated, and a body of accreditation shall measure the quality of provided services. All this shall be under the umbrella of the Universal Health Insurance, where defined eligibility criteria are set for patients, and access and referral mechanisms shall be developed.
Hospitals need to comply with a number of laws and regulations that maintain and organize the new healthcare initiative.

Chapter purpose:
This chapter includes multiple sectors. There is an emphasis on uniformity of care, a description of simple screening, assessment, and care provided to patient at the first point of contact of a patient with the hospital then a description of the basic screening, assessment, reassessment, and care processes. After that, some sections follow to describe either special forms of assessments and care processes based on the patient's needs or special forms based on patient's risks and, finally, a description of special assessments and care processes based on specially provided services.

Implementation guiding documents:
(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)
1. Egyptian Constitution
2. Drafted Egyptian law for Elderly care
3. Egyptian code of medical ethics 238/2003 (Medical Syndicate Publications)
4. Egyptian code of nursing ethics (Nursing Syndicate Publications)
5. Law 71/2009 on the care of psychiatric patients
6. Law 126/2008 on Egyptian Child
7. Law 10/2018 on the rights of handicapped
8. MOHP Ministerial decree 63/ 1996 for dialysis units
9. Regulation for the care of psychiatric patients 128/2010
10. Publications of Central Administration of Emergency and Critical Care, the Egyptian ministry of health and population
11. Emergency Department unified protocol, Egyptian ministry of health and population curative and critical sector

12. Prime Minister decree, 1063/2014 Management of Emergency cases
13. Requirements of inspection per MOHP law and regulation
14. National cancer treatment guidelines, High committee of cancer. The Egyptian ministry of health and population
15. Law 51/1981 for healthcare organizations
16. Managing victims of social abuse guidelines – ministry of health, UNFPA
17. Guidelines for the Provision of Intensive Care Services (GPICS) OCTOBER 2018 This is a joint project between the Faculty of Intensive Care Medicine (FICM) and the Intensive Care Society (ICS) https://www.ficm.ac.uk/sites/default/files/gpics_v2-public-consultation-draft-october-2018_0.pdf
18. Core Standards for Intensive Care Units https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
19. SAFE INITIATION AND MANAGEMENT OF MECHANICAL VENTILATION A White Paper from the American Association for Respiratory Care (AARC) and University HealthSystem Consortium's (UHC) Respiratory Care Network

Sustaining uniform care

ICD.01 Care delivery is uniform when a similar service is needed regardless of patient background, location, or time of care.

Equity

Keywords:
Uniform Care.

Intent:
Hospitals treat similar patients in a similar way regardless of their different backgrounds (such as religion, economic class, literacy level, race, language, etc.) and regardless of the location or the time the patients receive their care. Hospitals are expected not to discriminate between patients and provide them a uniform medical care per their clinical requirement. Hospitals are able to demonstrate a similar level of compliance across all departments and services, including home services. Also, hospitals are able to demonstrate a uniform process when a service is offered in a department under the supervision of another department (such as comply with dialysis protocols even if dialysis services are provided outside dialysis units). To ensure this, hospitals should have a policy that specifies what constitutes uniform care and what practices can be followed to ensure that patients are not discriminated based on their background or category of their accommodation. The essential part of the policy is the provision of uniform medical care and does not apply to those services and facilities that are non-clinical in nature.

Survey process guide:
During the GAHAR survey, the surveyor may assess compliance with the standard's requirements.

Evidence of compliance:
1. Clinical guidelines/protocols, life-saving measures, patient safety practices, emergency care, referral services, informed consents, rational use of assessment, diagnostic, ancillary, and therapeutic services are provided according to patient needs and without discrimination.
2. Quality reviews, satisfaction questionnaires, and medical audits are performed randomly to measure compliance regardless of patient background.
3. Potential discrimination events are reported and investigated.

Related standards:

PCC.04 Patient and family rights; PCC.11 Informed consent; ICD.14 Plan of care; ICD.16 Clinical care standards Usage; ICD.08 Medical assessment; ACT.08 patient Care responsibility; ACT.16 Referral and transfer sheet.

ICD.02 Patient care processes are collaborative.

Effectiveness

Keywords:

Collaborative Care.

Intent:

Collaborative patient management may have emerged in response to a shift in several key areas, such as a more complex patient population, a shift from a doctor-centered to a patient-centered approach, and the wide access to modern information and communication technologies. Examples of non-collaborative care, some hospitals showed instances where a nurse identifies a nutritional need, but the nutritionist is not informed directly because of process complexity, some other hospitals struggled to identify if a spine surgery should be admitted under orthopedics service or under neurosurgery service, also sometimes healthcare professionals of different disciplines don't see each other's recording of patient assessment and care processes. Collaborative care is an integrated team approach to healthcare. The evaluation of treatment options and treatment planning are collaborative processes involving medical and allied healthcare professionals in concertation with the patient and the patient's family. Individual, patient-specific treatment plans are developed, and delivery of care becomes a shared responsibility. This collaborative care team may include medical staff members, nurses, social workers, physiotherapists, nutritionists, and pharmacists. The hospital develops and implements a policy and procedures to guide the process of collaborative care.

The policy includes at least the following:

a) Identifying the scope of work, tasks, and treatments for each healthcare professional category.
b) Identify areas of overlap and clarify responsibilities.
c) A mechanism to ensure that all healthcare professionals are aware of care plans developed by other team members in response to each patient's needs.
d) Clear guidance on who will perform screening of special patient needs and how assessment and care will be provided when needed.

e) A mechanism to resolve conflicts between professionals regarding assessment and care plans in a defined timeframe.
f) A mechanism for involving medical and allied healthcare professionals in concertation with the patient and the patient's family in the evaluation of treatment options and treatment planning.

Survey process guide:

- GAHAR surveyor may review the hospital policy during the document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy that covers all elements mentioned in the intent from a) through f).
2. All staff members involved in patient care are aware of the hospital policy.
3. When a conflict occurs between healthcare professionals, actions are taken to ensure collaborative, safe care.
4. Collaborative care is demonstrated in the patient's medical record.

Related standards:

PCC.10 Patient and family education; PCC.17 Patient needs; ACT.09 Handover communication; ACT.12 Multidisciplinary management; ICD.08 Medical assessment.

Effective Screening, assessment, and care processes

ICD.03 Pre-hospital services are delivered according to applicable laws and regulations.

Effectiveness

Keywords:

Prehospital care, ambulance care, emergency medical care during disasters

Intent:

Pre-hospital care is provided by emergency medical responders, who are the initial healthcare professionals at the scene of the incident.

Emergency medical responders often are the first to recognize the nature of a disaster and can immediately evaluate the situation and determine the need for resources, including other medical resources.

Hospitals might owe ambulances or contract another organization for the sourcing of ambulance services. This does not apply to the national ambulance system. The hospital develops and implements a policy and procedures for pre-hospital care. The policy addresses at least the following:

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

Survey process guide:

- GAHAR surveyor may review the hospital policy during the document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy that covers all elements mentioned in the intent from a) through e).
2. Emergency staff members are aware of the hospital policy.
3. Drills are performed to ensure continuous readiness.
4. Pre-hospital care records are complete and kept in the patient's medical record.
5. There is a process of recording and monitoring of response times.

Related standards:

ICD.04 Emergency services; ICD.05 Emergency care guidelines.

ICD.04 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 develops and implements

a policy and procedures for emergency services. The policy addresses at least the following:

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

Survey process guide:

- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may interview patients or family members to assess their engagement.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- GAHAR surveyor may review emergency room records to check the registration of emergency patients.

Evidence of compliance:

1. The hospital has an approved policy for emergency services as mentioned in the intent from a) to c).
2. Competent staff members offer emergency services according to the policy of emergency services.
3. Patients and families are informed of their priority level and expected time to wait before being assessed by a medical staff member.
4. Evidence of registration of all emergency patients treated in the emergency room.
5. Emergency plan of care is recorded in the patient's medical record.

Related standards:

ICD.05 Emergency care guidelines; ICD.08 Medical assessment; ACT.11 Consultation process, ACT.14 Special care unit needs.

ICD.05 Clinical care standards for emergency care are adopted and/or adapted as deemed appropriate for hospital scope of service.

Effectiveness

Keywords:

Emergency Care Guidelines.

Intent:

Clinical practice guidelines include recommendations intended to optimize patient care supported with an evidence-based assessment of the benefits and harms of alternative care options. Clinical guidelines are also intended to be a reference for clinical staff members caring for patients and are not intended to replace healthcare professionals' clinical judgment. The hospital adopts and/or adapts clinical guidelines/protocols that address at least the following (when applicable):

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 obstructed labor.

Survey process guide:

- GAHAR surveyor may review the hospital guidelines during leadership interview session, followed by interviewing staff members to inquire about their training on approved guidelines.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. Clinical guidelines and protocols are adopted and adapted for at least the topics mentioned in the intent from a) through e) (when applicable).
2. Evidence of staff members training on relevant clinical guidelines/protocols.
3. Evidence that clinical guidelines/protocols were consulted during patient care processes.
4. Evidence of monitoring compliance of healthcare professionals to approved guidelines.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage.

ICD.06 Emergency care is recorded in the patient's medical record.

Safety

Keywords:

Emergency care recording.

Intent:

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

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

Survey process guide:

- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- GAHAR surveyor may perform an audit on time recording in emergency room areas and compare between times from multiple sources to check calibration.

Evidence of compliance:

1. Emergency assessment and reassessment by emergency care staff members and by all healthcare professionals is recorded in the patient's medical record.
2. The plan of care developed by emergency and non-emergency is recorded in the

patient's medical record.
3. Departure order is recorded and timed.
4. Watches, clocks, digital clocks, and timers used for time recording are calibrated.

Related standards:

ICD.04 Emergency services; ICD.05 Emergency care guidelines; ACT.11 Consultation process..

ICD.07 Outpatient care services are effective.

Patient centeredness

Keywords:

Outpatient Services.

Intent:

Hospitals experience increased trends in providing specialized healthcare clinics and subspecialized clinics. Reassessment is performed to re-evaluate patient health status; identify changes since initial or most recent assessment; determine new or ongoing needs. Reassessment findings determine the appropriateness of the current care plan and the need for any changes. Legible recording of findings ensures continuity of care. Hospitals develops and implements a policy and procedures for outpatient services that addresses at least the following:

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

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy that guides outpatient care; it addresses all the elements mentioned in the intent from a) through e).

2. All outpatient staff members are aware of the approved outpatient care process.
3. All clinics perform initial assessments within a defined time frame and responsibilities.
4. Reassessment is performed and recorded.
5. Plans of care are recorded in the patient's medical record.

Related standards:
ICD.08 Medical patient assessment; ICD.14 Plan of care; ACT.08 Patient's care responsibility

Effective basic screening, assessment, and care for hospitalized patients

ICD.08 Initial medical assessment and subsequent reassessments are performed.

Effectiveness

Keywords:
Medical patient assessments.

Intent:
The initial assessment is considered the basis of all medical care decisions, it aids determination of severity of a condition, and it helps in prioritizing initial clinical interventions. Initial assessment should be standardized, comprehensive, detailed, and completed within a specific time span to achieve high-quality care that fulfills patient needs. The Most Responsible Physician, or his/her designee, usually performs it. Reassessments may vary according to the patient's condition, the specialty of treatment, level of care, or diagnosis. Variation might go from recording one page every 30 minutes to recording one line every week. The hospital develops and implements a policy and procedures to define the minimum acceptable contents and frequency of clinical reassessments. The initial assessment includes at least the following:

a) Chief complaint.
b) Details of the present illness.
c) Previous hospital admissions, surgery, and invasive procedures.
d) Allergies.
e) Adverse drug reactions.
f) Medications history.
g) Social, emotional, and behavioral history.
h) Family history.
i) The required elements of the comprehensive physical examination.
j) Elements of history and examination related to the specialty.

The hospital should ensure continuous monitoring of patients' clinical status by defining

who is permitted to perform clinical reassessments and the minimum frequency and content of these reassessments. The hospital defines the timeframe for completion the initial assessment guided by clinical guidelines. The hospital also defines whenever history and physical examination completed prior to hospitalization may be used and whether hospital medical staff members verifies and/or accept the results of patient's assessments performed outside the hospital.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy to guide initial assessment and to define its timeframe and minimum content as per the elements from a) through j) in the intent.
2. Healthcare professionals are qualified and aware of the components of the initial assessment.
3. Initial medical assessments are performed within 24 hours of hospitalization.
4. All examinations, investigations and results done before hospitalization are managed uniformly.
5. Medical reassessments are performed recorded in the patient's medical record.

Related standards:

ICD.01 Uniform care; ICD.09 Nursing patient assessments; ICD.16 Clinical care standards Usage; ACT.12 Multidisciplinary management; ACT.15 Patient flow out

ICD.09 Initial nursing assessments and subsequent reassessments are performed.

Effectiveness

Keywords:

Nursing patient assessments.

Intent:

Nursing assessment is the gathering of information about a patient's physiological, psychological, sociological, and spiritual status by a licensed nurse. Nursing assessment is the first step in the nursing process. A section of the nursing assessment may be delegated to a certified nurse aide.

Nursing reassessments may vary according to the patient's condition, the specialty of treatment, level of care, or diagnosis. The hospital develops and implements 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
b) Pain
c) Additional measurements such as height, weight
d) Risk assessments. e.g., fall, bedsores
e) Airway, breathing, circulation, disability, skin, and hydration
f) Outputs (as relevant)
g) A detailed nursing assessment of a specific body system(s) relating to the presenting problem or other current concern(s) required.

The hospital should ensure the continuous monitoring of patients' clinical status by defining the minimum frequency and content of these reassessments.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy to guide nursing initial assessment and to define its timeframe and minimum content as per the elements from a) through g) in the intent.
2. Nurses are qualified and aware of the elements of nurse assessment.
3. Initial nursing assessments are performed within 24 hours of hospitalization.
4. Nursing reassessments are performed and recorded in the patient's medical record.

Related standards:

ACT. 07 Patient care responsibility; PCC.17 Patient needs.

ICD.10 Patient's healthcare needs are identified according to defined screening processes.

Patient-centeredness

Keywords:
Screening of healthcare needs

Intent:
Many people, especially those with chronic conditions, have complex health needs. A holistic approach to patient care needs to address all patient's needs, even the non-expressed ones. Nutritional screening is a first-line process for identifying patients who are already malnourished or at risk of becoming so. Nurses and medical staff members usually perform nutritional screening, while a nutritionist usually performs nutritional assessment. Functional screening helps to determine underlying neurological or development conditions. Usually, nurses and medical staff members perform it. A physiotherapist, occupational therapist, speech therapist, or others may perform functional assessment. Psychosocial screening can help to identify behavioral issues and social determinants of health. A social worker may do social assessment while a nurse may do social screening. Discharge needs define patient needs upon discharge, which impacts the progress of his/her condition. Signs of abuse and neglect may be screened and recorded by a medical staff member, or a nurse then referred to another specialty or a committee for further assessment or management. The hospital developed a policy and procedures to guide the healthcare needs screening process. The policy addresses at least the following:

a) Qualified healthcare professionals define screening criteria for assessing the following patients' risks and needs.
b) Timeframe to complete healthcare needs screening.
c) Process for identifying the need for further assessment by the specific service when defined criteria are met.
d) Screening occurs for at least the following:
    i. Nutritional status
    ii. Functional status
    iii. Psychosocial status
    iv. Discharge needs
    v. Victims of abuse and neglect

Survey process guide:

- GAHAR surveyor may review a patient's medical record to evaluate compliance with

standard's requirements.

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.

Evidence of compliance:

1. The hospital has an approved policy including elements in the intent from a) through d) to guide screening for patient's healthcare needs to define its content and timeframe based on guidelines.
2. Healthcare professionals are qualified and aware of the elements of the screening process.
3. All screens are completed and recorded within an approved timeframe and responsibilities.
4. Patients are referred for further assessment by the specific service when defined criteria are met.

Related standards:

ICD.08 Medical assessment; ICD.11 Fall screening and prevention; ICD.12 Pressure ulcers; ICD.13 Venous thromboprophylaxis; ICD.14 Plan of care; ICD.19 Pain screening, assessment, reassessment, and management; ICD.20 Patient nutritional needs; ICD.21 Patient psychological needs; ICD.22 Patient functional needs; PCC.17 Patient needs.

ICD.11 NSR.05 Patient's risk of falling is screened, assessed, periodically reassessed, and managed safely and effectively.

Safety

Keywords:

Fall screening and prevention.

Intent:

All patients are liable to fall; however, some are more prone to. Identifying the more prone is usually done through a risk assessment process in order to offer tailored preventative measures against falling. Effective preventive measures to minimize falling are those that are tailored to each patient and directed towards the risks being identified from risk assessment. The hospital develops and implements a policy and procedures to guide the Fall screening and prevention process. The policy addresses at least the following:

a) Patient risk screening at admission.
b) Risks include medication review and other risk factors.

c) Timeframe to complete fall screening.
d) Frequency of reassessment of risk of fall.
e) General measures are used to reduce risk of falling such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.
f) Tailored care plans based on individual patient fall risk assessment.

Survey process guide:

- The GAHAR surveyor may review the policy for fall prevention to check for patient risk assessment at admission, status change; noticing that medication review is part of the assessment, presence of general measures generated to reduce risk of falling and for tailored care plans based on individual patient fall risk assessment
- The GAHAR surveyor may review medical records for fall risk assessment including medication review, fall prevention care plan forms, fall risk labels, patient, and family education material.
- The GAHAR surveyor may interview healthcare professionals, patients, and their families to check their understanding and implementation of fall risk assessment and prevention measures
- The GAHAR surveyor may check 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 screening for patient's risk for fall and to define its content and timeframe based on guidelines. Policy includes all elements in the intent from a) through f).
2. Healthcare professionals, are qualified and aware of the elements of approved policy.
3. Patients who have higher level of fall risk and their families are aware and involved in fall prevention measures.
4. All fall risk screens are completed and recorded within an approved timeframe and responsibilities.
5. General measures and tailored care plans are recorded in the patient's medical record.
6. All fall risk reassessments are done within an approved timeframe.

Related standards:

ICD.08 Medical assessment; ICD.09 Nursing patient assessment; ICD.10 Screening of healthcare needs.

ICD.12 NSR.06 Patient's risk of developing pressure ulcers is screened, assessed, periodically reassessed, and managed safely and effectively.

Safety

Keywords:
Pressure Ulcers Prevention.

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

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ICD.08 Medical assessment; ICD.09 Nursing patient assessment; ICD.10 Screening of healthcare needs

ICD.13 NSR.10 Patient's risk of developing venous thromboembolism (deep venous thrombosis and pulmonary embolism) is screened, assessed, periodically reassessed, and managed safely and effectively.

Safety

Keywords:

Venous Thromboembolism Prophylaxis.

Intent:

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

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ICD.08 Medical assessment ; ICD.09 Nursing patient assessment; ICD.10 Screening of healthcare needs; ICD.15 Clinical practice guidelines adaptation and adoption; Clinical care standards Usage.

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

Patient-centeredness

Keywords:

Plan of Care.

Intent:

A plan of care provides direction on the type of healthcare the patient/family/ community may need. The focus of a plan is to facilitate standardized, evidence-based, and holistic care. Recording a plan of care ensures medical staff members, nurses,

and other healthcare professionals integrate their findings and work together with a common understanding of the best approach towards the patient's condition. The plan of care is:

a) Developed by all relevant disciplines providing care under the supervision of the most responsible physician (MRP).
b) Based on assessments of the patient performed by the various healthcare disciplines and healthcare professionals.
c) Developed with the involvement of the patient and/or family through shared decision making, with discussion of benefits and risks that may involve decision aids.
d) Includes identified needs, interventions, and desired outcomes with timeframes.
e) Updated as appropriate based on the reassessment of the patient.
f) Goals or desired results of the treatment or care
g) The progress of patient/service user in achieving the goals or desired results of treatment, care or service is monitored.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ICD.03 Prehospital care, ambulance care, emergency medical care during disasters; ICD.08 Medical assessments; ICD.10 Screening of healthcare needs; ICD.11 Fall screening and prevention; ICD.12 Pressure ulcers; ACT.12 Multidisciplinary management; ACT.15 Patient flow out (transfer, referral, temporary discharge and discharge)

ICD.15 The clinical practice guidelines development process is defined.

Effectiveness

Keywords:

Clinical practice guidelines adaptation and adoption.

Intent:

Clinical guidelines serve as a framework for clinical decisions and supporting best practices. Clinical practice guidelines are also statements that include recommendations intended to optimize patient care. Promoting uptake and use of clinical guidelines at the point of care delivery represents a final translation hurdle to move scientific findings into practice. Characteristics of the intended users and context of practice are as important as guideline attributes for promoting adaptation and adoption of clinical guidelines recommendations. The hospital developed a policy and procedure for clinical guidelines adaptation and adoption. The policy addresses at least the following:

a) How clinical practice guidelines/protocols are adopted and reinforced, reviewed, evaluated, updated, and adopted based on evidence-based literature.
b) The hospital should adapt and adopt guidelines or protocol for the most common/ high risk three diagnoses managed in the hospital annually.
c) Clinical practice guidelines adapted/adopted by the hospital are evaluated at least annually or when needed.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may learn during hospital orientation session about the developed/adopted clinical guidelines.
- The GAHAR surveyor may review a staff member file to check training records.
- The GAHAR surveyor may review medical records to check implementation of clinical practice guidelines.

Evidence of compliance:

1. The hospital has an approved policy that guides all the elements mentioned in the intent from a) through c).
2. All medical and nursing leaders are aware of the hospital policy.
3. Training programs are implemented to communicate and train staff members on the approved clinical guidelines.
4. At least three clinical guidelines are developed/adopted in the hospital annually.

5. Clinical practice guidelines are implemented uniformly to all patients with the same condition.

Related standards:
ICD.16 Clinical care standards Usage; ICD.05 Emergency care guidelines; ACT. 14 Special care unit access.

ICD.16 GAHAR clinical care standards are used when applicable to patient condition.

Patient-centeredness

Keywords:
Clinical care standards Usage.

Intent:
Clinical care standards serve as a framework for clinical decisions and supporting best practices. A systematic review of evidence and an assessment of the benefits and harms of alternative care options builds clinical care standards. Evidence-based clinical care standards are a key aspect of clinical audits. The hospital ensures that clinical care standards are used when indicated. This will require continuous awareness, education and monitoring of clinical care standards requirements and standards of practice.

Survey process guide:
- GAHAR surveyors may review the hospital's scope of service to identify the list of applicable clinical care standards.
- Sample of medical records of cases with diagnosis related to applicable clinical care standards may be reviewed.
- Surveyors may review indicators /measure done by hospital leaders to monitor clinical care standards implementation.
- GAHAR surveyor may review a staff member file to check training records and link between compliance to clinical guidelines and other performance evaluation processes.

Evidence of compliance:
1. All clinical staff members are aware of the clinical care standards pertinent to their jobs.
2. Staff members have access to approved clinical care standards when they need to.
3. Compliance to clinical care standards is used for privileging, performance evaluation and peer review processes.

4. The hospital implements GAHAR mandated clinical standards related to emergency and non-emergency care under supervision of hospital leaders.
5. Hospital leaders measure compliance of GAHAR clinical care standards and report the results to GAHAR at least quarterly.

Related standards:
ICD.01 Uniform care; ICD.15 Clinical practice guidelines adaptation and adoption; ICD.05 Emergency care guidelines; ACT.14 Special care unit access.

ICD.17 Information is available to support medical staff members' orders and requests.

Safety

Keywords:
Orders and requests.

Intent:
Orders and requests represent communication from a medical staff member directing that service to be provided to the patient. It may take several forms such as in writing, by telephone, verbally, electronic patient's medical record entries, physician order entry (POE). The hospital should ensure that the required information is available for the patient and for those who are going to execute the order. Information includes at least the following:

a) Name of the ordering medical staff members.
b) Date and time of order.
c) Patient identification, age, sex.
d) Clinical reason for ordering and requesting a service.
e) Preparation requirements.
f) Precautions to be taken.
g) Site and laterality for medical imaging studies.
h) Prompt authentication by the ordering medical staff members.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. All medical staff members are aware of the full order requirements.
2. Medical orders follow all the required elements.
3. There is a process to follow when medical orders lack one or more of the abovementioned elements.

Related standards:

DAS.04 Medical imaging pre-examination process; DAS.15 pre-examination process; DAS.31 Ordering of blood and blood products; ICD.02 Collaborative care; PCC.09 Patient and family education materials; ACT.11 Consultation process; ACT.12 Multidisciplinary management; ACT.16 Referral and transfer sheet.

ICD.18 NSR.02 Verbal or telephone orders are communicated safely and effectively.

Safety

Keywords:

Verbal and telephone orders.

Intent:

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

This also provides an opportunity for verification. The hospital develops and implements a policy and procedures of receiving verbal and telephone communication. The policy addresses at least the following:

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

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy to guide verbal communications and to define its content that addresses at least all elements mentioned in the intent from a) through d).
2. Healthcare professionals, are aware of the elements of the policy.
3. All verbal orders and telephone orders are recorded in the patient's medical record within a predefined timeframe.
4. The hospital tracks, collects, analyzes, and reports data on verbal and telephone order process.
5. The hospital acts on improvement opportunities identified in verbal and telephone order process.

Related standards:

ACT.12 Multidisciplinary management; DAS.04 Medical imaging pre-examination process.

Patient-tailored screening, assessment, and care processes

ICD.19 Inpatients and outpatients are screened for pain, assessed whenever pain is present, and managed accordingly.

Patient-Centeredness

Keywords:

Pain screening, assessment, reassessment, and management.

Intent:

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

a) Pain screening tool.
b) Complete pain assessment elements that includes nature, site, and severity.
c) Frequency of pain reassessments.
d) Pain management protocols.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.

- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy to guide pain management processes that addresses all elements mentioned in the intent from a) through d).
2. All staff members are aware of the policy.
3. All inpatients and outpatients are screened for pain using a valid and approved tool.
4. Pain assessment, reassessment, and management plans are recorded in the patient's medical record.
5. Qualified Individuals are responsible for managing the pain and recording pain management plan effectiveness in the patient's medical record.

Related standards:

ICD.08 Medical patient assessment; ICD.14 Plan of care.

ICD.20 Patients' special nutritional needs are assessed and managed.

Patient-centeredness

Keywords:

Patient's nutritional needs.

Intent:

A nutrition assessment is an in-depth evaluation of both objective and subjective data related to patient's food and nutrient intake, lifestyle, and medical history. Once the data on an individual is collected and organized, the healthcare professional can assess and evaluate the nutritional status of that person. The assessment leads to a plan of care, or intervention, designed to help the patient either maintain the assessed status or attain a healthier status. The hospital develops and implements a policy and procedures for assessment, reassessment, and management of nutritional needs. The policy addresses at least the following:

a) Availability of competent individuals for assessment and management of patient's nutritional needs.
b) Defined criteria for the involvement of nutritional services into the patient care process.
c) Components of nutritional assessment.
d) Management and care for 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) Management and storage of food brought in by family members.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. All inpatient medical and nursing staff members are aware of the hospital policy.
3. Qualified healthcare professionals are responsible for the assessment and management of the patient's nutritional needs.
4. Patient's nutritional needs are assessed and managed according to the policy.
5. Patient's nutritional needs assessment and management is recorded in the patient's medical record.

Related standards:

ICD.02 Collaborative care; ICD.08 Medical patient assessment; ICD.14 Plan of care; PCC.09 Patient education materials; ACT.16 Discharge summary.

ICD.21 Patients' special psychosocial needs are assessed and managed.

Patient-centeredness

Keywords:

Patient psychosocial needs

Intent:

As psychological factors become increasingly recognized as determinants of therapeutic progress, the need becomes clearer for hospitals, medical staff members, and nurses to consider the psychosocial needs of patients, to treat the whole person and not

merely a disease entity. The hospital develops and implements a policy and procedures for assessment, reassessment, and management of psychosocial needs. The policy addresses at least the following:

a) Availability of competent individuals for assessment and management of patient's psychosocial needs.
b) Defined criteria for the involvement of psychosocial services into the patient care process.
c) Components of Psychosocial assessment that includes at least stress, anxiety, depression, social isolation, and poor relationships.
d) Management and care of patient's Psychosocial needs:
   i. A list of community resources for health promotion and vulnerability support is available.
   ii. Education of patients and/or their families on available community resources when needed.
e) Management and support in case of a patient's disability, infectiousness, and inability to afford the payment of care costs.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. All inpatient medical and nursing staff members are aware of the hospital policy.
3. Competent individuals are responsible for the assessment and management of patient's psychosocial needs.
4. Patient's psychosocial needs are assessed and managed according to policy.
5. Patient's psychosocial needs assessment and management is recorded in the patient's medical record.

Related standards:

ICD.02 Collaborative care; ICD.08 Medical patient assessment; ICD.14 Plan of care; PCC.09 Patient education materials; ACT.16 Discharge summary.

ICD.22 Patients' special functional needs are assessed and managed.

Patient-centeredness

Keywords:

Patient's functional needs.

Intent:

Functional needs assessment offers an approach to identifying the strengths, needs and adjustments required for patients with disabilities and additional needs. It aims to widen the focus from medical diagnosis to the functional needs of the patients, the healing environment and what the hospital can put in place to meet these needs. The hospital develops and implements a policy and procedures for assessment, reassessment, and management of functional needs. The policy addresses at least the following:

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

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

- GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through d).
2. All inpatient medical and nursing staff members are aware of the hospital policy.
3. Competent individuals are responsible for the assessment and management of patient's functional needs.
4. Patient's functional needs are assessed and managed.
5. Patient's functional needs assessment and management is recorded in the patient's medical record.

Related standards:

ICD.08 Medical patient assessment; ICD.14 Plan of care; ACT.04 Hospitalization process; ACT.16 Discharge summary.

ICD.23 Special screening, assessment, reassessment, and care components for special patient populations are defined.

Patient-centeredness

Keywords:

Special-needs patient populations.

Intent:

The greater need for healthcare services among special needs populations is generally costlier to the system, especially if care is not managed appropriately. Members with Special Healthcare needs populations may also have unique challenges in accessing care, and are often overlooked with the context of broader services. The hospital develops and implements a policy and procedures for assessment, reassessment, and management of special-needs patient populations. The policy addresses at least the following:

a) Identification of special-needs patient populations that visit the hospital which should include at least the following:
   i. Adolescents
   ii. Elderly
   iii. Disabled
   iv. Immunocompromised

v. Patients with communicable diseases
vi. Patients with chronic pain
vii. Victims of abuse and neglect

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.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through d).
2. All inpatient medical and nursing staff members are aware of the hospital policy.
3. Special patient population needs are assessed and managed.
4. Special patient populations' needs assessment and management is recorded in the patient's medical record.

Related standards:

ICD.08 Medical patient assessment; ICD.14 Plan of care

ICD.24 For women in labor, the childbirth process is assessed and managed safely

Safety

Keywords:

Safe Childbirth Process.

Intent:

The current birth rate for Egypt in 2019 is 25.957 births per 1000 people, a 2.19% decline from 2018. Yet it is among the world's highest fertility rates. On one hand, according to recent studies, there is a steady rise in C-sections in Egypt that has reached an alarming level in recent years. This increase appears to be associated with a shift towards

delivery in private healthcare facilities. Multiple factors affect this process, including the mother's aesthetic preferences and financial incentives. On the other hand, While Egypt's maternal mortality ratios are improving, yet there is an area of improvement in terms of inequalities between socio-economic groups. The WHO Safe Childbirth Checklist is a tool intended to improve the quality of care for women and babies at the time of childbirth. The Checklist is an organized list of evidence-based essential birth practices targeting major causes of maternal deaths, intrapartum-related stillbirths, and neonatal deaths that occur in facilities around the world. The hospital develops and implements a policy and procedures to guide childbirth process.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved policy that guide childbirth process.
2. All involved staff members are aware of the process.
3. Childbirth process is assessed and managed.
4. Checklists, protocol, or other tools are used successfully for every delivery.
5. Childbirth process assessment and management is recorded in the patient's medical record.
6. There is evidence of monitoring the implementation process.

Related standards:

ICD.08 Medical assessment; ICD.14 Plan of care.

ICD.25 Clinical guidelines are used to define the assessment and care management of pediatric population.

Patient-centeredness

Keywords:

Pediatric Care.

Intent:

Ongoing patient assessments are critical to providing safe care and are an essential part of medical and nursing practice. The hospital develops and implements a policy

and procedures for assessment, reassessment, and management of the pediatric population. The policy addresses at least the following:

a) Immunization status.
b) Nutritional assessment and care.
c) Cognitive abilities assessment and care.
d) Congenital diseases screening and care.
e) Social assessment and care according to national child law and regulation.
f) Growth charts.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may trace a patient journey and assess implementation.
- GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

Evidence of compliance:

1. The hospital has an approved assessment and care management of pediatric population policy that includes all the elements mentioned in the intent from a) through f).
2. All staff members involved in pediatric patient care are aware of the assessment and care management of pediatric population policy.
3. Competent individuals are responsible for the assessment and management of pediatric patients.
4. Children are assessed and managed safely.
5. Children assessment and care management is recorded in the patient's medical record.

Related standards:

ICD.08 Medical patient assessment; ICD.14 Plan of care; ICD.20 Patient nutritional needs; ACT.16 Discharge summary; ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Guidelines usage.

ICD.26 Terminally-ill patients needs are assessed and managed.

Patient-centeredness

Keywords:

Terminally ill patients.

Intent:

Usually, the quality of life after a critical illness is diminished and shortened for many patients. Active aggressive, interventional treatments with associated pain and distress place considerable burdens on patients. When these burdens outweigh the potential benefits of life-supporting treatments, Healthcare professionals may serve only to prolong death rather than life. In such circumstances, a transition to palliative care may be in patients' best interests. Such a transition prioritizes symptom management, psychosocial support of patients and families, and alignment of treatments with individual care goals, values, and preferences. Once patients are recognized as being in their final days/hours of life, therapeutic goals need to be reviewed and accordingly altered to focus on comfort and dignity. Interventions that do not contribute towards this may be withdrawn.

Therapeutic options for analgesia, dyspnoea, anxiety, and agitation when needed. Medication doses need to be titrated for symptom relief based on explicit assessments. The needs of patients and families to be with, care for, and otherwise attend to dying patients need to be met as far as is possible. If appropriate, religious expertise might be sought. The hospital develops and implements a policy and procedures for assessment, reassessment, and management of the terminally ill patient population. The policy addresses at least the following:

a) The preparation of patients and their families for death
b) Clinical decisions should be individualized, and includes a shared approach for decision-making with the involvement of the patient and/or family
c) Management of symptoms, including pain and depression.
d) Provision of patient and family support for psychosocial, emotional, cultural and spiritual needs.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence assessment.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through d).
2. All staff members involved in terminally ill care are aware of the hospital policy.
3. Competent individuals are responsible for the assessment and management of terminally ill patients.
4. Terminally ill patients are assessed and managed safely.
5. Terminally ill patients' assessment and management is recorded in the patient's medical record.

Related standards:

PCC.04 Patient and family rights; PCC.09 Family education; ICD.08 Medical assessment; ICD.14 Plan of care.

ICD.27 Mental health patients' rights during assessments, and care plans are maintained according to applicable laws and regulations.

Patient-centeredness

Keywords:

Psychiatric patients.

Intent:

People living with mental health conditions are people. They have people they love, activities they enjoy, and dreams for their lives. As people, they deserve to be treated with dignity, and under the laws, regulations and international references they have rights and protections. Unfortunately, it has long been the case that patients with mental health conditions are among the most abused and discriminated against in multiple countries. Abuse and discrimination continue to be serious problems today. The shackling or restraining of children, keeping people out of work, and denying access to services are just a few examples of the way this standard addresses. The hospital develops and implements a policy and procedures for assessment, reassessment, and management of the psychiatric patient population. The policy addresses at least the following:

a) Compulsory treatment.
b) Informed consent.
c) Restraints usage.
d) Overnight visits.
e) Monitoring and follow-up of non-returning patients.

f) Electroconvulsive therapy.
g) Vocational and recreational activities.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs.

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 with mental healthcare are aware of the hospital policy.
3. Competent individuals are responsible for the assessment and management of mental health patients.
4. Mental health patients are assessed and managed safely.
5. Mental health patients' assessment and management is recorded in the patient's medical record.

Related standards:

PCC.04 Patient and family rights; PCC.11 Informed consent; PCC.18 Patient dignity, privacy, and confidentiality; ICD.08 Medical assessment; ICD.14 Plan of care; ICD.28 Restraint and seclusion

ICD.28 Restraint and seclusion are used safely, appropriately and in a manner that respect patient's rights.

Patient-centeredness

Keywords:

Restraint and seclusion.

Intent:

Coercion is a theme of worldwide importance and is defined as the use of an intervention against a person's will. Coercive measures can also have other dimensions, in particular, limitations of freedom of movement that are frequently used in psychiatry, usually for containment of aggressive behaviors, but also in other circumstances and settings,

including every medical specialty. In the context of overriding a person's will, coercion raises ethics and legal questions. These measures limit several fundamental human rights, such as liberty of choice or movement, autonomy, and physical integrity, and are therefore subjected to laws and regulations. Determining the clinical effects of coercion is a difficult challenge, raising ethical, legal, and methodological questions. Despite limited scientific evidence on effectiveness, coercive measures are frequently used, especially in psychiatry. These interventions should be used with caution and as a last resort. Patients' preferences should be considered when deciding to perform these measures. The therapeutic relationship could be a focus for improvement of effects and subjective perception of coercion. The hospital develops and implements 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 based on continuing need and according to laws and regulations.
h) Management and care for patients needs during restraint and seclusion.
i) Termination of restraints and seclusion is according to defined criteria.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence assessment.

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 safely.
5. Restraints and seclusions are recorded in the patient's medical record.

Related standards:

PCC.04 Patient and family rights; PCC.18 Patient dignity, privacy, and confidentiality; ICD.08 Medical assessment; ICD.14 Plan of care; ICD.17 Order and request; ICD.27 Psychiatric patients.

ICD.29 Victims of drug abuse and addiction are assessed and managed according to applicable laws and regulations and clinical guidelines/protocols.

Patient-centeredness

Keywords:

Victims of drug abuse and addiction.

Intent:

Alcoholism and drug addiction have obvious effects on chronic substance abusers. Prolonged abuse of alcohol and/or drugs will deteriorate a person's physical health, impair mental functioning, and damage overall spirit.

a) The hospital develops and implements a policy and procedures for assessment, reassessment, and management of victims of drug abuse and addiction patient population.
b) The policy addresses at least the following:
c) Assessment of history of drug use, including the age of onset, duration, intensity, patterns of use, used drugs, consequences, and complications.
d) Types of previous treatment and responses to the treatment.
e) History of mental, emotional, and behavioral problems.
f) Features of the environment that promote compliance and wellness or obstacles to recovery
   i. Financial status.
   ii. Current living situation and family circumstances.
   iii. Need for family participation in the patient's care.
   iv. Treatment acceptance or the motivation for treatment.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.

- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence assessment.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f).
2. All staff members involved in care of victims of drug abuse or addiction patients are aware of the hospital policy.
3. Competent individuals are responsible for the assessment and management of victims of drug abuse and addiction patients.
4. Victims of drug abuse and addiction patients are assessed and managed safely.
5. Victims of drug abuse and addiction patients' assessment and management are recorded in the patient's medical record.

Related standards:

PCC.18 Patient dignity, privacy, and confidentiality; ICD.08 Medical assessment; ICD.14 Plan of care; ICD.27 Psychiatric patients; ICD.17 Order and request; ICD.27 Psychiatric patients.

Safe critical and special diagnostic and care procedures

ICD.30 NSR.11 Critical results are communicated timely, accurately and safely.

Safety

Keywords:

Critical results.

Intent:

Patient safety and quality of care can be compromised when there are delays in completion of critical tests or in communicating the results of critical tests or critical test results to the requestor. Miscommunication is the commonest root cause for adverse events. Writing down and reading back the results, by the person receiving the information, minimizes miscommunication and reduces errors from unambiguous speech, unfamiliar terminologies, or unclear pronunciation.

This also provides an opportunity for verification. The laboratory, medical imaging service, non-interventional cardiology laboratory and point of care testing program are defined and the critical values for specific tests/ studies. The process includes

instructions for immediate notification of the authorized individual responsible for the patient with results that exceed the critical intervals. The hospital develops and implements a policy and procedures to guide the process of identifying and reporting critical results. The policy addresses at least the following:

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. The mean of notification.
   ii. Date and time of notification.
   iii. Identification of the notifying responsible staff member.
   iv. Identification of the notified person.
   v. Description of the sequence of conveying the result.
   vi. Examination results conveyed.
   vii. Any difficulties encountered in notifications.
d) Measures to be taken in case of critical results.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy to guide critical results communications and to define its content that addresses at least all elements mentioned in the intent from a) through d).
2. Healthcare professionals, are aware of the elements of the policy.
3. All critical results are recorded in the patient's medical record within a predefined timeframe including all elements in the intent from i) through vii).
4. The hospital tracks, collects, analyzes, and reports data on critical results reporting process.
5. The hospital acts on improvement opportunities identified in critical results reporting process.

Related standards:

APC.02 Safety requirements; ICD.06 Emergency care recording; ICD.14 Plan of care; ICD.18 Verbal and telephone orders; DAS.08 Medical imaging results; DAS.23 STAT results.

ICD.31 Chemotherapy and/or radiotherapy services are provided according to laws and regulations.

Safety

Keywords:

Chemotherapy and radiotherapy.

Intent:

Chemotherapy is a drug treatment that uses powerful chemicals to kill fast-growing cells in your body. Chemotherapy is most often used to treat cancer, since cancer cells grow and multiply much more quickly than most cells in the body, it may be given by mouth, injection, or infusion, or on the skin, depending on the type and stage of the cancer being treated.

Radiotherapy is a cancer treatment that uses high doses of radiation to kill cancer cells and shrink tumors.

Chemotherapy drugs and radiation can destroy all types of healthy blood cells and harm the body's production of new ones.

The hospital develops and implements a policy and procedures for assessment, reassessment, and management of patients undergoing chemotherapy or radiotherapy that address at least the following:

a) Identification of special-needs patient populations that visit the hospital
b) Availability of competent individuals for assessment and management of special patient populations needs.
c) Required modifications for regular patient assessment methods to match these patients' needs.
    i. Before the first administration of a new regimen, such as Pathologic confirmation or verification of initial diagnosis, Initial cancer stage, or current cancer status, the treatment plan, including, at a minimum, the patient diagnosis, drugs, doses, duration of treatment, and goals of therapy.
    ii. On each clinical encounter or day of treatment, healthcare professionals performs and records patients' assessments that includes at least the following elements, and takes appropriate action: Weight, Height, Treatment toxicities and adverse

effects.

d) Management and care for patients undergoing chemotherapy and/or radiotherapy needs through an individualized plan of care including management of complications such as extravasation, anaphylaxis, and neutropenia.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence assessment.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through d).
2. All staff members involved in chemotherapy or radiotherapy services are aware of the hospital's policy.
3. Competent individuals are responsible for the management and use of chemotherapy and/or radiotherapy.
4. Management and use of chemotherapy and/or radiotherapy occurs safely.
5. Management and use of chemotherapy and/or radiotherapy is recorded in the patient's medical record.

Related standards:

ICD.08 Medical assessment; ICD.14 Plan of care; ICD.17 Order and request; IPC.13 Immunocompromised hosts and protective environment.

ICD.32 Dialysis services are provided and managed according to laws and regulations.

Safety

Keywords:

Dialysis services.

Intent:

Patients on dialysis are poorly active and show a low level of physical functioning. Objective measurements of spontaneous physical activity are available as well as

complex-expensive or simple, inexpensive tests useful to assess the patient's exercise capacity. Performance assessment unravels patients' capabilities, enables a tailored exercise prescription, and provides predictive information on main clinical outcomes and therefore this topic should be of interest for healthcare professionals. A routinely minimal pool of tests might be usefully performed in a dialysis service to stratify the patient's risk and to recognize patients in need of exercise training in order to address them to various healthcare programs. The hospital develops and implements a policy and procedures for the safe process of the management of dialysis services. The policy addresses at least the following:

a) Initial assessment requirements.
b) Reassessment requirements.
c) Periodic laboratory testing.
d) Clinical guidelines/protocols for at least the following:
    i. Care of arteriovenous access (AVE access).
    ii. Anticoagulation usage.
    iii. Dialysis-induced complications.
e) Cardiopulmonary collapse and urgent medical conditions during dialysis.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence 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. All staff members involved in dialysis services are aware of the hospital policy.
3. Management and use of dialysis services occurs safely.
4. Management and use of dialysis services is recorded in patient's medical record.
5. There is a process for safety and prevention of seroconversion for patients with positive HCV (Ab) and negative PCR (grey zone dialysis machines).

Related standards:
ICD.08 Medical assessment; ICD.14 Plan of care; ICD.17 Order and request.

ICD.33 Critical Care services are provided according to laws, regulations, and clinical guidelines.

Safety

Keywords:
Critical care.

Intent:
Critical care services meet the needs of patients facing an immediate life-threatening health condition specifically, that in which vital system organs are at risk of collapse. Using advanced therapeutic, monitoring, and diagnostic technology, the objective of critical care services is to maintain organ system functioning and improve the patient's condition such that his or her underlying injury or illness can then be treated. Specialized teams of health care professionals provide these services. Thus, critical care units play a pivotal role in acute care hospitals. If these units get overwhelmed with a sudden spike or surge in patient volumes, some surgeries are cancelled and emergency department wait times can be backed up. These services are both expensive and limited. At the core of the critical care system is the hospital Intensive Care Unit (ICU). ICU health care professionals work around the clock to save the lives of critically ill patients. The hospital develops and implements a policy and procedures for the safe process of the management of critical care patients.
The policy addresses at least the following:

a) Minimum resources required for each bed, such as: space, skills, and equipment.
b) Initial assessment requirements including circulation, respiration, and oxygenation.
c) Reassessment requirements.
d) Monitoring of equipment.
e) Management of critical care procedures such as; Tracheostomy, Intubation, prone positioning, and Delirium screening.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may trace a patient journey and assess implementation.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance with standard requirements.

- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence 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. All staff members involved in critical care services are aware of the hospital policy.
3. Competent individuals are responsible for the management and provision of critical care services.
4. Management and use of critical care services is safe.
5. Management and use of critical care are recorded in the patient's medical record.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage; ICD.08 Medical assessment; ICD.14 Plan of care; ACT.09 Handover communication; ACT.11 Consultation process; ACT.12 Multidisciplinary management; ACT.16 Referral and transfer sheet.

ICD.34 NSR.08 The hospital has an approved policy and procedure for managing critical alarms.

Safety

Keywords:

Critical alarms.

Intent:

Medical devices especially those related to vital functions are fitted with alarms that alert staff members on conditions of device malfunction or patient's critical situation. Losing that function exposes patients to increased risk of morbidity and mortality. Alarms are intended to induce immediate appropriate action from staff members to either check device malfunction or initiate action that will revert the situation. This can be ensured when all the staff members become fully aware of alarm settings (values and volume) and their significance and are trained on the required actions to be taken when triggered. Annual competency testing for staff members is needed to ensure the safe use of monitors and other devices that has critical alarming systems. an appropriate competency tool is one that not only addresses the clinician's ability to. The hospital develops and implements a policy and procedures for the safe management and use of critical alarms. The policy addresses at least the following:

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

Survey process guide:

- The GAHAR surveyor may review policy for maintenance and testing of critical alarm systems, which should include staff responsible, control measures, assurance measures, and remedial action GAHAR surveyor may check whether the procedures cover testing of alarms, appropriate settings procedures, priorities for competing alarms, staff authorization for disabling alarms or changing their settings, and monitoring of response to alarm activation.
- The GAHAR surveyor may review inventory of all devices with critical alarms including settingguidelines.
- The GAHAR surveyor may review maintenance record for evidence of responsible staff, responsible company, schedule, agreed settings, evidence of function, reporting of malfunction, and remedial action.
- The GAHAR surveyor may review the schedules of alarm tests and list of current active settings at difference care areas.
- The GAHAR surveyor may interview staff around devices with critical alarm and maintenance staff to check their knowledge of critical alarm settings and response to their activation.
- The GAHAR surveyor may observe (listen) or activate critical alarms to check for suitability of alarm volume to working space.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through f).
2. All staff members using devices with critical alarms are aware of the hospital policy.
3. Competent individuals are responsible for the management and use of critical alarms.
4. Management and the use of critical alarms is safe.

5. Management and use of critical alarms are recorded according to policy including evidence of responsible staff members, responsible company, schedule, agreed settings, evidence of function, reporting of malfunction, and remedial action.

Related standards:

ACT.08 Patient Care responsibility; ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage.

ICD.35 NSR.04 Systems are implemented to prevent catheter and tubing misconnections.

Safety

Keywords:

Catheter and tube misconnections.

Intent:

Tubing and catheters are important steps of daily healthcare provision for the delivery of medications and fluids to patients. Patients, especially within critical and specialized care areas, are connected to many tubes and catheters, each with a special function (monitoring, access, drainage). During care, these tubes and catheters may be misconnected leading to the administration of wrong material via the wrong route resulting in grave consequences. The hospital develops a policy and procedures for catheter and tubing misconnections. The policy addresses at least the following:

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

Evidence of compliance:

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

2. All staff members using tubes and catheters are aware of the hospital policy.
3. Competent individuals are responsible for the management and use of tubes and catheters.
4. Management and the use of tubes and catheters is safe.
5. Management and use of tubes and catheters are recorded in the patient's medical record.

Related standards:

APC.02 Monitoring safety requirements; ACT.08 Patient Care responsibility; ACT.09 Handover communication.

Life threatening conditions management

ICD.36 Emergency equipment and supplies are available and functioning as required by law, regulations, and guidelines.

Safety

Keywords:

Emergency equipment and supplies.

Intent:

Adequate and functioning equipment is a cornerstone for resuscitating patients in emergency conditions. Their availability all the time ensures successful resuscitation. The hospital develops and implements a policy and procedures to ensure safe process of the management of emergency equipment and supplies. The policy addresses at least the following:

a) Identification of required emergency equipment and supplies list according to laws, regulations, and standards of practice.
b) Emergency equipment and supplies are available all over the hospital.
c) Emergency equipment and supplies are age-appropriate.
d) Emergency equipment and supplies are replaced immediately after use or when expired or damaged.
e) Emergency equipment and supplies are checked daily for their availability and readiness.

Survey process guide:

- The GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may review a patient's medical record to evaluate compliance

with standard requirements.
- The GAHAR surveyor may review staff file for those responsible for assessment and management of patient's needs to check competence assessment.
- The GAHAR surveyor may check emergency equipment or supplies to assess continuous maintenance and checking.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. All staff members involved in life-threatening conditions management are aware of the hospital policy.
3. Management of medical emergencies and cardio-pulmonary arrests occurs safely.
4. Management of medical emergencies and cardio-pulmonary arrests is recorded in the patient's medical record.
5. Equipment and supplies are checked daily and replaced after use.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage.
ICD.33 Critical care; ICD.37 Recognition and response to clinical deterioration.

ICD.37 NSR.09 The hospital has an approved policy and procedures to ensure hospital-wide recognition of and response to clinical deterioration.

Safety

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

a) Defined criteria of recognition of clinical deterioration.
b) Education of staff members on the defined criteria.

c) Identification of involved staff members to respond.
d) Mechanisms to call staff members to respond; including code(s) that may be used for calling emergency.
e) The time frame of response.
f) The response is uniform 24 hours a day and seven days a week.
g) Recording of response and management.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ICD.36 Emergency equipment and supplies; ICD.33 Critical care; ICD.37 Recognition and response to clinical deterioration.

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

Safety

Keywords:

Cardiopulmonary resuscitation and medical emergencies.

Intent:

Any patient receiving care within a hospital is liable to suffer from a medical emergency requiring a rapid and efficient response. Time and skills are essential elements for an emergency service to ensure satisfactory outcomes. Therefore, trained staff members, at least on basic life support, should be available during working hours ready to respond to any emerging situation. The hospital develops and implements a policy and procedures to ensure safe management of medical emergencies and cardio-pulmonary arrests. The policy addresses at least the following:

a) Defined criteria of recognition of emergencies and cardio-pulmonary arrest including adults and pediatrics.
b) Education of staff members on the defined criteria.
c) Identification of involved staff members to respond.
d) Mechanisms to call staff members to respond; including code(s) that may be used for calling emergency.
e) The time frame of response.
f) The response is uniform 24 hours a day and seven days a week.
g) Recording of response and management.

Survey process guide:

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

and communication of medical emergencies or cardio-pulmonary arrest.
- The GAHAR surveyor may observe compliance with policies for medical emergencies and cardio-pulmonary arrest.

Evidence of compliance:

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

Related standards:

ICD.36 Emergency equipment and supplies; ICD.33 Critical care; ICD.37 Recognition and response to clinical deterioration.

Diagnostic and Ancillary Services

Chapter intent:

Patients seek medical help for the determination and treatment of various health problems. Sometimes a combination of the patient's history and a clinical examination by a physician are enough to decide whether medical treatment is needed, and what treatment should be given. However, often laboratory investigations or diagnostic imaging procedures are required to confirm a clinically suspected diagnosis or to obtain more accurate information.

The scope of this chapter covers the following diagnostic and ancillary services

Diagnostic Imaging

- Radiological Imaging
- Ultrasound
- Mammography
- Nuclear medicine
- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Echocardiography
- Bone densitometry

Laboratory Medicine

- Sample collection
- Chemistry and Immunology
- Microbiology
- Hematology
- Anatomic pathology and cytology
- Molecular Biology
- Cytogenetics
- Point-of-care testing

Transfusion medicine

There are generally three phases in the process of diagnostic investigation:

1. Before doing the investigation: comprises the time and all processes for the preparation of a patient for a diagnostic investigation to the moment when the investigation is performed.
2. During doing the investigation: comprises the time and all processes of a diagnostic investigation.

3. After doing the investigation: The post-analytical phase comprises the time and all processes for reporting the results of the diagnostic investigation to the person who then provides care to the patient.

Made errors during each phase influence the clinical relevance of a diagnostic report, and precautions should be taken to avoid results that are misleading or provide false information.

The diagnostic services familiarizes the clinician with the value of the information obtained from an investigation, including its diagnostic specificity. This requires constant communication between clinical staff and the diagnostic service. Diagnostic reports are valuable only when the information can be used for patient management. It is, therefore, an obligation for the diagnostic service to provide the results to the clinician in a timely manner so that the results can be interpreted together with the clinical findings for the patient.

The chapter also covers blood transfusion services as one of the critical ancillary services. The quality and safety of blood and blood products should be assured and traced throughout the process from the selection of blood donors to the administration of blood to the patient or safe disposal of the blood/ blood component.

From the national perspective, laws, regulations, and guidelines are covering most of the critical processes and offer guidance to the healthcare professionals for the provision of appropriate safe care especially in the Medical Imaging and transfusion services, In the laboratory and other diagnostic services international guidelines are available to ensure effective analysis.

GAHAR surveyors may be focusing on the communication of the patient information to ensure correct and effective patient management plans. The accuracy and precision of the results reported to clinicians are one of the main targets of the survey together with the safety of the patients, staff, and facility since significant organization hazards are present in these areas, whether biological, chemical, radiological or others.

Chapter purpose:

The main objective is to ensure that the hospital provides diagnostic services and blood bank service safely and effectively; that is why the chapter discusses the following objectives:

- Safe and effective medical imaging services.
- Safe and effective clinical laboratory and pathology services.
- Safe and effective blood transfusion services

Implementation guiding documents:

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

1. National law for laboratories, 367/ 1954
2. Law 59/1960 regulation of Medical Imaging work
3. Law 178/1960 on organizing blood collection transport and storage
4. Law 104/1985 Blood banking services
5. MOHP Ministerial decree 385/1975 for management of blood banks
6. MOHP Ministerial decree 420/1994 for blood donor incentives
7. Law 192/2001 for Hazardous waste management
8. National Blood transfusion Policy, MOHP, 2007
9. Anatomic pathology and Microbiology checklists, CAP accreditation program, 2014
10. ISO 15189, 2012
11. Requirements of blood bank staff, Egyptian MOHP
12. Requirements and equipment of blood bank, Egyptian MOHP
13. Requirements of a sub-blood bank, Egyptian MOHP
14. Tuberculosis Labs manual, Egyptian MOHP 2015
15. Laboratory biosafety manual, WHO, 2007
16. Good clinical diagnostic practice, WHO, 2005
17. Lab quality management system, WHO, 2011
18. Egyptian Swiss Radiology program, MOHP
19. List of essential in-vitro diagnostic tests, WHO, 2018
20. Law 51/1981 for healthcare organizations

Medical Imaging

Efficient planning and management of radiological services

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

Efficiency

Keywords:

Planning medical imaging services.

Intent:

Medical Imaging is a cornerstone of any hospital. An efficient, high-quality, medical imaging service increases patient satisfaction as a result of its ability to improve patient care. Over time, the service adds significant patient's volumes to the hospital.

The location of medical imaging is important for easy access by emergency patients, ambulant patients and inpatients, different functional areas needs to be identified.

Special attention given to the design of a medical imaging unit such as structural support for equipment, equipment positioning and safe patient movement, provision for cable support trays, ducts or conduits may be made in floors, walls, and ceilings, Equipment ventilation, required space and required special human expertise.

Medical Imaging services being expensive and complex are selected and agreed upon accordingly by the hospital leaders according to a study of the needs of the center that may dynamically change from one year to another thus continuous evaluation is required.

The hospital should plan and design a system for providing medical imaging services required by its patient population, clinical services offered, and healthcare practitioner needs.

The hospital can provide some or all of the services on-site or can refer to/ contract with other healthcare professionals for some or all of the services, quality expectations and professional standards.

When a medical imaging service is provided outside the designated radiology service area, it should follow the same protocols, guidelines, and safety procedures as the hospital main radiology service area.

The medical imaging services should meet national laws, regulations, and applicable guidelines.

Survey process guide:

- GAHAR surveyor may learn about the provision of medical imaging services through

the hospital orientation session, licenses and permits may be reviewed during environment and facility plans evaluation session.
- 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 uniformity and standardization of services.
- GAHAR surveyor may review contractual agreements and related reports during financial stewardship review session or during leadership interview session.

Evidence of compliance:
- Medical Imaging services provided either onsite or through outside source meet laws, regulations, and applicable guidelines.
- All related licenses, permits and guidelines are available.
- Medical Imaging list of services meets the scope of clinical services of the hospital.
- Medical Imaging services are provided in a uniform manner regardless of time or location.
- The hospital demonstrates evidence of monitoring of the quality and safety of outsourced medical imaging services.
- There is evidence of annual evaluation of the medical imaging services provided in a report discussed by the hospital leaders and presented to the governing body.

Related standards:
ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage; ICD.01 Uniform care; ACT.01 Granting access (before patient registration)
ACT.05 Physical access and comfort; ACT.13 Patient transportation; PCC.17 Patient needs; PCC.21 Patient and family feedback; PCC.21 Complaints and suggestions

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

Efficiency

Keywords:
Provision of medical imaging service.

Intent:
Medical imaging professionals are vital members of a multidisciplinary team that forms a core of highly trained healthcare professionals, who each bring expertise to the area of patient care.

They also play a critical role in the delivery of health services as new modalities emerge and the need for medical imaging procedures increases within the laws and regulations. Medical imaging integrates scientific knowledge, technical competence, and patient interaction skills to provide safe and accurate procedures with the highest regard to all aspects of patient care.

Medical imaging professionals remains sensitive to the needs of the patient through good communication, patient assessment, patient monitoring and patient care skills. As members of the healthcare team, medical imaging professionals participate in quality improvement processes and continually assess their professional performance.

When Medical Imaging services are provided on-site at the hospital they are managed by a healthcare professional who is qualified by education and training consistent with applicable laws and regulations.

The medical imaging services develops a policy and procedures describing the performance and documentation of staff members' competency assessment that addresses at least the following:

a) Direct observation of routine work processes and procedures, including all applicable safety practices.
b) Direct observation of equipment maintenance, function checks; and monitoring recording and reporting of examination results
c) Review of imaging professionals human resources records.
d) Assessment of problem-solving skills;
e) Training on special modalities, equipment, and studies.
    - Competence of medical imaging services staff can be assessed annually using any combinations, all of the approaches mentioned in the policy or following the guidelines according to the assigned job.
    - Privileges for performing each medical imaging service function is determined based on documented evidence of competency (experience- qualifications – certifications-skills) that is reviewed and renewed as needed.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy that addresses all the mentioned elements

from a) through e) in the intent.

2. Privileges are granted for performing each medical imaging service function based on assessed competencies.
3. Competency assessment is performed annually and recorded in medical imaging staff file.
4. There is a mechanism to grant privileges temporarily in emergency situations.

Related standards:

WFM.02 Staffing plan; WFM.04 Job description; WFM.03 Recruitment; WFM.05 Verifying credentials; WFM.09 Staff performance evaluation.

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

Effectiveness

Keywords:

Technical standards (Practice Parameters).

Intent:

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

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

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

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

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

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

The hospital develops and implements procedures for medical imaging to ensure safety and usability of modalities.

For each modality, Procedure manuals addresses at least the following:

a) Scope and general overview

b) Equipment description
c) Maintenance procedures
d) Quality control
e) Safety procedures
f) Critical findings

Survey process guide:

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 assess compliance with standard requirements.

Evidence of compliance:

1. The medical imaging service has a written procedure for each study type.
2. Procedure manuals are readily available in the medical imaging department. Each procedure includes all the required elements from a) through f) in the intent.
3. Staff are trained and knowledgeable of the contents of procedure manuals.
4. The procedures are consistently followed.
5. Authorized staff members review the procedures on predefined intervals.

Related standards:

ICD.30 Critical results; ACT.15 Patient flow out; DAS.02 Provision of medical imaging services.

Effective operational processes of medical imaging

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

Effectiveness

Keywords:

Pre-examination process

Intent:

Pre-examination processes in the path of workflow for medical imaging include all activities from the time the medical imaging services are ordered through the time that the patient is present in the medical imaging service area.

Medical imaging service should provide referrers and patients with information regarding the merits of the various diagnostic imaging techniques, so that referrers can make informed decisions about the diagnostic information and relative value of the range of studies provided as information about patient preparation requirements is important to ensure effectiveness.

The medical imaging service develops and implements a pre-examination policy that can be in the form of medical imaging service manual and communicate it with all service users.

The policy includes at least the following:

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

Survey process guide:

- GAHAR surveyor may review medical imaging pre-examination policy during document review session.
- GAHAR surveyor may trace a patient receiving a medical imaging service and review service request, patient preparation and service manual.
- GAHAR surveyor may interview nurses and other healthcare professionals to check their awareness on preparation requirements.
- 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 request review, patient identification process and communication with referrers and patients.

Evidence of compliance:

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

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

Related standards:

ICD.17 Order and request; ICD.18 Verbal and telephone orders; ACT.03 Patient identification; ACT.16 Referral and transfer sheet; PCC.09 Patient education materials; PCC.11 Informed consent.

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

Effectiveness

Keywords:

Medical imaging quality assurance and control

Intent:

Management of the routine quality control (QC) of medical imaging equipment is a major responsibility of the medical imaging professionals.

Quality control measures are performed to monitor and ensure the reliability of study results produced by the medical imaging service.

Quality controls can identify performance problems not identified by quality control systems and helps the medical imaging service to determine accuracy of images.

Management of routine quality control includes developing the QC protocols, implementation of the program, oversight of the program, and responsibility for determining the need for corrective action.

Quality control data is reviewed at regular intervals and recorded.

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

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

a) Elements of the internal quality control performed according to risk assessment for each study/modality.
b) The frequency for quality control testing is determined by the hospital according to guidelines and manufacturer instructions whichever is more stringent.

c) Quality control methods to be used. It can be handled and tested in the same manner and by the same medical imaging staff member.
d) Quality control performance expectations and acceptable results should be defined and readily available to staff so that they will recognize unacceptable results in order to respond appropriately.
e) The quality control program is approved by the designee prior to implementation.
f) Responsible authorized staff member reviews Quality Control data at a regular interval (at least monthly).
g) Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

Survey process guide:

- GAHAR surveyor may visit areas were medical imaging services are provided including radiology department or other departments where portable medical imaging services are provided to check quality control procedures and records.
- GAHAR surveyor may interview medical imaging service staff members and other healthcare professionals to check their awareness on quality control performance.

Evidence of compliance:

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

Related standards:

DAS.03 Technical standards practice parameters

DAS.06 Medical imaging examination is consistent, safe and effective.

Safety

Keywords:

Medical imaging examination protocols.

Intent:

Medical imaging service protocols ensure that, where it is known, the clinical radiologist is not available to provide appropriate additional input for particular modalities or examinations, as detailed in the protocols, the medical imaging team members do not proceed with an examination.

Medical imaging service shall develop documented professional supervision protocols for the performance of imaging examinations under the professional supervision of the clinical radiologist.

Documented imaging protocols shall be available and include all necessary information for the proper conduct of the examination, considering any specifications for the required qualifications, experience, and specialization of the healthcare professionals.

The hospital shall ensure that examinations requiring sedation of the patient are not undertaken unless an appropriately trained medical staff member is available to immediately personally attend the patient, and the safety requirements are met.

These protocols shall cover radiographic factors, positioning, sterile tray set-up, and aftercare according to the relevant examinations and/or modalities performed at the service.

These protocols shall also address medical emergencies.

Imaging protocols for pediatric patients shall optimized to obtain the required imaging data while delivering the lowest radiation dose possible and with minimal use of sedation and anesthesia.

Survey process guide:

- GAHAR surveyor may review medical imaging examination protocols.
- GAHAR surveyor may trace and observe a patient receiving a medical imaging service and review positioning, radiographic factors, sterile tray set-up or aftercare processes.
- GAHAR surveyor may interview medical imaging staff members to check their awareness on examination protocols.
- 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 observe medical imaging equipment, setup, and modalities.

Evidence of compliance:

1. Medical imaging protocols are documented and they address radiographic factors, positioning, sterile tray set-up, and aftercare according to the relevant examinations

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

Related standards:
DAS.03 Technical standards practice parameters.

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

Timeliness

Keywords:
Medical imaging reports.

Intent:
Reporting medical imaging investigations within the planned and targeted time frame is crucial for proper decision making and an essential function of the service, whenever emergency conditions occur.
Turnaround time (TAT) is the time interval from the time of submission of a process to the time of the completion of the process.
The process is initiated when a request is made. A medical imaging service staff member identify the patient and performs the study. Next stage is to record the study result and write a report for it and finally the result is sent back to the referring medical staff member.
The hospital develops and implements a policy and procedures to guide the process of reporting medical imaging investigations that addresses at least the following:
a) Time frames for reporting various types of images to healthcare professional and to patients.
b) Emergency and routine reports.

c) Accountabilities on the medical Imaging services across the hospital.
d) Qualified licensed medical staff member is responsible for interpretation and reporting.

The medical imaging service shall have an implemented process for notifying the referrer when a study is delayed.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) through d).
2. Staff members involved in interpreting and reporting results are competent to do so.
3. Results are reported within approved timeframe.
4. The hospital tracks, collects, analyzes, and reports data on its reporting times for medical imaging services.
5. The hospital acts on improvement opportunities identified in its medical imaging service reporting times.
6. Delays in reporting medical imaging studies are notified to referrers.

Related standards:

ICD.36 Emergency equipment and supplies.

Safe medical imaging studies

DAS.08 Copies of medical Imaging results are recorded in the patient's medical record.

Safety

Keywords:

Medical imaging results

Intent:

The written medical Imaging report is the most important means of communication between the radiologist and the referring medical staff member.

It is part of the patient's medical record, and interprets the investigation in the clinical context.

Appropriate construction, clarity, and clinical focus of a radiological report are essential to high quality patient care that addresses at least the following:

a) The hospital name.
b) Patient identifiers on each page.
c) Type of the investigation.
d) Results of the investigations.
e) Time of reporting.
f) Name and signature of the reporting medical staff member.

Survey process guide:

- GAHAR surveyor may perform patient's medical record review and assess completion of medical imaging service reports.
- GAHAR surveyor may interview nurses, medical imaging service staff members and other healthcare professionals to inquire about report completion requirements and actions to be taken in case of incomplete reports.

Evidence of compliance:

1. There is a process to complete medical imaging reports that addresses all elements mentioned in the intent from a) through f).
2. All medical imaging staff involved in result reporting are aware of the required elements.
3. Complete medical imaging reports are recorded in the patient's medical record.
4. When reports are not complete, there is a process to inform reporting medical staff member.

Related standards:

ACT.03 Patient identification; ICD.30 Critical results.

DAS.09 NSR.25 Radiation safety program is developed and implemented.

Safety

Keywords:

Radiation Safety Program.

Intent:

Radiation safety program provides information and training on the theory, hazards, biological effects, protective measures, monitoring and disposal of radioactive materials and radiological equipment; develops policies by which radiological equipment are used safely; ensures compliance with regulations; and provides emergency response assistance.

The hospital environment, staff, patients, relatives and vendors should be safe from radiation hazards, as medical Imaging services are provided on-site, the hospital has a radiation safety program that shall address all components of the hospital medical Imaging services.

The hospital develops and implements a program to guide the process of radiation safety program to ensure hospital environment, staff, patients, families, and vendors are safe from radiation hazards that address at least the following:

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

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved radiation safety program for patients and staff that addresses potential safety risks and hazards encountered in the hospital in addition to all elements mentioned in the intent from a) through h).

2. Identified radiation safety risks are mitigated through processes and safety protective devices, for both staff and patients.
3. Staff members involved in medical imaging are aware of radiation safety precautions and receive on-going education and training for new procedures and equipment.
4. Radiation doses measured and monitored for patients and does not exceed approved maximumlevel.
5. Radiation doses for patients in all radiology areas are recorded in the patient's medical record.
6. The radiation safety program is part of the hospital environment and facility safety program.

Related standards:

EFS.02 Environment and facility safety program monitoring.

Clinical Laboratory

Appropriate planning and management

DAS.10 Laboratory services are planned, provided, and operated according to applicable laws, regulations, and applicable guidelines.

Effectiveness

Keywords:

Laboratory services planning and management.

Intent:

Planned laboratory services are critical to ensuring that communities receive good clinical care.

Despite recent major efforts to improve laboratory services, many laboratory systems are inadequate to meet priority needs.

There is a major need to develop effective laboratory plans, provision and operation to strengthen clinical care systems, as an integral part of strengthening overall hospital systems.

The hospital develops and implements a management and technical system for providing laboratory services required by its patient population ,offered clinical services, and healthcare professional needs as well as hospital mission.

Laboratory scope of services is required to be enlisted and available for patients, hospital staff, and healthcare professionals.

The designated area includes the following:

a) Is physically separate from other activities in the hospital.
b) Accommodate all laboratory activities.
c) According to the governance's requirements.

Survey process guide:

GAHAR surveyor may visit the laboratory area(s) as part of a patient tracer or hospital tour. During this visit, the surveyor may check laboratory scope of services and match it with related laws and regulations.

Evidence of compliance:

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

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage; PCC.17 Patient needs; PCC.21 Patient and family feedback; PCC.21 Complaints and suggestions.

DAS.11 Licensed, competent healthcare professionals are assigned to operate laboratory services and duties.

Effectiveness

Keywords:

Laboratory Staff.

Intent:

Laboratory competent staff have an influential role in the creation of a safe, healthy, productive working environment.

Staff competency assessment is an ongoing process for managers to evaluate an employee's work performance, identify strengths and weaknesses, offer feedback, and set goals for future performance.

The laboratory develops a policy and procedures describing the performance and

documentation of personnel competency assessment that includes at least the following:

a) Direct observation of routine work processes and procedures, including all applicable safety practices.
b) Direct observation of equipment maintenance, 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, inter-laboratory comparison materials, or split samples.

Competence of laboratory staff can be assessed annually using any combinations, all of the approaches mentioned above or following the guidelines according to the assigned job.

Privileges for performing each laboratory function is determined based on documented evidence of competency (experience- qualifications – certifications-skills) that is reviewed and renewed as needed.

Survey process guide:

- GAHAR surveyor may interview laboratory services staff members to inquire about competence assessment methods, frequency and granting privileges.
- GAHAR surveyor may review laboratory services staff members to verify competence assessment process.

Evidence of compliance:

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

Related standards:

WFM.02 Staffing plan; WFM.04 Job description; WFM.03 Recruitment; WFM.05 Verifying credentials; WFM.09 Staff performance evaluation.

DAS.12 Reagents and other laboratory supplies are managed effectively.

Effectiveness

Keywords:

Reagent Management.

Intent:

Managing laboratory reagents and supplies is important for reducing substantial costs and ensuring a high quality of reagents as direct contributors to test results. It also enables laboratory management to run the laboratory efficiently and increase productivity.

The hospital develops and implements a policy and procedures that guide the process of management of laboratory reagents and other supplies that includes at least the following:

a) Criteria for inspection, acceptance, and rejection of provided reagent
b) Methods of identification, enlisting and labeling of all reagents present in the laboratory
c) Method to ensure reagents quality before use for testing
d) Measures to ensure that the laboratory does not use expired materials
e) Define safety limits for the reordering of the laboratory materials according to the laboratory needs.
f) Requesting, issuing and dispatching reagent and supplies as well as identifying responsible person

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session.
- GAHAR surveyor may review the list of reagents and other supplies and observe their storage, labelling, use, and quality check processes.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the mentioned elements from a) through f) in the intent.
2. List of all reagents and supplies that are used for all testing processes.
3. Reagents and other supplies are inspected and accepted or rejected based on approved criteria.
4. Reagent quality is checked before use.
5. Reagents and supplies are accurately recorded and labeled.
6. Reagents are requested, issued, and dispatched effectively.

Related standards:

DAS.10 Laboratory services planning and management; PCC.17 Patient needs

DAS.13 Referral laboratory services are selected and monitored effectively.

Efficiency

Keywords:

Referral Laboratory

Intent:

A clinical Laboratory often requires the assistance of an outside laboratory or laboratories to perform unique or unusual services, as a backup service, or for routine services that the referring (primary) laboratory does not perform, as a result, primary laboratories refer selected tests as to be sent to referral laboratories.

Laboratory remains responsible for the quality of testing even when it refers samples for testing to other laboratories (referral laboratories), so the performance of the referral laboratories Should be monitored to assure the quality of performance as referral laboratory services control includes:

a) Selection

   Selection should be based primarily on quality of performance.

   Whenever possible, referral specimens are sent to a national or international accredited laboratory.

b) Evaluation:

   The laboratory should implement an evaluation process either before starting contracting, during the contract, or upon renewal of the contract for the referral laboratory through monitoring the quality of performance, turnaround time, and result reporting.

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. 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.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session, and review referral laboratory agreement and results during financial stewardship session or leadership interview session.
- GAHAR surveyor may review send-out test records in the laboratory.
- GAHAR surveyor may review the evidence of referral laboratory accreditation status.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) to c).
2. There is a written agreement between the two laboratories describing the expectations of the two parties fulfilling items in the intent from i) to viii).
3. Referral laboratory meets the selection criteria.
4. Referral laboratory is evaluated based on a predefined criteria and timeframe.
5. Records of send-out tests support compliance.

Related standards:

ACT.08 Patient care responsibility; ACT.16 Referral and transfer sheet; PCC.17 Patient needs.

DAS.14 Minimum retesting interval is utilized to assist in appropriate test requesting at all levels of the request cycle.

Efficiency

Keywords:

Minimal retesting intervals.

Intent:

Minimal retesting intervals are defined as the minimum time before a test should be repeated, based on the properties of the test and the clinical situation in which it is used. It represents the time required to allow a significant change to occur in the test. It also reflects the test's biological variability and biological half-life and is a useful guide to determine when the test should be repeated.

Any intervention that acts to reduce unnecessary test request and avoid unnecessary phlebotomy/booking appointment contributes to the optimization of patient care and proper utilization of laboratory resources.

Frequency of repeating a test should be based on a number of criteria:

a) The physiological properties affecting the analyte

b) Biological half-life
c) Analytical aspects
d) Treatment and monitoring requirements
e) Established guidelines

The following processes need to be in place to enable effective practice:

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

There shall always be the option for the clinicians/requesters to override a rule if they feel that it is clinically appropriate to continue to request the test.

If implementing the minimal retesting intervals into a laboratory information system or remote request system, the programmer shall be aware of how the system counts time so that the correct unit is used for each test.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session followed by interviewing staff members to inquire about their awareness of hospital policy, responsibilities and possibilities to override a rule.
- GAHAR surveyor may visit the laboratory to assess utilization measures and logic rules.

Evidence of compliance:

1. The hospital has an approved policy to guide the process of minimal retesting interval that addresses all elements from a) through j).
2. Medical staff members are educated on appropriate tests are requested at the right time and for the right patient.
3. Hospital approved rules are implemented in the laboratory to remove or restrict

requests based on previous patient data.
4. Requests to repeat tests are restricted to a particular grade or level of staff.
5. Medical staff members explain reasons to override a rule.
6. Utilization management measures are developed.

Related standards:
ICD.17 Order and request; ICD.18 Verbal and telephone orders; DAS.12 Reagent management

Effective operational processes in the laboratory

DAS.15 Laboratory pre-examination process is effective.

Effectiveness

Keywords:
Pre-examination process.

Intent:
Pre-examination processes is the path of workflow for clinical laboratory including all activities from the time the laboratory tests are ordered through the time that the specimens are processed and delivered to the laboratory testing location.
Informing the client of what the laboratory provides is paramount to the quality of laboratory services.
Understanding pre-analytical variation and reducing errors in the pre-examination phase of the testing process are important for improved safety and quality of laboratory services delivered to patients.
The laboratory shall develop a pre-examination policy that include all needed information for the patient and laboratory staff for at least the following:

a) Proper completion of request form to include: patient identification (Full patient name, date of birth, gender, patient contact, and location), name of the ordering physician, tests requested, date and time of specimen collection, identification of the person who collected the specimen, clinical information, type of specimen (source of specimens), special marking for urgent tests request.
b) Patient preparations including instructions for dietary requirements (e.g., fasting and special diets).
c) Description of specimen type collection techniques.
d) Proper specimen labeling.
e) Criteria for safe disposal of materials used in the collection.
f) Proper handling and transportation of specimens.

g) Turn around time of tests
h) Minimal Retesting Interval

The document shall provide an overview for the laboratory service, containing information about the laboratory to the clients and shall explain all information they need regarding the pre-examination phase.

This document should be communicated to all service users to provide valuable information about the service offered by the laboratory for best patient care.

Survey process guide:

- GAHAR surveyor may review laboratory pre-examination policy during document review session.
- GAHAR surveyor may trace a patient receiving a laboratory service and review service request, patient preparation and service manual.
- GAHAR surveyor may interview nurses and other healthcare professionals to check their awareness on preparation requirements.
- GAHAR surveyor may visit areas were laboratory services area to check request review, patient identification process and communication with requestors and patients.

Evidence of compliance:

1. The hospital has an approved policy to guide the pre-examination process that includes elements from a) to h) in the intent.
2. There is a laboratory service manual distributed to all users and available in all technical areas.
3. All staff involved in requesting laboratory tests are aware of the pre-examination policy.
4. Preparation of specimen collection and labeling requirements are implemented.
5. Specimens are handled and transported safely.
6. Specimens are disposed safely.

Related standards:

ICD.17 Order and request; ICD.18 Verbal and telephone orders; ACT.03 Patient identification; ACT.16 Referral and transfer sheet; PCC.09 Patient education materials; PCC.11 Informed consent.

DAS.16 Specimen reception, tracking, and storage processes are effective.

Effectiveness

Keywords:

Specimen reception, tracking and storage

Intent:

Specimen tracking is a process starting with specimen registration, collection, and labeling to specimen reception, analysis, and storage, to significantly allow workers to identify the specimen location, history, and status.

The hospital develops and implements a policy and procedures to describe securing patient samples and avoiding deterioration, loss, or damage during pre-examination activities and during handling, preparation, and storage.

The policy shall include at least the following:

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. Suboptimal specimen: Recording includes the date and time of specimen's reception/registration and the identity of the person, Indications of acceptance of suboptimal specimens and measures taken accordingly.
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.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session followed by interviewing staff members to inquire about their awareness of hospital policy.
- GAHAR surveyor may visit the laboratory to review records of received specimens and match reasons for rejection with approved criteria.

- GAHAR surveyor may also review laboratory specimen identification and traceability process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements in the intent from a) through e).
2. All staff involved in receiving specimens are aware of the policy requirements.
3. All received and accepted specimens are recorded including date and time of specimen's reception and the identity of the person receiving the sample.
4. Records for specimen rejection and specimens referred to other laboratories are maintained and include all data mentioned in the intent.
5. Evidence of traceability of all portions of the primary sample to the original primary sample.
6. Samples are stored in appropriate conditions during all pre-examination activities.

Related standards:

ICD.17 Order and request; ICD.18 Verbal and telephone orders; ACT.03 Patient identification.

DAS.17 Verified/validated analytical test methods are selected and performed.

Effectiveness

Keywords:

Verified / Validated test methods

Intent:

Analytical laboratory techniques and testing provide the data required to make critical decisions during clinical care, drive test improvement or meet regulatory compliance requirements.

In depth knowledge of analytical laboratory technologies and how to apply them to a specific sample is critical to driving understanding about a test during analysis.

These technologies are often highly specialized analytical instruments which can only be operated by competent professionals.

In order to ensure accurate and relevant test results, the laboratory uses accurate and reproducible analytical methods. This can be confirmed when the specified requirements for each examination procedure relate to the intended use of that examination.

The hospital shall assign competent staff member for different activities of the selected methods.

The validated examination procedures, used without modification shall be subject to verification by the laboratory before being in routine use.
The laboratory shall develop a policy for verification of examination procedure following reliable guidelines.
Once the manufacturer claim is confirmed, the laboratory documents the procedures used for verification, records the results obtained and the staff with the appropriate authority.
Whenever applicable, Verification of performance characteristics of the process shall include at least the following:

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

The laboratory shall validate the examination procedures when:

d) Using a non-standard method.
e) The standard method used outside its intended scope.
f) The validated method with modification.

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

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session and check the references used, followed by interviewing staff members to inquire about their awareness of hospital policy, their competence and knowledge of the introduced or changed tests.
- GAHAR surveyor may visit the laboratory to review verification/ validation and revalidation records.

Evidence of compliance:

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

on predetermined guidelines.

5. There is recorded evidence of reverification/revalidation whenever indicated.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage;; DAS.10 Laboratory services planning and management.

DAS.18 Instructions for performing test methods and procedures are consistently and effectively followed.

Effectiveness

Keywords:

Examination procedures

Intent:

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

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

A procedure manual provides a foundation for the laboratory's quality assurance program.

The laboratory shall provide carefully documented instructions—in the form of procedures—for all activities that support the performance of analytic testing. These instructions provide essential information for both new and experienced employees on how to perform all examination procedures.

Its purpose is to ensure consistency while striving for quality.

The laboratory shall develop technical procedures for all analytical test methods.

The technical laboratory procedures should be written in a language commonly understood by the working staff and available in an appropriate location.

It could be in a paper-based, electronic, or web-based format.

The Laboratory technical procedures are consistently followed and regularly reviewed.

They include at least the following:

a) Principle and clinical significance of the test.
b) Requirements for patient preparation and specimen type, collection, and storage. 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) Verified/Validated 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.

Survey process guide:

- GAHAR surveyor may review laboratory procedures.
- GAHAR surveyor may trace and observe a patient undergoing a laboratory service and review preparation processes.
- GAHAR surveyor may interview laboratory staff members to check their awareness on analytic procedures.
- GAHAR surveyor may visit areas laboratory service areas to observe medical calibration, reagent use, ranges and results.

Evidence of compliance:

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

Related standards:

DAS.20 Laboratory internal quality assessment; DAS.12Reagent management

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

Effectiveness

Keywords:

Laboratory Internal quality assessment

Intent:

Internal quality control testing is performed within a laboratory to monitor and ensure

the reliability of test results produced by the laboratory.
Control materials are used to monitor the test system and verify that quality patient test results have been attained.
A control is a stabilized sample with a predetermined range of result values that simulates a patient sample.
Quality control data shall be reviewed at regular intervals (at least monthly) and shall be recorded.
Outliers or trends in examination performance, that may indicate problems in the examination system, shall be analyzed, followed up and preventive actions shall be taken and recorded before major problems arise.
The laboratory develops and implements a procedure for internal quality control which shall include at least the following:

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

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved procedure describing the internal quality control process of all laboratory tests addressing all elements in the intent from a) through

h).
2. Laboratory staff members involved in internal quality control are competent in internal quality control performance.
3. All quality control processes are performed according to the internal quality control procedure.
4. All quality control processes are recorded.
5. Responsible authorized staff member reviews quality control and function check data at least monthly.
6. Corrective action is taken when indicated.

Related standards:
DAS.20 Laboratory external quality assessment; DAS.12 Reagent management.

DAS.20 External quality assessment program or its alternatives is developed and implemented.

Effectiveness

Keywords:
Laboratory external quality assessment

Intent:
External quality control program is a system designed to objectively assess the quality of results obtained by laboratories, by means of an external body.
It provides a measure for individual laboratory quality and "state of the art" for a test, It supplements internal quality control procedures, It obtains consensus values when true values are unknown and it acts as an educational stimulus to improvement in performance.
External quality testing can identify performance problems not identified by internal quality control systems and helps the laboratory determine how its results compared with those of other laboratories that use the same methodologies.
The laboratory shall participate in an external quality assessment program that covers the maximum number and complexity of tests performed by the laboratory.
The laboratory shall subscribe to proficiency testing according to the laboratory scope.
The laboratory shall test proficiency specimens according to a written protocol and submits results back to the proficiency-testing provider within the required time.
Samples shall be tested along with the laboratory's regular patient testing workload by staff members who routinely perform the laboratory test(s) using routine methods.
The laboratory shall not send samples to another laboratory for analysis.

Review of returned results includes the following:

a) When results are graded and returned, the laboratory director or a designated supervisor shall review the report and documents the review.
b) Remedial action is recorded for any single or multiple challenges of each analyte that does not fall within acceptable limits.
c) The results are used for education, reeducation, or training of one or more employees whenindicated.

The laboratory shall consistently analyze and report results. Records for test handling, examination, and reporting results are retained for at least two years.

When there is no proficiency testing available, the laboratory performs interlaboratory comparison according to guidelines. This system is used, and its results are recorded at least semiannually.

Survey process guide:

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

Evidence of compliance:

1. The laboratory subscribes to an external proficiency-testing program that covers the all number of analytes performed by the laboratory and available from the provider, as well as the complexity of the testing processes used by the laboratory.
2. Evidence that the samples are tested along with the laboratory's regular patient testing workload by staff members who routinely perform the laboratory test(s) using routine methods.
3. The laboratory is consistent in testing and reporting results within the required timeframe.
4. A review of returned reports includes the requirements of elements a) through c) in the intent.
5. Records of all processes, including testing, reporting, review, conclusions, and actions, are retained for at least two years.
6. Evidence of proficiency testing alternative procedures used according to guidelines whenever no proficiency testing is available.

Related standards:

DAS.19 Laboratory internal quality assessment; DAS.12 Reagent management.

DAS.21 Laboratory post-examination process is developed and implemented effectively to ensure accurate reporting and release of verified laboratory tests.

Effectiveness

Keywords:

Post examination process

Intent:

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

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

The hospital develops and implements a policy and procedures for post examination process

The post-shall include at least the following:

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

Survey process guide:

- GAHAR surveyor may visit laboratory area to check specimen storage and retention times.
- GAHAR surveyor may perform patient's medical record review and assess laboratory result report time and authorization.
- GAHAR surveyor may interview laboratory healthcare professionals to inquire about their experience regarding laboratory retention time.

Evidence of compliance:

1. The hospital has an approved policy to guide the post-examination process that include all elements mentioned in the intent from a) through e).
2. The laboratory defines the authorized staff member who review and release the patient's results.

3. The retention process of a final laboratory report is implemented with easy retrieval.
4. The procedure of specimen storage and retention is implemented.
5. Required specimens are easily retrieved.

Related standards:

DAS.22 Laboratory turnaround time; DAS.23 STAT results, ICD.30 Critical results.

DAS.22 Laboratory results are reported within the acceptable turnaround time.

Timeliness

Keywords:

Laboratory turnaround time.

Intent:

Turnaround time (TAT) is a period of time required for completing a particular process. TAT is commonly measured in the clinical analyses in the lab, but nowadays, TAT includes all the phases from request of the samples till the reporting of test results.

The process is initiated when a request is made. A nurse or phlebotomist identify the patient and draw the specimen. Next stage is to transport the specimen to the laboratory, and record the sample when it arrives in the laboratory. Thereafter, the sample is being analyzed and finally the result is sent back to the requesting medical staff member.

The laboratory shall develop a policy defining the total turnaround time for each laboratory test.

The laboratory shall have a process for measuring turnaround times and shall assign responsible laboratory staff member for measuring and monitoring it.

The process includes means to ensure that turnaround times are acceptable. When turnaround times for one or more tests are unacceptable, laboratory leaders evaluate the data and, when necessary, the testing process and take action to either modify the testing and reporting process or set more reasonable turnaround times.

The laboratory shall have an implemented process for notifying the requester when testing is delayed.

Survey process guide:

- GAHAR surveyor may trace a patient receiving a laboratory service and review service request, sample time, test time and reporting time.
- GAHAR surveyor may perform patient's medical record review and assess laboratory result report time.

- GAHAR surveyor may interview nurses, medical staff members and other healthcare professionals to inquire about their experience regarding laboratory service reporting time.

Evidence of compliance:

1. The hospital has approved policy and procedures defining each laboratory test's total turnaround time and means of measuring it.
2. Turnaround times are reviewed and monitored for laboratory tests.
3. Cases of unacceptable turn-around time are investigated, and proper actions are taken accordingly.
4. The hospital tracks, collects, analyzes, and reports data on its reporting times for laboratory tests.
5. The hospital acts on improvement opportunities identified in its laboratory service reporting times.
6. Delays in turnaround time are notified to requestors.

Related standards:

DAS.21Post examination process; ICD.04 Emergency care services; ICD.06 Emergency care recording; DAS.23 STAT results.

DAS.23 STAT results are reported within safe and effective timeframe.

Safety

Keywords:

STAT results.

Intent:

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

The laboratory shall develop processes to meet the needs of its customers for rapid test and improve turn-around time of emergency samples with the aim of reaching quicker diagnosis.

The laboratory process for urgent samples shall address the four main parts to the STAT testing process. ordering, collection, testing, and results reporting.

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

Survey process guide:

- GAHAR surveyor may trace a patient receiving a laboratory service and review

service request, sample time, test time and reporting time.
- GAHAR surveyor may perform patient's medical record review and assess laboratory result report time.
- GAHAR surveyor may interview nurses, medical staff members and other healthcare professionals to inquire about their experience regarding STAT laboratory service reporting time.

Evidence of compliance:

1. The hospital has an approved policy to guide ordering, collection, testing and results reporting of urgent tests.
2. The laboratory has a STAT List of tests with acceptable STAT reporting time for each laboratory test is defined.
3. STAT tests turnaround times are reviewed and monitored for laboratory tests.
4. Cases of unacceptable STAT turn-around time are investigated, and proper actions are taken accordingly.
5. Delays in STAT turnaround time are notified to requestors.

Related standards:

DAS.21 Post examination process; ICD.04 Emergency care services; ICD.06 Emergency care recording; DAS.22 Laboratory turnaround time.

Safe laboratory services

DAS.24 NSR.26 A comprehensive documented laboratory safety program is implemented.

Safety

Keywords:

Laboratory Safety Program.

Intent:

The laboratory environment can be a hazardous place to work.

Laboratory staff member are exposed to numerous potential hazards including chemical, biological, physical and radioactive hazards, as well as musculoskeletal stresses.

Laboratory safety is governed by numerous regulations and best practices. Over the years, multiple guides were published to make laboratories increasingly safe for staff members.

Laboratory management should design a safety program that maintains a safe environment for all laboratory staff, patients, and families.

The laboratory should have a documented program that describes the safety measures for laboratory facilities according to the national requirements.
This program should be properly implemented and communicated to all staff. The program shall include at least the following:

a) Safety measures for Healthcare professionals.
b) Safety measures for the specimen.
c) Safety measures for the environment and equipment.
d) Incidents handling and corrective action are taken when needed.
e) Proper Disposal of Laboratory Waste.
f) Material Safety Data Sheets (MSDS) Requirements.
g) Handling Chemical Spills/Spill Clean Up.
h) Instructions for the use of personal protective equipment.
i) Risk management process.

Survey process guide:

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

Evidence of compliance:

1. A written program that describes safety measures for laboratory services and facilities is documented and includes the items in the intent from a) to i).
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 tracks, collects, analyzes and reports data on laboratory safety program and it acts on identified improvement opportunities.

Related standards:

EFS.02 Environment and facility safety program monitoring.

Effective Point of care testing

DAS.25 Point-of-care testing is monitored for providing accurate and reliable results.

Effectiveness

Keywords:
Point of care testing.

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

Survey process guide:
During tracers and tours, GAHAR surveyor may review procedure manual in each point of care testing area, patient results and reporting process, quality control, maintenance, and function checks, evidence of testing staff member training and competency records.

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

Related standards:
DAS.19 Laboratory internal quality assessment; DAS.20 Laboratory external quality assessment; DAS.12 Reagent management; PCC.17 Patient needs.

Blood Transfusion Services

Efficient planning and management of blood bank

DAS.26 Blood transfusion services are planned, operated and provided uniformly according to applicable laws, regulations and clinical guideline /protocol.

Efficiency

Keywords:

Blood Transfusion services management.

Intent:

With the growing population and the advancement in medical science, the demand for blood has increased. Lack of communication between the blood donors and the blood recipients lead to a situation where most of the patients in need of blood do not get blood on time.

Improper management of blood may lead to wastage of the available blood inventory.

These problems can be dealt with by developing a robust management system for blood transfusion services to bridge the gap between the donors and the recipients and to ensure safety and efficiency.

The blood bank should function under the direction of a certified physician who is trained and experienced on blood bank activities

Blood bank should have its own policies and procedures manual.

The manual addresses at least the following:

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

Suitable and safe space, environment and equipment should be available

All blood bags, tubes, connections, reagents and supplies used for storage, preservation or testing of blood and blood components should meet professional requirements

Survey process guide:

- GAHAR surveyor may visit areas where blood banking and transfusion occur as part of a patient tracer or hospital tour. During these visits, Surveyor may check space and design to ensure safe blood transfusion process
- GAHAR surveyor may interview blood transfusion services staff members to inquire about competence assessment methods, frequency and granting privileges for requestors
- GAHAR surveyor may review blood transfusion services staff members' files to verify competence assessment process.

Evidence of compliance:

1. There is an approved quality manual that addresses all elements mentioned in the intent from a) through j).
2. All blood transfusion staff members are aware of the quality manual.
3. Blood transfusion services have suitable space, environment, equipment and supplies.
4. Blood transfusion services are monitored by a licensed qualified medical staff member.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage

Effective operational processes of blood transfusion service

DAS.27 Blood is accepted only from voluntary, non-remunerated, low risk, safe and healthy donors.

Safety

Keywords:

Safe blood donation.

Intent:

Millions of people need blood transfusions each year. Some may need blood during surgery. Others depend on it after an accident or because they have a disease that requires blood components. Blood donation makes all of this possible.

There is no substance yet that can act as a 100% substitute for human blood functions. Blood donation remains the main source of human blood

The hospital develops and implements a policy and procedures for donors selection

and retention.

The policy shall include at least the following:

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
   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 behaviors and self-exclusion for patient safety, tests carried out on donated blood and potential side effects. (questionnaires may be used)
d) Donor safety and privacy

Survey process guide:

- GAHAR surveyor may review blood transfusion services policy during document review session.
- GAHAR surveyor may interview a person donating blood unit to inquire about assessment and counseling.
- GAHAR surveyor may review blood donation records.
- GAHAR surveyor may visit areas were blood donation 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).
2. Blood bank staff are aware of the hospital policy.
3. Blood donors are selected safely
4. Blood donors receive pre-donation counselling.
5. Blood donor selection and counselling is recorded.

Related standards:

DAS.26 Blood transfusion services management.

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

Safety

Keywords:
Blood Procurement.

Intent:
Blood collection has been practiced for centuries and is still an invasive procedure in healthcare.
Each step in the process of blood procurement (collection, handling and testing) affects the specimen quality, thus it is important for preventing specimen laboratory error, subsequent patient injury or even death.
For example, the touch of a finger to verify the location of a vein before insertion of the needle increases the chance that a specimen will be contaminated. This can cause prolong hospitalization, delay diagnosis and cause unnecessary use of antibiotics.
The hospital develops and implements a policy for management of blood and blood components.
The policy addresses at least the following:

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

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through d) and based on national guidelines.
2. Blood bank staff 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

Related standards:

DAS.26 Blood transfusion services management; APC.02 Monitoring safety requirements.

DAS.29 Blood and blood components are labelled, stored in the blood bank according to regulations and national requirements.

Effectiveness

Keywords:

Blood Storage.

Intent:

Blood banking is logistic in nature. It attempts to bring the potentially life-saving benefits of transfusion to the patient who needs them by making blood and/or blood components available, safe, effective and cheap.

The easiest way to ensure the timely availability of blood and/or is to have an appropriate inventory on the shelf at all times.

A numeric or alphanumeric system should be used, that will track any unit of blood or component from source to final destination and to recheck records applying to the

specific unit. Labels should include at least the following:

a) Traceable number
b) Name of blood bank
c) Product type and volume
d) Blood group and Rh group
e) Seronegative
f) Used anticoagulant, when applicable
g) Required storage conditions
h) Date of collection
i) Date of expiry

Storage conditions should limit deterioration and prevent damage to materials in process and final products. Storage should be access-controlled.

Refrigerators, freezers and platelets incubators in which blood and blood components are stored should be used for storage of blood, blood components and blood samples only and not for any other items and should have monitored temperature as per approved guidelines

Expiry dates should be monitored and actions are taken for expired blood or blood components as per approved guidelines

Blood bank should have physical separation between screened and unscreened blood bags

Method of disposal of blood bags Should comply with requirements of waste management rules, regulations, and approved hospital process.

Survey process guide:

- During the GAHAR survey, the surveyor may observe at the blood storage and preparation areas to assess storage conditions and labeling.
- Areas such as perioperative and procedural settings may be visited to check handling conditions of blood bags before their use

Evidence of compliance:

1. There is a system is in place to ensure that blood/blood component bags are labelled seronegative according to serological investigation.
2. Labels of blood and/or blood components include all elements in the intent from a) through i).
3. There is a system in place to trace blood and blood products from entry into the hospital to transfusion, discard or transfer.
4. Blood and/or blood components are stored under access-controlled and

temperature-controlled conditions.
5. An alarm system and a provision for alternate power supply is available.
6. Expired blood or blood components are managed effectively.

Related standards:
DAS.26 Blood transfusion services management.

DAS.30 Obtaining blood from a blood bank outside the hospital has a safe and effective process.

Safety

Keywords:
Contracted blood banks.

Intent:
Due to regulations organizing blood transfusion services and the pressure to provide quality services while operating cost-effectively, providing all required blood and blood components types in-house becomes unfeasible.
As a result, hospital blood bank may obtain blood units from an outside blood bank.
Blood bank should take all necessary measures to ensure quality of blood or blood components; this means that the performance of the outside blood bank should be evaluated to assure the quality of performance.
Proper control of outside blood bank services includes:

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
   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:
   i. Checking for meeting predefined acceptance criteria for each blood component received.
   ii. Evaluation and verification of units' identification information including unit numbers, ABO/Rh-D and Expiration dates.
   iii. Conformation of ABO/Rh-D for RBC components.
   iv. Actions taken for unsatisfactory blood or blood component units.
   v. Evaluation and verification of the transportation condition of each blood component.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session, and review contracted blood bank agreement and results during financial stewardship session or leadership interview session.
- GAHAR surveyor may review records in the blood bank or observe the receiving process.

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements mentioned in the intent from a) to d).
2. There is a written agreement between the two blood banks describing the expectations of the two parties fulfilling items in the intent from i) to xiii).
3. Contracted blood bank meets the selection criteria.
4. Contracted blood bank is evaluated based on predefined criteria.
5. Blood bank staff members involved in receiving blood or blood components from contracted blood banks are aware of the predefined acceptance criteria.
6. Records of inspecting received blood and blood components support compliance.

Related standards:

APC.02 Monitoring safety requirements, OGM.15 Contract Management, DAS.26 Blood transfusion services management.

Safe transfusion services

DAS.31 Requesting blood and/or blood component services occurs in a safe and effective way.

Safety

Keywords:
Ordering of blood and blood products.

Intent:
Access to sufficient supplies of safe blood and blood products provided within a blood transfusion service is a vital component in achieving equitable health outcomes.
To ensure timely and equitable access to safe blood transfusion, the providers of blood for transfusion need to know how much blood is required for their patients and where and when it is needed so that blood is neither under- or over-supplied.
A realistic assessment of blood requirements is fundamental to effective planning for the rational, fair, and effective distribution of blood and blood components within a blood transfusion service.
Usually, A physician's order is required for blood components and products. In some case; such as elective surgeries, over ordering of blood is a common practice.
The hospital develops and implements a policy and procedure to address safe blood transfusion service.
The policy shall include at least the following:

a) Assessment of 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 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 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 the transfusion request form are identical. In case of any discrepancy or doubt, a new sample should be obtained.

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing medical staff members, nurses and other healthcare professionals to inquire about order

process in any location including inpatient wards, procedure areas, emergency room and operative rooms.
- GAHAR surveyor may observe patient's medical records to assess the completion, legibility and clarity of blood transfusion orders.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through g).
2. Blood bank staff members are aware of the hospital policy.
3. Indication for transfusion is recorded in the patient's medical record.
4. Blood bank staff members receive information about indication of transfusion, clinical information of the patient and whether the request is needed on emergency or routine basis.
5. Blood sample label and blood transfusion request are completed with all required data and cross-checked before issuing blood or blood components

Related standards:

ICD.17 Orders and requests.

DAS.32 Blood and/or blood components are distributed from the blood bank safely.

Safety

Keywords:

distribution of blood and blood components.

Intent:

distribution of blood and/or blood components is a big line of defense to prevent tragic mistakes that could cost a patient his/her life.

By following the steps of safe distribution process and using a few good techniques to reduce the risk of error.

The hospital develops and implements a policy and procedures for safe distribution of blood and blood components

The policy addresses at least the following:

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.
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, hemolysis 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.

Survey process guide:

GAHAR surveyor may interview blood transfusion services staff members, nurses, porters and other healthcare professionals involved in blood unit issuance to inquire about the process, its variations and may observe the process.

Evidence of compliance:

1. The hospital has an approved policy that describes all elements mentioned in the intent from a) through h).
2. Blood bank staff members are aware of the hospital policy.
3. Cross matching reports show recipient and donor data.
4. Standard compatibility test is completed promptly.
5. If discrepancy in the result is noted, the concerned healthcare professional is informed immediately to discontinue the transfusion.
6. Special situations are managed safely.

Related standards:

APC.02 Monitoring safety requirements; WFM.04 Job description.

DAS.33 Blood and/or blood components are transfused safely.

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 hemolytic transfusion reactions and other significant morbidities.
The hospital shall develop a policy and procedures for transfusion of blood and/or blood components
The policy addresses at least the following:

a) Visually checking 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 use of blood components.
h) Management of transfusion complications.

Survey process guide:

- GAHAR surveyor may interview blood transfusion services staff members, nurses, other healthcare professionals involved in blood transfusion to inquire about the process, its variations, this can occur in any location including inpatient wards, emergency room and procedure areas.
- GAHAR surveyor may observe the process of blood transfusion.
- GAHAR surveyor may review patient's medical record to check records of blood transfusion.

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 patient condition during transfusion is recorded in patient's medical record.
5. A system is implemented to prevent and to manage transfusion complications.

Related standards:

ACT.08 Patient care responsibility.

Surgery, Anesthesia, and Sedation

Chapter intent:

Generally, surgery and invasive procedure refer to a technology consisting of a physical intervention on human tissues. This definition includes those procedures that investigate and/or treat diseases and disorders of the human body to:

Take out or eliminate all or a portion of a body part through excision, resection, extraction, destruction or detachment.

1. Putting in or on, putting back, or moving living body parts through transplantation, reattachment, reposition and transfer.
2. Take out or eliminate solid matters, fluids or gases from body parts.
3. Bypass, dilation, Occlusion or restriction of a tubular body part.
4. Insertion, replacement, supplement, removal, change or revision of a device attached in/to the body.
5. Cutting, revision, release, alteration, creation, or fusion of a body part.
6. Stopping or attempting to stop post-procedural bleeding.
7. Restoring a body part to its normal anatomic structure and function.
8. Cutting, removing, altering, or insertion of diagnostic/therapeutic scopes.

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

1. Operation Rooms (OR) whether used for hospitalized patients, outpatients or emergency patients.
2. Endoscopy unit.
3. Catheterization laboratory.
4. Emergency rooms.
5. Interventional radiology.
6. Outpatient rooms.
7. Any other unit in the hospital either with or without anesthesia or sedation, including local anesthesia.

Surgical and invasive procedures include an approach to the human body that maybe

1. Through skin or mucous membrane whether through an open cut, percutaneous or percutaneous endoscopic.
2. Through an orifice via an opening, opening endoscopic or opening with percutaneous endoscopicassistance.

Procedural sedation is defined as the technique of administering sedatives or dissociative

agents with or without analgesics to induce an altered state of consciousness that allows the patient to tolerate painful or unpleasant procedures while preserving cardiorespiratory function.
GAHAR surveyors shall survey all areas were surgery, invasive procedures, anesthesia, or sedation are taking place; to ensure patient safety, staff competency, and effective utilization of these areas.

Chapter purpose:
The main objective is to ensure that organizations provide/maintain safe, timeliness, patient-centeredness, and effective surgical, procedural, anesthesia care, and sedation services.
The first part includes standards related to the implementation of laws and regulations, booking, and patient care, followed by required processes before, during, and after the procedure. The second part includes standards related to anesthesia care, stated by laws and regulations, about anesthesia leadership, followed by pre-anesthesia, during anesthesia, and post-anesthesia required processes. The third part includes standards related to sedation care, stated by pre-sedation, during sedation, and post-sedation care.

Implementation guiding documents:
(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)
1. Egyptian Constitution
2. Law 51/1981 for healthcare organizations
3. MOHP Ministerial Decree 216 for operation procedures
4. Prime Minister decree, 1063/2014 Management of Emergency cases
5. MOHP Ministerial decree 236/2004 on anesthesia service requirements
6. MOHP Ministerial Decree 153/2004 on minimum requirements for anesthesia services
7. MOHP Ministerial decree 244/2001 on competencies of surgeons
8. MOHP Ministerial decree 34/2001 on surgery and anesthesia services
9. Patient Safety during operation procedure committee recommendations, 2003
10. Egyptian code of medical ethics 238/2003 (Medical Syndicate Publications)
11. MOHP Ministerial decree 284/1985 on requirements for OR
12. Egyptian code of nursing ethics (Nursing Syndicate Publications)
13. Emergency Department unified protocol, Egyptian ministry of health and population

curative and critical sector

14. Requirements of inspection per MOHP law and regulation
15. ICD-10-PCS
16. WHO Surgical Safety checklist

Safe and effective surgical and invasive procedures care

SAS.01 Provision of surgery and invasive procedure services is according to applicable laws and regulations and clinical guidelines/protocols.

Safety

Keywords:
Surgery and Invasive Procedure Services.

Intent:
The laws, regulations, and guidelines control the provision of surgery and invasive procedure services by determining the appropriate spaces, infrastructure, flow of patients, clean and waste flow, and the minimum required equipment and staffing. The hospital is required to provide the surgery and invasive procedure services all over the hospital safely by providing the required resources as obliged by the national laws and regulations.

Survey process guide:
GAHAR surveyor may visit the operating room department, endoscopy unit, cardiac catheterization unit, and any special unit where surgery or invasive procedures are performed. The visit includes observation of the place, infrastructure supplies, medications, and equipment available, interviewing staff about patient flow, clean and waste flow. Then the surveyor will obtain a sample from performed surgeries and invasive procedures to check the staff competency in performing those procedures.

Evidence of compliance:
1. All units providing surgery and invasive procedure services have appropriate spacing, ventilation, infrastructure including medical gases, and well maintained.
2. All units providing surgery and invasive procedure services have appropriate equipment, medical supplies, and medication.
3. All staff performing surgery and invasive procedure services are competent and qualified.

Related standards:
ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage; WFM.14 Medical staff performance evaluation.

SAS.02 Booking of surgeries and invasive procedures is effective and safe.

Safety

Keywords:

Booking of surgeries and invasive procedures

Intent:

The process of booking the elective procedures is a critical step in the operation of the operating rooms and all other units where surgeries and invasive procedures are performed, proper booking while taking into consideration the allowed elective time, staffing level, and clinical privileges of physicians will ensure effective utilization of the unit as well patient safety.

Applying the process of booking in the hospital decreases the waiting time for surgeries and invasive procedures and allowing the hospital to plan efficiently in providing the surgery and invasive procedure services.

The hospital develops and implements a policy and procedures for booking surgery and invasive procedures addresses at least the following:

a) Surgeries and invasive procedures are booked according to granted clinical privileges
b) The hospital records surgeries and invasive procedures, whether they are scheduled, performed, or canceled.
c) Clear and safe mechanism to identify patients in the records.
d) A clear and safe mechanism to call patients for surgeries or invasive procedures.

Analysis of the postponed and canceled surgeries and invasive procedures support the hospital with reliable data for better management and utilization of the available resources.

Survey process guide:

GAHAR surveyor may review the hospital policy followed by staff interviews for the process of booking, reviewing the evidence of an ongoing accurate and consistent process of booking and analysis of the causes of postponing or cancellation of surgeries or invasive procedures. Also, the surveyor will confirm that physicians requesting booking or performed surgeries and invasive procedures are privileged in the hospital to perform those types of surgeries and invasive procedures. Finally, the surveyor may review the recorded timing of all patient flow steps inside the unit and the analysis of this punctuality.

Evidence of compliance:

1. The hospital has an approved policy to guide the booking process that addresses all

elements mentioned in the intent from a) through d).
2. All physicians booked or performed procedures are permitted to do so, as stated in the clinical privileges.
3. There is an ongoing process for booking all elective procedures and determining the needed time for each procedure.
4. There is an ongoing process for analysis of postponed or canceled procedures.
5. Punctuality of the procedural unit is maintained and recorded starting by patient call till room cleaning after the procedure.

Related standards:
WFM.13 Clinical privileges.

SAS.03 Patient assessment is performed by a medical staff member(s) and nurse(s) before surgery and invasive procedure.

Safety

Keywords:
Assessment before surgery and invasive procedures.

Intent:
Completed patient assessment before surgery with requesting the needed investigations either for ensuring the diagnosis, revealing risk factors, assessing patient medical condition, or determining baseline patient condition followed by proper management of all identified diagnoses and risk factors.
Accordingly, risk assessment of the patient's condition is needed for all surgeries to determine the precautions needed and informing the patient and family about the expected outcome of the surgery.
Patient assessment should be reviewed and repeated if a surgery/invasive procedure is postponed or canceled to maintain the validity of the patient assessment.
The hospital is required to perform a complete patient assessment before any elective surgery supported by the results of required investigations and followed by risk evaluation for the surgery.

Survey process guide:
GAHAR surveyor may trace a patient who underwent surgery or invasive procedure through staff interview and document review to ensure compliance with a complete assessment of the patient, availability of results of requested investigations and risk classification before surgery or invasive procedure, and appropriate management of the risk factors.

Evidence of compliance:

1. A complete medical assessment is performed for all patients going for surgery or invasive procedure.
2. Complete nursing assessment is performed for all patients going for surgery or invasive procedure.
3. Results of investigations are available for healthcare professionals before surgery or invasive procedure.
4. the identified risks of the patient's conditions are documented in the patient medical record before surgery or procedure)
5. Action is taken for the management of the risk factors before surgery or invasive procedure.

Related standards:

ICD.08 Medical assessment; ICD.14 Plan of care; SAS.04 Brief assessments; WFM.04 Job description.

SAS.04 In life-threatening emergencies, a brief assessment and planning is performed.

Timeliness

Keywords:

Brief assessments.

Intent:

Life-threatening emergencies requiring immediate intervention to save the patient life. As I such situations, a complete patient assessment could be time-consuming, leading to compromising the patient's condition.

The hospital is required to perform a focused patient assessment, which should be documented in the patient's medical record for the medico legal issues and proper communication between staff followed by determining the patient's plan of care and immediate intervention that includes at least the following:

a) Patient needs and condition.
b) Preoperative diagnosis.
c) Plan for surgery (and invasive procedure).

Survey process guide:

GAHAR surveyor may trace a patient who underwent emergency surgery through staff interview and document review to ensure that the focused patient's assessment as

done as related to the patient's medical condition, completed risk classification and at time intervention.

Evidence of compliance:

1. A focused medical assessment is performed for patients going for life-threatening surgery.
2. The risk classification of the patient's condition is determined before surgery.
3. The focused assessment is documented in the patient's medical record.
4. The plan of care is performed on time for those patients.

Related standards:

SAS.03 Assessment before surgery and invasive procedures; ICD.08 Medical assessment; ICD.14 Plan of care; ICD.03 Prehospital care, ambulance care, and emergency medical care during disasters.

SAS.05 NSR.17 Precise site where a surgery or invasive procedure shall be performed is clearly marked by the physician with patient's involvement.

Safety

Keywords:

Surgical Site Marking.

Intent:

Performing the right surgery on the right patient and on the right side without any retained instrument is the mainstay objective of surgical safety.

Establishing related policies and procedures, otherwise known as the universal protocol, is the initial step for offering safe surgery.

Visible and clear site marking is an error reduction strategy that should be performed by the physician who will perform the surgery and invasive procedure with the involvement of the patient if the patient is an adult and fully conscious or patient's family in other situations.

The site marking in each organization should be unified, detectable, and placed on the nearest site to the surgical site.

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

APC.02 Monitoring safety requirements; ACT.08 Patient care responsibility; ACT.09 Handover communication; SAS.06 Pre-operative checklist.

SAS.06 NSR.18 Documents and equipment needed for procedures and anesthesia or sedation are verified to be on hand, correct, and properly functioning before calling for the patient.

Safety

Keywords:

Pre-Operative Checklist

Intent:

Ensuring the availability of all needed items as blood booking, results of the requested investigation or special prosthesis should be done as a preoperative verification process to ensure patient safety and appropriateness of care.

Ensuring the availability and functioning of needed equipment minimizes the risk of errors by preventing the use of malfunctioning equipment or cancellation of surgery and invasive procedure after the patient went to the operating rooms or invasive procedure unit. Implementing regular checkups is a quality improvement process that should be guided by designed checklists performed by trained staff.

The hospital is required to ensure the availability and functioning of equipment needed

for the surgery and invasive procedure before calling for the patient. This equipment and tools could be differed according to the type of surgery and invasive procedure or the use of anesthesia and sedation.
Also, the hospital is required to develop a process for preoperative verification of the availability of all needed or requested documents and other items before the patient going for the surgery or invasive procedure.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

PCC.11 Informed consent; SAS.05 Surgical site marking; SAS.03 Assessment before surgery and invasive procedures; ICD.08 Medical assessment.

SAS.07 NSR.19 Correct patient, procedure, and body part is confirmed preoperatively and just before starting a surgical or invasive procedure (time out).

Safety

Keywords:

Timeout

Intent:

Time out for verification of the correct patient, correct surgery or invasive procedure, and correct site and side of surgery or invasive procedure is a single process that has

been proved to reduce wrong-site surgery.
When performing a surgery or invasive procedure, healthcare professionals should verify the right patient, the right type of surgery, right site, right side, and the patient received the prophylactic antibiotic if applicable.
The hospital develops and implements a policy and procedures to ensure correct patient, correct surgery or invasive procedure and correct site and side of surgery or invasive procedure and apply the time out process just before the start of the surgery or invasive procedure (after induction of anesthesia).

Survey process guide:
GAHAR surveyor may review the policy and procedure for preventing the wrong patient, wrong site/side, and wrong surgery/invasive procedure and ensure that it supports patient, procedure, as well as part of body verification just before start of the procedure, regardless whether the patient is anesthetized, sedated or awake (Time Out). This is followed by observing a case during the time-out process and review the document used to record this process. Document review of the open and closed medical record will also be performed in addition to staff interviews on how to perform the process and its special circumstances.

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

Related standards:
APC.02 Monitoring safety requirements; SAS.05 Surgical site marking; ACT.03 Patient identification; ACT.08 Patient care responsibility.

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

Safety

Keywords:
Operative Report.

Intent:

Immediate reporting of the procedure has a significant role in the continuity of care.
Planning for postoperative care depends on findings and special events that occurred during the procedure, as failure to report these events markedly compromises patient care.
The hospital is requested to immediately report the procedure details before the patient leaving the procedural unit.
Recording the names of all staff involved in the procedure has a 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 the procedure is done.
Use of any prosthesis or implantable devices should be stated in the report, including any special precautions when dealing with or to remove it.
Occurrence of complications during the procedure should be recorded with the action taken to manage.
Any specimen removed from the body should also be stated clearly in the procedure report. That addresses at least the following:

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:
ACT.08 Patient care responsibility; ACT.09 Handover communication.

SAS.09 NSR.20 Accurate counting of sponges, needles, and instruments pre and post-procedure is verified.

Safety

Keywords:
Instrument Retention Prevention.

Intent:
Missing sponges, needles, towels, or instruments inside the patient body act as a foreign body and causes serious morbidity in the form of pain, organ injury and sepsis, which necessitate to reopen the patient and could reach up to mortality.
The hospital is required to spend every effort by the surgical team to prevent missing any foreign body during surgery/invasive procedure by meticulous counting of any used item before, during the closure of each body space, and after the closure of the skin.

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

Evidence of compliance:
1. Counting of sponges, needles, towels, or instruments is done pre, during, and after the surgery or invasive procedure by two staff as the second one is acting as a witness for the first one.
2. There is a record for the preoperative, intraoperative and postoperative count of sponges, needles, towels, or instruments.
3. The performing physician confirmed the process and signed the count sheet.
4. The hospital tracks, collects, analyzes and reports data on the counting process
5. The hospital acts on improvement opportunities identified in the counting process

Related standards:
APC.02 Monitoring safety requirements; ACT.08 Patient care responsibility.

SAS.10 Surgically removed tissue is sent to the hospital laboratory services for pathological examination unless present in the list of exempted tissues from the pathological examination.

Effectiveness

Keywords:
Pathological Examination.

Intent:
Surgically removed tissue from the human body needs to be sent for pathological, histopathological, or immune histochemical examination for continuity of care as it is essential to confirm or prove a diagnosis.
Operative care also may depend on findings in the examination of the frozen section.
For some surgically removed tissues, there is no need to have a pathological examination of these tissues.
The hospital has to identify these tissues clearly to be exempted from pathological examination in routine cases unless requested by the physician.
The hospital is required to design a pathway for tissues removed from the human body to the laboratory to obtain a sample for examination, then sent to the appropriate disposition according to the type of tissue.

Survey process guide:
GAHAR surveyor may trace the pathway of a surgically removed body part till its disposition. This tracing includes staff interviews and document review in the operating room and laboratory. Closed medical record review will be performed to review the availability of pathology results and time frame of the results.

Evidence of compliance:
1. There is a clear pathway of any surgically removed tissue.
2. There is a list of exempted tissue from pathological examination.
3. Surgically removed tissues are sent for pathological examination, and the results of the examination are available in the patient's medical record within the defined time frame.

Related standards:
DAS.15 Pre-examination process; ACT.09 Handover communication.

SAS.11 System for recall of implantable devices is developed, implemented and recorded.

Safety

Keywords:
Implantable Devices.

Intent:
The implantable device is a medical device that is permanently placed into the body to continuously assist, restore, or replace a function or structure of the body throughout the useful life of the device.
Examples include orthopedics prosthesis, stents, intracardiac defibrillator, cardiac pacemaker, intraocular lens, Intra-uterine devices, dental implants and infusion pumps. There are many considerations while using implantable devices, which include the special instructions for use, sterility, manufactural consideration, and malfunction. The hospital is required to track the implantable device from its primary source to discover any unstable, contaminated, defective, or imitation product.
Every patient who has an implantable device should be easily identified, easily reachable within a defined time frame to be ready for any device recall.

Survey process guide:
GAHAR surveyor may review the hospital policy followed by retrospective tracing of an implantable device. The surveyor will review a complete case from the patient, the primary source of the device.

Evidence of compliance:
1. There is a list of implantable devices used in the hospital.
2. There is a process for the retrospective tracing of any implantable device.
3. The procedure report includes the details of any used implantable device, including the batch number.
4. There is a process for the recall of a patient who has an implantable device when necessary.

Related standards:
ICD.08 Medical assessment; ACT.08 Patient care responsibility; PCC.09 Patient education materials.

SAS.12 Postoperative care plan is determined and recorded before patient transfer.

Patient-centeredness

Keywords:

Post-operative care.

Intent:

Postoperative care is a main factor in determining procedure outcome.

Creating the postoperative care plan should start immediately after the procedure before the patient leaving the procedural room to prevent any delay, wrong, unnecessary, or missing care.

Postoperative plan of care is developed by the physician who performed the procedure and the anesthesiologist (when applicable) and includes the level of care, patient position, activity, required monitoring, diet, medications, intravenous fluids, required investigations and follow up.

Survey process guide:

GAHAR surveyor may review closed and open medical records for the postoperative plan of care followed by observing the implementation of the physician orders related to the postoperative plan of care

Evidence of compliance:

1. There is a postoperative care plan for all patients performing the procedure.
2. The postoperative care plan is documented in the patient's record before leaving the procedure room.
3. The postoperative care plan is implemented.

Related standards:

ICD.14 Plan of care; ACT.09 Handover communication.

SAS.13 Provision of anesthesia and sedation services is according to applicable laws and regulations and clinical guideline/protocol.

Safety

Keywords:

Anesthesia Services.

Intent:

The provision of anesthesia and sedation is a high risk and problem-prone service;

Laws, regulations, and guidelines sets governing framework and control for these

services.
Anesthesia services is performed by a qualified anesthesia physician with the uniform provision of the service all over the hospital.
Sedation service could be performed by a physician, if he/she is trained in performing sedation service and have a valid certificate in advanced life support under the overall responsibility of an anesthesiologist.
For the safe perform of anesthesia and sedation, a minimum setup shall be available, which includes equipment, medications, medical supplies, and medical gases.
Anesthesia and sedation services are provided based on the applicable professional practice standards for providing anesthesia and sedation care and meet all applicable national laws and regulations.

Survey process guide:
GAHAR surveyor may review the provision of anesthesia and sedation services through visiting the hospital units where anesthesia and sedation are performed to observe the structure of the place, available equipment, medications, and medical supplies followed by observing the provision of the services and reviewing the credentials of the staff involved in these services

Evidence of compliance:
1. The provision of anesthesia service meets the applicable professional practice guidelines, national laws, and regulations.
2. The provision of sedation service meets the applicable professional practice guidelines, national laws, and regulations.
3. Minimum setup shall be available, which includes equipment, medications, medical supplies, and medical gases.
4. Appropriate number of anesthesia staff members are available.

Related standards:
ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage;; WFM.02 Staffing plan.

SAS.14 Anesthesia and sedation services are performed under the direction of a qualified anesthesiologist.

Safety

Keywords:
Qualified Anesthesiologist.

Intent:

Safe perform of anesthesia and sedation services requires appointment of competent and qualified leadership.

Anesthesia leader determines minimum requirements for provision of service including: staffing, equipment, medications and medical supplies.

Anesthesia leader developed all required policies and procedures, the applicable guidelines and protocols for services.

Anesthesia leader provides professional and administrative oversight of all activities related to anesthesia and sedation services and also, evaluates the outcome of anesthesia and sedation services including staff ongoing practice professional evaluation.

The hospital is required to appoint a competently qualified anesthesiologist to lead the anesthesia and sedation services with a specific, detailed, and implemented job description.

Survey process guide:

GAHAR surveyor may review the organization chart of the organization and of the anesthesia department and the job description of the leader followed by an interactive interview with the anesthesia leader about the structure, process, and outcome of the anesthesia and sedation care.

Evidence of compliance:

1. There is a competent, qualified leader for the anesthesia and sedation services.
2. There is a clear, specific job description for the anesthesia and sedation leader.
3. The anesthesia and sedation leader determines the structure needed for providing these services.
4. The anesthesia and sedation leader follows up with the processes of providing these services.
5. The anesthesia and sedation leader evaluates the outcome of providing these services.
6. The anesthesia and sedation leader evaluate anesthesiologists and other physicians providing these services.

Related standards:

WFM.02 Staffing plan; WFM.04Job description; WFM.03 Recruitment; WFM.05 Verifying credentials; WFM.09 Staff performance evaluation

Safe and effective anesthesia care

SAS.15 Anesthesia and sedation services are uniform throughout the hospital and readily available 24 hours a day, seven days a week.

Safety

Keywords:
Uniform Anesthesia care.

Intent:
Shortage of qualified staff or proper equipment might lead to non-uniformity of anesthesia services which might affect patient safety.
Safe provision of anesthesia and sedation services is required to be uniform all over the hospital and during the 24 hours without any changes in the structure or process used.
According to the hospital scope and occupancy, Anesthesiologist(s) shall be present in the hospital 24 hours, seven days a week, to support elective and emergency anesthesia services.

Survey process guide:
GAHAR surveyor may review the schedule of anesthesiologists, followed by an interview with the anesthesia team for the distribution of duties and the daily tasks performed by them. The surveyor shall observe the structure of the operating rooms and other areas where sedation is provided and interview the staff for the policy of providing these services.

Evidence of compliance:
1. The provision of anesthesia services is uniform all over the hospital.
2. The provision of sedation services is uniform all over the hospital.
3. Anesthesia and sedation services are readily available 24 hours, seven days a week, to meet elective and emergency patient needs.

Related standards:
ICD.01 Uniform care.

SAS.16 Anesthesia techniques and management of serious anesthesia emergencies or complications are guided by clinical protocols.

Safety

Keywords:
Anesthesia Protocols.

Intent:

Anesthesia emergencies or complications include but not limited to vomiting, laryngospasm, difficult ventilation, and malignant hyperthermia.

Management of anesthesia emergencies and complications is the most important part of providing anesthesia care.

Written protocols for management of complications ensures professional management of these conditions if occurred.

To unify the provision of anesthesia services, clinical protocols shall be developed for the approved anesthesia techniques based on approved guidelines.

These protocols are developed according to the scope of service of the hospital and type of surgeries and invasive procedures. Clinical protocols shall be oriented to all anesthesia staff and applied.

Anesthesiologist shall be ready all the time for any anesthesia emergencies or complications to deal with.

This will occur through proper patient assessment, make sure for the availability of appropriate tools that will be used in the management of these conditions.

Survey process guide:

GAHAR surveyor may review the anesthesia protocols followed by an interview with the anesthesiologist for the application of these protocols while performing a medical record review for the recorded anesthesia technique used. Also, the surveyor shall review the protocols for the management of anesthesia emergencies and complications and observe the availability of all needed tools to apply these protocols if needed.

Evidence of compliance:

1. hospital approved protocols are implemented for anesthesia techniques used in the hospital.
2. hospital approved protocols are implemented for the management of anesthesia emergencies and complications.
3. The equipment, medications, and medical supplies needed during the anesthesia emergencies and complications are readily available in the hospital.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage;;

SAS.17 Patients' anesthesia plan is performed after pre-anesthesia assessment done by a qualified anesthesiologist.

Safety

Keywords:
Anesthesia Plan.

Intent:
Anesthesia services usually starts with a pre-anesthesia assessment.
Pre-anesthesia assessment determines patient's condition, risk scoring for receiving anesthesia, and required interventions/care before, during, and after receiving anesthesia.
The hospital is required to perform a pre-anesthesia assessment for all patients before transfer to perform the surgeries or procedures by a qualified anesthesiologist.
Assessment outcome includes: Risk scoring of receiving anesthesia and Anesthesia plan which includes:

a) Additional required investigations
b) Other required specialty consultation,
c) Premedication
d) Special feeding regimen
e) Type of anesthesia and anesthesia techniques
f) Needed monitoring before, during and after anesthesia, fluid management including blood and blood products,
g) Post-anesthesia care unit and post-anesthesia analgesia.

Survey process guide:
GAHAR surveyor may review the hospital policy for pre-anesthesia assessment followed by tracing a patient who received anesthesia to evaluate the process of pre-anesthesia assessment, including its validity and the process of development of anesthesia plan of care.

Evidence of compliance:

1. There is performed pre-anesthesia for patients before receiving anesthesia.
2. There is developed detailed anesthesia plan for patients after performing the pre-anesthesia assessment.
3. Pre-anesthesia assessment and the anesthesia plan development is performed by a qualified anesthesiologist.
4. The pre-anesthesia assessment and the anesthesia plan are recorded in the patient's medical record.

5. Immediate pre induction assessment is performed by anesthesiologist

Related standards:

ICD.08 Medical assessment; WFM.02 Staffing plan; WFM.04 Job description; WFM.04 Recruitment; WFM.05 Verifying credentials; WFM.09 Staff performance evaluation.

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

Safety

Keywords:

Physiological assessment by anesthesia.

Intent:

Administering anesthesia and performing surgeries and invasive procedures are associated with changes in the patient physiologic status that could be very rapid. Accordingly, the patient physiologic status is required to be continuously monitored starting before receiving the anesthesia to determine the baseline of patient condition, which is used in determining the patient criteria of discharge from the post-anesthesia care unit.

The type of monitoring is determined according to the patient's condition, age, type of anesthesia, type, and duration of surgery based on the clinical practice guidelines.

Continuous monitoring allows the anesthesiologist for on-time intervention for any changes in the patient's condition.

Survey process guide:

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

Evidence of compliance:

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

Related standards:
ICD.08 Medical assessment; SAS.16 Anesthesia protocols

SAS.19 Patient care during anesthesia is safe.

Safety

Keywords:
Patient care during anesthesia.

Intent:
In order to perform safe anesthesia, the process of anesthesia care is not including only the administration of anesthesia medications, it includes multiple acts from induction of anesthesia (take off) till safely return the patient to the previous condition before anesthesia (landing).
Patient physiological status shall be continuously monitored just before and during the administration of anesthesia and recorded.
The anesthesiologist is required to record anesthesia plan that includes:

i. Type of anesthesia used, either local anesthesia, regional anesthesia, or general anesthesia,
ii. Technique of induction, including the used medications with doses, route and time of administration.
iii. Airway management and patient ventilation.
iv. Fluid management, including deficit replacement and maintenance requirements with a final estimation of the fluid balance, including the types of used IV fluids, blood, or blood products.
v. Any administered medications or IV fluids during the anesthesia which also should be timed.
vi. Any unusual event that occurred during anesthesia shall be recorded with the management that occurred for effective communication.

Finally, after patient returns to the pre-anesthesia status, Physiological status shall be recorded.
Anesthesiologist shall order for patient transfer to either post-anesthesia care unit or intensive care unit, and record the time of transfer.
The record includes at least the following:

a) The patient's physiologic status.
b) Time of anesthesia induction.
c) Used type of anesthesia.

d) Administered medications with dose, route, and time of administration.
e) Fluid management includes intake and output.
f) Administered blood or blood products.
g) The occurrence of any unusual event.
h) The patient's condition before leaving the theatre.
i) Patient disposition.
j) Time of transfer.
k) Signature of the anesthesiologist

Survey process guide:
GAHAR surveyor may review the hospital policy for anesthesia care, followed by tracing a patient who received anesthesia to evaluate the process of anesthesia care. Then the surveyor will perform an open and closed medical record review for patients receiving anesthesia for the documented anesthesia care.

Evidence of compliance:
1. Anesthesia care is performed safely based on approved anesthesia techniques.
2. The implemented anesthesia care is recorded in the patient's medical record, including all elements from a) to k) in the standard.
3. A copy of the anesthesia record is kept in the patient's medical record.

Related standards:
ICD.14 Plan of care, SAS.16 Anesthesia protocols.

SAS.20 Post-anesthesia care unit is equipped according to applicable laws, regulations and clinical guideline/protocol.

Patient-centeredness

Keywords:
Post Anesthesia Care Unit Equipment.

Intent:
Anesthesia risks may occur even in post-anesthesia period, where the patient should be regularly monitored.
The hospital is requested to ensure the availability of this equipment while the patient is present in the unit.
There should be a post-anesthesia care unit with at least one bed for each operating room
Post-anesthesia care unit is necessary to be equipped by at least a monitoring equipment,

crash cart with a defibrillator, source of oxygen supply, recommended medications, and medicalsupplies.

Survey process guide:

GAHAR surveyor may observe the units where anesthesia is performed in the hospital for the area used in post-anesthesia care and the equipment and other resources available in that area.

Evidence of compliance:

1. There is a post-anesthesia care unit for each department where surgery or invasive procedures performed.
2. Laws, Regulations, Clinical guidelines and professional standards of practice are consulted to ensure post-anesthesia care units are equipped properly.
3. The post-anesthesia care unit is equipped with the required equipment.

Related standards:

ICD.08 Medical assessment; ICD.14 Plan of care; ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage;;

SAS.21 A competent clinical practitioner performs continuous monitoring of the patient's physiological status in the post-anesthesia care unit and the decision of the discharge/transfer from the post anesthesia care unit is made by anesthesiologist or by other clinical practitioner according to established criteria.

Safety

Keywords:

Post Anesthesia Care monitoring.

Intent:

Post-anesthesia care includes monitoring of the patient physiologic status that allows anesthesiologist to do an on-time intervention for any changes in patient's condition and determine patient's criteria of discharge from the post-anesthesia care unit.

Type of monitoring is determined according to the patient's condition, age, anesthesia used, type, and duration of surgery according to the clinical practice guidelines.

Patient monitoring is required to be done by a competent clinical practitioner.

Administration of any medications, IV fluids, blood, or blood products ordered and administered should be recorded in the patient's medical record.

The hospital is required to ensure good communication between staff in different units by ensuring the recording of special or unusual events occurred inside the post-anesthesia

care unit with the management provided, the time of receiving the patient, and the time of transfer from post-anesthesia unit. Competent clinical practitioner record includes at least the following:

a) The patient's physiologic status
b) Time of receiving the patient
c) Used type of anesthesia.
d) Administered medications with dose, route, and time of administration.
e) Fluid management includes intake and output.
f) Administered blood or blood products.
g) The occurrence of any unusual event.
h) The patient condition before leaving according to defined criteria
i) Patient disposition
j) Time of transfer from the post-anesthesia care unit
k) Signature of the clinical practitioner

Survey process guide:

GAHAR surveyor may continue tracing a patient who received anesthesia till the post anesthesia stage after reviewing the hospital policy of post-anesthesia care. This is followed by closed and open medical record review for patients who received anesthesia.

Evidence of compliance:

1. Post-anesthesia care is performed by a competent practitioner.
2. The patient physiologic status is monitored during the post-anesthesia care based on clinical practice guidelines
3. Patient physiologic status shall be recorded in the patient's medical record at least once every 15 minutes.
4. The provided post-anesthesia care from a) to k) in the standard is recorded in the patient's medical record.
5. A qualified anesthesiologist makes the decision of patient transfer/discharge from the post-anesthesia care unit. Or by other practitioner according to defined criteria

Related standards:

ICD.08 Medical assessment; SAS.16 Anesthesia protocols.

Safe and patient-centered sedation services

SAS.22 Sedation techniques and management of complications of sedation is guided by clinical protocols.

Patient-centeredness

Keywords:
Sedation Protocol.

Intent:
To ensure uniformity of sedation services, clinical protocols shall be developed for the approved sedation techniques based on approved guidelines.
These protocols are developed according to the scope of service of the hospital and type of surgeries and invasive procedures.
Clinical protocols shall be oriented to all medical staff privileged to perform sedation and applied.
These protocols should also include the management of complications that could occur by providing sedation.

Survey process guide:
GAHAR surveyor may review the sedation protocols followed by an interview with the medical staff for the application of these protocols while performing a medical record review for the recorded sedation technique used. Also, the surveyor shall review the protocols for the management of complications of sedation and observe the availability of all needed tools to apply these protocols if needed.

Evidence of compliance:
1. There is hospital approved protocols for sedation techniques used in the hospital.
2. There is hospital approved protocols for the management of complications of sedation.
3. The equipment, medications, and medical supplies needed during the sedation are readily available in the hospital.

Related standards:
ICD.15 Clinical practice guidelines adaptation and adoption; ICD.16 Clinical care standards Usage; SAS.23 Sedation Plan; ICD.14 Plan of care.

SAS.23 Determining the patients' sedation plan is performed after pre sedation assessment and is done by a competent physician.

Patient-centeredness

Keywords:
Sedation Plan.

Intent:
Sedation services start with performing a pre-sedation assessment.
The pre- sedation assessment determines patient's condition, risk scoring for receiving sedation, and required interventions/care before, during, and after receiving sedation.
Sedation services shall be performed by a competent medical staff who is a physician trained and certified on providing sedation service and have advanced competency in resuscitative services.
The hospital is required to perform pre- sedation assessment for all patients before transfer to perform the surgeries or procedures by a competent medical staff. The outcome of the assessment includes the risk scoring of receiving sedation and the sedation plan.

Survey process guide:
GAHAR surveyor may review the hospital policy for pre- sedation assessment followed by tracing a patient received sedation to evaluate the process of pre- sedation assessment, including its validity and the process of development for the sedation care.

Evidence of compliance:
1. There is a performed pre-sedation assessment for patients before receiving sedation.
2. There is a developed sedation plan for patients after performing the pre- sedation assessment.
3. Pre-sedation assessment and the sedation plan development is performed by a competent physician.
4. The pre-sedation assessment and the sedation plan are recorded in the patient's medical record.
5. Patient re-assessment by a competent physician is performed immediately prior to the start of sedation or by clinical practitioner according to defined criteria.

Related standards:
SAS.22 Sedation Protocol,ICD.14 Plan of care; ICD.08 Medical patient assessments; WFM.02 Staffing plan; WFM.04 Job description; WFM.03 Recruitment; WFM.05 Verifying credentials; WFM.09 Staff performance evaluation.

SAS.24 A competent clinical practitioner performs continuous monitoring of the patient's physiological status before and during sedation

Safety

Keywords:
Sedation physiological status monitoring.

Intent:
Changes in sedated patient physiologic status could be very rapid.
Patient physiologic status is required to be continuously monitored starting before receiving the sedation to determine the baseline of patient condition.
This also helps in determining patient criteria of discharge from the post-sedation care unit.
Continuous monitoring allows the medical staff for on-time intervention for any changes in the patient's condition.
Type of monitoring is determined according to the patient's condition, age, sedation technique, type, and duration of surgery/invasive procedure based on the clinical practice guidelines.

Survey process guide:
- GAHAR surveyor may observe a patient while receiving the sedation service to evaluate the process of patient monitoring and the staff involved in this process, this is followed by medical record review for open and closed patients' records received sedation.
- GAHAR surveyor may review the hospital policy for sedation care, followed by tracing a patient who received sedation to evaluate the process of sedation care. Then the surveyor will perform an open and closed medical record review for patients who received sedation for the documented sedation care

Evidence of compliance:
1. Patient physiologic status is monitored before and during sedation based on clinical practice guidelines.
2. Monitoring of patient physiologic status is performed by a competent clinical practitioner.
3. Monitoring results are recorded in patient's medical record according to hospital approved clinical guidelines.

Related standards:
SAS.23 Sedation plan; ICD.14 Plan of care; ICD.08 Medical patient assessments , SAS.26 Post sedation plan of care

SAS.25 Patient's care during sedation is recorded.

Safety

Keywords:
Care during Sedation.

Intent:
Safe sedation service includes multiple steps starting from pre-sedation assessment through administration of sedation medications till patient safe return to baseline condition.
Patient physiological status needs to be continuously monitored just before and during the administration of sedation and recorded.
Medical staff member is required to record the implemented sedation care, including used medications with doses, route, and time of administration.
Any unusual event that occurred during sedation and its management must be recorded.
Finally, after returning to pre-sedation status, patient physiological status must be recorded.
Medical staff member orders for patient transfer to either post-sedation care unit or intensive care unit, and records the time of transfer.
The record during sedation includes at least the following:

a) The patient's physiological status.
b) Time of start of sedation.
c) Sedation score.
d) Administered medications with dose, route, and time of administration.
e) Fluid management includes intake and output.
f) The occurrence of any unusual event.
g) The patient condition before leaving the theatre.
h) Patient disposition.
i) Time of transfer.
j) Signature of the physician.

Survey process guide:
GAHAR surveyor may review the hospital policy for sedation care, followed by tracing a patient who received sedation to evaluate the process of sedation care. Then the surveyor will perform an open and closed medical record review for patients who received sedation for the documented sedation care.

Evidence of compliance:

1. Sedation care is performed safely based on approved sedation techniques.
2. The sedation record including all elements in the intent from a) through j) is complete.
3. A copy of sedation record is kept in the patient's medical record.

Related standards:

ICD.14 Plan of care; ICD.08 Medical patient assessments.

SAS.26 Post sedation care is performed by a qualified healthcare professional in an appropriately equipped place.

Safety

Keywords:

Post sedation care

Intent:

Sedation risks may occur even during post-sedation period, So, patient should be regularly monitored.

The hospital shall be requested to ensure the availability of this equipment while the patient is present.

A nurse or physician training on the post-sedation care shall be assigned for the post-sedation care unit to perform required post-sedation care for the patients.

Accordingly, there shall be a post-sedation care unit equipped by at least a monitoring equipment, crash cart with a defibrillator, source of oxygen supply, recommended medications, and medical supplies.

Survey process guide:

GAHAR surveyor may observe the units where sedation is performed in the hospital for the area used in post-sedation care and the equipment and other resources available in that area. Then, the qualifications of the staff involved in post-sedation care are reviewed.

Evidence of compliance:

1. There is a post-sedation care unit for each department where surgery or invasive procedures performed.
2. The post-sedation care unit is equipped with the required equipment.
3. Post-sedation care is provided by a qualified healthcare professional.

Related standards:

SAS.25 Care during Sedation care; ICD.14 Plan of care; ICD.08 Medical patient assessments.

SAS.27 A competent clinical practitioner professional continuously monitors patient's physiological status during post sedation care.

Safety

Keywords:

Post Sedation monitoring.

Intent:

Post-sedation care includes monitoring of patient physiologic status that allows medical staff to do an on-time intervention for any changes in the patient's condition and determines the patient's criteria of discharge from the post-sedation care unit.

Type of monitoring is determined according to the patient's condition, age, sedation used, type, and duration of surgery/invasive procedure based on the clinical practice guidelines.

Patient monitoring is required to be done by a competent nurse or physician.

Administration of any medications or IV fluids should be ordered and administered should be recorded in the patient's medical record.

The hospital is required to ensure good communication between staff in different units by ensuring the recording of special or unusual events occurred inside the post-sedation care unit with provided management, the time of receiving the patient, and the time of transfer from the post-sedation unit.

Post-sedation care records includes at least the following:

a) Recording the patient's physiological status.
b) Time of receiving the patient.
c) The occurrence of any unusual event.
d) The patient's condition before leaving according to a defined score.
e) Patient disposition.
f) Time of transfer.
g) Signature of the physician.

Survey process guide:

GAHAR surveyor may continue tracing a patient who received sedation till the post sedation stage after reviewing the hospital policy of post-sedation care. This is followed by closed and open medical record reviews for patients received sedation.

Evidence of compliance:

1. The patient physiologic status is monitored during the post-sedation care based on clinical practice guidelines at least once every 15 minutes.
2. Monitoring of patient physiologic status is performed by a competent medical staff.
3. The provided post-sedation care from a) to g) in the intent is recorded in the patient's medical record.
4. A competent physician decides on the patient's transfer/discharge from the procedural sedation area according to defined criteria.

Related standards:

SAS.22 Sedation protocol; ICD.14 Plan of care; ICD.08 Medical patient assessments

Medication Management and Safety

Chapter intent:

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

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

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

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

Chapter purpose:

The aim of this chapter is to be a guiding principle for medication management and use in hospitals promoting safe, quality use of medications, and medication management.

It is intended to assist in providing a framework for an effective and safe medication management and use program.
It also aims to evaluate the continuity of medication management processes from planning to monitoring and evaluation with a special focus on the identification of risk points to improve patients' outcomes and patient's safety.
The chapter advocates a partnership and systems approach to achieve safe and quality use of medications and medication management in hospitals.
This document does not provide clinical practice guidelines for particular health conditions or procedures, but it is intended to be used as accreditation standards and comprehensive policy and procedure manual guidance for services.

Implementation guiding documents:

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

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6. Institute for Safe Medication Practices. ISMP Medication Safety Tools and Resources. Accessed Dec 6, 2017. https://www.ismp.org/tools/.
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12. Pharmaceutical care publication No (2) for the year 2017, the clinical pharmacist job description

13. Pharmaceutical care publication No (3) for the year 2017 of Documentation of clinical pharmacyinterventions
14. Rational Drug Use Publication No: 2 for the year 2017 of Local Drug and Therapeutic committee
15. Rational Drug Use Publication No: 3 for the year 2017 of the Drug formulary
16. Rational Drug Use Publication No: 4 for the year 2017 of Antimicrobial Stewardship
17. Rational Drug Use Publication No: 1 for the year 2019 of The Egyptian Crash cart and emergency drug list
18. The American Society of Health-System Pharmacists. Statement on the Pharmacy and Therapeutics Committee and the Formulary System. Am J Heal Pharm [Internet]. 2009;65:2384–6. Available from: https://www.ashp.org/-/media/assets/policy-guideli nes/docs/statements/pharmacy-and-therapeutics- committee-and-formulary-system.ashx?la=enandhash=ACA12AB7C42CAD55F8A26526F9D73C51BAFF2317
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20. The Egyptian Guidelines of Medication Management Standards first edition (2018)
21. The Minister of Finance decree No. 89- the year 1998 on the regulation of tenders and auctions law promulgated, and its implementing regulations.
22. The Minister of Health and Population decree number 104-y the year 2003 on the regulation pf expiry drugs.
23. The Minister of Finance decree number 182- the year 2018 on the regulation of tenders and auctions law promulgated, and its implementing regulations
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26. World Health Organization (WHO). Drug and Therapeutics Committee - A Practical Guide. 2005;14(3):4799– 804. Available from: http://apps.who.int/medicinedocs/pdf/s4882e/s4882e.pdf
27. World Health Organization (WHO). Operational principles for good pharmaceutical procurement. Manage drug supply [Internet]. 1999;32. Available from: http://apps.who.int/medicinedocs/pdf/whozip49e/whozip49e.pdf

Effective planning and management of medication

MMS.01 Medication organization, management, and usage are aligned with hospital scope of services to meet patients' needs according to the applicable laws and regulations.

Effectiveness

Keywords:
Medication management program.

Intent:
Medication management remains a primary concern in hospitals and is an important component in the palliative, symptomatic, and curative treatment of many diseases. The unsafe use of medication is not the only safety problem in the healthcare system, but it is certainly one of the most significant issues. Ensuring a safer medication management program in any hospital is a major challenge.
Medication management processes should be implemented according to the applicable Egyptian laws and regulations (The Egyptian Drug Authority (EDA), the Unified Medical Procurement Authority, and the Egyptian Ministry of Health and population (MOHP)).
The hospital develops and implements 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
h) Evaluation

A qualified trained and licensed healthcare professional shall directly supervise the medication management program, which shall be an interdisciplinary effort exerted by all healthcare professionals involved in the medication management process. Usually, the medication management system is managed and updated through the interdisciplinary Drug and Therapeutic Committee (DTC) (also known as pharmacy and therapeutic committee (PTC)).
The presence of DTC with clear terms of reference is essential in the management of medication use. The DTC is involved in the development and evaluation of the medication management program. In addition, a system review shall be performed at least annually.

Survey process guide:

- GAHAR surveyor may interview healthcare professionals involved in medication management processes during the medication management review session and inquire about all steps of the medication management process.
- During GAHAR survey, Surveyor may observe how medication management processes run and may review patients' medical records

Evidence of compliance:

1. The hospital develops medication management and safety programs according to the applicable laws and regulations. The program addresses all elements from a) through h) in the intent.
2. The hospital has a clear structure for pharmacy services, and a licensed, competent pharmacist supervises all pharmacy/pharmaceutical activities.
3. The hospital has a drug and therapeutic committee (DTC) with a clear term of references. The committee is involved in the development and ongoing evaluation of the medication management and safety program.
4. Updated and appropriate medication-related information sources are available either in an electronic or in a paper-based format to those involved in medication management.
5. The hospital selects and monitors process and outcome indicators for medication safety and medication management.
6. There is an annual documented review of the medication management and safety program, addressing elements from a) through h) in the intent as appropriate.

Related standards:

PCC.02 Interdisciplinary patient-centeredness.

MMS.02 Antimicrobial stewardship program is developed and implemented to enhance prescription and usage of antimicrobials.

Safety

Keywords:

Antimicrobial Stewardship Program.

Intent:

Due to repeated antimicrobial prescription for dubious indications and for longer than necessary, antimicrobial resistance is acquired, which can have a negative impact on patient outcomes and poses a major threat to patient safety.

Implementation of an antimicrobial stewardship program will reduce the development and spread of resistant bacteria and deliver better patient outcomes.

In October 2017, the EDA, Ministry of Health, Egypt, mandated in response to the global initiatives, the rational use of antibiotics, and the implementation of the antimicrobial stewardship program. In 2018, the national action plan for combating antimicrobial resistance was approved by the Egyptian Ministry of Health. One of the main pillars of this action plan is the implementation of the national antimicrobial stewardship program.

Antimicrobial stewardship programs are an organizational priority with leadership commitment and support. Leadership support examples include accountability documents, dedicating necessary resources, plans for infection prevention, performance improvement and strategic plans, and use of the patient's medical record to collect antimicrobial stewardship data. Appointing a healthcare professional leader responsible for program outcomes is important.

An effective antimicrobial stewardship program will implement at least one intervention that meets a need within the hospital. Using a stepwise implementation approach that help to familiarize staff with the new policies and procedures. Interventions may include the development and implementation of clinical guidelines based on either local, national, or international data (management of urinary tract infections, respiratory tract infection, and prophylactic use of antibiotics in surgery). Interventions may include the restriction of the use of certain antimicrobial agents based on the spectrum of activity, or cost, preauthorization, de-escalation of empirical antimicrobial therapy or the alteration of antimicrobial therapy once culture (if applicable) results become available, the development of clinical criteria and guidelines for switching from parenteral to oral agents, and detection and prevention of antibiotic-related drug-drug interactions. The decision to select which intervention should be based on staffing, patient population, as well as the clinical culture and resources.

Tracking the effectiveness of the program is important to assess, monitor and improve the program, examples include using measures such as inappropriate use of antimicrobials, adherence to antibiotic prescribing policies and antibiotic use, antimicrobial consumption, and cost (using defined daily doses (DDD)) or resistance pattern

It is important to ensure that antimicrobial stewardship reports are available to leadership, and healthcare professionals regularly, which serves as a reminder of the program's importance. It is also important to educate healthcare professionals,

patients and their families on optimal antimicrobial use, antimicrobial resistance, and antimicrobial stewardship practices

Survey process guide:

During patient journey tracer and medication management review sessions, the GAHAR surveyor may trace the prescription of antimicrobial agents and follow the process steps for selecting, ordering, dispensing, administering, and monitoring of the agent. GAHAR surveyor may use other opportunities during GAHAR survey course to assess program effectiveness and performance

Evidence of compliance:

1. The antimicrobial stewardship program is a hospital priority with leadership commitment and support.
2. The hospital has an approved interdisciplinary antimicrobial stewardship program based on the Center for Disease Prevention and Control (CDC) core elements and the law, regulations, and guidelines.
3. The hospital educates staff, patients, and their families about antimicrobial stewardship practices and the appropriate use of antimicrobials.
4. The antimicrobial stewardship program uses hospital-approved interdisciplinary protocols
5. The hospital tracks, collects, analyzes, and reports data on its antimicrobial stewardship program.
6. The hospital acts on improvement opportunities identified in its antimicrobial stewardship program.

Related standards:

IPC.20 Multi-drug resistant organisms; PCC.02 Interdisciplinary patient-centeredness; IPC.02 IPC program, risk assessment, guidelines

Efficient medication selection and procurement

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

Efficiency

Keywords:

Medication Procurement, Formulary.

Intent:

Medication selection and procurement is an interdisciplinary process, and it involves

(if not being done through higher authority outside the hospital) efforts to quantify medications requirements, selecting appropriate procurement methods, prequalifying suppliers, and products. It also involves managing tenders, establishing contract terms, assuring medications quality, obtaining the best prices, and is performed based on a clear process according to applicable laws and regulations.

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

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

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

Survey process guide:

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

Evidence of compliance:

1. The hospital (represented by the drug and therapeutic committee) has a hospital's approved process for appropriate selection and procurement of medications according to the applicable laws and regulations, hospital mission, patient needs and safety, and services provided to ensure uninterrupted availability of medication supply.

2. The hospital has an approved list of the approved medications (often referred to as a formulary), which includes at least items from a) to f) in the intent.
3. A controlled printed and/or electronic formulary copy of the approved medications shall be readily available and accessible to all those involved in medication management.
4. Medication list (formulary) is monitored, maintained, and updated
5. The hospital has an approved process to guide the addition/deletion of medication to/from the medication list (formulary).
6. The hospital has an approved process on proper communication about medication shortage and outage to prescribers and other healthcare professionals.

Related standards:
MMS.01 Medication management program.

Safe medication storage

MMS.04 NSR.14 Medications are safely and securely stored in stores, pharmacies, and patient care areas according to laws and regulations

Safety

Keywords:
Medication storage and labelling.

Intent:
Medications are normally stored in pharmacies, storage areas, or patient care areas in the hospital.
The stability/effectiveness of some medications depends on storing them at the correct conditions such as light, humidity, and temperature.
Appropriate storage of medications can reduce waste, incorrect medication dispensing, handling, and the incidence of missed doses
Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects the basic principles of safe medication management, yet it is routine in many hospitals
The hospital shall maintain appropriate storage conditions (temperature, light, humidity) in medication storage areas to protect the stability of medications 24 hours a day, seven days a week
The hospital shall limit access to medication storage areas with the level of security

required to protect it against loss or theft, depending on the types of medications stored.
The hospital should ensure that the labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications

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

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

Related standards:
MMS.01 Medication management program.

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

Safety

Keywords:
Emergency Medications.

Intent:
In situations when a patient emergency occurs, quick access to emergency medications

is critical and may be lifesaving.

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

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

ICD.05 Emergency care guidelines; ICD.36 Emergency equipment and supplies.

MMS.06 NSR.15 High-Alert medications and concentrated electrolytes are identified, stored, and dispensed in a way that assures that risk is minimized

Safety

Keywords:

High alert medications and concentrated electrolytes.

Intent:

- High-alert medications are those bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of an error are clearly more devastating to patients. Examples of high-alert medications include, but not limited to, anticoagulants, hypoglycemic agents, medications with narrow therapeutic range, anesthesia medications and inotropic agents
- Concentrated electrolytes include, but not limited to, potassium chloride [equal to or greater than 2 mEq/mL concentration], potassium phosphate [equal to or greater than 3 mmol/mL concentration], sodium chloride [greater than 0.9% concentration], and magnesium sulfate [equal to or greater than 50% concentration]. There are several reports of accidental deaths due to the inadvertent administration of concentrated electrolytes. Avoiding storage of concentrated electrolytes in patient care areas is a one method to minimize the risk of death or injury associated with these medications.
- The hospital develops and implements a policy and procedures to guide the process of safe use of high-alert medications and concentrated electrolyte that addresses at least the following:
  a) Lists of high-alert medications based on hospital own data and both national and international recognized organizations (e.g., Institute of Safe Medication Practice (ISMP) and the World Health Organization (WHO).
  b) List and inventory of concentrated electrolytes.
  c) Strategies are in place to prevent the inadvertent use and administration of these medications.
- Concentrated electrolytes must be safely stored including separation, and labeling throughout the hospital.

Survey process guide:

d) GAHAR surveyor may observe patient care areas and assess measures to ensure safety storage of high-alert medications (such as being labeled) and concentrated electrolytes (such as being removed whenever possible, labeled with a reminder of “MUST BE DILUTED” or separated in secure areas)

e) GAHAR surveyor may interview nurses at different patient care areas to assess their understanding of preventive strategies for managing these medications and may interview medical staff members to inquire about evidence based immediate medical necessity allowing for storing of concentrated electrolytes in these areas.

Evidence of compliance:

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

Related standards:

APC.02 Monitoring safety requirements; MMS.04 Medication storage, narcotic medications, electric power outage, and medication labelling

MMS.07 NSR.16 Look-alike and sound-alike medications are identified and stored in a manner to minimize the risk of medication dispensing and administration errors.

Safety

Keywords:

Look alike and Sound alike medications.

Intent:

Look-alike/sound alike (LASA) medications are those visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics. Any confusion between these medications may lead to harmful errors.

The Institute for Safe Medication Practices (ISMP) maintains an ongoing list of LASA medication names to highlight medications that may require special safeguards.

One strategy that ISMP recommends for reducing LASA medication errors is to include both the brand and nonproprietary names, dosage form, strength, directions, and the indication for use can be helpful in differentiating LASA medication names. If LASA medications have different indications, then associating an indication with a medication

may help differentiating it from another medication with a similar-sounding name. Other recommendations focus on ensuring prescription legibility through improved handwriting and printing.
Some hospitals may use physical separation and segregation of these medications in medication storage areas to minimize the risk
In addition, some hospitals use specially designed labels or use “tall man” (mixed case) lettering (e.g., DOPamine versus DoBUTamine) to emphasize drug name differences.
The hospital develops a risk management strategies to minimize adverse events with LASA medications and enhance patient safety.
The hospital develops and implements a policy and procedure to ensure safety of LASA that includes at least the following:

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

APC.02 Monitoring safety requirements; MMS.04 Medication storage, narcotic medications, electric power outage, and medication labelling.

MMS.08 When indicated, Medications are recalled safely.

Safety

Keywords:

Drug recall, expired and outdated medication.

Intent:

The great benefits derived from medications are also accompanied by many risks, which may be derived from the properties of the drug substance, the quality of the medications, or in some cases, the defectiveness of the product itself.

A drug recall is required when safety issues arise, and defective products are required to be returned to the manufacturer/distributor. This includes expired, outdates, damaged, dispensed but not used, and/or contaminated medications.

Drug recalls can be extremely costly and can damage consumer confidence in the product or company, so naturally all companies try the maximum to avoid such scenarios.

The hospital must have a process in place for the proper identification and retrieval of medications recalled by the Egyptian Drug Authority (EDA), the manufacturer, or other well-recognized bodies.

The hospital develops and implements a policy and procedures to guide the process of managing recalled medication. It ensures that expired medications cannot be inadvertently distributed, dispensed, or administered that addresses at least the following:

a) Maintaining product integrity requirements
b) Process to retrieve recalled medications
c) Labelling and Separation of recalled medications
d) Patient notification (when applicable)
e) Disposal or removal
f) Regular monitoring of disposal of unused, unwanted, or expired medications

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing pharmacists and nurses to inquire about processes to manage recalled, Expired, outdated, damaged, dispensed but not used, and/or contaminated medications.
- GAHAR surveyor may observe at the pharmacy, medication carts, medication

storage, medication preparation, and patient care areas to check the presence of recalled, expired, outdated, damaged, dispensed but not used, and/or contaminated medications
- GAHAR surveyor may request to trace a recalled drug from the reception of drug recall notice till disposal or removal

Evidence of compliance:

1. The hospital has an approved policy to guide the drug recall process that includes all elements from a) through f) in the intent.
2. Staff members involved in drug recall process are aware of the policy requirements.
3. Recalled drugs are retrieved, labeled, separated, and disposed of (or removed) safely.
4. Expired, outdated, damaged, dispensed but not used, and/or contaminated medications are stored safely.
5. Expired, outdated, damaged, dispensed but not used, and/or contaminated medications are disposed or removed safely.

Related standards:

MMS.01 Medication management program.

MMS.09 Management of nutrition products and medications that require special considerations is safe.

Safety

Keywords:

Radioactive medications, contrast, breast milk, medication brought by patients

Intent:

Some medications and nutrition products pose a challenge in their identification/ labeling, storage, and control of use. They require a special process for handling. Examples include (but are not limited to): Contrast media, Radiopharmaceuticals, medications brought by patients, and breast milk.

The hospital identifies that medications and nutrient products that may pose a challenge in their management

The hospital develops and implements a policy and procedures to guide the process of management of at least these medications (Contrast media, Radiopharmaceuticals, medications brought by patients, and breast milk) that addresses at least the following:

a) Receipt
b) Identification

c) Labeling
d) Storage
e) Administration
f) Monitoring

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing pharmacists, nurses, radiology technicians, and other healthcare professionals to inquire about processes to manage these medications.
- GAHAR surveyor may observe at the pharmacy, medication storage, medication preparation and patient care areas including radiology, maternal and child care areas to assess the identification, labeling, storage and administration of these medications

Evidence of compliance:

1. The hospital has an approved policy to guide use of these medication that addresses all elements mentioned in the intent from a) through f).
2. Staff members involved in managing these medications demonstrate knowledge of the procedures.
3. Contrast media and radiopharmaceuticals are received, identified, labeled, stored, and administered safely.
4. Medications brought by patients are received, identified, labeled, stored, and administered safely.
5. Breast milk received, identified, labeled, stored, and administered safely.
6. Effects and potential adverse effects of these medications are monitored.

Related standards:

MMS.04 Medication storage, narcotic medications, electric power outage, and medication labelling; EFS.02 Environment and facility safety program monitoring.

MMS.10 NSR.13 Medications are reconciled across all interfaces of care in the hospital.

Safety

Keywords:

Medication Reconciliation, best possible medication history (BPMH).

Intent:

Patients often receive new medications or have changes made to their existing

medications at times of transitions in care (hospital admission, transfer from one unit to another during hospitalization, or discharge from the hospital).
As a result, the new medication regimen prescribed at the time of discharge may inadvertently omit needed medications, unnecessarily duplicate existing therapies, or contain incorrect dosages. These discrepancies place patients at risk for adverse drug events (ADEs).
The medication reconciliation process is a multidisciplinary activity with responsibilities shared among physicians, nurses, pharmacists, and other clinicians involved in the patient's care. Medication reconciliation refers to the process of avoiding such inadvertent inconsistencies across transitions in care by reviewing the patient's complete medication regimen at the time of admission, transfer, and discharge and comparing it with the regimen being considered for the new setting of care.
The hospital develops and implements a policy and procedures to guide the medication reconciliation process that addresses at least the following:

a) Situations where medication reconciliation is required:
   i. On admission (matching the current medication orders with the best possible medication history (BPMH), ideally within 24 hours of admission).
   ii. During the episode of care (verifying that the current list of medications is accurately communicated each time care is transferred and when medications are recorded).
   iii. On discharge (checking that medications ordered on the discharge prescription match those on the discharge plan and the medications list, and confirming that changes have been documented).
b) Identify responsibility to perform medication reconciliation.
c) Patients and family involvement.
d) Steps of medication reconciliation process such as collecting the list of medications, vitamins, nutritional supplements, over-the-counter drugs, and vaccines used by patients, clarification whether these medications and their dosages are appropriate, matching with new list of medication and recording changes.
e) Timeframe for completion of the medication reconciliation process.

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing medical staff members, pharmacists, nurses, and other healthcare professionals to inquire about the medication reconciliation process.
- GAHAR surveyor may review a number of patient's medical records (usually more than 10) to assess recording of current medications upon admission.

- GAHAR surveyor may interview with appropriate number of patients to inquire about medication history assessment done by physicians and check their awareness regarding any interaction existed with newly prescribed medications.
- GAHAR surveyor may check if patient's own medications are matching the recorded current medications upon admission and are included in the medication reconciliation process.

Evidence of compliance:

1. The hospital has an approved policy for medication reconciliation that includes all elements mentioned in the intent from a) through e).
2. Staff responsible for reconciling medications are trained to take the best possible medication history (BPMH) and reconcile medications.
3. Medication reconciliation occurs on admission, during the transition of care and upon discharge within a defined timeframe.
4. Medication prescribers compare the list of current medications with the list of medications to be prescribed and make clinical decisions based on the comparison.
5. Reconciled medications are clearly recorded, and related information is clearly communicated to healthcare professionals involved in the patient's medication prescribing
6. Patients and families are involved in medication reconciliation.

Related standards:

ACT.08 Patient care responsibility; ACT.09 Handover communication; ICD.08 Medical patient assessments.

MMS.11 Medication ordering, prescribing, and transcribing processes are safe and according to laws and regulations

Safety

Keywords:

Ordering, prescribing, transcribing, abbreviations, and symbols.

Intent:

When prescribed and used effectively medications have the potential to significantly improve the quality of lives and improve patient's safety and outcomes. However, the challenges associated with prescribing the right medications, transcribing, and supporting patients to use them effectively should not be underestimated.
Treating a patient with medication(s) requires specific knowledge and experience.

Each hospital is responsible for identifying those individuals by experience and who are permitted by licensure, certification, laws, or regulations to prescribe or to order and Transcribing medications.
Abbreviations avoidance prevents misunderstanding, miscommunications, and administration of incorrect prescriptions.
The hospital develops and implements a policy and procedures to guide the processes of ordering, prescribing, and transcribing of medications that addresses at least the following:

a) Who is authorized to prescribe which type of medications?
b) Uniform location in the patient's medical record to order/prescribe/transcribe medications
c) Transcription process and use during appropriate situations
d) Listing of prescribed medications, their dosage and administration times
e) Process of cancelation or discontinuation of a medication prescription

Survey process guide:

- GAHAR surveyor may review the hospital policy followed by interviewing medical staff members, pharmacists, nurses, and other healthcare professionals to inquire about prescription/order process in any location including inpatient wards, radiology areas, emergency room and post anesthesia care units.
- GAHAR surveyor may observe patient's medical records to assess the completion, legibility, and clarity of medication orders

Evidence of compliance:

1. The hospital has an approved policy to guide the processes of ordering/prescribing and transcribing medications that addresses all elements mentioned in the intent from a) through e).
2. The hospital is responsible for identifying those healthcare professionals permitted by law and regulation, qualification, training, experience, and job description to order, prescribe, and transcribe medications.
3. Staff members involved in medication prescription, dispensing and administration processes are aware of who is authorized to prescribe which medications, locations of prescription, complete prescription and process of cancellation or discontinuation of prescriptions.
4. Medication transcription process is implemented and permitted under certain predefined situations.

Related standards:

APC.02 Monitoring safety requirements; IMT.04 abbreviations.

MMS. 12 Complete medication prescription elements are defined.

Effectiveness

Keywords:

Complete medication order, narcotic medications, special types of medication orders.

Intent:

Safe prescribing, ordering, and transcribing are guided by the hospital policies and procedures.

Medical, nursing, and pharmacy staff collaborate to develop and to monitor the ordering and prescribing policies and procedures.

Physicians are trained in correct prescribing and ordering practices. Qualified staff are trained in correct transcribing.

The hospital defines the elements of complete prescription and the types of orders that are acceptable for use to minimize the potential for errors when orders are recorded.

The hospital defines a process to guide the complete prescription process

The complete prescription includes at least the following:

a) The minimum required elements of complete medication prescriptions to include:
   i. Patient's identifications
   ii. Patient's demographics
   iii. Drug name
   iv. Dosage form
   v. Strength or concentration
   vi. Dosage, frequency, and duration of medication
   vii. Route of administration
   viii. Rates of administration (when intravenous infusions are ordered)
   ix. Indications for use (for PRN orders)
   x. Maximum frequency and maximum daily dose (for PRN orders)
   xi. Date and time of the order
b) Acceptability and special required elements of certain types of orders, for example, that are weight-based or otherwise adjusted, such as for children, elderly, and other similar populations.
c) Special types of orders, such as emergency, standing, or automatic stop.

Survey process guide:

- GAHAR surveyor may review the hospital policy describing complete prescriptions followed by interviewing medical staff members, pharmacists, nurses, and other healthcare professionals to inquire about prescription/order processes in any location, including inpatient wards, radiology areas, emergency room, and post-anesthesia care units.
- GAHAR surveyor may observe patient's medical records to assess the completion, legibility, and clarity of medication orders

Evidence of compliance:

1. Complete medication prescriptions and orders include elements from a) to c) in the intent as applicable.
2. Psychotropic, controlled, and narcotic medications are safely prescribed according to applicable laws and regulations.
3. Medication prescriptions are safe and complete, and are recorded for each patient.
4. Special types of orders, such as weight-based dosing, titration, tapering, or range orders are prescribed safely.
5. Incomplete, illegible, or unclear prescriptions are managed safely.

Related standards:

APC.02 Monitoring safety requirements; ACT.03 Patient identification; ICD.17 Orders and requests; MMS.04 Medication storage, narcotic medications, electric power outage, and medication labelling.

Safe medication preparation and dispensing

MMS.13 Medication prescriptions are reviewed for accuracy and appropriateness

Safety

Keywords:

Medication appropriateness review, competent pharmacist.

Intent:

Dispensing is a core clinical activity that enables pharmacists to ensure the safety and effectiveness of medications.

All medication orders are reviewed for accuracy and appropriateness before dispensing or removal from floor stock. The appropriateness review is performed by competent individual(s) (e.g., clinical pharmacist).

Each newly prescribed medication is reviewed for the following elements (when applicable):

a) The suitability of the medication regarding the indication.
b) The dosage regimen including the dose, frequency, and route of administration, and duration of treatment considering patient's physiological information.
c) Therapeutic duplication.
d) Variation from the hospital criteria for use.
e) Contraindications.
f) Real or potential allergies/sensitivities.
g) Real or potential interactions between the medication and other medications or food.
h) Potential toxicity.

A new appropriateness review is performed when the dosage or other appropriateness factors noted before changes; for example, when new medications are prescribed, and therapeutic duplication may be an issue. The hospital defines what patient-specific information that is required for the appropriateness review of the prescription.

Appropriateness reviews is always performed. For example, if the pharmacy is not open, and the medication to be dispensed from stock in the nursing unit. The full appropriateness review is performed within 24 hours from dispensing the first dose.

Survey process guide:

GAHAR surveyor may interview pharmacists, nurses, and other healthcare professionals involved in the appropriateness review to inquire about the process, its variations and may observe the process.

Evidence of compliance:

1. Patient-specific information and its source are available and accessible at all times to support an effective review process.
2. Healthcare professionals permitted to perform appropriateness reviews are competent to do so.
3. Each prescription is reviewed for appropriateness by a licensed pharmacist prior to dispensing and includes elements a) through h) in the intent, using current and updated resources.
4. When an on-site licensed, competent pharmacist is not available, a trained healthcare professional determined by the hospital to perform a review of critical elements f) through h) in the intent using current and updated resources.
5. There is a process to contact the prescriber when questions or concerns arise.

Related standards:

MMS.13 Medication preparation, medication preparation area, labelling of medications; MMS.11 Complete medication order, narcotic medications, special types of medication orders.

MMS. 14 Medications are prepared safely.

Safety

Keywords:

Medication preparation, medication preparation area, labeling of medications

Intent:

A safe, clean, and organized working environment provides the basis for good dispensing practice. This includes qualified/trained staff, appropriate physical surroundings, adequate shelving and storage areas, proper work surfaces, suitable equipment, and necessary packaging materials.

The hospital identifies the standards of practice for a safe preparation environment.

Healthcare professionals who prepare medications are requested to use techniques to ensure accuracy (e.g., double-checking calculations), and avoid contamination, including using clean or aseptic technique as appropriate; maintaining clean, and uncluttered areas for product preparation.

Healthcare professionals preparing compounded sterile products or preparing medications using multi-dose vials are trained on the principles of medication preparation and aseptic technique. Similarly, laminar airflow hoods are available and used when indicated by professional practices (e.g., cytotoxic medications).

Medications are labeled in a standardized manner. This requirement applies to any medication that is prepared but not administered immediately (this requirement does not apply to a medication prepared and administered immediately in the emergency situations).

At a minimum, labels must include the following (if not apparent from the container):

a) Patient identifications (2 unique identifiers),
b) Medication name,
c) Strength/concentration,
d) Amount,
e) Expiration date,
f) Beyond use date,
g) Directions for use,

h) Any special/cautionary instructions, and
i) Date prepared and the diluent for all compounded intravenous (IV) admixtures, and parenteral solutions (if available),

Survey process guide:

- GAHAR surveyor may observe at the pharmacy, medication storage, medication preparation and patient care areas including inpatient wards, procedure areas and operation rooms to assess the labeling and preparation of medications
- GAHAR surveyor may interview pharmacists, nurses, and other healthcare professionals involved in compounding and preparation of sterile and non-sterile preparations to inquire about processes of preparation and may observe the process.

Evidence of compliance:

1. Medications are prepared safely in clean, uncluttered, and separate areas provided with appropriate medical equipment and supplies and adhering to the applicable laws, regulations, and professional standards of practice.
2. The hospital identifies those healthcare professionals authorized to prepare medications in different situations.
3. The hospital has a system for safely providing medications to meet patient needs when the pharmacy is closed.
4. The hospital implements a process to guide the compounding and preparation of sterile and non-sterile preparations.
5. All medications prepared in the hospital are correctly labeled in a standardized manner with at least the elements from a) to i) in the intent.

Related standards:

MMS.04 Medication storage, narcotic medications, electric power outage, and medication labelling; MMS.06 High risk medications, concentrated electrolytes; MMS.07 Look-alike, Sound-alike; IPC.06 PPE, guidelines, physical barriers.

MMS.15 Medications are safely and accurately dispensed according to laws and regulations

Safety

Keywords:

Medication dispensing, distribution system, Patient education, and counseling.

Intent:

Dispensing medications within the hospital follows standardized processes to ensure

patient safety.
A uniform system for dispensing and distributing medications can help to reduce the risk of medication errors.
The hospital dispenses medications in the most ready-to-administer form possible to minimize opportunities for error during distribution and administration.
Medications are dispensed in quantities enough to meet patient's needs but at the same time to minimize diversion (i.e., quantities dispensed are not excessive to permit diversion).
The hospital educates patients and their families so that they have the knowledge and skills to participate and make decisions related to patient care processes.
This education (especially on patients' discharge) includes but not limited to verbal explanation and instructions by a pharmacist to patients and their families on the storage, safe and effective use, administration of the prescribed medications

Survey process guide:

- GAHAR surveyor may interview pharmacists, nurses, porters, and other healthcare professionals involved in medication dispensing to inquire about the process, its variations and may observe the process.
- GAHAR surveyor may interview a patient or a family member to inquire about the medication education process.

Evidence of compliance:

1. The hospital is responsible for identifying those healthcare professionals permitted by law and regulation, qualification, training, experience, and job description to dispense medications.
2. The hospital has a uniform medication dispensing and distribution system according to the applicable laws and regulations.
3. Psychotropic, controlled, and narcotic medications are dispensed according to the applicable laws and regulations
4. Medications are dispensed in the most ready-to-administer form and in quantities consistent with patient's needs and conditions.
5. Hospital pharmacy has a process for the provision of medication education and counseling (when applicable) to the patients and/or their families, especially on patients' discharge, and the patients are given a chance to ask questions.

Related standards:

PCC.10 Patient and family education process; ICD.14 Plan of care.

Safe medication administration

MMS.16 Medications are safely and accurately administered according to laws and regulations

Safety

Keywords:
Medication administration, order verification, medication-self administration.

Intent:
Medication administration to manage a patient requires specific knowledge and experience.
In addition, medications administered within the hospital follow standardized processes to ensure appropriateness, effectiveness, and safety of medication based on prescription or order.
The safe administration of medications includes verifying the following:

a) Presence of medication order
b) Patient identifications (2 unique identifiers)
c) Right medication
d) Reasons/indication of medication therapy
e) Right dosage amount and regimen
f) Right route of administration
g) The right time and frequency of administration
h) Review if the patient is allergic to any medication in the prescription or order.

In hospitals, patients have had their medications administered to them, and this shall normally continue, especially for those patients for whom self-administration of mediation is assessed as inappropriate.
Self-administration of medications is clearly defined if approved, known to the patient's physician, and noted in the patient's medical record. Self-administration competency of the patient (or relatives in case of the pediatric patient) is assessed by providing education to patients and the family then asking them to demonstrate. Education can also be provided about medications, dose, frequency, route, indications, and possible side effects.

Survey process guide:

- GAHAR surveyor may interview pharmacists, nurses, other healthcare professionals, patients and their families involved in medication administration to inquire about the process, its variations, this can occur in any location, including inpatient wards,

emergency room observation areas, and procedure areas.
- GAHAR surveyor may observe the process of medication administration.

Evidence of compliance:

1. The hospital identifies those healthcare professionals, by law and regulation, qualification, training, experience, and job description, authorized to administer medications and admixtures, with or without supervision.
2. Medication administration includes a process to verify the medication is correct based on the medication prescription or order covering elements from a) to h) in the intent.
3. Psychotropics, controlled, and narcotic medications are administered according to the applicable laws and regulations.
4. Patients are informed about the medications that they are going to be given, including if needed, any potential adverse drug reactions, or other concerns about administering medication and are given a chance to ask questions.
5. Medications administered, refused, or omitted is recorded in the patient's medical record.
6. The hospital implements a process that guides the safe and accurate self-administration of medications or administration of medications by a person who is not a staff member (If allowed) and addresses training, supervision, and administration documentation

Related standards:

APC.02 Monitoring safety requirements; ICD.14 Plan of care; ACT.03 Patient identification

Effective medication monitoring

MMS.17 Medication effects on patients are monitored.

Safety

Keywords:

Medication Monitoring, first dose of medications, adverse drug reaction.

Intent:

Medication monitoring is an interdisciplinary process where the patient and his or her physician, pharmacist, nurse, and other healthcare professions work together to monitor patients on medications.

The purpose of monitoring is to evaluate the therapeutic response of the medication(s), including safety and effectiveness, to adjust the dosage or type of medication when

required, evaluate for any medication interaction, and evaluate the patient for adverse effects or allergic reactions.
Medications are monitored for patient clinical effectiveness, and adverse medication effects to ensure that medication therapy is appropriate, and risks are minimized.
The record of each patient who receives medications in the hospital contains a list of the current medications prescribed or ordered. This list facilitates the monitoring of all the medications that a patient may currently be taking.
Monitoring medication effects include observing and recording any adverse effects. This is done using a standardized format (e.g., The Egyptian National Forms) for reporting and educating staff on the process and the importance of reporting. Reporting to the authorized institutions is done in the most appropriate time without any delay as per national/international regulations.

Survey process guide:

- GAHAR surveyor may interview medical staff members, pharmacists, nurses, other healthcare professionals, patients and their families involved in medication administration to inquire about the process of medication monitoring, this can occur in any location, including inpatient wards, radiology areas, and procedure areas.
- GAHAR surveyor may review the process of reporting adverse drug events

Evidence of compliance:

1. The patient's response to his/her medication is monitored according to the clinical conditions/status of the patient.
2. The hospital implements a process for monitoring the response to the first dose of medications that are new to the patient while under the direct care of the hospital.
3. Actual or potential medication adverse drug effects on patients are monitored and documented in the patient's record, including the action(s) to be taken in response.
4. Adverse drug events (ADEs) are reported in a manner consistent with national and international guidelines.
5. The hospital implements a process informing the prescriber when an adverse effect(s) occur(s).

Related standards:

PCC.02 Interdisciplinary patient-centeredness, QPI.11 Incident reporting system; QPI.12 Significant events; QPI.13 Sentinel event.

MMS.18 Medication errors, near misses, and medication therapy problems are detected, reported, and acted upon.

Safety

Keywords:
Medication errors, near miss, medication therapy problems.

Intent:
Each hospital can have a medication error, near miss, and medication-related problems (also known as drug therapy problems) detecting and reporting system. This system focuses on preventing and managing medication errors and near misses, or any other safety issues including but not limited to overdose, toxicity, misuse, abuse, occupational exposure, medication exposure during pregnancy, and lactation).
Medication errors and near misses are particularly important given the large and growing global volume of medication use. Medication errors can occur at a number of different stages of the medication prescription and use process. Although serious errors are relatively rare, the absolute number is sizeable, with the potential for considerable adverse health consequences.
The hospital develops a process to identify and report on medication errors and near misses.
The process includes defining a medication error and near-miss, using a standardized format for reporting, and educating staff on the process and importance of reporting. Definitions and processes are developed through a collaborative process that includes all those involved in the different steps in medication management.
The reporting process shall be part of the hospital quality improvement and patient safety program.
Medication errors, near misses and medication therapy problems,are identified and reported to:

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

Survey process guide:
GAHAR surveyor may interview healthcare professionals involved in medication management processes during the medication management review session and inquire

about the detection, analysis, reporting, and actions of medication errors, near misses, and medication therapy problems.

Evidence of compliance:

1. The hospital has an approved policy to guide the process of defining, reporting, analyzing, and acting on for medication errors, near misses, and medication therapy problems based on national/international references.
2. The hospital implements a process for detecting, reporting to bodies from a) to e) identified in the intent, and acting on medication errors, near misses, and medication therapy problems.
3. The hospital utilizes reported medication errors, near misses, and medication therapy problems to improve medication management and use programs.

Related standards:

APC.02 Monitoring safety requirements; ACT.08 Patient care responsibility; QPI.11 Incident reporting system; QPI.12 Significant events; QPI.13 Sentinel event.

SECTION 3

ORGANIZATION-CENTERED STANDARDS

Section 3: Organization-Centered Standards

While in the previous section, Patient safety and centered care was the focus. Yet, Patients are not the only customers of healthcare systems. Healthcare professionals face risks, as well. Although debate continues regarding whether worker wellbeing should be considered part of the patient safety initiatives, many organizations think about it that way, including major players in the healthcare industry worldwide. Three major aspects may affect worker's wellbeing; Safety, Stress, and Hospital Structure. Regarding Safety, according to the United States Department of Labor, Occupational Safety and Health Administration (OSHA), a hospital is one of the most hazardous places to work. Healthcare professionals experience some of the highest rates of non-fatal illness and injury surpassing both the construction and manufacturing industries. In 2011, U.S. hospitals recorded 253,700 work-related injuries and illnesses, a rate of 6.8 work-related injuries for every 100 full-time staff. From 2002 to 2013, the rate of serious workplace violence incidents (those requiring days off for an injured worker to recuperate) was more than four times greater in healthcare than in private industry on average. In fact, healthcare accounts for nearly as many serious violent injuries as all other industries combined. Many more assaults or threats go unreported. Workplace violence comes at a high cost; however, it can be prevented.

On the other hand, being exposed to stress for too long may lower a person's efficiency and could trigger negative consequences on one's health or family and social life. Nevertheless, not every manifestation of stress is always workplace stress. Workplace stress may be caused by various factors. Some professions are inherently more stressful than others are. Some studies showed that healthcare professions are among the first six most stressful ones. Not all health professionals develop the same level of stress, and not all of them develop signs of professional burnout either. According to several studies, Intensive Care Unit medical/nursing staff report that dealing with death is their first source of stress, compared to nurses who work in internal medicine or surgical departments. For those professionals, workload and adequate workforce planning may be the most important stress source.

Hospital structure provides guidance to all staff by laying out the official reporting relationships that govern the workflow of the company. A formal outline of a hospital structure makes it easier to add new positions in the hospital, as well, providing a flexible and ready means for growth. Organization management needs to be according to a clear ethical framework that is responsive to community needs. Organizations have

an obligation to act for the benefit of the community at large. Workers, as community members, need to be engaged in assessing community needs and responding to them, in addition, to being protected from safety and stress hazards while working in the hospital.

Nevertheless, both the hospital and the staff have the responsibility to keep the workforce safe. For example, while management provides personal protective equipment (PPE), such as safety glasses to keep debris and chemical splashes away from the eyes, it is the staff's responsibility to wear the PPE when performing work that management has identified as requiring it. More generally, it is the responsibility of management to prepare detailed work instructions that clearly describe how work should be performed in order to prevent quality and safety failures; the staff is responsible for following these procedures.

Thus, this section shall focus on some of the newer ideas about healthcare workplace suitability to provide a safe, efficient, and improving environment for healthcare service. One of the tools used to design this section is called HealthWISE, which is an action tool developed by the International Labor Organization (ILO) in collaboration with the WHO. This tool emerged from traditional thinking about patient safety and improvement more generally. It describes a process and structure that may lead to improved safety in a variety of healthcare settings.

Elements For Safe Healthcare

The aim of HealthWISE is to provide healthcare institutions with a practical, participatory and cost-effective tool to improve work conditions, performance, occupational health and safety for health workers, and the quality of health services provided. Improvements are introduced and sustained by the combined efforts of management and staff, brought together in a dedicated team. HealthWISE puts the health workforce in focus and addresses topics that are key to delivering quality care. It encourages everyone to participate in making their workplace not only a good place to work but a quality healthcare environment appreciated by patients and the community.

As organization management is responsible for providing an efficient hospital structure, where a governing body is well defined and responsive to the hospital needs, Leaders work collaboratively to run the hospital towards preset approved strategic directions. An established structure includes defining capacity and roles of the hospital workforce, providing sufficient orientation and education, and continuous monitoring and evaluation. Hence, strong information management and technology are needed to record data and information, in addition to a strong quality management program that can capture and interpret data and information.

Environmental and Facility Safety

Chapter intent:

Environmental and Facility Safety (EFS) in hospitals aims at minimizing potential risks for patients, visitors, staff, and buildings through compliance with local laws, regulations, fire, and building codes for providing a safe and secure work environment.

From an environmental standpoint, it involves creating a systematic approach to compliance with environmental regulations, such as managing waste and maintaining a safe environmental condition. From a safety standpoint, it involves creating organized efforts and procedures for identifying workplace hazards and reducing accidents and exposure to harmful situations and substances. It also includes training of staff members in accident prevention, accident response, emergency preparedness, and use of protective clothing and equipment. Globally, Healthcare design standards were developed to maintain proper hospital structure that maintain safety and efficiency for all users. Facility Guideline Institute issues periodical research-based standards for healthcare facility designs. OSHA, CDC, WHO and other international healthcare players sets certain standards for various aspects of healthcare design. Locally, Regulatory requirements play an important role in EFS. The hospital shall identify and understand all relevant EFS regulations to implement the required measures. National initiatives include but not limited to: Organization building codes, licensure requirements for the whole organization and the individual functions/machine/equipment/units inside the hospital, Civil defense laws, Green hospital initiative, Environmental laws. GAHAR surveyor is going to meet the concerned staff in EFS and discuss the different standards of chapter and review the documents, trace the activities and functions, and measure the facility awareness about safety. Facility tour is an important tool used by surveyors to measure environmental safety risks in a hospital.

Chapter purpose:

This chapter started by planning and effective management of the hospital environmental facility safety. Followed by requiring the development, implementation, monitoring, improvement, evaluation and annual update of the environmental safety plans The main objective is to ensure that organization is able to identify the safety issues and provide safe and effective program to handle and maintain environment safety. The chapter discusses the following:

- Fire safety:

Prevention, early detection, response, and safe evacuation in case of fire.

- **Hazardous materials:**

Safe handling, storage, transportation, and use of hazardous materials, and waste disposal.

- **Safety:**

Providing a safe work environment for all occupants, ensuring that the hospital buildings, construction areas, and equipment do not pose a hazard or risk to patients, staff, and visitors.

- **Security:**

Protection of all occupants' properties from loss, theft, destruction, tampering, or unauthorized access or use.

- **Medical equipment:**

Selection, inspection, testing, maintenance, and safe use of medical equipment.

- **Utility systems:**

Ensures efficiency and effectiveness of all utilities through regular inspection, maintenance, testing, and repair of essential utilities to minimize the risks of operating failures.

- **Disaster preparedness:**

Responding to the disasters and emergencies that have the potential of occurring within the geographical area of the hospital with an evaluation of the structural integrity of the patient care environment.

Implementation guiding documents:

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

1. Egyptian building codes for healthcare organizations.
2. Egyptian civil defense laws
3. MOHP regulation in NICU, 2007
4. MOHP requirements in the website www.mohp.org.eg
5. MOHP Ministerial decree 34/2001 on surgery and anesthesia services
6. Law 192/2001 for Hazardous waste management
7. Presidential decree number 3185/2016
8. MOHP Ministerial decree 284/1985 on requirements for OR
9. MOHP Ministerial decree 306/2002 on medication storage spaces
10. Egyptian Food safety guidelines
11. Egyptian Guideline for Medical Device Vigilance System
12. Guideline hospital disaster planning

13. National strategy in disasters management
14. National Law for Environment
15. Atomic Energy Commission rules
16. The Green Pyramid Rating System (GPRS)
17. WHO Early Warning Alert And Response Network in emergencies
18. WHO International Health Regulation
19. Guidance in environmental safety book – part 6
20. Core Medical equipment -WHO

Effective leadership and planning of environment and facility safety

EFS.01 Hospital facilities comply with laws, regulations, fire, and national building codes.

Safety

Keywords:

Hospital environment and facility safety structure.

Intent:

While hospitals are meant to provide healing and comfort, they also include certain dangers.

Hospitals contain hazardous chemicals, chemotherapeutic drugs, radioactive material, and infectious matter, among other threatening items.

For this reason, governmental authorities enforce laws and regulations to ensure protection against these exposures.

In addition, there are also dangers from fire and smoke that can be particularly perilous for vulnerable hospital patients.

Building cades were established to provide guidance on safety measures while designing hospitalsettings.

The hospital should comply with relevant laws, regulations, and codes like civil defense, fire and building codes to ensure the safety of patients, staff, visitors, vendors, and the environment.

a) If an external authority, such as civil defense, reported an observation during its inspection, the hospital leadership is responsible for providing a corrective action plan and for following up of any non-compliance within the required timeframe.

The hospital develops and maintains basic infrastructure for environmental and facility safety program:

b) Clinical and diagnostic services having adequate space according to applicable laws, regulations, and approved hospital scope of service.
c) Permits, licenses and hospital design drawings are available, valid, and current.
d) Budget is planned for upgrading and/or replacement of instruments or systems to keep environmental safety and/or to expand services provided within the hospital.
e) Qualified environmental safety staff are available and match requirements of hospital scope of services, laws and regulations.

The hospital builds an environmental safety oversight structure:

f) The hospital should have a committee overseeing environmental safety activities and trainings through regular meetings, the committee could be held urgently if

needed.

g) The committee role should include review of aggregated essential data, incident reports, drill reports, and safety plans measures, recommended actions, and following up to ensure compliance with all safety requirements.
h) The committee should report to the hospital's leadership quarterly and a feedback from hospital leadership should be received.

Survey process guide:

- GAHAR surveyor may review documents demonstrating hospital drawings, budget, safety staff qualifications, external authorities reports with action plans and recorded committee meeting notes and agenda.
- During hospital tours and tracers, GAHAR surveyor may observe compliance to laws and regulations and matching of allocated spaces to departmental functions.

Evidence of compliance:

1. The hospital leadership complies with environmental safety laws, regulations, and national building codes.
2. The hospital maintains basic requirement for development of environment and facility safety program.
3. The hospital has a committee overseeing environmental safety with approved terms of references.
4. Environment and facility safety committee meets regularly and meetings are recorded.
5. The hospital's leadership ensures compliance with external inspection reports and correction of observations within the required timeframe.

Related standards:

PCC.02 Interdisciplinary patient-centeredness, DAS.24 Laboratory safety program; DAS.09 Radiation safety program.

EFS.02 Hospital environment and facility safety program is continuously monitored.

Safety

Keywords:

Environment and facility safety program monitoring.

Intent:

Maintaining an active environment and facility safety program requires special skills to

measure performance, identify gaps and do corrective actions.

Environment and Facility safety supervisors are responsible for inspecting buildings to identify maintenance and safety issues, such as clogged drains, leaky ceilings, and faulty electrical switches.

They report them and create work assignments for the staff.

Supervisors perform human resource duties such as hiring, training, promoting, and dismissing staff. They also motivate employees, resolve disputes, and perform performance evaluations. Administrative duties include creating periodic reports, such as work schedules, employee payroll and budget planning. Supervisors also maintain inventory, such as cleaning supplies, tools, and office supplies.

The hospital ensures availability of qualified staff according to the scope of provided services, local laws, and regulations.

a) The hospital defines the number and skills of staff required to support environmental and facility safety program.
b) The hospital specifies the required qualifications according to the job description.
c) Sometimes, a minimum number and skills of environment set by a higher authority or the governing body, the hospital shall define if there are such requirements.
d) When the hospital doesn't have an available staff to manage certain parts of the program, the hospital must take actions to ensure that the service is appropriately managed.

The hospital builds capacity to support environmental and facility safety program

e) The hospital identifes basic requirements for staff education on environmental and facility safety related topics.
f) The hospital orientation program should provide information about basic safety requirements.
g) The hospital staff training programs should include identification and reporting of environment and facility related risks.

The hospital should create continuous monitoring mechanisms for environment and facility safety.

h) An interdisciplinary environment and facility surveillance team is formed from all stakeholders.
i) The team shall perform surveillance rounds across all hospital areas and services at least twice annually.
j) The team shall provide reports of environment and facility surveillance rounds to the concerned stakeholders, environment and facility safety committee and hospital leadership.

Survey process guide:

- GAHAR surveyor may review documents that demonstrate environment and facility surveillance rounds schedule, plan, agenda, notes or reports. the surveyor may review environment and facility safety committee meeting notes to verify if the round report observation were discussed or not.
- During the GAHAR survey, the surveyor may interview staff or review staff files to assess environment safety staff numbers and qualifications and to assess staff awareness of environment safety requirements.

Evidence of compliance:

1. The hospital ensures availability of qualified staff that matches the needs of hospital scope of services, laws, and regulations.
2. The hospital builds capacity to support environmental and facility safety program.
3. The hospital ensures that interdisciplinary environment and facility surveillance rounds are performed across all hospital areas and services at least twice annually.
4. There is a biannual report submitted to the hospital's governing body about the significant observations during the environment and facility surveillance rounds with corrective actions taken or needed.

Related standards:

EFS.04 Smoking-free areas.

Safe fire planning

EFS.03 NSR.21 Fire and smoke safety plan addresses prevention, early detection, response, and safe evacuation in case of fire and/or other internal emergencies.

Safety

Keywords:

Fire and smoke safety.

Intent:

One of the critical considerations in the safety design for hospitals is the prevention of fire, particularly with respect to the combustibility of construction and furnishing materials and the spread of fire and smoke.

In the event of either accidental or malicious fires, suppression equipment needs to be readily accessible to combat these fires.

Staff members of the hospital need to have working knowledge of how to use the equipment and to avoid panic.

The last resort, failing the ability to completely suppress the fire, is to evacuate the hospital.

Moving all patients, visitors, and staff out of dangerous and/or damaged facilities as safely as possible is always the goal of an evacuation.

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

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

a) An ongoing risk assessment that will have the following features:
   i. Assesses ccompliance with Civil Defence regulations.
   ii. Assesses compliance with fire and building codes.
   iii. Includes fire and smoke separation, areas under construction and other high-risk areas for example stores, fuel tanks, kitchens including hoods, generators, laundry, oxygen supply, medical gases rooms, electrical control panels, medical records room, garbage room, etc.
   iv. Addresses the safety of all occupants including patients, families, full time staff, part time staff, visitors, suppliers, contractors and others.
   v. Addresses evacuation for fire and non-fire emergencies, for example, dangerous gas leakage.
   vi. A special risk assessment is performed during renovation and construction.
b) Early detection of fire and smoke system, including the central control panel connected to all areas in hospitals according to its functionality, and ensure continuous monitoring 24/7.
c) Fire suppression system such as water system, automated or manual fire extinguisher.
d) Listing of firefighting and alarm systems includes maintenance testing, inspection schedule.
e) Availability of safe, unobstructed fire exits, with clear signage to assembly areas and emergency light, in addition to other related signages like how to activate the fire alarm using a fire extinguisher and hose reel.
f) Inspection of all firefighting and alarm systems should be in place, and results are recorded with needed corrective actions.
g) Safe storage and handling of highly flammable materials.
h) The hospital should perform proper annual training and orientation of all staff in a practical manner to make sure that everyone in the hospital can:
   i. Demonstrate RACE and PASS.
   ii. Define who is responsible for medical gas valves shut off, with alternative oxygen

.sources in case of fire.

iii. Safely evacuate all occupants.

iv. Provide specific training for the evacuation of high-risk patients like (Operating theatres, Intensive care units).

v. Hospital evacuation pathway, gathering areas, and assembly points.

i) Documentation of all results in a proper way and repetition according to the training plan.

j) The plan is evaluated annually and, if needed, according to related performance measures results or major incidents.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

EFS.04 Smoking-Free Environment, EFS.02 Environment and facility safety program monitoring

EFS.04 The hospital clinical and non-clinical areas are smoking-free.

Safety

Keywords:

Smoking-Free Environment.

Intent:

According to Center for Disease Control (CDC), Smoking causes about 90% (or 9 out of 10) of all lung cancer deaths. More women die from lung cancer each year than from breast cancer. Smoking causes about 80% (or 8 out of 10) of all deaths from chronic obstructive pulmonary disease (COPD). Cigarette smoking increases risk for death from all causes in men and women.

Literature shows that although hospitals restrict smoking inside, many people continue to smoke outside, creating problems with second-hand smoke, litter, fire risks, and negative role modeling.

Smoke-free policies are an important component of an ecological and social-cognitive approach to reducing tobacco use and tobacco-related disease.

In addition, Anti-smoking policies were reported to cause numerous positive effects on employee performance and retention.

The hospital ensures a smoking-free environment for patients and environmental safety through the availability of smoking-free environment policy and procedure, proper signage according to laws and regulations.

The policy should include any exceptions, penalties, and the designated smoking area outside the building.

All staff should be oriented about the smoking-free environment policy.

Survey process guide:

- GAHAR surveyor may review the smoking-free policy followed by interviewing staff and/or patients to check their awareness of hospital policy, smoking areas location and consequences of not complying to the policy.
- During the GAHAR survey, surveyors may be observe evidences of not complying to the policy such as cigarette remnants and cigarette packs specially in remote areas.

Evidence of compliance:

1. The hospital has an approved policy for a smoking-free environment.
2. Staff, patients and visitors are aware of the hospital policy.
3. Occupants, according to laws and regulations, do not smoke in all areas except designated areas.
4. The hospital monitors compliance to smoking-free policy.

Related standards:

EFS.03 Fire and smoke safety, EFS.02 Environment and facility safety program monitoring

EFS.05 NSR.22 Fire drills are performed in different clinical and non-clinical areas, including at least one unannounced drill annually.

Safety

Keywords:

Fire drills.

Intent:

Fire drills are designed to:

a) Ensure through regular training and simulations, staff members will: have knowledge and understanding of the fire safety plan so that they can act swiftly, safely, and in an orderly manner.
b) Have increased self-confidence and power to fulfill their responsibilities in the event of a fire.

The hospital staff should be well trained on firefighting and safe evacuation through practical simulations and regular drills to ensure staff readiness in case of fire and/or other internal emergencies.

The hospital records fire drills details including, but are not limited to, the following:

a) Dates and timings.
b) Staff who participated in the drill.
c) Involved areas.
d) Shifts.
e) Drill evaluation and corrective action plan.

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

EFS.01 Hospital environment and facility safety structure.

Safe hazardous materials and waste management plan

EFS.06 NSR.23 The hospital plans safe handling, storage, usage and transportation of hazardous materials and waste disposal.

Safety

Keywords:

Hazardous materials safety.

Intent:

Hazardous materials are chemical substances, which, if released or misused, can pose a threat to the environment, life or health. Industry, agriculture, medicine, research, and consumer goods use these chemicals.

Hazardous materials come in the form of explosives, flammable and combustible substances, poisons, and radioactive materials. These substances are most often released because of transportation accidents or chemical accidents in hospitals.

Because the effects of hazardous materials can be devastating and far-reaching, it is important that hospitals to plan their safe use and establish a safe working environment.

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

Healthcare waste includes infectious, chemical, expired pharmaceutical and radioactive items and sharps. These items can be pathogenic and environmentally adverse. Other waste items generated through healthcare but not hazardous include medication boxes, the packaging of medical items and food, remains of food, and waste from offices.

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

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

Hazardous material and waste are categorized into the following categories according to the WHO classification:

i. Infectious
ii. Pathological and anatomical
iii. Pharmaceutical
iv. Chemical
v. Heavy metals
vi. Pressurized containers
vii. Sharps
viii. Genotoxic/cytotoxic
ix. Radioactive

Hazardous materials and waste management plan includes, but is not limited to, the following:

a) A current and updated inventory of hazardous materials used in the hospital, the inventory should include the material name, hazard type, location, usage, consumption rate, and responsibility.
b) Material safety data sheet (MSDS) should be available and includes information such as physical data, hazardous material type (flammable, cytotoxic, corrosive, carcinogenic, etc.), safe storage, handling, spill management and exposures, first aid, and disposal.
c) Appropriate labeling of hazardous materials.
d) Procedure for safe usage, handling, storage, and spillage of hazardous materials.
e) Appropriate segregation, labeling, handling, storage, transportation, and disposal of all categories of hazardous waste.
f) Availability of required protective equipment and spill kits.
g) Investigation and documentation of different incidents such as spill and exposure.
h) Compliance with local laws and regulations, availability of required licenses, and/or permits.
i) Staff training and orientation.
j) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review the hazardous material and waste management program to make sure that it covers all safety requirements of hazardous materials, safe storage, handling, spills, required protective equipment and waste disposal according to local laws and regulations.

- GAHAR surveyor may review the hazardous material and waste disposal plan, hazardous material, and waste inventories, as well as Material Safety Data Sheet (MSDS) during document review session or during hospital tours and tracers.
- GAHAR surveyor may inspect hazardous material labeling and storage in addition to waste collection segregation storage and final disposal.

Evidence of compliance:

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

Related standards:

EFS.01 Hospital environment and facility safety structure; EFS.02 Environment and facility safety program monitoring; DAS.24 Laboratory safety program, DAS.09 Radiation safety program.

Safety and security planning

EFS.07 NSR.24 A safe work environment plan addresses high-risk areas, procedures, risk mitigation requirements, tools, and responsibilities.

Safety

Keywords:

Safety Management Plan.

Intent:

Health services are committed to providing a safe environment for patients, staff, and visitors.

Hospital safety arrangements keep patients, staff, and visitors safe from inappropriate risks such as electricity and from inappropriate behavior such as violence and aggression.

The hospital must have a safety plan that covers the building, property, medical equipment, and systems to ensure a safe physical environment for patients, families,

staff, visitors, and vendors.

The safety plan includes at least the following:

a) Proactive risk assessment.
b) Effective planning to prevent accidents and injuries and minimize potential risks, to maintain safe conditions for all occupants to reduce and to control risks.
c) Processes for pest and rodent control.
d) The hospital identifies potential risks because of system failure and/or staff behavior, for example: wet floor; water leakage from the ceiling beside electrical compartments; improper handling of sharps; non-compliance to personal protective equipment in case of working at heights, cutting, and welding, dealing with high voltage; and unsafe storage.
e) Regular inspection with documentation of results, performing corrective actions, and appropriate follow up.
f) Improvements for long-term upgrading or replacement.
g) Safety training depending on job hazard analysis.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

EFS.01 Hospital environment and facility safety structure; IPC.02 IPC program, risk assessment, guidelines; DAS.24 Laboratory safety program; DAS.09 Radiation safety program.

EFS.08 The hospital performs a pre-construction risk assessment when planning for construction or renovation.

Safety

Keywords:

Pre-Construction risk assessment.

Intent:

New construction or renovation in a hospital has an impact on all occupants, who could suffer from changing air quality by dust or odors, noise, vibration, and wreckage.

Upon new construction or renovation in the hospital, a pre-construction risk assessment (PCRA) should be performed and evaluated in order to develop a plan that will minimize associated risks.

The hospital ensures involvement of all departments affected by construction or renovation, including project management, infection control, safety, security, housekeeping, information technology, engineering, clinical departments, and external constructors.

The pre-construction risk assessment includes, but is not limited to, the following:

i. Noise level
ii. Vibration
iii. Infection control
iv. Air quality
v. Fire risk
vi. Utilities affected (electricity, water, gases, etc.)
vii. Hazardous materials
viii. Waste and wreckage
ix. Any other hazards related to construction/renovation

The hospital ensures monitoring, documentation of all activities, and all risks related to construction and renovation.

Survey process guide:

- GAHAR surveyor may review pre-construction risk assessment documents and check implementation of risk assessment recommendations.
- GAHAR surveyor may interview staff, patients, or contractors in the construction area to check if they are aware of required precautions.

Evidence of compliance:

1. The hospital performs a pre-construction risk assessment before any construction or renovation.
2. All affected departments are involved in the risk assessment.
3. The hospital plans corrective actions whenever indicated.
4. If a contractor is used, contractors' compliance is monitored and evaluated by the hospital.

Related standards:

EFS.01 Hospital environment and facility safety structure.

EFS.09 Security plan addresses security of all occupants and properties including restricted and isolated areas with risk mitigation, control measures, tools, and responsibilities.

Safety

Keywords:

Security Plan.

Intent:

Security issues such as violence, aggression, thefts, harassment, suicide, bomb threat, terrorism, gunshot, and child abduction are common in hospitals.

Usually, hospitals enforce a code of behaviour that does not tolerate physical or verbal aggression, or abuse towards staff, patients, family members or visitors.

To keep staff, patients and visitors safe, hospitals may use a range of security measures, including the use of (closed-circuit television) CCTV cameras, duress alarms for staff members and electronic access control systems for doorways. Some hospitals also employ security staff.

The hospital ensures protection of all occupants from violence, aggression, thefts, harassment, suicide, bomb threat, terrorism, gunshot, and child abduction.

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

a) Security risk assessment.
b) Ensuring the identification of patients, visitors, and staff in the hospital.
c) Identification of vendors/contractors with the restriction of their movement within the hospital.
d) Vulnerable patients such as the elderly, infants, those with mental disorders, and handicapped should be protected from the abuse and above-mentioned harms.
e) Children should be protected from abduction.

f) Drill for child abduction should be performed at least annually.
g) Monitoring of remote and isolated areas.
h) Staff training and orientation.
i) The plan is evaluated annually and, if needed, according to related performance measures results or major incidents.

Survey process guide:

- GAHAR surveyor may review security plan/s to make sure that they include suitable risk assessment surveillance, security high-risk areas and security requirements, as well as access control areas.
- GAHAR surveyor may review surveillance rounds plan. Checklist, different observations, and proper corrective actions when applicable.
- GAHAR surveyor may check security plan, cameras, monitors, staff ID and access-controlled areas.

Evidence of compliance:

1. The hospital has an approved security plan that includes items a) through i) in the intent.
2. Security plan education is provided on at least annually to all staff.
3. Security measures are implemented including identification of occupants.
4. Occupants are protected from harm, such as violence, aggression, infant/child abduction.
5. Restricted and isolated areas are protected and secured.
6. Security plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:

EFS.01 Hospital environment and facility safety structure, ICD.32 Dialysis services; ICD.34 Critical alarms; ICD.36 Emergency equipment and supplies.

Safe medical equipment

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

Safety

Keywords:

Medical Equipment Plan.

Intent:

Medical equipment is critical to the diagnosis and treatment of patients.

In most hospitals, a trained biomedical and engineering team manages the entire medical inventory, and is responsible for dealing with medical equipment hazards. Being responsible for such an extensive array of devices can be cumbersome, especially when the stakes are so high. Not only does lazy monitoring and management lead to inefficiency, but it can also seriously harm patient outcomes. As an example, poor maintenance increases the chances of downtime, and inadequate servicing and sterilization can be harmful to both doctors and patients.

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

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

a) Developing criteria for selecting new medical equipment.
b) Inspection and testing of new medical equipment upon procurement and on a predefined interval basis.
c) Training of staff on safe usage of medical equipment upon hiring upon installation of new equipment, and on a predefined regular basis by a qualified person.
d) Inventory of medical equipment including availability, criticality, and functionality.
e) Identification of critical medical equipment that should be available for the operator even through provision of back-up such as life-saving equipment, ventilator, DC shock.
f) Specialized and critical equipment(s) lists are identified.
g) Periodic preventive maintenance according to the manufacturer's recommendations which usually recommends using tagging systems by tagging dates and due dates of periodic preventive maintenance or labelling malfunctioned equipment.
h) Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.
i) Malfunction and repair of medical equipment.
j) Dealing with equipment adverse incidents, including actions taken, backup system, and reporting.
k) Updating, retiring and/or replacing for medical equipment in a planned and systematic way.

Survey process guide:

- GAHAR surveyor may review the medical equipment maintenance program to ensure availability of all required documents, inventory of medical equipment, preventive

maintenance schedule, calibration schedule and staff training records.
- During the GAHAR survey, surveyor may check medical equipment functionality and trace some medical equipment records.

Evidence of compliance:

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

Related standards:

EFS.01 Hospital environment and facility safety structure; EFS.02 Environment and facility safety program monitoring;

Safe utility plan

EFS.11 NSR.28 Essential utilities plan addresses regular inspection, maintenance, testing and repair.

Safety

Keywords:

Utilities Management.

Intent:

Hospitals are expected to provide safe and reliable healthcare to their patients. Planning appropriate response and recovery activities for a failure of the hospital's utility systems is essential to satisfy this expectation.

These systems constitute the operational infrastructure that permits safe patient care to be performed.

Some of the most important utilities include mechanical (e.g., heating, ventilation and cooling); electrical (i.e., normal power and emergency power); domestic hot and cold water as well as other plumbing systems; waste; technology systems, including the

myriad communications and data-transfer systems; vertical transportation utilities; fuel systems; access control, duress alarm and surveillance systems; medical gases, air and vacuum systems; and pneumatic tube systems.

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

a) Inventory of all utility key systems, for example, electricity, water supply, medical gases, heating, ventilation and air conditioning, communication systems, sewage, fuel sources, fire alarm, and elevators.
b) Layout of the utility system.
c) Staff training on utility plan.
d) Regular inspection, testing, and corrective maintenance of utilities.
e) Testing of the electric generator with and without a load on a regular basis.
f) Providing fuel required to operate the generator in case of an emergency.
g) Cleaning and disinfecting of water tanks and testing of water quality with regular sampling for chemical and bacteriological examination with documentation of the results at least quarterly and/or more frequently if required by local laws and regulations or conditions of the source of water.
h) Preventive maintenance plan, according to the manufacturer's recommendations.
i) The Hospital performs regular, accurate data aggregation, and analysis for example, frequency of failure, and preventive maintenance compliance for proper monitoring, updating, and improvement of the different systems.

Survey process guide:

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

Evidence of compliance:

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

6. The plan is evaluated and updated annually with aggregation and analysis of necessary data.

Related standards:

ACT.16 Referral and transfer sheet; ICD.03 Prehospital care, ambulance care, emergency medical care during disasters.

EFS.12 Water services are safe and effective.

Safety

Keywords:

Water services.

Intent:

Water delivery systems are essential components of the environment of care in hospitals that must be continually maintained in a safe way.

Failure of safe water delivery will increase infection risk either directly through unsafe water consumption or use, or indirectly due to the inability of healthcare professionals to comply to basic infection control measures such as hand hygiene.

Water of appropriate quality used in the preparation of dialysis fluid is an essential component of hemodialysis and related therapies to protect hemodialysis patients from adverse effects arising from known chemical and microbiological contaminants found in water and improperly prepared dialysis fluid.

Safe water services are dependent upon maintenance of water quality standards employed by the community public water supplier, typically a municipality in the region of the hospitals.

This responsibility for water quality then transitions to the facility once water enters the facility water distribution infrastructure, reflecting complementary roles for prevention of infections (refer to WHO WASH PROGRAM).

The hospital develops and implements a policy and procedures for the safe process of the management of water services that addresses at least the following:

a) Routine maintenance and monitoring of water distribution and treatment systems.
b) Continuing training and education of operators of water treatment systems.
c) Monitoring of water at all stages (feed, product and dialysis water).
d) Methods and frequency of measuring microbiological and chemical contaminants.
e) Maximum allowable concentrations of microbiological contaminants.

Survey process guide:

- GAHAR surveyor may review the hospital policy during document review session, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may observe the accessibility of water on all premises.
- GAHAR surveyor may review chemical and bacteriological analysis reports for water services and dialysis water.
- GAHAR surveyor may assess corrective actions that were taken by the hospital.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. The hospital has available continuous water supply.
3. Regular chemical and microbiological analyses for water services and dialysis water are performed and recorded.
4. The hospital conducts appropriate corrective actions when needed.

Related standards:

EFS.11 Utilities management

Safe emergency preparedness plan

EFS.13 Emergency preparedness plan addresses responding to disasters that have the potential of occurring within the geographical area of the hospital.

Safety

Keywords:

Disaster Plan.

Intent:

With climate changes, increased pollution and advancement of technologies, Earth is becoming vulnerable to natural disasters. Floods, droughts, cyclones, earthquakes, and landslides are common. Last few decades have witnessed an increased frequency in disasters causing tremendous human casualties, in terms of loss of life and disability in addition to huge economic losses. Although these may not be totally-preventable but their impact can be minimized by effective planning. Equally important are the peripheral emergencies like road, rail and air accidents, fire, drowning and stampedes in mass gathering, industrial accidents, explosions and terrorist attacks that have an inherent potential to convert into a mass casualty incident. The loss of life and disability are compounded by the lack of adequate medical preparedness both qualitatively and

quantitatively across the country.

The hospital must have a risk assessment tool to prioritize potential emergencies based on probability and impact.

The hospital has emergency preparedness plan includes at least the following

a) Risk assessment of potential emergencies. internal and external disasters, such as heavy rains, earthquake, floods, hot weather, wars, bomb threats, terrorist attacks, traffic accidents, power failure, fire, gas leakage.
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 be in the form of Clear call tree that includes staff titles and contact numbers, and External communication channels may include civil defence, ambulance centre, police.
e) Clear duties and responsibilities for hospital leaders and staff.
f) Identification of required resources such as utilities, medical equipment, medical, and non-medical supplies, including alternative resources.
g) Business Continuity:
    i. Triaging.
    ii. Staff 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 back-up utilities.
    iv. Safe patient transportation in case of emergency is arranged by the hospital.
h) Drill schedule. The hospital must have a drill schedule for emergencies at least annually and ensure the attendance of staff; Proper evaluation and recording of the drill includes, but is not limited to:
    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.

Survey process guide:

- GAHAR surveyor may review emergency preparedness plan and its records to confirm that it covered all the identified risks.
- GAHAR surveyor may review preparations in terms of equipment, medication, supplies, action cards and others during hospital tours and tracers.

- GAHAR surveyor may review staff training through training documents interviewing with the staff

Evidence of compliance:

1. There is approved hospital emergency preparedness plan that includes items a) through g) in the intent.
2. Staff training is performed, tested, and evaluated.
3. The hospital performs at least one drill annually that includes item (g) in the intent.
4. The hospital demonstrates preparedness for identified emergencies.
5. The plan is evaluated regularly with aggregation and analysis of necessary data.

Related standards:

ACT.16 Referral and transfer sheet, ICD.03 Prehospital care, ambulance care, emergency medical care during disasters.

Infection Prevention and Control

Chapter intent:

Infection Prevention and Control (IPC) is a scientific approach and practical solution designed to prevent harm caused by infection to patients and/or health workers. It is grounded in infectious diseases, epidemiology, social science, and health system strengthening. IPC occupies a unique position in the field of patient safety and quality universal health coverage since it is relevant to health workers and patients at every single health-care encounter.

The IPC program aims at identifying and reducing or eliminating the risks of acquisition and transmission of infections among patients, healthcare workers, volunteers, visitors, and the community. Usually, the IPC program is risk-based; this means that a risk assessment is required to promptly identify and proactively address possible infection risks among individuals and in the environment. Then, solutions shall be tailored accordingly by developing appropriate policies and procedures, in conjunction with proper staff education. Therefore, IPC activities shall differ from one organization to another, depending on the hospital clinical activities, scope of services, and served patient population.

It is the responsibility of the IPC team members to oversee the IPC program, and they should all have detailed job descriptions. The staff member(s) shall be qualified enough to meet the hospital needs. These needs are driven by the hospital size, complexity of activities, and level of risks, as well as the program's scope. The required qualifications could be in the form of education, training, experience, and certification.

The IPC program and its activities are based on current scientific knowledge, the national guidelines, accepted international practice guidelines (CDC, APIC, IFIC), besides applicable laws and regulations. The program shall need to be planned, disseminated, taught, and monitored.

Chapter purpose:

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

- Effective structure of infection prevention and control.
- Standard precautions through addressing policies and procedures, implementation, and monitoring.
- Environmental cleaning and disinfection activities.
- Safe injection practices.
- Transmission based precautions and patient placement.

- The infection prevention and control program in all supportive services (CSSD, kitchen, laundry, and waste management).
- Preventive measures during construction and renovation.
- Monitoring and quality improvements.
- Designing and implementation of the IPC improvement projects based on monitoring of the IPC program and analysis of the performance measures.

Implementation guiding documents:

(All mentioned references need to be read in the context of its conditions, amendments, substitutes, updates, and annexes)

1. National guidelines for infection control
2. MOHP Ministerial decree for developing infection prevention and control departments
3. MOHP Ministerial decree 187/2004 for infection control personnel
4. Presidential decree 14/2014 for performance evaluation
5. MOHP Ministerial decree 753 / 2015 for medical waste management
6. MOHP Ministerial decree 153 / 2004 for prevention of viral hepatitis
7. MOHP Ministerial decree 523 / 2015 for reuse of single used devices and instruments
8. The Egyptian code for healthcare facilities design
9. Egyptian law of environment.

Efficient structure of the infection prevention and control program

IPC.01 A dedicated team of qualified healthcare professionals oversees the infection prevention and control activities according to applicable laws and regulations, national and international guidelines.

Effectiveness

Keywords:

Infection prevention and control (IPC) Team, certification, IPC qualification and training.

Intent:

The presence of a qualified and dedicated IPC team in the hospital ensures increased effectiveness of the IPC program in all its phases including development, implementation, and monitoring

To ensure the infection prevention and control program effectiveness, a qualified team develops a program, supervise it, and put an action plan to implement this program, and educate all staff members on their roles in it.

The team members' qualifications and number meets the hospital needs.

These needs are driven by the hospital size, complexity of activities, and level of risks, as well as the program's scope.

The required qualifications could be in the form of education, training, and certification.

Survey process guide:

- GAHAR surveyor may learn about the infection control structure in the organization chart during the hospital orientation session.
- GAHAR surveyor may verify the presence of an approved team formation decision of dedicated staff by interviewing them, check their job descriptions, certification, or qualifications during staff file review session.

Evidence of compliance:

1. There is an assigned dedicated IPC team.
2. The IPC team leader is a competent healthcare professional.
3. The IPC Team members are qualified through certification and education, and they are well trained.
4. The IPC team leader and each member has a defined job description or terms of reference.
5. The IPC team member(s) has the ability to communicate with the top management and all functioning departments effectively.

Related standards:

ICD.15 Clinical practice guidelines adaptation and adoption; WFM.02 Staffing plan; WFM.04 Job description; WFM.03 Recruitment; WFM.05 Verifying credentials; WFM.09 Staff performance evaluation

IPC.02 A comprehensive infection prevention and control program is developed, implemented, and monitored.

Safety

Keywords:

IPC program, risk assessment, guidelines.

Intent:

Healthcare associated infections are common risks encountered in any hospital.
Therefore, constructing a comprehensive IPC program is of utmost importance in order to effectively reduce these risks.
The IPC program is an integrated part of quality improvement and patient safety programs, using measures that are epidemiologically important to the hospital.
Measurement information is essential to improve infection prevention and control activities and reduce healthcare-associated infection rates.
A hospital can best use measurement data and information by understanding similar rates and trends in other similar organizations.
An effective IPC program must be comprehensive and includes all aspects of patient care, staff health, and the entire services provided by the hospital such as (hand hygiene guidelines implementation, antimicrobial stewardship, safe injection, etc) .
The program development requires a multidisciplinary approach that is carried on by qualified staff members and is reinforced by sound up-to-date knowledge and resources in order to fulfill its mission and objectives.
The program shall also assure the education and training of all working staff members and provide necessary patients, visitors, and families' education.
Surveillance of all activities shall be performed by the hospital based on the IPC program is also a necessity.
The IPC program must be based on the annual hospital risk assessment plan, national and international guidelines (CDC, APIC, IFIC, etc.), accepted practices, and applicable laws and regulations.
The National laws and regulations shall define elements of the basic program, the response to infectious disease outbreaks, and reporting requirements within the

hospital and the public health agencies.
Each hospital can design its own performance measures to monitor, assess, and improve the IPC program. Examples of performance measures include the percentage of hand hygiene compliance and the results of sterilization monitoring.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to evaluate the presence of a risk assessment, an IPC program that is based on the risk assessment and covers all hospital areas and includes all relevant individuals, a training plan or an annual evaluation report and update of the IPC program.
- GAHAR surveyor may check the documentation of monitoring of data, performance measures, data analysis reports, recommendations for improvement and observe their implementation.

Evidence of compliance:

1. The program describes the scope, objectives, expectations, and surveillance methods.
2. The program includes all areas of the hospital and covers patients, staff, visitors, and the external community.
3. The program is based on IPC risk assessment, current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.
4. The program includes a training plan for all healthcare professionals, in addition to patient awareness.
5. The hospital tracks, collects, analyzes, and reports data on its infection control program.
6. The hospital acts on improvement opportunities identified in its infection control program.

Related standards:

IPC.04 Infection risk, risk assessment; QPI.05 Performance measures; QPI.08 Data review, aggregation, and analysis; QPI.09 Data validation.

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 for their continuous evaluation of the situation.

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 the continuous link between the upper managerial level, IPC team and all other hospital departments.

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

The IPC committee is responsible for at least the following

a) setting criteria to define hospital associated infections
b) surveillance methods and process
c) strategies to prevent infection and control risks
d) reporting infection prevention and control activities

Survey process guide:

GAHAR surveyor may perform an infection control program review to assess the presence of an approved IPC committee formation decision, recorded monthly meetings of the previous six months, 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 includes at least from (a) to (c) in the intent.
2. All relevant disciplines are represented in the committee.
3. The committee meets at least monthly.
4. The committee meetings are recorded
5. Implementation of the decisions taken by the committee at the end of each meeting are followed up.

Related standards:

QPI.01 Quality committees; OGM.06 Committee structure; PCC.02 Interdisciplinary patient-centeredness.

IPC.04 The hospital identifies the procedures and processes that are associated with an increased risk of infection.

Safety

Keywords:
infection risk, risk assessment.

Intent:
The hospital assesses and cares for patients using many simple and complex processes, each being associated with a particular level of infection risk to patients and staff.
Therefore, it is important for the hospital to assess and review those processes and, as appropriate, implement the required strategies, such as policies, procedures, education, and evidence-based activities, in order to reduce this risk.
The hospital identifies the procedures associated with increased risk by defining policies, procedures followed by staff education, and evidence-based activities, in order to reduce these identified risks.

Survey process guide:
GAHAR surveyor may perform an infection control program review to assess the presence of a list of procedures and processes associated with increased risk of infection, policies and procedures in IPC unit and departments in scheduled visits or IPC improvement plan(s).

Evidence of compliance:
1. The hospital identifies departments and services with increased potential risk of infection.
2. The hospital has defined and implemented policies and procedures to decrease these risks.
3. The hospital tracks, collects, analyzes, and reports data on its infection prevention and control program activities.
4. The hospital acts on improvement opportunities identified in its infection prevention and control program activities.

Related standards:
IPC.02 IPC program, risk assessment, guidelines; OGM.20 Staff health; DAS.24 Laboratory safety program; EFS.06 Hazardous materials waste management; QPI.08 Data review, aggregation, and analysis.

Safe standard precautions

IPC.05 NSR.03 Evidence-based hand hygiene guidelines are adopted and implemented throughout the hospital in order to prevent healthcare-associated infections.

Safety

Keywords:
Hand Hygiene.

Intent:
Hand hygiene is the cornerstone of reducing infection transmission in all healthcare settings. It is considered the most effective and efficient strategy for infection prevention and control.
Hand hygiene facilities and supplies (hand soap, hand antiseptics, and single-use towels) must be present in appropriate numbers and places.
Alcohol-based hand rubs are now the preferred products for routine hand hygiene in healthcare facilities unless hands are visibly soiled to overcome the shortage in sinks.

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

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

Related standards:
APC.02 Monitoring safety requirements, IPC.07 Detergents, antiseptics, and disinfectants.

IPC.06 Personal protective equipment is available and used correctly when indicated.

Safety

Keywords:
PPE, guidelines, Physical Barriers.

Intent:
Wearing personal protective equipment (PPE) is an important tool in the protection of both patients and healthcare professionals.
PPE term refers to the availability and appropriate use of barriers that a susceptible host may wear to provide a physical barrier between him/her and an infectious agent/ infected source.
PPE include gloves, gowns, masks, facial protection, eye protection (including face shields, or masks with visor attachments) and respirators.
Proper selection of PPE depends on risk assessments that are performed at the points of care, so staff education and training are therefore of utmost importance.
The staff must be trained on the proper way and sequence of donning and doffing of various PPE to maintain maximum protection throughout the process

Survey process guide:
- During GAHAR Survey, the surveyor may check the availability and accessibility of PPE and may interview staff members to inquire about the constant availability, accessibility and proper use of PPE
- GAHAR surveyor may review PPE standardized products specifications.
- GAHAR surveyor may review disbursement permits of PPE.

Evidence of compliance:
1. Choice of PPE to be purchased is based on standardized products specifications
2. The hospital provides PPE that is easily accessible and appropriate to the task.
3. Proper selection and use of PPE according to the patient's suspected infection and when indicated
4. PPEs are stored in appropriate areas that are easily accessible.

Related standards:
MMS.13 Medication preparation, medication preparation area, labelling of medications; ICD.31 Chemotherapy and radiotherapy; ICD.33 Critical care; EFS.06 Hazardous materials waste management; DAS.24 Laboratory safety program; DAS.09 Radiation safety program.

IPC.07 Soap, washing detergents, antiseptics, and disinfectants are available, selected and used according to current clinical care standards.

Safety

Keywords:
detergents, antiseptics, and disinfectants.

Intent:
Detergents, antiseptics, and disinfectants must always be available in the appropriate places and with sufficient amounts.
Availability of these products helps in implementation of several items of standard precautions like hand hygiene, environmental cleaning and aseptic techniques and all of which are crucial for effective infection control.
Detergents, antiseptics and disinfectant are selected based on standardized prerequisite specifications. Their effective and appropriate use depends on risk assessment at the point of care and staff education and training is mandatory for proper use.

Survey process guide:
- During GAHAR Survey, the surveyor may observe the availability, accessibility and use of detergents, antiseptics, and disinfectants in the relevant areas and their compatibility with standardized products specifications.
- GAHAR surveyor may review disbursement permits of detergents, antiseptics, and disinfectants.

Evidence of compliance:
1. Choice of purchased detergents, antiseptics, and disinfectants is based on standardized product specifications.
2. The hospital provides detergents, antiseptics, and disinfectants that are readily available, easily accessible, and appropriate to the task.
3. Proper selection and use of antiseptics and disinfectants according to the patient's suspected infection and according to the required procedure occurs.
4. Antiseptics and disinfectants are stored in appropriate areas that are easily accessible.

Related standards:
APC.02 Monitoring safety requirements; IPC.05 Hand hygiene.

IPC.08 Respiratory hygiene is implemented as an element of standard precautions.

Safety

Keywords:

Respiratory Hygiene Protocol, cough etiquette.

Intent:

Respiratory hygiene and cough etiquette interventions are intended to limit the spread of infectious organisms from persons with potentially undiagnosed respiratory infections.

In order for respiratory hygiene interventions to be effective, early implementation of infection prevention and control measures needs to exist at the first point of entry to the hospital and be maintained throughout the duration of the stay.

The effort of respiratory hygiene interventions shall be targeted at patients and accompanying significant others with respiratory symptoms and applies to any person entering a hospital with signs of respiratory illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions.

Survey process guide:

- During GAHAR Survey, the surveyor may observe the availability of respiratory hygiene/cough etiquette posters in appropriate places, accessibility and use of detergents, antiseptics, and disinfectants in the relevant areas and the availability and accessibility of the relevant resources in proper places.
- During GAHAR Survey, the surveyor may observe assigned areas for patients with suspected respiratory infections and the implementation of respiratory patient placement.

Evidence of compliance:

1. Respiratory hygiene /cough etiquette posters are displayed at appropriate places.
2. Resources such as tissues and surgical masks are available in numbers matching patients' and staff members' needs.
3. Hospital designate space for patients with suspected respiratory infections to separate them from others.
4. Patients with suspected respiratory infections are identified and placed in designated areas.

Related standards:

IPC.06 PPE, guidelines, physical barriers; IPC.04 Infection risk & risk assessment.

IPC.09 Injection practices are safe.

Safety

Keywords:
Safe injection practices.

Intent:
In the hospital, both inpatients and outpatients are continuously in need for injections whether for diagnostic or therapeutic purposes, unfortunately however it carries an associated risk of infection for the patients.
Moreover, needle stick injuries among healthcare professionals 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, needle for each injection given, and ensure that all injection equipment and medication vials remain free from contamination.

Survey process guide:
During GAHAR Survey, the surveyor may observe the availability of Intravenous bottles and its proper use and of single dose vials and the proper use of multi-dose vials.

Evidence of compliance:
1. Hand hygiene facilities are available
2. the Intravenous bottles/bags are not used interchangeably between patients.
3. Use of single-dose vials versus multi-dose vials follows regulations and hospital approved clinical guidelines
4. The hospital ensures single use of the fluids infusion /administration sets (e.g., tubing and connections).

Related standards:
IPC.04 Infection risk, risk assessment; IPC.02 IPC program, risk assessment, guidelines, hand hygiene.

IPC.10 Environmental cleaning activities are aligned with current evidence-based guidelines.

Safety

Keywords:
Environmental cleaning, evidence-based guidelines.

Intent:

Healthcare environment is considered a reservoir for pathogens and may be a significant source of healthcare associated infections so, cleaning and disinfection of environmental surfaces is an important tool to prevent development of these infections.

Contact with contaminated surfaces in the hospital can easily lead to cross contamination of microorganisms between the environment and healthcare professionals

To provide quality of care, the hospital must have a clear method and schedule for environmental cleaning and disinfection including walls, floors, ceilings, and furniture; this must be performed according to the classification of areas.

Schedule must address environmental cleaning activities for each area as follows:

a) Activities to be done every day
b) Activities to be done every shift
c) Deep cleaning activities

Survey process guide:

- During GAHAR Survey, the surveyor may review the list of all environmental services that require cleaning, cleaning schedules and spill kits.
- During GAHAR Survey, the surveyor may interview healthcare professionals and environmental cleaning staff members to inquire about the availability and accessibility and use disinfectant and spill kits properly.

Evidence of compliance:

1. Cleaning activities and times are listed for each area and include all elements mentioned in the intent from a) through c).
2. Staff members involved in environmental cleaning activities are trained on approved policies.
3. Cleaning technique and disinfectant of choice matches the requirements of each cleaned area.
4. Blood/body fluid spills are properly managed and spill kits (disinfectants/PPE) are available and accessible for use.

Related standards:

IPC.04 Infection risk, risk assessment; IPC.06 PPE, guidelines, physical barriers; EFS.06 Hazardous materials waste management.

IPC.11 Current evidence-based aseptic techniques are followed during all medical procedures.

Safety

Keywords:
Sterile technique, Aseptic technique.

Intent:
Asepsis is a basic infection prevention method, as well as an important factor in patient safety in medical practice.
Aseptic technique is adaptable to minimize the risk of infection transmission.
This technique prevents contamination from person to person and from one body site to another and from the environment to the patient. Aseptic technique refers to practices designed to render and maintain objects and areas maximally free from microorganisms.
The term 'aseptic technique' encompasses several key elements: clean environment, conscientious practicing of hand hygiene, use of appropriate personal protective equipment, and use of standardized routine cleaning, disinfection, and sterilization practices.
All healthcare professionals shall be cognizant of their movement, barrier use, and practices to prevent inadvertent breaks in aseptic techniques, alerting others when the field or objects are potentially contaminated.
Asepsis is defined as the process of keeping away disease-producing microorganisms. It is implemented to protect the patient by minimizing contamination to reduce the risk of infection.

a) Surgical asepsis is the use of a sterile technique to prevent the transfer of any organisms from one person to another or from one body site to another. The goal of the sterile technique is to maintain the microbe count at an irreducible minimum.
b) Surgical aseptic technique outside of the operating room refers to a practice in a setting outside the operating room may not have the capacity to follow the same strict level of surgical asepsis applied in the operating room. However, the goal to avoid infection remains in all clinical settings.
c) Medical asepsis, or clean technique, refers to practice interventions that reduce the number of microorganisms to prevent and reduce transmission risk from one person (or place) to another.

Choice of level of antisepsis shall be based on a risk assessment.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- During GAHAR Survey, the surveyor may observe the places and practices of performing aseptic techniques in the relevant departments.
- During GAHAR Survey, the surveyor may interview healthcare professionals to inquire about how they choose and perform aseptic techniques properly in relevant departments.

Evidence of compliance:

1. Healthcare professionals are trained and educated on aseptic techniques as relevant to their jobs.
2. All medical procedures are performed in environment, that don't pose the risk of infection
3. Items that are used for medical procedures are not contaminated in any way.
4. Various aseptic techniques are performed in the hospital according to evidence-based guidelines.

Related standards:

IPC.02 IPC program, risk assessment, guidelines; IPC.04 Infection risk, risk assessment.

Safe transmission-based precautions and precautions for immunocompromised hosts

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

Safety

Keywords:

Isolation precautions.

Intent:

Isolation precautions creates barriers between people and microorganisms that help in preventing the spread of germs in the hospital.

If the patient is determined to be at an increased risk for transmission of microorganisms, the patient is placed in the hospital's standardized isolation room.

The hospital must have one or more standardized isolation room(s)

When the standardized isolation room(s) is not currently available, the patient should be separated in separate assigned areas/room.

Patients who present with clinical respiratory syndromes are instructed to practice respiratory hygiene and cough etiquette and given a surgical mask to wear until an examination room can be provided.
The hospital must develop protocols to identify patients with known or suspected airborne infections. Patients requiring airborne precautions are placed in a negative pressure room. If a negative pressure room is not available, place the patient in an examination room with a portable high-efficiency particulate air (HEPA) filter. If no portable HEPA filter is available, ensure that the patient wears a surgical mask. Regardless of the type of room the patient is in, contacting staff must always wear appropriate respiratory protection (as N95 respirator).
Environmental measures: Routine cleaning of high touch surfaces is standard.

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy to guide transmission-based precautions.
2. Healthcare professionals are trained and educated on approved policies.
3. The hospital has one or more standardized isolation room(s) according to laws and regulations
4. Patients with suspected/ confirmed clinical communicable diseases are identified and separated in separate assigned areas/room.
5. Healthcare professionals caring for patients with a suspected communicable disease are adherent to suitable PPE and hand hygiene practices according to the type of isolation.

Related standards:

IPC.02 IPC program, risk assessment, guidelines, IPC.08 Respiratory hygiene protocol and cough etiquette.

IPC.13 A safe and protective environment is provided to immunocompromised hosts depending on their clinical needs.

Safety

Keywords:
immunocompromised hosts, protective environment.

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.
An immunocompromised host is an individual who has one or more defects in the body's normal defense mechanisms hence predisposing him/ her to infections, which may be life threatening.
These individuals continue to be at risk for common infections as well but may pursue a more aggressive course than they might otherwise.
Several categories of immunity compromise exist, and some patients may have more than one type.
Hematopoietic stem cell transplant recipients demonstrate clear examples of severe immune suppression due to a variety of reasons, including neutropenia, mucositis, and application of indwelling catheters.
A protective environment shall be provided for hematopoietic stem cell transplant inpatients including positive-pressure, high-efficiency particulate absorption-filtered air handling as well as Legionella-free water supply.
In addition, specially trained staff members who adopt a team approach to infection prevention concerns shall be taking care of these patients, since consistent use of standard precautions as well as transmission-based precautions when indicated, is the most important of all interventions.
Signage shall be positioned prominently outside the room of a patient in transmission-based precautions. This is to ensure staff and visitors do not enter without appropriate PPE.

Survey process guide:
- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- During GAHAR Survey, the surveyor may observe the presence of standardized

protective environment, the use of transmission-based precautions and performance of hand hygiene

Evidence of compliance:

1. The hospital defines conditions that require transmission-based precautions.
2. Healthcare professionals are trained on transmission-based precautions.
3. The hospital ensures the availability of a protective environment if needed that meets national and international design standards for a healthcare facility.
4. Facility deign supports the provision of a safe environment for immunocompromised hosts
5. Signage is positioned prominently outside the room of a patient in transmission based precautions
6. Transmission-based precautions are performed when required

Related standards:

IPC.11 Isolation precautions; IPC.06 PPE guidelines, physical barriers.

IPC.14 Patient care equipment are disinfected/sterilized based on evidence-based guidelines and manufacturer recommendations.

Safety

Keywords:

Disinfection, sterilization.

Intent:

Processing of patient care equipment is a very critical process inside any hospital
In clinical procedures that involve contact with medical/surgical equipment, it is crucial that healthcare professionals follow standard practices and guidelines to clean and disinfect or sterilize.
Cleaning process is a mandatory step in processing of patient care equipment.
Cleaning, disinfection, and sterilization can take place in a centralized processing area.
Assigned processing area shall have workflow direction.
The hospital develops and implements a policy and procedures to guide the process of sterilization/disinfection that addresses at least the following:

a) Receiving and cleaning of used items.
b) Preparation and processing.
   i. Processing method to be chosen according to Spaulding classification. Disinfection of medical equipment and devices involves low, intermediate, and high-level

techniques. High-level disinfection is used (if sterilization is not possible) for only semi-critical items that come in contact with mucous membranes or non-intact skin as gastrointestinal endoscopes, respiratory and anesthesia equipment, bronchoscopes and laryngoscopes etc. Chemical disinfectants approved for high-level disinfection include glutaraldehyde, orthophtaldehyde and hydrogen peroxide.

ii. Sterilization must be used for all critical and heat-stable semi-critical items.

iii. Low-level disinfection (for only non-critical items) are used for items such as stethoscopes and other equipment touching intact skin. In contrast to critical and some semi-critical items, most non-critical reusable items may be decontaminated where they are used and do not need to be transported to a central processing area.

c) labeling of sterile packs.

d) Storage of clean and sterile supplies: properly stored in designated storage areas that are clean, dry and protected from dust, moisture, and temperature extremes. Ideally, sterile supplies are stored separately from clean supplies, and sterile storage areas must have limited access.

e) Logbooks are used to record the sterilization process.

f) Inventory levels.

g) Expiration dates for sterilized items.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals.
- During the hospital tours and tracers, the surveyor may observe the number of functioning pre-vacuum class B sterilizers, the presence of physically separated areas according to the standard with unidirectional airflow, and the presence of storage areas that meet the standard criteria.
- GAHAR surveyor may check the ability of the staff to perform the sterilization process properly.

Evidence of compliance:

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

and recommendations guide sterilization or disinfection.

5. There are a 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 and dry and protected from dust, moisture, and temperature extremes.

Related standards:

IPC.06 PPE guidelines, physical barriers; IPC.07 Detergents, antiseptics, and disinfectants.

IPC.15 A disinfection/sterilization quality control program is developed and implemented

Safety

Keywords:

Disinfection/Sterilization quality control program.

Intent:

Sterilization/ disinfection is a critical process in any hospital ; therefore, monitoring of the sterilization/ disinfection process is crucial for ensuring a reliable and efficient sterilization process.

Management of the routine quality control (QC) of medical equipment disinfection/ sterilization is a major responsibility of the healthcare professionals.

Quality control measures are performed to monitor and ensure the reliability of disinfection / sterilization processes.

Quality controls can identify performance problems not identified automatically and helps to determine safety of procedures

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 shall be reviewed at regular intervals and shall be recorded

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

The hospital develops and implements a policy for quality control which includes at least the following:

a) Quality control elements, method and frequency include
   i. Physical parameters (temperature, time and pressure), which are monitored every cycle.

ii. Chemical parameters (internal chemical indicator inside the sterilization pack-external chemical indicator on the outside of the sterilization pack), which are monitored every pack.
iii. Biological indicator which is done at least weekly.
iv. The test for adequate steam penetration and rapid air removal shall be done every day before starting to use the autoclave through the use of Class 2 internal chemical indicators and process challenge devices which is either porous challenge device or hollow challenge device.
v. Porous challenge Pack: Bowie-Dick Sheets (class 2 indicator) inside a porous challenge pack (every load). Hollow load challenge (Helix test): a class 2 chemical indicator (strip) inside a helix (every load).
vi. Chemical test strips or liquid chemical monitors shall be used for determining whether an effective concentration of high-level disinfectants is present despite repeated use and dilution. The frequency of testing shall be based on how frequently these solutions are used.

b) Quality control performance expectations and acceptable results shall be defined and readily available to staff so that they will recognize unacceptable results 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 a regular interval.
e) Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals.
- GAHAR surveyor may visit areas were disinfection/sterilization is performed to check quality control procedures and records.
- GAHAR surveyor may interview staff members involved in sterilization/disinfection and other healthcare professionals to check their awareness on quality control performance.
- GAHAR surveyor may assess the quality of packaging material, the availability of mechanical monitoring, chemical and biological indicators that meet the standardized product specifications.
- GAHAR surveyor may review logbooks for chemical indicators and biological indicators documentation for each autoclave and logbook for chemical indicators.

Evidence of compliance:

1. The hospital has an approved policy describing the quality control process of disinfection/sterilization process addressing all elements in the intent from a) through e).
2. Quality of packaging material, as well as chemical and biological indicators, are determined based on standardized product specifications.
3. Healthcare professionals involved in sterilization/disinfection are competent in quality control performance.
4. Quality control tests for monitoring sterilization and high-level disinfectants are done regularly.
5. Quality control processes are recorded.
6. Corrective action is taken whenever results are not satisfactory.

Related standards:

IPC.06 PPE guidelines, physical barriers, IPC.07 Detergents, antiseptics, and disinfectants;

Safe laundry and healthcare textile management

IPC.16 Laundry service and healthcare textile management are safe.

Safety

Keywords:

Laundry service, textile.

Intent:

Procedures that involve contact with contaminated textile can be a source for introducing pathogens that lead to infection.

Failure to properly clean, disinfect, or store textiles put not only patients, but also staff members who transport them at risk of infection.

It is critical that healthcare professional follow standard practices to clean and disinfect used textiles.

Infection risk is minimized with proper cleaning and disinfection processes.

The washing machine shall have a pre-cleaning cycle.

Healthcare professionals shall follow manufacturer's instructions of detergents and disinfectants use and washing instructions.

The hospital develops and implements a policy and procedures to define laundry and healthcare textile services that addresses at least the following:

a) Processes of collection and storage of contaminated textile.
b) Cleaning of contaminated textile.

c) Water temperature, detergents, and disinfectants usage.
d) Processes of storage and distribution of clean textile.
e) Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- GAHAR surveyor may visit areas were laundry and health textile management is performed to observe its design, the presence of functioning washing machine/s, recorded water temperatures and quality control records

Evidence of compliance:

1. The hospital has an approved policy to guide the safe laundry and healthcare textile services management that addresses all elements in the intent from a) through e)
2. Staff members involved in laundry and health textile management are aware of the approved policy
3. Contaminated textile are collected, stored and transported safely
4. There is at least one functioning washing machine
5. There are a least three physically separated areas for sorting, washing, and drying and/or storing
6. A quality control program, including water temperatures, is implemented and recorded

Related standards:

IPC.06 PPE guidelines, physical barriers; IPC.07 Detergents, antiseptics, and disinfectants.

Safe construction and renovation

IPC.17 Infection risks during demolition, renovation, or construction projects are reduced.

Safety

Keywords:

demolition, renovation, construction.

Intent:

Demolition, construction, or renovation anywhere within the hospital , can be a major risk to infection prevention and control.

Exposure to construction dust and debris and other biohazards can be potentially

dangerous to lung function and to the safety of staff and visitors.
The hospital shall assess the magnitude of the risks resulting from the impact of the renovation or new construction on the predetermined air-quality, IPC and utility requirements and initiate a plan to minimize such risks.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- GAHAR surveyor may visit areas under demolition/renovation/construction and review infection risk assessment for these areas. A documented work permission from the IPC team, if required by the hospital policy, may be reviewed as well.

Evidence of compliance:

1. The hospital has an approved policy for infection risk assessment for areas under demolition, renovation, or construction.
2. Infection risk assessment of renovations, or new constructions has defined criteria
3. Staff members involved in demolition/construction/renovation are trained on approved policy.
4. There is a mechanism, such as work permission, to empower infection risk assessment and recommendations.
5. Infection prevention measures, considerations and recommendations are considered during any demolition, renovation, or construction projects.

Related standards:

IPC.02 IPC program, risk assessment, guidelines; IPC.04 Infection risk, risk assessment; EFS.09 Security plan.

Effective epidemiological surveillance and monitoring

IPC.18 Healthcare-associated infections surveillance process is effective.

Effectiveness

Keywords:

Surveillance, Healthcare associated infections.

Intent:

Surveillance is an essential component of an effective IPC program; since the use of data contributes to improving the healthcare quality system.
Moreover, it helps in detecting emerging and reemerging healthcare-associated infections.

An effective surveillance program shall be based on comprehensive epidemiological and statistical principles.
Surveillance plays a critical role in identifying outbreaks, emerging infectious diseases, and multidrug-resistant organisms in order to institute appropriate IPC measures.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals.
- GAHAR surveyor may review surveillance documents, quarterly surveillance reports that are reviewed by the IPC committee and recommendations for improvement.
- GAHAR surveyor may observe implementation of IPC committee recommendations.

Evidence of compliance:

1. The hospital has an approved policy to guide the surveillance process.
2. Healthcare professionals are trained on approved policy.
3. The hospital tracks, collects, and analyzes data on its surveillance program
4. The hospital reports data on its surveillance program to stakeholders and reports are reviewed at least quarterly by the IPC committee.
5. The hospital acts on improvement opportunities identified in its surveillance program.

Related standards:

IPC.02 IPC program, risk assessment, guidelines; IPC.03 IPC committee meetings.

IPC.19 Outbreaks are investigated and managed effectively.

Effectiveness

Keywords:

Outbreaks investigation.

Intent:

Outbreaks of infectious diseases can occur in healthcare settings and pose a threat to patient safety.
The goal of outbreak investigations is to identify the most probable contributing factors in order to stop the outbreaks and prevent their recurrence.
Outbreaks shall be suspected in cases of increased rate of healthcare associated infections or when new or unusual pathogens are recovered from samples.
Effective management of outbreaks shall require cooperation between infection prevention and control team and other clinical specialties.

Outbreak management shall include immediate control measures, general control measures and recovery measures.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- GAHAR surveyor may review reporting system for notifiable communicable diseases and outbreaks investigation analysis reports

Evidence of compliance:

1. The hospital has an approved process for outbreak investigations.
2. There is a reporting system of patients with suspected communicable diseases as required by laws and regulations.
3. Outbreak investigation and management occur through multidisciplinary efforts.
4. Outbreak management includes immediate control measures, general control measures and recovery measures.
5. The hospital tracks, collects, analyzes, and reports data on its outbreaks.
6. The hospital acts on improvement opportunities identified in its outbreak management process.

Related standards:

IPC.02 IPC program, risk assessment, guidelines; IPC.03 IPC committee meetings.

IPC.20 Multi-Drug resistant organisms (MDROs) are controlled.

Safety

Keywords:

Multi-Drug Resistant Organisms.

Intent:

MDROs have increased in prevalence over the last three decades and have become a global health-threatening problem, and cause important implications for patients' safety.

This concern is due to the extremely limited treatment options for treating patients with these infections.

Also, MDRO infections are associated with increased lengths of stay, costs, and mortality.

Successful prevention and control of MDROs require effective administrative and scientific leadership as well as a financial and human resources commitment.

Resources shall be provided for infection prevention and control, including expert

consultation, laboratory support, adherence monitoring, and data analysis in order to prevent transmission.

Survey process guide:

- GAHAR surveyor may perform an infection control program review to assess developed policies and procedures, training records of healthcare professionals
- GAHAR surveyor may observe the process of containment of MDROs such as isolation , monitoring....etc

Evidence of compliance:

1. The hospital has an approved policy for MDRO spread control
2. Healthcare professionals are trained on approved policy.
3. Measures are taken to control MDRO infection spread

Related standards:

IPC.02 IPC program, risk assessment, and guidelines.

Safe water and food services

IPC.21 Food services are safe and effective.

Safety

Keywords:

Food Services.

Intent:

Food services provided by the hospital's kitchen can be a potential source of infection if improperly prepared, handled, and/or stored.

Foodborneillnessescanposeasignificanthealththreat,especiallytoimmunocompromised patients.

Consequently, effective IPC measures are crucial to prevent these infections.

Safe food services involve all processes starting from receipt of food and other nutritional products throughout their storage, preparation, handling, and until they are safely delivered.

The hospital develops and implements a policy and procedures to guide safe food services that addresses at least the following:

a) Food receiving process.
b) A safe storage process including food rotation system that is consistent with first in first out principles.
c) Monitoring of temperature during preparation and storage.

d) Prevention of cross-contamination of food whether directly from raw to cooked food, or indirectly through contaminated hands, working surfaces, cutting boards, utensils, etc.
e) Food transportation process.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

EFS.11 Utilities management; ICD.20 Patient nutritional needs.

IPC.22 Postmortem care is safe.

Effectiveness

Keywords:

Postmortem Care.

Intent:

Postmortem care includes the processes of preparing the deceased for burial. Postmortem care presents occupational risks that need to be anticipated and addressed in the policy.

The hospital develops and implements a policy and procedures for postmortem care. includes at least the following:

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.

Generally, standard IPC precautions are applied and any transmission based precautions that were applied on patients shall be continued after death.

Survey process guide:

- GAHAR surveyor may review hospital policy during document review session, followed by interviewing staff to check their awareness.
- GAHAR surveyor may observe that Standard and transmission based precautions are applied on dead bodies and body parts.

Evidence of compliance:

1. The hospital has an approved policy that addresses all the elements mentioned in the intent from a) through g).
2. Staff members involved in postmortem care are aware of approved policy.
3. Safe postmortem care practices are implemented according to current evidence-based guidelines, laws and regulations.
4. Standard and transmission based precautions are applied on dead bodies and body parts as applicable.

Related standards:

IPC.10 Environmental cleaning, evidence-based guidelines.

Organization Governance and Management

Chapter intent

This chapter is concerned with structures for governance and accountability that may differ according to the hospital and its size, mandate, and whether it is publicly or privately owned. Possible structures include an individual or group owner, government committee or ministry, or Board of Directors. Having a defined governing body structure provides clarity for everyone in The hospital, including managers, clinical leadership, and staff, regarding who is accountable for making final decisions and oversight of The hospital's overall direction. While governance provides oversight and support, it is the commitment and planning efforts of the hospital leadership as well as the departments and services leaders that ensure the smooth and efficient management of the hospital. Effective planning is initiated by identifying the stakeholders' needs and designing the service accordingly, Egypt's 2030 vision that has been recently developed provides a direction and common goal to all hospitals to ensure effective safe and patient-centered care is provided equally for all Egyptians and is to be considered the cornerstone for organization planning. The hospital's plan should be continuously aligned with the governmental initiated campaigns addressing therapeutic, prophylactic, social, and nutritional aspects of healthcare. The chapter guides the hospital to assign duties to the different levels of management and to ensure effective communication to achieve planned goals and objectives.

Recently the landscape of healthcare is shifting closer to a fully quality-driven future and pay for performance model. The chapter has focused on the financial side of healthcare, a focus that affects both patients and providers. With value-based care and higher levels of efficiency on the rise, the keys to medical practice success are evolving rapidly. The chapter handles various organization-wide topics as contracted services, ethical management, and staff engagement, which may reflect the efficient and effective collaborative management efforts.

GAHAR surveyors, through leadership/ staff interviews, observations, and process evaluation, shall assess the efficiency and effectiveness of the governing body and leadership structure. The ability of leaders to motivate and drive the staff is instrumental for the success of a hospital and can be assessed throughout the survey.

Chapter purpose:

The chapter focuses on checking the hospital structure resilience by looking into the following:

- Effectiveness of governing body
- Effectiveness of direction
- Effectiveness of leadership
- Effectiveness of financial stewardship
- Efficient contract management
- Ethical management
- Effective staff engagement, health, and safety

Implementation guiding documents:

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

1. Egyptian Constitution
2. Egypt 2030 vision, Ministry of Planning
3. Law 51/1981 organization healthcare facilities
4. MOHP Ministerial 186/2001 Patient right to know the expected cost of care
5. Law 181/2018 on Egyptian Consumer Protection
6. Egyptian standards for accounting, 609/2016
7. Women council publications on gender equality
8. Professional code of ethics—prime minister decree 238, the year 2003
9. Law 206/2017 on advertisement for healthcare services
10. National Labor Law
11. WHO-ILO HealthWISE action manual
12. Staff Health and Safety regulations
13. Effective governing body

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

Effectiveness

Keywords:

Governing body Structure.

Intent:

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

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

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

OGM.05 Hospital director; OGM.09 Hospital leaders; OGM.10 Departmental management.

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

Effectiveness

Keywords:
Mission Statement.

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

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

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

Related standards:
OGM.07 Strategic planning.

OGM.03 Governing body responsibilities and accountabilities are identified.

Effectiveness

Keywords:
Governing body responsibility.

Intent:
Governing bodies are responsible for the health and wealth of their organization and are thus accountable primarily for its sustainability.
Therefore, to establish an accountability statement, governing bodies have to first identify their principle stakeholders and then define in what way they are accountable

to them.

One key role of any governing body is the oversight of the hospital's performance. Governing bodies do that by monitoring the effectiveness of the management strategies set to achieve the hospital's goals. In this process of oversight, certain deficiencies may be identified, which should be fulfilled through new or revised strategies. appointing a director, allocating resources, providing expertise, effective financial planning, and responsiveness to internal and regulatory inspection reports.

Governing body responsibilities are defined and directed towards the hospital's principal stakeholders.

The governing body supports, promotes and monitors the performance's improvement measures, patient safety, risk management efforts, and safety culture.

Data presented for review should be in a format that facilitates comparison, internally with set targets or over time and externally with other similar organizations or established standards. Resources include financial, human resources, technology, information systems.

A typical scenario could be a shortage of resources to meet customer expectations. Therefore, governing bodies should develop plans for resource allocation to increase efficiency and transparency. Activities that aim at achieving mission-related objectives should be legible for resource allocation.

The process of prioritization among selected activities follows this process of selection. Prioritization criteria should be known to all to ensure a fair and transparent resource allocation process.

The governing body responsibilities includes approval, receiving reports, and regular evaluation and update of at least the following:

a) The hospital strategic plan.
b) The operational plan and budget, capital investments.
c) The quality improvement, patient safety, and risk management programs.
d) Community assessment and involvement program.

Survey process guide:

GAHAR surveyor may observe governing body role and responsibilities through the whole process of survey with special attention given to opening presentation, document review session and leadership interview session, questions may include reviewing the required documents and checking their details and approvals in addition to reviewing monitoring reports of the approved plans.

Evidence of compliance:

1. The governing body has defined its responsibilities and accountabilities to each stakeholder and has a process for resource allocation that includes clear criteria for selection and prioritization.
2. The strategic plan is approved, monitored, and updated by the governing body.
3. Operational plan and budget are approved, monitored, and updated by the governing body.
4. Quality improvement and patient safety and risk management programs are approved, monitored, and updated by the governing body.
5. Community assessment and involvement program is approved, monitored, and updated by the governing body.

Related standards:

OGM.01 Governance structure; OGM.07 Strategic planning; OGM.08 Operational planning; QPI.02 Quality plan; CAI.02 Planning for community involvement.

OGM.04 The hospital leaders ensure effective communication with the governing body.

Effectiveness

Keywords:

Effective communication with governing body.

Intent:

Uncontrolled communication between governing body members on one-hand and organization management team and staff, on the other hand, may lead to misinterpretation and confusion.

A clear two-way communication process between governance and management, usually between the head of the governing body and the hospital director, enhances The hospital's well-being.

It ensures the governing body's understanding of the hospital's performance and associated risks that can hinder the achievement of its goals.

In addition, it provides the hospital director the opportunity to report and receive feedback on The hospital's performance, especially those that are problematic.

Hospitals need to define the types of communication channels between the governing body, the management team, and the hospital staff. Communication channels may be in the form of social media, town hall meetings, monthly or annual conferences or other channels.

Survey process guide:

GAHAR surveyor may observe evidences of open defined communication channels, frequency of communication and evidence of feedback to submitted reports on both sides.

Evidence of compliance:

1. There is a defined process of communication between the governing body and the hospital leaders.
2. The governing body members and hospital leaders are aware of the process of communication and approve the communication channel.
3. The governing body submits feedback reports to the hospital director.

Related standards:

OGM.01 Governance structure; OGM.09 Hospital leaders; OGM.10 Departmental management.

Effective organization direction

OGM.05 A full-time qualified director is appointed by the governing body to manage the hospital according to applicable laws and regulations.

Effectiveness

Keywords:

Hospital Director.

Intent:

Any organization needs an executive that is responsible and accountable for implementing the governing body's decisions and to act as a link between the governing body and the hospital staff. Such a position requires a dedicated full-time qualified director guided by relevant laws and regulations and/or as further defined by the governing body

The hospital director must have appropriate training and/or experience in healthcare management, as defined in the job description.

The job description covers at least the following:

a) Providing oversight of day-to-day operations.
b) Ensuring clear and accurate posting of the 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 a functional, organization-wide program for performance improvement, patient safety, and risk management with appropriate resources.

Survey process guide:

- GAHAR surveyor may expect to meet a full-time hospital director at least once during the course of the hospital survey.
- GAHAR surveyor may review hospital director staff file to check compliance with all required documents of training, job description, role and responsibilities
- GAHAR surveyor may review an authority matrix or delegation letters for tasks that the hospital director delegated to any other staff member

Evidence of compliance:

1. There is a full-time qualified director managing the hospital.
2. There is an appointment letter for hospital director according to applicable laws and regulations.
3. There is a job description for the hospital director covering the standard requirements from a) through g) as in the intent.
4. The hospital director has appropriate training and/or experience in healthcare management, as defined in the job description.
5. There is evidence that the director assumes his/her assigned responsibilities or delegates them to another competent employee.

Related standards:

OGM.01 Governance structure; OGM.09 Hospital leaders.

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

Effectiveness

Keywords:

Committee structure.

Intent:

Accomplishing the hospital mission requires engagement and teamwork.
Such requirements are established through knowledge sharing and staff involvement in decision making.

Committees are tools for mixing distributed knowledge and abilities of various parts of the hospital in the format of one active and integrated unit that can have an effective role in decision- making.
A multidisciplinary selection of members of every committee and regular holding of committees can enhance its productivity.
The hospital leadership, medical staff, nursing staff, and other staff are involved in the relevant committees.
Each committee must have terms of references that include its membership, duties, accountability/reporting, frequency of meeting, quorum, and baseline agenda.
The committee meetings are to be held regularly, and minutes of the meeting are documented.
The hospital has at least the following committees:

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

PCC.02 Interdisciplinary patient-centeredness; OGM.02 Mission statement; OGM.03 Governing body responsibility; CAI.02 Planning for community involvement.

OGM.07 A strategic plan is developed under oversight and guidance of the governing body.

Effectiveness

Keywords:
Strategic Planning.

Intent:
Strategic planning is a process of establishing a long-term plan to achieve a hospital's specified vision and mission through the attainment of high-level strategic goals.
A strategic plan looks out over an extended time horizon. The plan establishes where the hospital is currently, where leadership wants to go, how they will get there, and how they will know when they have arrived.
The strategic plan provides an overall framework within which all stakeholders can find their appropriate roles and make their appropriate contribution.
It is essential that stakeholders are involved in developing the plan to ensure legitimacy, ownership, and commitment to the plan.
A strategic plan might be established on a higher level (governing body) with the involvement of hospital leaders.

Survey process guide:
GAHAR surveyor may receive information about strategic plan during the opening presentation, then more questions about involvement and monitoring of strategic plan shall be posed during the leadership interview session.

Evidence of compliance:
1. The hospital has a strategic plan with goals/desired outcomes and defined achievable timelines.
2. Participation of staff, hospital leaders, community, and other identified stakeholders in the strategic plan.
3. There are progress review reports to monitor the strategic plan at least annually.

Related standards:
CAI.01 Community initiatives; PCC.02 Interdisciplinary patient-centeredness; OGM.02 Mission statement; OGM.03 Governing body responsibility.

OGM.08 Operational plans are developed to achieve the strategic plan goals and objectives, and meet identified input from staff, service providers, and other stakeholders.

Efficiency

Keywords:
Operational Planning.

Intent:
Operational plans are the means through which organization fulfill their mission. They are detailed, containing specific information regarding targets and related activities and needed resources within a timed framework.
Leaders establish operational plans that include at least the following:
a) Clear goals and objectives.
b) Specific activities and tasks for implementation.
c) Timetable for implementation.
d) Assigned responsibilities.
e) Sources of the required budget.
Leaders regularly assess the annual operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle. Any planning cycle ends with an analysis or an assessment phase through which planners understand what went well and what went wrong with the plan. This analysis or better-called lessons learned should feed into the new cycle of planning to improve the hospital performance.

Survey process guide:
GAHAR surveyor may inquire about operational plans during hospital tours and tracers to give an opportunity to staff and department leaders to talk about their plans and how they are communicated. GAHAR surveyor may be looking for evidence of monitoring plan progress, identification of opportunities of improvement and actions taken to improve performance.

Evidence of compliance:
1. The hospital has operational plans that include a) to e) in the intent.
2. Staff are involved in designing the related operational plans.
3. Operational plans progress/analysis reports.
4. The plans are communicated throughout the hospital.
5. Leaders evaluate the operational plans annually, and lessons learned are considered for a new cycle of planning.

Related standards:
OGM.02 Mission statement; OGM.03 Governing body responsibility; OGM.07 Strategic planning.

OGM.09 The responsibilities and accountabilities of the hospital leaders are identified.

Effectiveness

Keywords:
Hospital leaders.

Intent:
Usually, governing body leaves it to their executives to see that their decisions are carried out and that the day-to-day operations of the hospital are performed successfully.
While, another standard addresses hospital director's responsibilities, hospitals usually have nursing director, medical director, information officer, financial director, and sometimes operational director, who also carry a lot of weight.
The top executives forms the central core management.
The hospital shall establish administrative authorities and responsibilities for hospital leader
The hospital leadership is responsible for:

a) Sustaining firm hospital structure:
   i. Planning for upgrading or replacing systems, buildings, or components needed for continued, safe, and effective operation.
   ii. Collaboratively developing a plan for staffing the hospital that identifies the numbers, types, and desired qualifications of staff.
   iii. Providing appropriate facilities and time for staff education and training.
   iv. Ensuring all required policies, procedures, and plans have been developed and implemented.
   v. Providing adequate space, equipment, and other resources based on strategic and operational plans and needed services.
   vi. Selecting equipment and supplies based on defined criteria that include quality and cost-effectiveness.
b) Running smooth directed operations:
   i. Creating a safe and just culture for reporting errors, near misses, and complaints, and use the information to improve the safety of processes and systems.
   ii. Designing and implementing processes that support continuity, coordination of

care, and risk reduction.

iii. Ensuring that services are developed and delivered safely according to applicable laws and regulations and approved organization strategic plan with input from the users/staff.

c) Continuous monitoring and evaluation:

i. Ensuring that all quality control monitoring is implemented, monitored, and action is taken when necessary.

ii. Ensuring the hospital meets the conditions of facility inspection reports or citations.

iii. Annually assessing the operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle.

iv. Annually 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.

d) Continuous Improvement

Survey process guide:

GAHAR surveyor may interview hospital leaders during the course of GAHAR survey and during leadership interview session, questions about their responsibilities and their evaluations shall be raised. Answers shall be matched with job description review during staff file review session.

Evidence of compliance:

1. There is a job description for each hospital leader to identify the required qualification andresponsibilities.
2. The responsibilities of the hospital leaders include at least a) through d) in the intent.
3. Hospital leaders understand their responsibilities.
4. Hospital leaders perform their responsibilities and present reports on their activities.

Related standards:

OGM.02 Mission statement; OGM.03 Governing body responsibility; OGM.07 Strategic planning, OGM.08 Operational planning.

Effective departmental leadership

OGM.10 A designated qualified staff member is assigned to supervise each department and service with defined responsibilities.

Effectiveness

Keywords:

Departmental management.

Intent:

An effective and efficient department/service supervisor ensures that department services are known and are aligned with other department services and that there are adequate resources to offer them.

Each department or service has to have a designated staff member responsible for delivering the required services as defined by the hospital mission and related plans to ensure alignment between departments/services and with the hospital a whole.

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 annually to leadership.
h) Ensuring that the department is involved in the performance improvement, patient safety, and risk management program(s).

Survey process guide:

GAHAR surveyor may interview department leaders during the course of GAHAR survey, questions about their responsibilities and their evaluations shall be raised. Answers shall be matched with job description review during staff file review session.

Evidence of compliance:

1. There are job descriptions for each departments/ services supervisor to identify the required qualification and responsibilities.
2. There is a supervisor for each department of the hospital who is qualified as required by the job description.
3. The responsibilities of the Departments/ services supervisor include at least a) to h) in the intent.
4. Departments and services heads understand their responsibilities.
5. Departments and services heads perform their responsibilities and present reports on their activities.

Related standards:

OGM.02 Mission statement; OGM.03 Governing body responsibility; OGM.07 Strategic planning; OGM.08 Operational planning.

Efficient financial stewardship

OGM.11 The hospital defines supply chain management processes.

Efficiency

Keywords:

Supply Chain Management.

Intent:

The supply chain generally refers to the resources needed to deliver goods or services to a consumer. In healthcare, managing the supply chain is typically a very complex and fragmented process.

Healthcare supply chain management involves obtaining resources, managing supplies, and delivering goods and services to providers and patients. To complete the process, physical goods and information about medical products and services usually go through a number of independent stakeholders, including manufacturers, insurance companies, hospitals, providers, group purchasing organizations, and several regulatory agencies. However, by promoting efficiency in the healthcare supply chain, hospitals and physician practices can create substantial cost-reducing opportunities across their organization.

The hospital should develop a policy and procedures for Supply Chain Management

The policy 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.

Survey process guide:

GAHAR surveyor may review supply chain documents and records during document review sessions, and discussions shall take place during a financial stewardship session.

Evidence of compliance:

1. A policy addresses all elements from a) through e).
2. Supply chain process is recorded, monitored, and evaluated at least annually
3. Suppliers are monitored and evaluated at least annually
4. Actions are taken to ensure that critical supplies are available when needed.

Related standards:

PCC.02 Interdisciplinary patient-centeredness; DAS.12 Reagent management; MMS.03 Medication procurement, formulary.

OGM.12 The hospital manages its storage, stock, and inventory.

Efficiency

Keywords:

Stock Management.

Intent:

Inventory is the stock of any item or resource used in a hospital.

An inventory system is the set of policies and controls that monitor levels of inventory and determine what levels should be maintained when stock should be replenished, and how large orders should be.

Inventory control is universal for achieving the aim of the right materials in the right quantity at the right price and at the right place, and it is essential for the appropriate utilization of existing resources.

Unavailability of the needed supplies can adversely affect the hospital operation and

cause serious health problems for patients. Inventory control helps in efficient and optimum use of scarce financial resources, avoiding the shortage of medical materials and elimination of out-of-stock situations.

Effective management of medical stores entails priority setting in the purchase and distribution of medical materials.

The hospital shall develop a policy and procedures for managing storage, stock, and inventory shall 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 the use of critical resources

Stock items should at least have the following records (unless stated otherwise by laws and regulations)

a) Date received
b) Lot number and expiration date
c) Whether or not acceptance criteria were met and if any follow-up
d) Date placed in service or disposition, if not used.

Survey process guide:

GAHAR surveyor may review hospital policy during document review session and discussions shall take place during financial stewardship session

Evidence of compliance:

1. The hospital has an approved policy for managing storage, stock, and inventory addresses at least from a) through d) in the intent.
2. As required by laws and regulations, basic information is recorded for stock items as mentioned in the intent from e) through h)
3. There is an inventory control system that includes identification of utilization rate, re-order limit for each item and monitoring of out-stock events.
4. The hospital identifies its critical resources and ensures their continuous availability

Related standards:

PCC.02 Interdisciplinary patient-centeredness; DAS.12 Reagent management; MMS.03 Medication procurement, formulary; OGM.11 Supply chain management.

OGM.13 The hospital has at least one efficient utilization improvement project annually.

Efficiency

Keywords:
Cost Reduction Project.

Intent:
Improvement project methodology includes the development of tools to evaluate the use of resources for the existing process and then reevaluate the use of resources for the improved process. The improvement shall be continuously monitored to ensure sustainability.
The hospital shall ensure efficient utilization of its resources through Identification of high frequency and high-cost processes, either clinical or non-clinical, and perform improvement projects to eliminate wastes and redundancies in these processes.

Survey process guide:
GAHAR surveyor may expect to see a full cycle of improvement that starts with showing reasons for choosing a specific project over others, steps taken to define, measure, analyze and improve the process in addition to monitoring of the process afterward to ensure the continues improvement

Evidence of compliance:
1. The hospital identifies high frequency and high-cost processes, e whether clinical or non- clinical.
2. The hospital participates in at least one efficient utilization improvement project annually that leads to the elimination of waste and redundancies.
3. Improvement results are monitored to ensure sustainability.

Related standards:
OGM.11 Supply chain management; OGM.14 Billing system.

OGM.14 The hospital manages the patient billing system.

Efficiency

Keywords:
Billing System.

Intent:
The billing process is a crucial component of hospital management.

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

The hospital develops a policy and procedures for the billing process that addresses at least the following:

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

OGM.11 Supply chain management; PCC.14 Patient and family education on administrative processes; MMS.03 Medication procurement, formulary.

OGM.15 The hospital implements a process for selection, evaluation, and continuously monitoring contracted services.

Effectiveness

Keywords:
Contract Management.

Intent:
Hospital leadership defines the nature and scope of services provided by contracted services, including clinical and non-clinical services, for example, laboratory and radiology services, housekeeping, or catering services.
Head of departments/services shall participate in the selection, evaluation, and continuously monitoring contracted services to ensure service providers comply with required environmental safety, patient safety, and quality requirements, policies and procedures, and all relevant accreditation standards requirements.
The hospital has to ensure current competency, licensure, education, and continuous improvement of competency for contracted clinical staff.
The contracted services shall be monitored through performance measures and evaluated at least annually to determine if a contract should be renewed or terminated.

Survey process guide:
GAHAR surveyor may receive information about contracted services during the opening presentation, then questions about contracts, contractors monitoring, evaluation, and renewal shall be posed during the financial stewardship session.

Evidence of compliance:
1. There is a list of all contracted services, including clinical and non-clinical services.
2. There are selection criteria for each service.
3. Head of departments/services participate in the selection, evaluation, and monitoring of contracted services.
4. There are performance measures for monitoring contracted services.
5. Each contract is evaluated at least annually to determine if it should be renewed or terminated.

Related standards:
DAS.01 Planning medical imaging services; DAS.10 Laboratory services planning and management; DAS.31Contracted blood banks; EFS.02 Environment and facility safety program monitoring; ICD.03 Prehospital care, ambulance care, emergency medical care during disasters; MMS.03 Medication procurement, formulary; EFS.09 Security plan; EFS.10 Medical equipment plan; WFM.07 Orientation program.

Safe, ethical, and positive organization culture

OGM.16 Leaders create a culture of safety and quality within the facility.

Effectiveness

Keywords:
Safety Culture.

Intent:
Healthcare is complex, and sometimes, due to unintentional errors, it can harm patients and even staff. To minimize such risk, causes of errors and near misses should be explored and efforts made to prevent their occurrence in the future.
For this to happen, a safety culture within the facility is essential where staff feel confident when reporting on a safety incident that they will be treated fairly, in a confidential manner, and that the information they provide will be used to improve the care process and environment.

Survey process guide:
- GAHAR surveyor may review records of leaders' safety rounds during the leadership interview session.
- GAHAR surveyor may interview staff to check support for quality initiatives safety culture.

Evidence of compliance:
1. Leaders participate in safety rounds.
2. Leaders support quality and patient safety initiatives, monitoring, and improvement activities.
3. Leaders creates a just culture to encourage reporting errors and near misses.

Related standards:
APC.02 Monitoring safety requirements; QPI.11 Incident reporting system; QPI.12 Significant events; QPI.13 Sentinel event.

OGM.17 The hospital ensures positive workplace culture.

Effectiveness

Keywords:
Positive Workplace Culture.

Intent:
Studies highlighted the importance of attention to healthcare professional needs for a

safe and comfortable work environment.
The hospital has an approved policy and procedures of positive workplace culture
The policy addresses at least the following:

a) Workplace cleanliness, safety and security measures
b) Management of workplace violence, discrimination, and harassment
c) Communication channels between staff and hospital leaders
d) Staff feedback measurement
e) Planning for staff development

Survey process guide:

- GAHAR surveyor may review approved policy for positive workplace culture
- GAHAR surveyor may observe workplaces and shall interview staff to inquire about workplace incidents related to this standard

Evidence of compliance:

1. The hospital has an approved policy for positive workplace culture, The policy addresses at least a) to e) in the intent.
2. The workplace is clean, safe, and security measures are implemented.
3. Measures of workplace violence, discrimination, and harassment are implemented.
4. There are communication channels between staff and hospital leaders
5. Staff feedback and staff satisfaction are measured.

Related standards:

EFS.02 Environment and facility safety program monitoring; OGM.18 Ethical managements; OGM.20 Staff health; WFM.07 Orientation program; WFM.08 Continuous education program.

OGM.18 The hospital ensures ethical management.

Effectiveness

Keywords:

Ethical Management.

Intent:

Medical ethics involves examining a specific problem, usually a clinical case, and using values, facts, and logic to decide what the best course of action should be. Healthcare professionals may deal with a variety of ethical problems, for example, conflict of interest and inequity of patient care.
The policy of ethical management addresses at least the following:

a) Developing and implementing the code of ethics
b) Developing and implementing of hospital values
c) Handling Medical errors and medico-legal cases
d) Managing clinical research
e) Identifying conflict of interest
f) Gender equality

Survey process guide:

- GAHAR surveyor may review hospital policy
- GAHAR surveyor may interview staff to inquire about code of ethics, handling of medical errors and clinical research issues
- GAHAR surveyor may interview human resources manager and hospital leaders during leadership session to inquire about all elements including mechanisms put in place to ensure gender equality as per the Egyptian law requirements

Evidence of compliance:

1. The hospital has an approved policy for ethical management that addresses at least a) to F) in the intent.
2. Staff members are aware of the policy
3. Ethical issues are discussed and managed according to the approved code of ethics.
4. Solved ethical issues are used for education and staff professional development

Related standards:

OGM.17 Positive workplace culture; EFS.02 Environment and facility safety program monitoring; OGM.20 Staff health; ADD.06 Research ethical framework.

Effective staff engagement, safety, and health

OGM.19 The hospital ensures that there are spaces matching required staff working conditions.

Effectiveness

Keywords:

Staff Working Conditions.

Intent:

Staff rest areas, including spaces that are used solely by employees for hygiene needs, clothes change, rest, and eating when applicable, such as staff lounge and sleeping areas. Providing a comfortable and ergonomically supportive setting for workers has become a priority to punch up staff productivity as well as recruitment and retention.

Staff rest areas should be ventilated, lit and clean, not overcrowded, reachable through communication tools, and secure.

Survey process guide:
During the GAHAR survey, the surveyor shall observe one or two staff resting areas to check standard compliance

Evidence of compliance:
1. Staff rest areas are ventilated, lit, and clean.
2. Staff rest areas are not overcrowded.
3. Staff rest areas are reachable through communication tools.
4. Staff rest areas are secured and not readily-accessible for non-staff members.
5. The staff has access to healthy food and water supply.

Related standards:
OGM.17 Positive workplace culture; EFS.02 Environment and facility safety program monitoring; OGM.18 Ethical management; OGM.20 Staff health.

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

Safety

Keywords:
Staff Health.

Intent:
The hospital shall implement a staff health program to ensure the safety of the staff according to workplace exposures.
A cornerstone of the staff occupational health program is the hazard/risk assessment, which identifies the hazards and risks related to each occupation.
This is done in order to take the necessary steps to control these hazards to minimize possible harm arising and, if not possible, to lessen its negative sequel.
This is achieved through a hospital-wide risk assessment program that identifies high risks areas and processes.
The program scope covers all staff, the program address at least the following:
a) Pre-employment medical evaluation of new staff
b) Periodic medical evaluation of staff members
c) Screening for exposure and/or immunity to infectious diseases.
d) Exposure control and management to work-related hazards

i. Ergonomic hazards that arise from the lifting and transfer of patients or equipment, strain, repetitive movements, and poor posture
ii. Physical hazards such as lighting, noise, ventilation, electrical and others
iii. Biological hazards from 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) Recording and management of staff incidents (e.g., injuries or illnesses, taking corrective actions, and setting measures in place to prevent recurrences).
h) A pre-employment medical examination is required for all employees' categories to evaluate their appropriateness for safe performance, and staff that is exposed to certain hazards as radiation should have periodic specific medical evaluation (tests and examinations). The situational examination may be required in case of exposure to specific substances. Results of the medical evaluation are documented in staff health records, and action is taken when there are positive results, including employee awareness of these results and provision of counseling and interventions as might be needed.
i) Infection control staff shall be involved in the development and implementation of the staff health program as the transmission of infection is a common and serious risk for both staff and patients in healthcare facilities.
j) All staff occupational health program-related results (medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulation

Survey process guide:

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

Evidence of compliance:

1. There is an approved hospital's staff health program according to local laws and regulations that cover a) through j) in the intent.
2. There is an occupational health risk assessment that defines occupational risks within the hospital.
3. Staff members are educated about the risks within the hospital environment, their

specific job-related hazards, and periodic medical examination.

4. All staff members are subject to the Immunization program and to work restrictions according to laws and regulations and approved hospital guidelines.
5. All test results, immunizations, post-exposure prophylaxis and interventions are recorded in the staff's health record.
6. There is evidence of taking action and informing employees in case of positive results.

Related standards:

OGM.17 Positive workplace culture; EFS.02 Environment and facility safety program monitoring; OGM.18 Ethical management.

Community Assessment and Involvement

Chapter intent:

A community is a group of individuals, families, groups, facilities, or organizations that interact with one another, cooperate in common activities, solve mutual concerns, usually within the geographic area served by a hospital. Communities are always dynamic and live. Changes occur in community structure, function, conditions, or behaviors that may result in changes in community health needs and risks. Dynamic hospitals can clearly define their communities, frequently assess their needs, and respond to those needs. The response can be in the form of widening organization scope, improving certain internal issues that form patient perception, or even reaching out to the community and working with community leaders to engage and involve communities in health-related activities. Such activities, whether educational, cultural, artistic, outreach, or other activity, can promote certain healthy practices among community members. Nevertheless, Community involvement means also that organizations work to ensure avoiding harming the community by any potential risk imposed by the hospital.

Globally, WHO has identified multiple factors as social determinants of health Those factors are responsible for health inequalities within and among communities. In the late 1990s, the term Social Accountability came to the public as a motive for private sector organizations to participate in helping communities to face globalization challenges and to sustain community development. In April 2018, the Arab Labor Organization addressed this issue in its conference, where it emphasized the importance of compliance to certain standards of social accountability under the following four domains; Human Rights, Labor Standards, Environment Protection, Anticorruption measures.

Locally, the Ministry of Planning issued a clear definition of what a catchment area means for each hospital category. Multiple published studies focused on assessing the impact of certain social determinants of health and its link to health inequalities. Accordingly, during the period of 2018-2019, Egyptian authorities announced multiple initiatives such as Universal Health Insurance, 100 Million Healthy Lives, and Reduction of Waiting Lists for critical conditions and other activities. Multiple hospitals have provided outreach programs to reach patients where healthcare services are not sufficient

Practically, A hospital forms a link between international, national, and local initiatives on one side and healthcare community on the other side. Alignment with some of these initiatives and taking part in executing them is important for the Egyptian community as a whole as it produces more compassion, culturally competent, and

community-responsive healthcare.
During the GAHAR survey, surveyors shall evaluate the efficiency of the community assessment and involvement program of the hospital.

Chapter purpose:
The main objective is to ensure that the hospital provides community involvement effectively; The chapter discusses the following objectives:

- Effective community needs assessment
- Alignment with international, national, regional, or local community initiative

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

1. Ministry of Planning publications; Planning of Healthcare services
2. MOHP Social services webpage: http://www.mohp.gov.eg/SectorServicesaspx?Deptcode=7andandSectorCode=4
   including
   - scope of practice as approved by MOHP
   - Quality measurement for a social services specialist in healthcare organizations
   - Implementation of quality standards
   - Social services role in the control of infectious diseases
3. WHO/UNICEF Baby-friendly hospital initiative

Alignment with healthcare eco-system changes

CAI.01 Hospital services are planned in line with international, national, regional, or local community initiatives.

Effectiveness

Keywords:
Community Initiatives.

Intent:
Community is a group of individuals, families, groups, facilities, or organizations that interact with one another cooperate in common activities, solve mutual concerns, usually within the geographic area served by a hospital.
The hospital develops and implements a plan for community assessment and involvement initiatives that may include:

a) Implementation of international baby-friendly initiatives
b) National initiatives of Universal Health Insurance, 100 Million Healthy Lives, Reduction of Waiting Lists for critical conditions or others
c) Others

Survey process guide:

- GAHAR surveyor may review community involvement plan to check that is it aligned with other initiatives and with laws and regulations
- GAHAR surveyor may inquire about community involvement plan during leadership interview session
- GAHAR surveyor may interview staff to check their awareness of community initiatives

Evidence of compliance:

1. The hospital has an approved plan for community involvement initiatives that reflect alignment with international, regional, and/or national community initiatives
2. Relevant staff are aware of hospital's planned community initiatives.
3. Community initiatives are in compliance with laws and regulations.

Related standards:
OGM.07 Strategic planning.

Effective community services

CAI.02 Community needs are assessed in collaboration with community representatives.

Patient-centeredness

Keywords:
Planning for community involvement.

Intent:
Healthcare organizations must support communities to shape their own health by involving community members in the governance of a hospital in terms of policy formulation, decision-making, and oversight is important for ensuring the relevance of services offered to the community.
Furthermore, involving community members in the hospital committees ensures the relevance of decisions at the community level.
Availability of population information that is updated regularly as defined by the policy and when new data is available promotes evidence-based decisions and optimizes health program utilization.
Local population data may include demographics, health status, health determinants that should be regularly reviewed for better health planning, as data sources could be primary or secondary. Primary data is data directly collected through surveys of citizens and providers, interviews, focus groups, etc. Secondary data is data obtained from other entities as vital statistics, cancer registry, censuses, etc.
The hospital developed a community assessment and involvement program that addresses at least the following:

a) Identification and description of the catchment area.
b) Gap analysis process involving at least the following:
    i. Accessibility and timeliness of services
    ii. Risk assessment of the community hazards including environmental problems
    iii. Healthcare needs
    iv. Healthcare education needs
    v. Healthcare expectation
c) Planning for interventions
d) Identifying potential solutions
e) Announcing or posting selected solutions to the community
f) Training tools and information provided for the community education program.

Survey process guide:

- GAHAR surveyor may review community assessment and involvement program to check that is it aligned with other initiatives and with laws and regulations
- GAHAR surveyor may inquire about community assessment program during leadership interview session
- GAHAR surveyor may interview staff to check their awareness of community initiatives

Evidence of compliance:

1. The hospital has an approved program for community assessment and involvement that covers all elements in the intent from a) through f).
2. A designated person (s) to coordinate community involvement activities and public relations.
3. There is evidence that gap analysis is done in collaboration with community members
4. Selected solutions are announced and/or posted to the community

Related standards:

OGM.06 Committee structure; EFS.02 Environment and facility safety program monitoring.

CAI.03 Hospital community activities, whether educational, cultural, recreational, outreach, or other activities, meet the identified learning needs and educational level of the community.

Effectiveness

Keywords:

Community Education.

Intent:

Hospitals should align their services with community health needs. Such a process requires collaboration with specialized bodies that have the capacity to define community health needs.

A community health needs assessment should be followed with a community health improvement plan that is expressed in the hospital strategic plan and through its services. Such approach accomplishes the hospital responsibility towards its community.

However, to ensure an effect that is reasonable in magnitude and sustainable, frequently, several hospitals work collaboratively on certain priority community health needs.

The hospital may decide to perform multiple activities to achieve a certain health

improvement goal. These activities may be in the form of educational, cultural, recreational, outreach, or other activities. There may be performed in collaboration with nearby schools, factories, markets, malls, police stations, or other community players. Topics of social activities may cover smoking cessation, life cycle approach to nutrition, healthy lifestyle, sexual and reproductive health, and mental health, including depression and addiction.

Survey process guide:

- GAHAR surveyor may review community assessment and involvement program to check that is it aligned with other initiatives and with laws and regulations
- GAHAR surveyor may inquire about community assessment program during leadership interview session
- GAHAR surveyor may interview staff to check their awareness of community initiatives

Evidence of compliance:

1. The hospital identifies the community partner organizations that can collaborate with the hospital in defining the community's health needs.
2. Hospital staff are aware of their specific community health needs.
3. There is evidence of performed community involvement activities.

Related standards:

CAI.01 Community initiatives; CAI.02 Planning for community involvement.

CAI.04 Outcomes of community assessment and involvement program are monitored and evaluated.

Effectiveness

Keywords:

Community Involvement program evaluation.

Intent:

Assessment of the community health needs ensures alignment of hospital mission and services with community health problems leading to better resource utilization and improved community health.

Evaluation of the program activities is important to validate the effectiveness of the activities and identify the learned lessons.

Hospitals may perform an evaluation of the community involvement program as follows:

Reassessment of community needs and risks at least every two years

Effectiveness of interventions
Community satisfaction of provided social activities is measured
Complaints from the community and external customers are addressed

Survey process guide:

- GAHAR surveyor may review community assessment and involvement plan to check that it measures its outcomes.
- GAHAR surveyor may inquire about community assessment and involvement plan during leadership interview session.
- GAHAR surveyor may interview staff to check their awareness of community initiatives.

Evidence of compliance:

1. The hospital performs an evaluation for the community needs at least every two years
2. The hospital performs an evaluation for the community risks at least every two years
3. The hospital measures community satisfaction of the provided social activities using a variety of methods.

Related standards:

CAI.01 Community initiatives; CAI.02 Planning for community involvement; CAI.03 Community education.

CAI.05 The hospital handles and manages community suggestions and complaints.

Effectiveness

Keywords:

Community suggestions and complaints.

Intent:

Organizations should ensure the availability of a transparent, visible, two-way communication process for its community to express their concerns and for the hospital to show its adequate and caring response.

The hospital develops and implements a policy and procedures to guide the process for dealing with at least the following:
External business customers.
Internal or External customer complaints.
Situations to call police help, including aggressive behavior.
Media

Survey process guide:

- GAHAR surveyor may review community assessment and involvement plan to check that it measures its outcomes
- GAHAR surveyor may inquire about community assessment and involvement plan during leadership interview session
- GAHAR surveyor may interview staff to check their awareness of community initiatives

Evidence of compliance:

1. The hospital has an approved policy for managing the community, business customer complaints, and suggestions
2. Community and business customers' complaints and suggestions are investigated by the hospital.
3. Community and business customers' complaints are resolved in a timely manner and recorded in a specific register.
4. Community and business customers receive feedback about their complaints or suggestions within approved timeframes.
5. Measures are in place to handle aggressive situations, including calling the police when needed.
6. There is a process for dealing with media and social media

Related standards:

PCC.01 Hospital advertisement.

CAI.06 The accredited hospital shares experience with neighboring (or other) healthcare organization(s) to understand, achieve, or maintain accreditation.

Effectiveness

Keywords:

Promoting quality of care.

Intent:

Accredited hospitals carry a social responsibility towards their communities to raise awareness of the quality of care, as hospitals shall help other organizations to seek accreditation.

Survey process guide:

GAHAR surveyor may review hospital activities related to cooperation with other hospitals seeking accreditations

Evidence of compliance:

1. The hospital identifies other hospitals seeking accreditations and the possibility of cooperation
2. The hospital identifies areas in the accreditation process that can be shared with other hospitals during their accreditation journey
3. The hospital provides support in terms of education, expertise and resources that can be helpful to other hospitals
4. The hospital works with other hospitals to ensure compliance to standards in any mutually executed processes

Related standards:

APC.01 Sustaining registration requirements; APC.02 Monitoring safety requirements; APC.05 Accreditation process value.

Workforce Management

Chapter intent:

The hospital needs an appropriate variety of skilled, qualified people to fulfill its mission and to meet patient needs. The hospital workforce refers to the staff within the hospital. Planning the appropriate number and skill mix of the workforce is essential. Developing clear job descriptions, strong orientation, and training programs help staff in delivering proper healthcare. A good organization must always have a clear structure of its medical staff, including departments, divisions, and medical committees.

This chapter defines the medical staff leaders' roles and responsibilities in credentialing, privileging, bylaws development, committees, and departments' management (head), as well as performance improvement. The medical staff includes licensed physicians and licensed dentists, it's particularly important to carefully review the credentials of all medical staff and other healthcare professionals, The hospital should provide medical staff with opportunities to learn and to advance personally and professionally Independent practitioners are other licensed healthcare professionals as (pharmacists, physiotherapist, nutritionist…) that are permitted by law and regulation to provide patient care services independently in the hospital, those special group of healthcare professionals shall be identified by the hospital and their clinical privileges shall be clarified and reviewed.

Globally, the shortage of healthcare professionals is seen in multiple places in the world. In some countries, licenses are renewable, which means that physicians, nurses, and other healthcare professionals need to go through a renewal process periodically and prove their competence and continuous development. National bodies that govern medical and nursing education are established in different countries. National performance evaluation and ranking of healthcare professionals is on the rise, with many healthcare systems moving towards the pay-per-performance concept.

Locally, Egypt also has experienced migration of healthcare professionals to other countries. The new Universal Health Insurance system tackled the pay-per-performance concept in its initial phases. Licenses are not linked to the frequent evaluation of professional development yet, but discussions are established to build a system for monitoring this process. MOHP licensing body requires specific lists of documents for almost all healthcare professionals. The licensing registers include physicians, dentists, physiotherapy specialists, physiotherapy practitioners, pharmacists, clinical pathologists, pathologists, medical chemists, bacteriologists, radiologists, radiology

technicians, nurse supervisors, nurses, nurse technicians, midwives, Community health technicians, Opticians, Anesthesia technicians, Biostatisticians, Prosthesis technicians, medical equipment technicians, denture technicians, and others.
GAHAR surveyors shall review the implementation of laws and regulations, medical bylaws, nursing bylaws, Policies, procedures, and plans reflecting processes of human resources department through interviews with leadership and staff and reviewing different healthcare professional's staff files.

Chapter purpose:
The main objective is to ensure that hospitals maintain an effective Workforce Management program; The chapter addresses the following objectives:

- Effective workforce Planning.
- Effective orientation, continuous medical education, and training program
- An efficient mix of staff
- Periodic evaluation of staff performance.

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

1. Egyptian code of medical ethics 238/2003
2. Egyptian code of nursing ethics (Nursing Syndicate Publications)
3. Code of ethics and behavior for civil service staff,2019, if applicable
4. Pharmacist code of ethics
5. Law 415/1954 Practicing the profession of human medicine
6. Law 140/1981 on practicing midwifery
7. Law 198/1956 Practicing of Psychotherapy
8. Law 3/1985 Practicing Physiotherapy profession
9. Law 127/1955 on practicing the profession of pharmacy
10. Law 537/1954 on Practicing of the dental profession
11. National law for laboratories, 367/ 1954
12. Law 178/1960 on organizing blood collection transport and storage
13. Law 59/1960 regulation of Medical Imaging work
14. MOHP ministerial decree 70/1996 work of foreign experts
15. MOHP ministerial decree 90/1999 for the use of foreign experts
16. MOHP Ministerial decree 236/2004 on anesthesia service requirements
17. MOHP Ministerial Decree 153/2004 on minimum requirements for anesthesia services

18. Law 213/2017 of trade unions and protection
19. MOHP Ministerial decree 25/2002 for medical responsibility and suspension of medical practice
20. MOHP Ministerial decree 293/2000 on the promotion of doctors
21. MOHP Ministerial decree 62/2004 on the promotion of healthcare professionals
22. MOHP Ministerial decree 244/2001 on competencies of surgeons

Efficient workforce planning

WFM.01 Workforce recruitment, education, training, and appraisal processes comply with laws and regulations.

Efficiency

Keywords:
Workforce Laws and regulations.

Intent:
Labor laws and regulations mediate the relationship between workers, hospital, syndicates and the government.
Individual labor law concerns employees' rights at work also through the contract for work.
Employment standards are social norms for the minimum socially acceptable conditions under which employees or contractors are allowed to work.
The hospital identifies all applicable laws, regulations and norms including syndicates codes and requirements and define the legal framework for its workforce management
The hospital complies with the workforce legal framework during all steps of workforce management

Survey process guide:
During the GAHAR survey, the surveyor may review the legal framework documents, observe workforce management practices, or review staff files including independent practitioner to check compliance to laws and regulations

Evidence of compliance:
1. Hospital recruitment practices comply with laws and regulations
2. Hospital workforce education and all training activities comply with laws and regulations.
3. Hospital workforce performance appraisals comply with laws and regulations.

Related standards:
WFM.04 Recruitment, WFM.07 Orientation program, WFM.08 Continuous education program.

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

Efficiency

Keywords:
Staffing Plan.

Intent:
Staff planning is the process of making sure that a hospital has the right people to carry out the work needed for business successfully through matching up detailed staff data including skills, potential, aspirations, and location with business plans.
Shortage of competent healthcare professionals in multiple areas is an alarming sign, especially in critical care disciplines such as intensive care units and anesthesia
The hospital must comply with laws, regulations and recommendations of professional practices that define desired education levels, skills, or other requirements of individual staff members including independent practitioner or that defines staffing numbers or mix of staff for the hospital.
The staffing plan is reviewed on a regular basis and updated as necessary by the leaders of each clinical or managerial area who defines the individual requirements of each staff position.
The hospital maintains a safe level of staff members including independent practitioners numbers and skill level that matches at least 60% of its requirements specially in critical care areas.
Leaders consider the following factors to project staffing needs:
a) The hospital mission, strategic and operational plans
b) Complexity and severity mix of patients served by the hospital
c) Services provided by the hospital
d) Technology and equipment used in patient care

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

Evidence of compliance:

1. Staffing plan matches the mission, strategic and operational plans
2. Staffing plan complies with laws, regulations, and recommendations of professional practices
3. Staffing plan identifies the estimated needed staff numbers including independent practitioners and skills with staff assignments to meet the hospital needs.
4. In critical care and anesthesia services, Competent staff members' number matches at least 60% of the required numbers in the staffing plan
5. Staffing plan is monitored and reviewed at least annually

Related standards:

OGM.07 Strategic planning, OGM.08 Operational planning.

WFM.03 A uniform recruitment process is applied with the participation of service / department leaders.

Equity

Keywords:

Recruitment.

Intent:

Recruitment and selection are the process of advertising a vacant position and choosing the most appropriate person for the job.

The hospital provides an efficient and centralized process for recruiting and hiring staff members including independent practitioners for available positions

If the process is not centralized, similar criteria, processes, and form must result in a uniform process across the hospital for similar types of staff.

The process addresses at least the following:

a) Collaboration with service/department leaders to identify the need for a job
b) Communicating available vacancies to potential candidates
c) Announcing criteria of selection
d) Application process
e) Recruitment procedures

Survey process guide:

- GAHAR surveyor may review a policy describing the recruitment process
- GAHAR surveyor may check a sample of staff files including independent practitioner's files to assess compliance to standard requirements

- the surveyor may interview staff members who are involved in recruitment process to assess the process

Evidence of compliance:

1. The hospital has an approved policy to recruit staff members including independent practitioners that addresses all the elements from a) through e) in the intent
2. Staff who are involved in recruitment, are aware of the hospital policy
3. The recruitment process is uniform across the hospital for similar types of jobs
4. The hospital leaders participate in the recruitment process
5. Selection criteria are recorded in the staff's file

Related standards:

WFM.01 Workforce laws and regulations, WFM.02 Staffing plan.

WFM.04 Hospital job descriptions, address each position requirements and responsibilities.

Effectiveness

Keywords:

Job Description.

Intent:

The job description is a broad, general, and written statement of a specific job, based on the findings of a job analysis.

It generally includes duties, purpose, responsibilities, scope, and working conditions a job.

In the hospital, a job description is required to make sure that staff including independent practitioner's requirements and responsibilities are aligned with the hospital mission.

It allows leaders to make informed staff assignments, recruitment, and evaluation.

It also enables staff members to understand their responsibilities and accountabilities.

The hospital starts by building a job description template that includes a description of the job.

The hospital ensures that results of staff planning process, such as skill mix, are aligned with job requirements mentioned in the job description

Job descriptions are required for all clinical, non-clinical, full- time, and part-time, temporary staff, and those who are under training.

Survey process guide:

GAHAR surveyor may check a sample of staff files to assess compliance to standard requirements.

Evidence of compliance:

1. There is a job description for every position.
2. Job descriptions include the requirements (license, certification or registration, education, skills, knowledge, and experience) and responsibilities of each position.
3. Job descriptions are discussed with staff including independent practitioners' members and discussion is recorded in the staff's file.
4. Performance evaluation is based on job descriptions

Related standards:

OGM.09 Hospital leaders; OGM.10 Departmental management.

WFM.05 New and current staff credentials are verified.

Safety

Keywords:

Verifying credentials.

Intent:

Credentials are documents that are issued by a recognized entity to indicate completion of requirements or the meeting of eligibility requirements, such as a diploma from a medical school, specialty training (residency) completion letter or certificate, completion of the requirements of the related syndicates, authorities and/or others, a license to practice.

These documents, some of which are required by law and regulation, and need to be verified from the original source that issued the document.

When staff members including independent practitioners are hired by the hospital, the process of verifying credentials and evaluating the qualifications that match the requirements of the position with the qualifications of the prospective staff member must be done.

Survey process guide:

- GAHAR surveyor may review an approved document describing the credential verification process
- GAHAR surveyor may check a sample of staff member including independent practitioner's files to assess compliance to standard requirements
- the surveyor may interview staff members who are involved in credentialing process to assess compliance to standard requirements

Evidence of compliance:

1. Required credentials for each position are kept in staff files including independent practitioners' files.
2. There is a process for verifying credentials and evaluating the qualification in the hospital
3. The process is uniformly applied to assess staff members' credentials.
4. Actions are taken when credentials cannot be verified

Related standards:

WFM.01 Workforce laws and regulations.

Efficient staff filing process

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

Efficiency

Keywords:

Staff Files.

Intent:

It is important for the hospital to maintain a staff file for each staff member including independent practitioners.

An accurate staff file provides recording about the staff's knowledge, skill, competency, and training required for carrying out job responsibilities.

In addition, the record shows evidence of staff performance and whether they are meeting job expectations.

Each staff member in the hospital including independent practitioners have a record(s) with information about his/ her qualifications; required health information, such as immunizations and evidence of immunity; evidence of participation in orientation as well as on-going in-service and continuing education; results of evaluations, including staff member performance of job responsibilities and competencies; and work history. Records are standardized and kept currently according to the hospital policy.

Staff files including independent practitioners may contain sensitive information and that must be kept confidential.

The hospital developed a policy and procedures that guide management of staff files including independent practitioners that addresses at least the following:

a) Staff file initiation
b) Standard Contents such as; verified certification, license, Education, training and work history, Current job description, recorded evidence of orientation to the hospital,

the assigned department, and the specific job, Evidence of initial evaluation of the staff member's ability to perform the assigned job, Ongoing In-service education received, Copies within three months evaluations and Copies of annual evaluations

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

Survey process guide:

- GAHAR surveyor may check a sample of staff files to assess compliance to standard requirements
- GAHAR surveyor may visit the area where staff files are kept to assess storage conditions, retention, confidentiality, and disposal mechanism
- GAHAR surveyor may interview staff involved in creation, use and storage of staff files to assess the process

Evidence of compliance:

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

Related standards:

WFM.01 Workforce laws and regulations.

Effective orientation program

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

Effectiveness

Keywords:

Orientation Program.

Intent:

The decision to appoint an individual to a hospital sets several processes in motion. To perform well, a new staff member, no matter what his or her employment experience,

needs to understand the entire hospital structure and how his/ her specific clinical or nonclinical responsibilities contribute to the hospital mission.
This is accomplished through a general orientation to the hospital and his/ her role and a specific orientation to the job responsibilities of his/ her position
Staff orientation, especially when first employed, with the hospital policies, ensures alignment between hospital mission and staff activities.
It also helps to create a healthy hospital culture where all staff works with a shared mental model and towards agreed-upon objectives.
Staff orientation also facilitates the integration of new staff with the already available to rapidly form effective teams that offer safe and quality care.
The hospital builds a comprehensive orientation program that is provided to all staff members regardless of their terms of employment
Staff orientation occurs on three levels: General orientation, department orientation and job-specific orientation
General orientation program addresses at least

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

Department orientation program addresses at least:

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

Job Specific orientation

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

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

Survey process guide:

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

Evidence of compliance:

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

Related standards:

WFM.03 Job description.

Effective training and education

WFM.08 A continuing education and training program is developed and implemented.

Effectiveness

Keywords:

Continuous Education Program.

Intent:

For any hospital to fulfill its mission, it has to ensure that its human resources have the capacity to deliver its services over time.

Continuous education and training programs help guarantee that, especially if designed to satisfy staff needs necessary to deliver the hospital mission.

The program is designed in a flexible manner that satisfies all staff categories based on a process of need assessment, tailored training plan, delivery, and reflection.

The program is designed based on services provided, new information, and evaluation of the staff needs.

Evidence-based medical and nursing practices and guidelines and other resources are accessible 24 hours to all staff.

The hospital ensures that education and training are provided and recorded according to the staff member's relevant job responsibilities needs, that may include the following:

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 provides 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 cultural beliefs, needs and activities of different groups served
l) Defined abuse and neglect criteria
m) Medical equipment and utility systems operations and maintenance

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the process of continuous education and training
- GAHAR surveyor may check a sample of staff files to check evidence of attendance of education and training program

Evidence of compliance:

1. There is a continuing education and training program for all staff categories that may include elements in the intent from a) through m).
2. Resources (human and non-human) are available to deliver the program.
3. The program is based on needs assessment of all staff.
4. Results of a performance review are integrated into program design.

Related standards:

WFM.04 Job description, WFM.13 Clinical privileges.

Equitable staff performance evaluation

WFM.09 Staff performance and competency are regularly evaluated.

Equity

Keywords:

Staff Performance Evaluation.

Intent:

Staff performance evaluation is an ongoing process that is also called performance appraisal or performance review which is a formal assessment for managers to evaluate an employee's work performance, identify strengths and weaknesses, offer feedback, and set goals for future performance

Performance evaluation effectively contributes to individual, team, hospital improvement when based on a defined transparent process with clear declared criteria relevant to the job functions.

Performance evaluation also promotes communication between employees and leaders, enabling them to make informed decisions about staff planning, selection, incentives, training and education, and career planning.

Performance appraisal offers the chance to give feedback to staff about what they do well or poor in a confidential respectful manner, thus promoting a learning culture within the hospital.

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

Recorded process of employees' performance evaluation including performance review methods, tools, evaluation dimensions, criteria, time interval, appeal process, and responsible person for each staff category,

Survey process guide:

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

Evidence of compliance:

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

Related standards:

WFM.04 Job description.

Efficient medical staff structure

WFM.10 An organized medical staff structure is developed to provide oversight on quality of care, treatment, and services.

Effectiveness

Keywords:
Medical Staff Structure.

Intent:
Medical staff are all physicians, dentists, and other professionals who are licensed to practice independently (without supervision) and who provide preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services to patients; or who provide interpretative services for patients, such as radiology, or laboratory services.
The term medical staff is thus inclusive of all physicians, and other professionals permitted to treat patients with partial or full independence, regardless of their relationship to the hospital
The hospital defines those other practitioners, such as house officers, and junior doctors, that are no longer in training, but may or may not be permitted by the hospital to practice independently.
Those medical staff have a diagram describing the line of authority within the hospital.

Survey process guide:
GAHAR surveyor may review a document describing medical staff structure; this document may be presented during the opening presentation, document review session or leadership interview session.

Evidence of compliance:
1. The hospital has a medical staff structure that is developed according to the hospital's mission, scope of services and recommendations of professional practices to meet patient needs.
2. Medical staff structure is approved by the governing body
3. Medical staff structure clearly defines lines of responsibilities during working hours and after hours

Related standards:
WFM.01 Workforce laws and regulations; WFM.02 Staffing plan.

Efficient medical workforce structure

WFM.11 Medical staff bylaws are developed.

Effectiveness

Keywords:
Medical Staff Bylaws.

Intent:
The medical staff bylaws are documents approved by the hospital governing body.
It is treated as a contract in some systems that establishes the requirements for the members of the medical staff to perform their duties and standards for the performance of those duties.
Medical Staff Bylaws may address the following points:

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

Survey process guide:
GAHAR surveyor may review a document describing medical staff bylaws. This document may be presented during the document review session or leadership interview session.

Evidence of compliance:

1. The governing body approves medical staff bylaws.
2. Medical staff bylaws are consistent with laws, regulations, and professional practices recommendations
3. The documents include elements in the intent from a) through j)

Related standards:
WFM.01 Workforce laws and regulations; WFM.07 Orientation program; WFM.08 Continuous education program; WFM.09 Staff performance evaluation.

WFM.12 Appointment of medical staff members is performed according to applicable laws and regulations and approved medical staff bylaws.

Safety

Keywords:
Medical Staff Appointment.

Intent:
The appointment is the process of reviewing an initial applicant's credentials to decide if the individual is qualified to provide patient care services that the hospital patients need, and the hospital can support with qualified staff and technical capabilities.
For initial applicants, the information reviewed is primarily from outside sources.
The hospital policy identifies the individuals or mechanisms accountable for this review, any criteria used to make decisions, and how decisions will be documented.
The policy identifies the process of appointment of independent practitioners for emergency needs or a temporary period

Survey process guide:
- GAHAR surveyor may check a sample of staff files to assess compliance to standard requirements
- GAHAR surveyor may interview staff members who are involved in appointment process to assess compliance to standard requirements

Evidence of compliance:
1. There is a uniform process for the initial appointment of medical staff members.
2. Medical staff appointments are made according to the hospital medical staff bylaws
3. Medical staff appointments are consistent with the hospital mission and services.
4. Medical staff appointments are according to laws and regulations.

Related standards:
WFM.01 Workforce laws and regulations, OGM.02 Mission statement.

WFM.13 Medical staff members have current and specific delineated clinical privileges approved by the medical staff committee

Safety

Keywords:
Clinical Privileges.

Intent:
The process whereby a specific scope and content of patient care services (that is clinical privileges) are authorized for a healthcare professional by a hospital, based on evaluation of the individual's credentials and performance. The determination of a medical staff member's current clinical competence and making a decision about what clinical services the medical staff member will be permitted to perform often called privileging is the most critical determination a hospital will make to protect the safety of patients and to advance the quality of its clinical services.
Decisions regarding a practitioner's clinical competence, and thus what clinical privileges he/she is to be granted, are based primarily on information and documentation received from outside the hospital
There is no one best way to delineate those clinical activities the new medical staff member is privileged to perform.
Specialty training programs may identify and list the general competencies of that specialty in areas of diagnosis and treatment with the hospital assigning privileges to diagnose and treat patients in those specialty competency areas.
The clinical privileges address the following:

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

Survey process guide:

- During the GAHAR survey, the surveyor may interview medical staff members and inquire about delineated privileges. Also, surveyor may visit hospital operative areas and check if delineated clinical privileges are known and used for booking
- GAHAR surveyor may check a sample of staff files to assess compliance to standard requirements
- GAHAR surveyor may interview staff members who are involved in privileging process to assess compliance to standard requirements

Evidence of compliance:

1. The hospital has an approved policy that addresses at least all elements from a) through f) in the intent
2. Medical staff members are aware of the process of clinical privileges delineation and what to do when they need to work outside their approved clinical privileges
3. Clinical privileges are delineated to medical staff members based on defined criteria
4. Clinical privileges are accessible to and used by staff involved in booking of surgery and invasive procedures
5. Physicians' and dentists' files contain personalized recorded clinical privileges, including renewal when applicable.
6. Physicians and dentists comply with their clinical privileges.

Related standards:

WFM.05 Verifying credentials; WFM.08 Continuous education program; WFM.09 Staff performance evaluation; WFM.11 Medical staff bylaws.

WFM.14 Performance of each medical staff member is reviewed and recorded at least annually

Efficiency

Keywords:

Medical Staff Performance Evaluation.

Intent:

Evaluation of healthcare professional performance over their professional career ensures quality and safe patient care.

Such evaluations are used at the time of for re- privileging. As it helps healthcare professionals develop their knowledge, skills, and attitudes (competencies) in a manner that fulfills their needs and ensures the sustainability of services offered by the hospital.

Evaluations determine continued competence to provide patient care services
The availability of agreed-upon criteria for performance evaluation ensures process uniformity and relevance of assessment towards the hospital mission and healthcare professional efficiency.

Performance evaluation criteria includes those related to patient's medical record recording and medication use. Such as:

a) Patient's medical record review for completeness and timeliness.
b) Utilization practice and medication use.
c) Compliance with approved clinical guideline
d) Complications, outcomes of care, mortality, and morbidity
e) Professional development

Survey process guide:

- During the GAHAR survey, the surveyor may interview medical staff members and inquire about performance evaluation
- GAHAR surveyor may check a sample of staff files to assess compliance to standard requirements

Evidence of compliance:

1. Performance evaluation records include at least all elements from a) through e) in the intent
2. Medical staff members are aware of performance evaluation criteria
3. Evidence of medical staff members' performance is assessed based on defined criteria, including patient's medical records completion and medication use.
4. Performance evaluation results are used to improve individual medical performance

Related standards:

OGM.02 Mission statement.

WFM.15 An ongoing peer review process is developed.

Effectiveness

Keywords:

Peer Review.

Intent:

Peer review an activity that involves case evaluation by an unbiased internal or external practitioner to measure, assess, and improve professional practice and the quality of patient care.

The results of peer review activities are used to identify opportunities that include, but are not limited to: improving patient care, improving clinical judgment and technical skill, providing information related to clinical competency determination for reappointment, and re-privileging, and as necessary, for implementing corrective action.

The hospital develops and implements a policy and procedures for peer review process that addresses at least the following:

a) Defined criteria for referring clinical cases for peer review
b) Defined criteria for referring clinical cases for external peer review
c) The data and information from peer review are used for competence assessment and considered at the time of re-appointment and re-privileging

Survey process guide:

- GAHAR surveyor may review a document describing the peer review process
- GAHAR surveyor may inquire about peer review process during leadership interview sessions or during hospital tracers

Evidence of compliance:

1. The hospital has an approved policy that addresses all elements from a) through c) in the intent
2. Medical staff members are aware of the peer review processes
3. Peer review processes are implemented
4. Results/reports of peer review are used for reappointment and re-privileging of relevant regulatory bodies

Related standards:

WFM.13 Clinical privileges.

Organized nursing structure

WFM.16 Legal requirements governing the professional regulation of nurses are followed.

Effectiveness

Keywords:

Nursing laws and regulations.

Intent:

The hospital needs to ensure that it has qualified nursing staff that appropriately matches its mission, resources, and patient needs. The nursing staff is responsible for providing direct patient care.

In addition, nursing care contributes to overall patient outcomes.
The hospital ensures that each nurse is qualified to provide safe and effective care and treatment to patients by understanding the applicable laws and regulations that apply to nurses and nursing practice.
The hospital ensures that legal requirements governing the professional regulation of nurses and other healthcare professionals are followed.

Survey process guide:
During the GAHAR survey, the surveyor may review the nursing legal framework documents, observe nursing practices to check compliance to laws and regulations

Evidence of compliance:
1. The hospital has a standardized procedure to gather and document the education, certifications, and experience of each nursing staff member.
2. Education, training, and certifications are verified.
3. Laws and regulations of nursing care are followed
4. When a violation to nursing care laws or regulations is identified, corrective actions are taken

Related standards:
WFM.01 Workforce laws and regulations; WFM.02 Staffing plan.

WFM.17 The hospital has a defined nursing structure that is led by a qualified nurse director.

Effectiveness

Keywords:
Nursing Structure.

Intent:
The nursing director has an influential role in the creation of a safe, healthy, productive working environment for nursing staff that promotes collaboration, productivity, and professional growth. Successful nursing directors have qualifications and expertise in management and leadership.
Standards of nursing practice provide and outline the expectations of the professional role for nurses, including scope and standards of practice and related competencies. They reflect a desired and achievable level of performance against which a nurse's actual performance can be compared. The main role of the nursing director is to direct and maintain the safe and effective nursing practice.

Nursing staff newly hired and freshly graduate practice must be under supervision after receiving all educational and training needs for the job.
The hospital clearly defines the nursing structure
The nurse director responsibilities are to include at least the following:

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

The hospital defines the trainee nurses and their role in the hospital during the training period. Also, supervisors of the trainee nurse's monitors and evaluate their performance during the training period
The hospital sets guidelines for nursing practices

Survey process guide:

- GAHAR surveyor may review a document describing nursing staff structure; this document may be presented during the opening presentation, document review session or leadership interview session.
- GAHAR surveyor may review staff file of nursing director
- During the GAHAR survey, the surveyor may interview nurse trainees/nurses and inquire about their performance and available scientific resources

Evidence of compliance:

1. There is a current, approved job description for the nursing director describing responsibilities as addressed in the intent
2. The nursing director file fulfills the licensure, qualification, and expertise as required by the job description.
3. The hospital defines trainee nurses and the duration of working under training
4. Trainee nurses' practice under supervision through their job description and their performance is monitored and evaluated.
5. Nursing standards of practice are adopted and educated
6. Nursing standards of practice are implemented

Related standards:

WFM.01 Workforce laws and regulations; WFM.02 Staffing plan; WFM.16 Nursing laws and regulations.

WFM.18 The hospital has a uniform process to identify job responsibilities and to make clinical work assignments based on other health care practitioners' credentials and any regulatory requirements.

Keywords:
other health care practitioners' job responsibilities.

Intent:
The hospital is responsible for identifying the types of activities or range of services these individuals will provide in the hospital. This can be accomplished through agreements, job assignments, job descriptions, or other methods In addition, the hospital defines the level of supervision (consistent with existing laws and regulations), if any, for these professionals

Survey process guide:
During the GAHAR survey, the surveyor may review the other health care practitioners framework documents, observe other healthcare professional practices to check compliance with the standard requirements and laws and regulations

Evidence of compliance:
1. Licensure, education, training, and experience of other health care practitioners are used to make clinical work assignments.
2. The process considers relevant laws and regulations
3. The process supports the staffing process for other health care practitioners. When a violation to nursing care laws or regulations is identified, corrective actions are taken.
4. Related standards:
5. WFM.01 Workforce laws and regulations; WFM.02 Staffing plan.

WFM.19 The hospital ensures safe and efficient working hours.

Safety

Keywords:
Working Hours

Intent:
Attention to the health and well-being of healthcare professionals become more important when we consider the fact that employees are the greatest cost in a hospital. Burnout is a combination of exhaustion, cynicism, and perceived inefficacy resulting

from long-term job stress.

The consequences of burnout are not limited to the personal well-being of healthcare professionals; many studies have demonstrated that healthcare professional burnout is detrimental to patient care.

For example, the number of major medical errors committed by a surgeon is correlated with the surgeon's degree of burnout and the likelihood of being involved in a malpractice suit.

Among nurses, higher levels of burnout are associated with higher rates of both patient mortality and the dissemination of healthcare- transmitted infections.

The hospital developed a policy and procedures to ensure management of staff working hours efficiently to avoid burnout that addresses at least the following:

a) Measures to avoid staff burnout
b) Planned rest times
c) Maternity protection and arrangements for breastfeeding

Survey process guide:

- GAHAR surveyor may review approved hospital policy
- GAHAR surveyor may pose questions about measures taken to ensure appropriate working hours during leadership interview session

Evidence of compliance:

1. The hospital has an approved policy to ensure safe and efficient working hours. The policy addresses a) to c) in the intent.
2. Staff are aware of the hospital's policy
3. The staff schedules ensure suitable working hours planned rest times, maternity protection, and arrangements for breastfeeding according to laws and regulations.
4. When working hours exceed the approved limits, measures are taken to ensure staff safety and satisfaction

Related standards:

OGM.18 Positive workplace culture; OGM.21 Staff health.

Information Management and Technology

Chapter intent

Information management is the process by which relevant information is provided to decision-makers in a timely manner. An effective information management system is a vital component of the healthcare service. Information management and technology in hospitals includes clinical, managerial information, and information required by external authorities and agencies. There are major risks associated with information management and technology in healthcare. One of these risks is the potential breach of patient confidentiality. Patient confidentiality means that personal and medical information given to a healthcare professional shall not be disclosed to others unless the patient has given specific permission for such release. Maintaining patient confidentiality is an ethical and legal concern, especially with the emerging technology of implementation of electronic information systems.

Another risk is associated with the use of abbreviations that may cause misunderstanding and affect patient safety. Implementation of do-not-use abbreviation list for medication shall be guided by reliable references, e.g., The Institute for Safe Medication Practices (ISMP) list and includes at least the following:

- U/IU - Q.D., QD, q. o. d., qod - MS, MSO4 - MgSO4 - No Trailing Zero - No leading Zero- Dose 'Frequency' Duration

Abbreviations also may cause harm regardless of the language used; organizations need to identify the approved reference in English or Arabic language

Globally, Information management and technology is emerging in healthcare. Artificial intelligence is on the surge where symptom checkers and clinical decision support systems becoming widely used. More hospitals are moving to be paperless, and special certifications are dedicated to encouraging that movement.

Locally, Egyptian laws and regulations have taken big steps recently to support electronic transactions. Electronic signature law was released. Electronic payment is approved. A new law on data privacy is expected.

Practically, Hospitals need to provide resources for the implementation of an information management system that ensures patient safety, continuity of care, security, and confidentiality of information.

During GAHAR Survey, surveyors shall be able to measure how organizations implement information management systems and technologies through reviewing documents pertinent to this chapter and doing patient tracers and interviews with staff. The leadership interview session may touch on this topic, as well.

Chapter purpose:

This chapter addresses the main concepts of information management in the hospital

- Effective Information Management Processes
- Maintaining Information Confidentiality and Security
- Availability of patient's medical record
- Effective information Technology in Healthcare

Standards included in this chapter applies for paper and electronic data and information

Implementation guiding documents:

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

1. Egyptian code of medical ethics 238/2003
2. Egyptian code of nursing ethics (Nursing Syndicate Publications)
3. MOHP - General Directorate of Technical Inspection. The administrative tool
4. Ministry of finance decree 270/2009: Governmental Archives list
5. Ministry of finance decree 18/2019: Non-Monetary Payment
6. MOHP Ministerial decree 254/2001 Discharge summary requirements
7. Ministry of communication and information technology decree 109/2005: Electronic signature.
8. Law 35/1960 National census and statistics
9. Law 2915/1964 Establishment of CAPMAS
10. Jeddah Declaration on Patient Safety 2019
11. HIPAA— Health Insurance Portability and Accountability Act Regulations1996.
12. The Institute for Safe Medication Practices (ISMP): List of Error-Prone Abbreviations, Symbols, and Dose Designations
13. Egyptian consent laws

Effective information management processes

IMT.01 Information management processes are implemented according to applicable laws and regulations.

Effectiveness

Keywords:
Information Management Processes.

Intent:
Egyptian laws and regulations address topics related to information management process include confidentiality and release of patient information, the retention period for documents, reporting of specific information to inspecting and regulatory agencies etc.
The hospital has to make the needed efforts and take steps to comply with relevant laws and regulations in the field of information management.

Survey process guide:
GAHAR surveyor may perform an interactive staff interview asking to demonstrate the process of information management compliance with requirements of law and regulations followed by review of related documents, which include response to required reports from inspecting and regulatory agencies.

Evidence of compliance:
1. The hospital leadership and responsible staff members of information management are aware of the requirements of law and regulations.
2. The hospital stores all its records and information according to law and regulations
3. The hospital responds timely to any required reports from inspecting and regulatory agencies
4. When gaps are identified, needed steps and interventions are taken to comply with law and regulations.

Related standards:
IMT.02 Information management plan.

IMT.02 Information management plan meets information needs.

Effectiveness

Keywords:
Information management plan.

Intent:

An information plan includes identification of the information needs of different departments and implementation of a process to meet those needs.

The information plan is aiming to provide accurate, meaningful, comprehensive, and timely information to assist in an information-based decision-making process.

The hospital developed an information management landscape in response to identified needs

Development of an effective information plan is based on:

a) The identified information needs of clinical and managerial hospital leaders.
b) The information needs and requirements of external authorities and agencies.
c) The size and type of services provided by the hospital.

Survey process guide:

GAHAR surveyor may perform a document review for the information management plan, followed by checking the implementation of the plan by interactive staff interview to demonstrate the process of information needs assessment and action taken to meet identified needs

Evidence of compliance:

1. The hospital leadership has performed information needs assessment
2. The hospital leadership has approved effective information plan that includes from a) through c) in the intent.
3. The hospital leadership ensures that actions are taken to meet identified information needs
4. The hospital leadership

Related standards:

IMT.01 Information management processes, OGM.07 Strategic planning; OGM.08 Operational planning.

Effective quality management system

IMT.03 Developing, approving, tracking, and revising quality management system documents for hospital's key functions are effective.

Effectiveness

Keywords:

Quality Management System Documents.

Intent:

Establishment of a uniform and consistent method for developing, approving, tracking, and revising quality management system documents (such as policies, plans, programs, procedures, and others) prevent duplication, discrepancies, omissions, misunderstandings, and misinterpretations.

The tracking system of issuing and changes allows staff to easily identify relevant policies and procedures and ensures that staff are informed about changed policies.

The hospital defines it's key functions that include but are not limited to

a) Emergency services
b) Assessment
c) Admission
d) Referral
e) Discharge
f) Procurement

The hospital develops a policy and procedures for document control system that addresses at least the following:

a) Standardized formatting
b) Document control system for tracking of issues and tracking of changes;
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 issue and/or reviewed the document and identification of changes of version.
d) Required policies are available and disseminated to relevant staff
e) Staff understand how to access those policies relevant to their responsibilities.
f) Retirement of documents
g) Policies revisions.

Survey process guide:

- GAHAR surveyor may perform a document review for the policy, followed by checking the implementation of the policy by review of the related documents which include the hospital policies and procedures (to ensure that they had standardized format, tracking system, identified approver, issuing and revision date at least every 3 years)
- GAHAR surveyor may interview staff to check staff awareness about the process of development, approving, tracking, and revising of policies, awareness about access to relevant policies, tracking changes in the policies and process for management of retirement of documents.

Evidence of compliance:

1. The hospital has an approved document that address at least elements from a) to g) in the intent at least for its key functions.
2. The hospital leadership, heads of services, and the relevant processes owners are aware of this policy.
3. Staff can access those policies relevant to their responsibilities.
4. Only the last updated versions of Policies are accessible and distributed between staff.
5. Policies are revised at least every three years.

Related standards:

IMT.02 Information management plan.

IMT.04 NSR.12 The hospital defines standardized diagnosis codes, procedure codes, definitions, symbols, and abbreviations.

Efficiency

Keywords:

Abbreviations

Intent:

Usually, the use of codes, symbols and abbreviations is done to squeeze a lot of writing into a small space

This may cause miscommunication between healthcare professionals and potential errors in patient care

The hospital developed a policy and procedures for approved and non-approved codes, symbols, and abbreviations according to the hospital scope of service and approved official language of communication inside the hospital that addresses at least the following:

a) Approved symbols/abbreviations list
b) Not-to- use symbols/abbreviations list.
c) Implementation of do-not-use abbreviation list for medication is guided by reliable references, e.g., The Institute for Safe Medication Practices (ISMP) list and includes at least the following:
   - U/IU
   - Q.D.,
   - QD,
   - q. o. d

- qod
- MS
- MSO4
- MgSO4
- No Trailing Zero
- No leading Zero

d) Non-English abbreviation and illegible handwriting
e) Situations where Symbols and abbreviations (even the approved list) must not be; such as informed consent and any record that patients and families receive from the hospital about the patient's care.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

MMS.11 Ordering, prescribing, transcribing, abbreviations, and symbols; APC.02 Monitoring safety requirements, ICD.17 Orders and requests.

Patient-centered confidentiality and security of information

IMT.05 Data and information are confidential.

Patient-centeredness

Keywords:

Confidentiality and Security of data and information.

Intent:

Information security is the protection of information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction.

Information security is achieved by ensuring the confidentiality, integrity, and availability of information.

Confidentiality means the property that health information is not made available or disclosed to unauthorized persons or processes.

Integrity means the property that health information has not been altered or destroyed in an unauthorized manner.

Availability means the property that health information is accessible and useable upon demand by an authorized person.

The hospital refines who is authorized to view and administer health information, or clarify and improve how and when health information is provided to patients or other healthcare entities.

The hospital develops and implements a policy and procedures to ensure information confidentiality and security that addresses at least the following:

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 follow if confidentiality or security of information has been breached

All staff must be committed to information confidentiality and security; by signing an agreement that they understand the details of the confidentiality policy and procedures and know their roles well.

Survey process guide:

- GAHAR surveyor may review the policy, followed by checking the implementation through reviewing of related documents such as list of the authorized individuals to have access to the patient medical record and signed confidentiality agreement in each staff member personal file.
- GAHAR surveyor may observe implementation of confidentiality measures including storage of patient's medical records in limited access place, each staff use of

passwords and staff has no access to the information not related to their job.
- GAHAR surveyor may interview staff to assess staff awareness of confidentiality measures

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through d)
2. All staff are aware of the policy requirements
3. There is a list of authorized individuals to have access to the patient's medical record.
4. Only authorized individuals have access to patient's medical records.
5. There is a signed confidentiality agreement in each staff member's personal file.
6. Procedures are followed if confidentiality or security of information has been breached.

Related standards:

PCC.04 Patient and Family Rights; ACT.08 Patient care responsibility.

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

Safety

Keywords:

Integrity of Data and Information.

Intent:

Data integrity is a critical aspect to the design, implementation and usage of any information system which stores, processes, or retrieves data as it reflects the maintenance of, and the assurance of the accuracy and consistency of data over its entire life cycle

Any unintended changes to data as the result of a storage, retrieval or processing operation, including malicious intent, unexpected hardware failure, and human error, is failure of data integrity.

Patient's medical record and information are protected at all times and in all places. Including protecting it from water, fire, or other damage, and unauthorized access.

keep security policies current, and decrease the likelihood and/or impact of electronic health information being accessed, used, disclosed, disrupted, modified, or destroyed in an unauthorized manner.

Medical records storage area must implement measures to ensure medical records

protection, e.g., controlled access and the suitable type of fire extinguishers

Survey process guide:

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

Evidence of compliance:

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

Related standards:

IMT.05 Confidentiality and security of data and information

IMT.07 Retention time of records, data, and information are performed according to applicable laws and regulations.

Timeliness

Keywords:

Retention of Data and Information.

Intent:

As medical records, data, and information have an important role in patient care, legal documentation, continuity of care, research, and education, the hospital has to retain it for a sufficient period of time.

The different data retention policies weigh legal and privacy concerns against economics and need-to-know concerns to determine the retention time, archival rules, data formats, and the permissible means of storage, access, and encryption.

The hospital develops and implements a policy and procedures on data and information retention that addresses at least the following:

a) Retention time for each type of documents.
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

Survey process guide:

- GAHAR surveyor may review retention time policy
- GAHAR surveyor may review list of retention time for different types of information
- GAHAR surveyor may interview staff asking to demonstrate the process of records retention and destruction and/or removal of records, data, and information
- GAHAR surveyor may observe record/logbook of documents destruction and/or removal

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through d)
2. All staff are aware of the policy requirements
3. The information confidentiality is maintained during the retention time
4. Data are archived as per policy
5. Destruction and/ or removal of records, data, and information are done as per law, regulation, policy, and procedure

Related standards:

IMT.05 Confidentiality and security of data and information, IMT.03 Quality management system documents.

Availability of patient-specific information

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

Effectiveness

Keywords:

Patient's Medical record Management.

Intent:

Without a unified structure of the patient's medical record, each healthcare professional will have his/her own solution, and the end result will be incompatibility of systems and the inability to share information.
Every patient evaluated or treated in the hospital has a medical record.
The file is assigned a number unique to the patient, used to link the patient with his or her health record.

A single file with a unique number enables the hospital to locate patient's medical record easily and document care of patient over time.
The patient's medical record must have uniform contents and order.
The main goal of developing a uniform structure of the patient's medical record is facilitating the accessibility of data and information to provide more effective and efficient patient care.
Patients' medical records are available to assist the healthcare professional in having quick access to patient information and to promote continuity of care and patient satisfaction.
The hospital developed a policy and procedures that addresses at least the following:

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

Survey process guide:

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

Evidence of compliance:

1. The hospital has an approved policy that includes all the points in the intent from a) through e)
2. All staff who are using patient's medical record are aware of the policy requirements
3. A patient's medical record is initiated with a unique identifier for every patient evaluated or treated.

4. The patient's medical record contents, format, and location of entries are standardized.
5. The patient's medical record is available when needed by a healthcare professional.

Related standards:
IMT.03 Quality management system documents; IMT.05 Confidentiality and security of data and information; IMT.06 Integrity of data and information; IMT.07 Retention of data and information.

Effective patient's medical record management

IMT.09 Patient's medical record is reviewed effectively.

Effectiveness

Keywords:
Medical Record Review.

Intent:
The Hospital ensure through the medical record review that they have accurate, current, clinically pertinent, complete, and readily available medical records as to ensure the continuous patient care process.
Medico-legal requirements and medical research recommend action when problems arise in relation to medical records and the medical filing service
The hospital developed a policy and procedures that assess the content and the completeness of patient's medical record that addresses at least the following:
a) Review of a representative sample of all services
b) Review of a representative sample of all disciplines/staff
c) Involvement of representatives of all disciplines who make entries
d) Review of the completeness and legibility of entries
e) Review occurs at least quarterly
f) Random sampling and selecting approximately 5% of patient's medical record

survey process guide:
- GAHAR surveyor may review of the policy of patient's medical record review
- GAHAR surveyor may interview staff to assess staff awareness about the process of reviewing patient's medical record
- GAHAR surveyor may check results of review process and actions taken to improve performance

Evidence of compliance:
1. The hospital has an approved policy that includes all the points in the intent from

a) through f)

2. All staff who are using patient's medical record are aware of the policy requirements
3. Review results are reported to the hospital leaders
4. Corrective interventions are taken when needed

Related standards:

IMT.03 Quality management system documents; IMT.04 Use of codes, symbols, and abbreviations; IMT.05 Confidentiality and security of data and information; IMT.06 Integrity of data and information.

Effective information technology in healthcare

IMT.10 Health information technology systems are assessed, tested prior to implementation are evaluated for quality and patient safety.

Efficiency

Keywords:

Health information technology evaluation.

Intent:

Implementation of health information technology systems can facilitate work flow, improve the quality of patient care, and patient safety.

The selection and implementation of health information technology systems require coordination between all involved stockholders to ensure proper integration with all interacting processes.

Following implementation, evaluation of the usability and effectiveness of the system must be done continuously.

Survey process guide:

GAHAR surveyor may perform an interactive staff interview asking to demonstrate the process of selection, implementation, and evaluation of information technology, followed by checking the implementation of the process by review of the related documents, which include result of system evaluation.

Evidence of compliance:

1. Health information technology stakeholders participate in the selection, implementation, and evaluation of information technology.
2. Health information technology systems are assessed and tested prior to implementation.
3. Health information technology systems are evaluated following implementation for

usability, effectiveness, and patient safety.
4. When patient safety issues are identified, actions are taken to maintain safety

Related standards:
APC.02 Monitoring safety requirements; PCC.02 Interdisciplinary patient-centeredness.

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

Efficiency

Keywords:
Downtime of Data Systems.

Intent:
Downtime event is any event where a Health information technology system is unavailable or fails to perform as designed.
The downtime may be scheduled (planned) for purposes of maintenance or upgrading the system or unplanned due to unexpected failure.
These events may significantly threaten the safety of the care delivery and interruption of organization operations in addition to the risk of data loss.
The hospital develops and implements a program to ensure continuity of safe patient care processes during planned and unplanned downtime include the alternative paper forms and other resources required.
The program includes the downtime recovery process to ensure data integrity.
All staff receives training about the transition into a downtime environment to respond to immediate patient care needs.

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

Evidence of compliance:
1. There is a program for response to planned and unplanned downtime.
2. The program includes downtime recovery process.

3. The staff is trained in response to the downtime program.
4. The hospital tests the program at least annually to ensure its effectiveness.

Related standards:
IMT.01 Information management processes, IMT.02 Information management plan, IMT.10 Health information technology evaluation.

IMT.12 Data backup process is defined.

Safety

Keywords:
Data Back-up.

Intent:
Data backup is a copy of data that is stored in a separate location from the original, which may be used to restore the original after a data loss event, so having a backup is essential for data protection.
Backups must occur regularly to prevent data loss, and backup data may be stored inside or outside the hospital. In both cases, the hospital ensures that backup information is secure and accessible only by those authorized to use it to restore lost data.

Survey process guide:
GAHAR surveyor may review the process by asking stakeholders, and checking the implementation of the data backup process

Evidence of compliance:
1. There is a process for data backup include the type of data, frequency of backup, and location.
2. Backups is performed on a scheduled basis to meet user requirements
3. Backup schedules are developed for all new systems and the restore is tested.
4. Backup data is secured during extraction, transfer, storage, and retrieval.
5. Backup log is reviewed frequently to identify exceptions / failures.

Related standards:
IMT.01 Information management processes; IMT.02 Information management plan; IMT.10 Health information technology evaluation.

Quality and Performance Improvement

Chapter intent:

It is essential for organizations to have a framework to support continuous improvement and risk management activities. This requires leadership support, established processes, active participation from all heads of departments and staff. Performance improvement and risk management are parts of both strategic and departmental operational plans.

Globally, Hospitals have adopted, adapted, and even created improvement tools to help to enhance the services provided to patients. Florence Nightingale, a nurse, was one of the pioneers in improving healthcare quality. Dr. Avedis Donabedian was a founder of the study of the quality of healthcare and medical outcome research. Multiple quality improvement methodologies were used in hospitals such as PDCA, FOCUS PDCA, Six Sigma, Lean Methodology, and others.

Locally, The Egyptian Ministry of planning adopted the EFQM award for excellence in promoting quality practices among governmental entities. Some Egyptian hospitals have participated in international conferences with Six Sigma and FOCUS PDCA projects. In 2013, the Health Insurance Organization issued what was known as Hospital Performance Indicators Guide.

Practically, Hospitals need to cherish the culture of continuous improvement. GAHAR standards do not mandate a specific improvement tool nor specific monitoring performance measures, yet, a minimum number of monitoring indicators are required. Among many improvement opportunities, GAHAR standards highlighted the importance of improving patient journey and supply chain. It is important that each one in the hospital understand his/her role in improving healthcare quality and safety by focusing on the leadership support, department-level input and participation, measures and data collection, and sustaining improvement. The application of the standards must be according to applicable Egyptian laws and regulations.

During the GAHAR survey, surveyors are going to meet the leadership, heads of departments, and staff to discuss the QPI aspects, initiatives, and projects. Surveyors may perform tracers to check data selection, collection, analysis of data, and methods that used to follow the improvement projects and impact of projects on improving the quality dimensions.

Chapter purpose:

The main objective is to ensure that the hospital provides effective performance improvement program; The chapter discusses the following objectives:

- Effective leadership support
- Effective departmental participation
- Effective performance measurement and data management
- Effective improvement sustainability

Implementation guiding documents:

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

1. MOHP Quality and Safety Guide, 2019
2. Hospital Performance Indicators Guide by HIO, 2013
3. National EFQM based excellence award www.Egea.gov.eg
4. Law 35/1960 National census and statistics
5. Law 2915/1964 Establishment of CAPMAS

Effective leadership support

QPI.01 Quality management program is governed by an interdisciplinary performance improvement, patient safety and risk management committee(s).

Efficiency

Keywords:

Quality Committee (s).

Intent:

Performance improvement, patient safety and risk management committee 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 at improving performance, governance and hospital effectiveness and ensuring that the plan will be directed and managed daily.

The hospital establishes a multidisciplinary committee for performance improvement, patient safety, and risk management, with a membership of top leaders as committee chairperson.

The committee shapes the quality culture of the facility through terms of references that includes at least

a) Ensuring that all designated care areas participate,
b) Establishing organization wide priorities for improvement
c) Ensuring that all required measurements are monitored including the frequency of data collection
d) Reviewing the analysis of aggregate data
e) Taking action in response to identified performance improvement or patient safety issues
f) Reporting information to governing body, hospital leaders and to appropriate staff members about the performance data and the quality improvement activities
g) Evaluating the performance of the committee in an annual base

Periodical meeting helps to provide the required information and feedback about plans and activities. It also helps to improve collaboration, to provide an opportunity to evolve as a team, and to comply with laws and regulation requirement.

Survey process guide:

- GAHAR surveyor may perform an interactive session with hospital leaders and members of the committee(s) to identify leadership's approach for improving the quality of care and continuous improvement,

- The discussion may cover the role of the committee and responsibility of its members, measures selection, reporting and review the minutes of meeting and recommendations of action plans for the selected improvement projects and its effect on the level of quality and safety in the hospital.

Evidence of compliance:

1. There is a multidisciplinary performance improvement, patient safety, and risk management committee in comply with relevant law and regulations including items from (a) to (g) in the intent.
2. There is official assignment document for designated committee chairperson who leads and actively participates in the committee meetings
3. The committee meets at predefined intervals and record the agenda discussion and its recommendations
4. The committee evaluates its performance on an annual basis

Related standards:

OGM.06 Committee structure; PCC.02 Interdisciplinary patient-centeredness; IPC.03 IPC committee meetings.

QPI.02 There is a hospital-wide performance improvement, and patient safety plan.

Effectiveness

Keywords:

Quality Plan.

Intent:

Performance improvement is an ongoing process that helps the hospital continually find new and better ways of doing things so that can enhance care for patients, increase satisfaction and achieve even better clinical outcomes.

The performance improvement and patient safety plan helps the hospital to document and review the current performance in a variety of areas.

With this plan, the hospital will be able to clearly see the targeted areas for improvement and chart the progress.

Leadership and planning are essential for development, implementation, and monitoring. Leadership and planning begin with the governing body, along with the department leaders.

The hospital leaders, including the hospital director, are responsible for establishing

and providing ongoing support for a hospital commitment to quality
leaders are to select the approach to be used by the hospital to measure, assess, and improve quality, patient safety and risk management. Leaders also determine how the plan will be directed and managed daily, how the committee will achieve collaboration, and how the program will have adequate resources. The plan is updated annually and approved by the governing body.
Leaders developed the performance improvement, patient safety and risk management plan, that address at least the following:

a) The goal(s) (clinical and operational goals) that fulfil the hospital mission.
b) Organization structure and improvement reporting channels.
c) Roles and responsibilities of leaders
d) Define Hospital Priorities
e) Performance measures road map selection
f) Data collection, data analysis tools and validation process.
g) Defined criteria for prioritization and selection of performance improvement projects
h) Quality Improvement model(s) used.
i) Information flow and reporting frequency
j) Training on quality improvement and risk management approaches.
k) Regular evaluation of the plan (at least annually).

Survey process guide:

- GAHAR surveyor may perform a document review for the hospital plan, then followed by an interactive session with hospital leaders to identify leadership's approach for improving the quality of care and continuous improvement,
- The discussion may cover plan contents, monitoring the priority focus areas, staff training related to quality concept and data management, in addition to the plans' implementation in different leadership clinical and non-clinical areas

Evidence of compliance:

1. There is a current and approved performance improvement, patient safety and risk management plan that defines at least items from a) through k) in the intent
2. Hospital director and leaders actively participate in the planning, supporting, and monitoring of the performance improvement, patient safety and risk management.
3. The plan was implemented hospital wide, according to the timetable and plan of improvement.
4. The plan is evaluated and updated annually.
5. The plan is communicated to the relevant stakeholders

Related standards:
OGM.02 Mission statement; OGM.03 Governing body responsibility; OGM.05 hospital director; OGM.07 Strategic planning; OGM.08 Operational planning; OGM.09 Hospital leaders; OGM.10 Departmental management.

QPI.03 A qualified staff member is assigned as performance improvement coordinator/manager.

Effectiveness

Keywords:
Quality management Team.

Intent:
Because errors are caused by system or process failures, it is important to adopt various process-improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems and that required a qualified individual with a clear job description to follow up the plan and put it into operation by utilizing the knowledge , skills and experience in different improvement technique, data management, project selection and sustaining improvement.
The qualified team is to be certified in healthcare quality and risk management and have an experience to support the training and facilitate the program organization wide.

Survey process guide:
GAHAR surveyor may perform a record review in a staff qualification session include the qualification and job description

Evidence of compliance:
1. An individual with knowledge, skills and experienced in performance improvement techniques and risk management related activities.
2. There is a clear job description that support the work of performance improvement team to train, facilitate and coordinate the program activities.
3. Quality management team receives required support in terms of space, equipment, resources, and staffing.

Related standards:
WFM.02 Staffing plan; WFM.04 Job description.

Efficient department level input and participation

QPI.04 The hospital staff including medical staff members, nurses and others participate in performance improvement activities.

Efficiency

Keywords:
Staff Participation in Quality Management Activities.

Intent:
Engaging physicians, nurses, and other staff in the work of performance improvement and risk management is essential to achieving excellence in clinical care and to bring it to the bedside.
The hospital promotes active involvement of staff and prepare them to be competent and confident, they will be stakeholders in performance improvement initiatives and build a team work environment.

Survey process guide:
GAHAR surveyor may perform a document review of performance Improvement, patient safety and risk management committee(s) term of reference that may cover the members, their role in the committee and participation, followed by an interactive session about the training they received that support them to carry on the responsibility of continuous improvement

Evidence of compliance:
1. The hospital encourages staff members to perform performance improvement activities
2. The hospital provides training to educate staff of quality management concepts to be actively participants in performance improvement program' activities.
3. The participating staff member(s) from physicians, nurses and other staff have appropriate knowledge and skills for data review, aggregation, and analysis.
4. The hospital includes performance improvement activities in individual performance evaluation

Related standards:
PCC.02 Interdisciplinary patient-centeredness.

Efficient data management

QPI.05 Performance measures are identified, defined, and monitored for all significant processes.

Effectiveness

Keywords:
Performance Measures.

Intent:
Performance measurement seeks to monitor, evaluate, and communicate the extent to which various aspects of the health system meet their key objectives.
Performance measure is a quantitative variable that either directly measures or may indirectly reflect the quality of care provided and has to be aligned with accountability by enabling stakeholders to make informed decisions by collecting the data and able to interpret it.
Each performance measure must be Specific, Measurable, Achievable, Relevant, and Time-bounded (SMART). To define a measure properly, a description of at least the following is needed:

a) Definition
b) Defined data source
c) Specified frequency
d) Sampling techniques
e) Formula
f) Methodology of data collection and analysis
g) Bench mark the results

Collection of data will create a database that is be aggregated and trended over time and used for comparison over time within the hospital and for comparisons with other organization.

Survey process guide:

- GAHAR surveyor may perform a document review of performance improvement and patient safety plan, followed by an interactive session discussion with the key responsible staff for the plan implementation.
- The discussion may cover the process for data collection and monitoring in order to assess aspects of the structure, process, or outcome of health care, benchmark used in the hospital, reports and actions taken for improvement.

Evidence of compliance:

1. There is an approved documented work sheet (Data analysis report) for each selected performance measure, standardized template is preferred, that include all elements mentioned in the intent from a) through g)
2. The work sheets (Data analysis report) clarify the definition, defined data source, specified frequency, sampling techniques, used formulae and methodology of data collection and analysis for each performance measure.
3. Those responsible for the collection, interpretation and/or use of performance measurement are aware of its definition and specified frequency, sampling technique, used formulae and methodology of data collection, and analysis.
4. The hospital makes its performance results/data publicly available at least quarterly
5. The results are used in benchmark internally, externally and with best practice
6. Results of measures analysis are reported to those accountable for improvement and taking action.

Related standards:

QPI.02 Quality plan; QPI.06 Clinical performance measures, QPI.07 Managerial performance measures.

QPI.06 Clinical Care Performance Measures are used to identify opportunities for improvement and track progress toward hospital 'objectives.

Effectiveness

Keywords:

Clinical Performance Measures.

Intent:

Performance measures are values which demonstrate a hospital's performance, strengths, and opportunities for improvement. Effective design and clarity of scope are crucial fundamentals in establishing and maintaining value added business indicators.

The hospital selects a mixture of measures that focus on activities that might be risky in nature to patients or staff, occurring in high volume, associated with problems or high cost. includes appropriate and relevant indicators in the following areas:

a) Waiting times in the relevant service areas
b) Patient assessment is complete, accurate and within approved time frames
c) Health education
d) Proper nutrition
e) Screening and detection of diseases

f) Communicable and non-communicable diseases
g) Immunization
h) Invasive procedures and use of sedation
i) Use of medications
j) Patient's medical record, including availability and content
k) Infection control, surveillance, and reporting.
l) Medication errors, near-miss and adverse outcomes
m) Patient safety requirements
n) Clinical effectiveness

Once data has been collected for a meaningful amount of time, process improvements can begin to be evaluated.

The amount of data that needs to be evaluated for a performance measure will obviously vary based on how often the data is reported and the frequency with which the subject of the measure occurs.

The hospital uses different charts to track the improvement progress and decides the next step in the improvement plan.

Survey process guide:

- GAHAR surveyor may interview some staff members and ask them about clinical performance measurement in their departments/services.
- Also, surveyor may perform a document review for the selected clinical measures, and assist the criteria of selection, prioritization, followed by an interactive session to assist the implementation of the measures and staff awareness about the improvement

Evidence of compliance:

1. For each relevant standard care areas, the hospital selected appropriate performance measures according to its scope of services, requirements in the intent, governing laws and regulations, and Egypt's 2030 Vision.
2. The relevant clinical care areas for each standard is monitored frequently
3. Performance measures are calculated and displayed in a table, curve, or a graph
4. Performance measures are used by hospital leaders to take decisions

Related standards:

QPI.02 Quality plan; QPI.07 Managerial performance measures

QPI.07 Managerial Performance Measures are used to identify opportunities for improvement and track progress toward hospital 'objectives.

Effectiveness

Keywords:

Managerial Performance Measures.

Intent:

Performance measures are values, which demonstrate a hospital's performance, strengths, and opportunities for improvement. Effective design and clarity of scope are crucial fundamentals in establishing and maintaining value added business indicators.

The hospital selects a mixture of measures that focus on activities that might be risky in nature to patients or staff, occurring in high volume, associated with problems or high cost.

Measures include appropriate and relevant indicators for at least the following:

a) Community needs assessment
b) Community involvement
c) Compliance with law and regulations
d) Patient and family expectations and satisfaction
e) Patient complaints and suggestions
f) Staff expectations and satisfaction
g) Staff complaints and suggestions
h) Patient demographics, diagnoses and procedures
i) Procurement of routinely required supplies and medications
j) Financial management
k) Risk management
l) Staff and professional performance
m) Utilization management

Once data has been collected for a meaningful amount of time, process improvements can begin to be evaluated.

The amount of data that needs to be evaluated for a performance measure will obviously vary based on how often the data is reported and the frequency with which the subject of the measure occurs.

The hospital uses different charts to track the improvement progress and decides the next step in the improvement plan.

Survey process guide:

- GAHAR surveyor may interview some staff members and ask them about managerial

performance measurement in their departments/services.

- Also, surveyor may perform a document review for the selected clinical measures, and assist the criteria of selection, prioritization, followed by an interactive session to assist the implementation of the measures and staff awareness about the improvement

Evidence of compliance:

1. For each relevant standard care areas, the hospital selected appropriate performance measures according to its scope of services, intent requirements, governing laws and regulations, and Egypt's 2030 Vision.
2. The relevant managerial areas for each standard are monitored frequently
3. Performance measures will be calculated and displayed in a table, curve, or a graph
4. Performance measures are used by hospital leaders to take decisions

Related standards:

QPI.02 Quality plan; QPI.06 Clinical performance measures

QPI.08 A staff member(s) with appropriate experience, knowledge, and skills is assigned for data review, aggregation, and analysis within approved time frame.

Effectiveness

Keywords:

Data review, aggregation and analysis.

Intent:

A qualified staff having the appropriate knowledge and skills must be assigned to do data management related to performance improvement and improvement projects. The required knowledge is covered revision of data, aggregation, analysis, trending, properly displayed and transformed into useful information to reach conclusions and to make decisions, Hospital leaders are expected to understand data trends and charts to make decision based on the provided information.

Survey process guide:

The GAHAR surveyor may perform an interactive quality management program review session to review data management skills that were used in the selected clinical and managerial measures, or in the improvement projects

Evidence of compliance:

1. There is a written process of data management includes the aggregation and analysis.

2. Responsible staff members for data aggregation and analysis are aware of their roles.
3. Data is aggregated and trended over-time
4. Descriptive analysis is done.

Related standards:

QPI.02 Quality plan, IMT.10 Health information technology evaluation; IMT.12 Data back-up.

QPI.09 Data validation is performed according to defined criteria

Effectiveness

Keywords:

Data Validation

Intent:

Data validation means checking the accuracy and quality of data source before using the data, as it is vital to ensure that data is clean, correct, and useful.

The hospital uses these elements of data quality for data review and validation:

a) Validity: data measure what it is supposed to measure.
b) Reliability: everyone defines, measures, and collects data uniformly.
c) Completeness: data include all the values needed to calculate performance measure
d) Precision: data have sufficient detail.
e) Timeliness: data are up to date. Information is available on time.
f) Integrity: data are true.

Survey process guide:

- GAHAR surveyor may perform an interactive quality management program review session to assure the data validation is performed, followed by an interactive discussion to make sure the only useful data is used
- Discussion may address situations and mechanisms used for data validation performance through selected examples done in the hospital

Evidence of compliance:

1. There is a written process for data review and validation
2. Responsible staff for data review is aware of their roles.
3. Data review techniques are implemented to ensure all the elements from a) to f) in the intent are considered.

4. Data validation is done when data is going to be published, sent to external bodies, a change in the tool, person or process used for measurement

Related standards:
QPI.02 Quality plan; IMT.10 Health information technology evaluation; IMT.12 Data back-up; QPI.08 Data review, aggregation, and analysis.

Efficient risk management program

QPI.10 A risk management plan/program is developed

Safety

Keywords:
Risk Management Program.

Intent:
Risk management is designed to identify potential events that may affect the hospital and to protect and minimize risks to the hospital property, services, and employees.
Organization needs to adopt a proactive approach for risk management such as risk analysis where the hospital assesses the high-risk processes, including developing risk mitigation strategies.
Hospital are to take reactive and proactive measures to address identified risks
Risk management plan/program contains essential components that includes at least the following:

a) Scope, objective, and criteria for assessing risks
b) Risk management responsibilities and functions
c) Staff training on risk management concepts and tools
d) Risk identification
e) Risk prioritization and categorization (i.e. strategic, operational, reputational, financial, other)
f) Risk reporting and communication with stakeholders
g) Risk Reduction plans and tools with priority given to high risks

Failure Mode Effect Analysis (FMEA) is one of analysis tool that can be used in the hospital as a proactive approach.

Survey process guide:
GAHAR surveyor may perform an interactive quality management program review session to check the risk management plan/program by reviewing the risk assessment

steps and how the hospital identifies clinical and managerial risks, followed by an interactive session to evaluate the implementation of risk control measures.

Evidence of Compliance:

1. The hospital has a risk management plan/ program that includes all the elements from a) to g) in the intent
2. A plan, policies, procedures, a risk register and processes support hospital risk management framework.
3. High risk processes are re- designed based on the result of the analysis.
4. The hospital has an approved proactive risk reduction tool for at least one high risk process annually.

Related standards:

QPI.02 Quality plan; QPI.11 Incident reporting system.

QPI.11 An incident-reporting system is developed.

Safety

Keywords:

Incident Reporting System.

Intent:

Strong risk management is supported by efficient incident reporting systems that defined by the system can identify an incident that could be any event that affects patient or employee safety.

In most hospital injuries, patient complaints, medication errors, equipment failure, adverse reactions to drugs or treatments, or errors in patient care are to be included and reported.

The incidents reporting has an important influence on improving patient safety.

They can provide valuable insights into how and why patients can be harmed at the hospital level.

Incident reports help to detect, monitor, assess, mitigate, and prevent risks that 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) Incidents requiring immediate notification to the management
d) Incident classification, analysis, and results reporting
e) Indication for performing intensive analysis and its process

Survey process guide:

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

Evidence of compliance:

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

Related standards:

QPI.10 Risk management program; QPI.12 Significant events; QPI.13 Sentinel event.

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

Safety

Keywords:

Significant Events.

Intent:

Certain events require intensive analysis for identification of root causes using quality tools.

Significant unexpected/near misses events can happen even in the hospital, such as:

a) Confirmed transfusion reactions
b) Significant anesthesia and sedation events that cause harm or have the potential to cause harm to a patient
c) Significant differences between pre- and post-operative diagnoses, including surgical pathology findings
d) Significant adverse drug reactions that cause harm or have the potential to cause harm to a patient
e) Significant medication errors that cause harm or have the potential to cause harm to a patient

f) Pulmonary Embolism or Deep Venous Thrombosis developed due to missing appropriate thromboprophylaxis treatment and improper VTE assessment risk
g) Patient escape or attempted escape

Such events need for immediate investigation and response.

The hospital has to perform a root cause analysis to identify actions that be taken to improve processes of care and prevent event reoccurring.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

QPI.10 Risk management program; QPI.11 Incident reporting system; QPI.13 Sentinel event.

QPI.13 The hospital defines investigates, analyzes and reports sentinel events, and takes corrective actions to prevent harm and recurrence.

Safety

Keywords:

Sentinel events.

Intent:

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

a) Definition of sentinel events such as:
   i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient' illness or underlying condition
   ii. Wrong patient, wrong site, wrong procedure events
   iii. Patient suicide, attempted suicide or violence leading to death or permanent loss of function
   iv. Unintended retention of a foreign object events in a patient after surgery or invasive procedure
   v. Wrong delivery of radiotherapy
   vi. Any peri-partum maternal death
   vii. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
b) Internal reporting of sentinel events.
c) External reporting of sentinel events.
d) Team member's involvement.
e) Root cause analysis.
f) Corrective actions plans taken.

All sentinel events are communicated to GAHAR within seven days of the event or becoming aware of the event. All events that meet the definition must have a root cause analysis in order to have a clear understanding of contributing factors behind the system gaps. The analysis and action must be completed within 45 days of the event or becoming aware of the event.

Survey process guide:

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

Evidence of compliance:

1. The hospital has a sentinel events management policy covering the intent from a) through f) and leaders are aware of the policy requirements.
2. All sentinel events are analyzed and communicated by a root cause analysis in a time period specified by leadership that does not exceed 45 days from the date of the event or when made aware of the event.
3. All sentinel events are communicated to GAHAR within seven days of the event or

becoming aware of the event.
4. The root cause analysis identifies the main reason(s) behind the event and the leaders take corrective action plans to prevent recurrence in the future.

Related standards:
QPI.10 Risk management program; QPI.08 Data review, aggregation, and analysis.

Sustaining improvement

QPI.14 Appropriate and sustained improvement activities are performed within approved time frame.

Efficiency

Keywords:
Sustaining Improvement.

Intent:
Although staff play a vital part in the continuous improvement process, it is management's role to train, empower and encourage the staff to participate with ideas.
An effective continuous improvement program needs continuous measurement and feedback.
Before start, hospital baseline performance needs to be measured, as new ideas for improving performance can then follow.
Plan-Do-Check-Check (PDCA) cycle, Focus PDCA or other improvement tools allows to scientifically testing improvement progress.
The cycle ensures continuous improvement by measuring the performance difference between the baseline and target condition.
This information gives immediate feedback on the effectiveness of the change that can helps in measuring the impacts of continuous improvement program and that is the most effective way of sustaining it.

Survey process guide:
- GAHAR surveyor may perform a review of an improvement project, to learn how the hospital utilize data to identify potential improvements and to evaluate actions' impact,
- GAHAR surveyor may review the hospital monitoring and control mechanisms to sustain achieved improvements

Evidence of compliance:
1. There is a written process or methodology for improvement.

2. Actions to correct problems were taken timely and appropriately.
3. Improvement activities were tested and the results were recorded and implemented.
4. There is evidence that patient safety processes were improved and controlled

Related standards:

QPI.02 Quality plan; OGM.02 Mission statement, OGM.09 Hospital leaders.

SECTION 4

ADDITIONAL REQUIREMENTS

Section 4: Additional Requirements

Additional Standards for Organizations with Academic, Research or Organ/Tissue Transplantation Services

Implementation guiding documents:

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

1. Research: MOHP- Research ethics committee guidelines,2013
2. WHO Standards and Operational Guidance for Ethics Review of Health-Related Research with Human Participants
3. Regulation 1002/1975 on teaching institutes
4. Law 5/2010 Egyptian Law for an organ transplant
5. Law 310/2009 on Eye banks
6. Cairo Declaration on Human Rights in Islam, 1990
7. https://www.who.int/transplantation/donation/taskforce-transplantation/en/

Patient safety focused clinical education

ADD.01 An educational governance structure is established to improve quality and outcome of education.

Effectiveness

Keywords:
Educational Governance.

Intent:
It is in the public and patients' interests that a hospital builds an effective, robust, transparent, and fair oversight of education and training.
The clinical learning environment is multidisciplinary, so an effective learning culture will value and support trainees and students from all professional groups.
Students and trainees will have a good educational experience and education providers will be valued where there is a hospital commitment to, and support for, learning.
The hospital shall assign the responsibility of overseeing medical education activities to a committee, a taskforce, or a staff member to build effective systems of educational governance and leadership to manage and control the quality of medical education and training.
These responsibilities shall include continuous improvement of the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met

Survey process guide:
GAHAR surveyor may perform an interactive medical education program review session to assess medical education program structure and enrollment steps.

Evidence of compliance:
1. The hospital clearly assigns the responsibility of medical education supervision
2. Staff members' qualification and number matches hospital needs for clinical supervision, working patterns and workload including planning of services of clinical care
3. The hospital has an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed.
4. Students and other learners are not expected to work beyond their competence.
5. Hospital ensures that students and other learners have an induction in preparation for each placement that clearly sets out their duties, supervision requirements, scientific resources, and support

Related standards:
WFM.07 Orientation program; WFM.08 Continuous education program.

ADD.02 Medical students, house officers, residents and trainees are allowed to raise concerns about patient safety, and the standard of care or of education and training.

Safety

Keywords:
Safe Clinical Education Culture.

Intent:
Environment and culture for education and training affects students and trainees' needs
Sharing Information across educational and clinical governance systems helps to identify risk to patient safety and the quality of education and training, and to ensure transparency and accountability
The hospital shall ensure safe, open culture, and provides a good standard of care and experience for patients;
Education and training should be a valued part of the hospital culture.
The learning environment shall be safe for patients and supportive for students and other learners.
The culture is caring, compassionate and provides a good standard of care and experience for patients and their families.
The learning environment and hospital culture value and support education and training so that students and other learners are able to demonstrate what is expected as good medical practice and to achieve the learning outcomes required by their curriculum.

Survey process guide:
- GAHAR surveyor may assess safety culture during leadership interview session followed by asking students, house officers, residents or trainees during hospital tours and tracers
- GAHAR surveyor may perform a tour to assess hospital educational resources such as education facilities, class rooms, used technologies and solutions

Evidence of compliance:
1. The educational and clinical governance systems are integrated, allowing students and other learners to address concerns about patient safety, the standard of care, and the standard of education and training.

2. The hospital has the capacity, resources, and facilities to deliver safe and relevant clinical learning opportunities, clinical supervision and practical experiences for students and learners.
3. The hospital investigates and takes action to address concerns and correct them.
4. The hospital seeks and responds to feedback from students, house officers, residents, and trainees on compliance with standards of patient safety and care, and on education and training

Related standards:
OGM.16 Safety culture; APC.02 Monitoring safety requirements.

Equitable and efficient medical education

ADD.03 Placement, planning, education, training, and appraisal of medical students are performed according to laws and regulations.

Safety

Keywords:
Medical Education for Undergraduates.

Intent:
Patient safety is at the core of this standard. Culture of patient safety promotion during early medical education stages is essential for building patient-safety oriented healthcare professionals
This requires providing support and resources to educators to deliver effective education and training.
Medical school activities should give medical students also learning opportunities that integrate basic and clinical science, Patient safety is a key component in the medical education process enabling them to link theory and practice and to develop generic professional capabilities
Medical educators should be managed and supported

Survey process guide:
GAHAR surveyor may perform an interactive medical education program review session to assess medical school curricula development process followed by asking students and educators during hospital tours and tracers

Evidence of compliance:
1. Learning outcomes are defined for each level of training/education
2. Medical school curricula and assessments are developed and implemented to

achieve the required learning outcomes
3. Medical school curriculum includes patient safety related topics
4. Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.
5. Educators receive the support, resources, and time to meet their education and training responsibilities.

Related standards:
OGM.16 Safety culture.

ADD.04 Activities of house officers and residents are arranged.

Effectiveness

Keywords:
Activities of house officers and residents.

Intent:
While learning process depends on learners' abilities and dedication, Support is needed from hospitals to ensure that house officers and residents are able to demonstrate what is expected in good medical practice and to achieve the learning outcomes required by their curriculum.
The hospital should build an education program for house officers and residents. This program should cover at least the following:
a) Establishing scope of house officer and resident assessment and treatment of patients
b) Providing educational support
c) Designing Postgraduate curricula and assessments
d) Providing education on hospital policies, procedures, plans and other systems
e) Protected time for learning while house officers and residents are doing clinical or medical work, or during academic training, and for attending organized educational sessions, training days, courses, and other learning opportunities

Survey process guide:
GAHAR surveyor may perform an interactive medical education program review session to assess postgraduate curricula development process, education process and scope of work for house officers and residents followed by interviewing these learners and their supervisors during hospital tours and tracers

Evidence of compliance:

1. The hospital has an approved program that includes all the points in the intent from a) through e).
2. House officers and residents are oriented about their scope of practice.
3. House officers and residents are oriented to and comply with medical staff rules and regulations, hospital policies and procedures.
4. House officers and residents are given protected time for learning.

Related standards:

WFM.08 Continuous education program.

ADD.05 The hospital participating in professional graduate education programs,

Effectiveness

Keywords:

Training of Specialty Medical Trainees.

Intent:

While learning process depends on learners' abilities and dedication, Support is needed from hospitals to ensure that medical specialty trainees are able to demonstrate what is expected in good medical practice and to achieve the learning outcomes required by their curriculum.

The hospital builds a professional graduate education program that includes at least the following:

a) Clear curriculum and 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 inter-professional multidisciplinary working
e) Regular, useful meetings with clinical and educational supervisors

Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.

When assessments are required, they should be mapped to the requirements of the approved curriculum and appropriately sequenced to match doctors' progression through their education and training.

Someone with appropriate expertise in the area being assessed shall carry out assessments, and who has been appropriately selected, supported, and appraised.

Survey process guide:

GAHAR surveyor may perform an interactive medical education program review session to assess postgraduate curricula, assessment processes, educational activities and records followed by interviewing these learners and their supervisors during hospital tours and tracers

Evidence of compliance:

1. The hospital has an approved program that includes all the points in the intent from a) through e).
2. Medical specialty trainees are oriented to and comply with medical staff rules and regulations, hospital policies, and procedures.
3. Medical specialty trainees comply with policies and procedures of the hospital
4. Educators are trained and calibrated in the assessments they are required to perform.

Related standards:

WFM.08 Continuous education program.

Equitable and efficient research program

ADD.06 The hospital establishes an ethical framework for research activities.

Patient-centeredness

Keywords:

Research Ethical Framework.

Intent:

As the primary concern of research is research ethics, hospitals usually assign the responsibility of ethical review of research protocols and their supporting documents to a committee.

Approval or disapproval is based on the ethical acceptability of the research, including its social value and scientific validity, an acceptable ratio of potential benefits to risks of harm, the minimization of risks, adequate informed consent procedures (including cultural appropriateness and mechanisms to ensure voluntariness), measures to ensure protection of vulnerable populations, fair procedures for selection of participants, and attention to the impact of research on the communities from which participants will be drawn, both during the research and after it is complete. The review considers any prior

scientific reviews and applicable laws.
The research ethics committee (REC) shall be established according to a charter or other document that establishes the manner in which members and the Chair will be appointed.
The hospital shall support REC with staff, adequate in number and training to enable it to carry out its technical and administrative responsibilities; also with adequate resources for the staff to fulfil its assigned functions, including office space and equipment and supplies (e.g. computers, stationery, telephones, photocopying machines, shredding machine) to perform administrative business, to store committee files, and to keep documents secure and confidential;
Support includes access to appropriate space for the committee to meet and adequate means for members to communicate as needed between meetings; and adequate financial resources to permit the committee to produce high-quality work.
The hospital shall ensure committee members are trained on the role and responsibilities of the REC, the full range of ethical considerations relevant to research with human participants; Basic aspects of research methodology and design (for members who lack such background); The impact of different scientific designs and objectives on the ethics of a research study; and the various approaches for recognizing and resolving the tensions that can arise among different ethical considerations and modes of ethical reasoning.

Survey process guide:

- GAHAR surveyor may assess research activities during leadership interview session followed by interviewing some committee members either through a focused session or during hospital tours and tracers.
- GAHAR surveyor may perform document review for committee structure documents, meeting agenda and meeting notes

Evidence of compliance:

1. The hospital ensures that the research ethics committee has a multidisciplinary membership, and that it includes individuals with backgrounds relevant to the areas of research.
2. The hospital supports the committee with resources, including staffing, facilities, and financial resources.
3. The committee members are trained and competent to perform their job.
4. The committee sets minimum requirements for approval of research protocols.

5. The committee approves all research protocols that involve human subjects as required by law and regulation.

Related standards:
OGM.18 Ethical management; OGM.06 Committee structure

ADD.07 Patient rights are protected during research activities.

Patient-centeredness

Keywords:
Research Patient Rights.

Intent:
In ethically acceptable research, risks have been minimized and are reasonable in relation to the potential benefits of the study. The nature of the risks may differ according to the type of research to be performed, harm may occur either at an individual level or at the family or population level.
Enrollment into a research experiment might carry uncertainty and fear to participants. Also, withdrawal from it might make the participants fearful of being discriminated against.
Invasions of privacy and breaches of confidentiality are disrespectful to participants and can lead to feelings of loss of control or embarrassment, as well as tangible harms such as social stigma, rejection by families or communities, or lost opportunities such as employment or housing.
The ethical foundation of informed consent is the principle of respect for persons. Competent individuals are entitled to choose freely whether to participate in research, and to make decisions based on an adequate understanding of what the research entails.
The hospital develops a research policy and procedures that includes at least:
a) Eligibility for enrollment in research projects or protocols
b) Patient rights during research enrollment
c) Confidentiality guarantees for photographs and patient information included in the research
d) Patient right to withdraw from research experiment without fear of retribution
No one should be deprived of its fair share of the benefits of research; these benefits include the direct benefits of participation (if any) as well as the new knowledge that the research is designed to yield.
Informed consents should be taken; decisions for children or adults who lack the mental

capacity to provide informed consent should be made by an authorized surrogate decision-maker.

Survey process guide:

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

Evidence of compliance:

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

Related standards:

PCC.04 Patient and family rights, OGM.16 Safety culture.

Equitable and safe organ transplantation program

ADD.08 Organ and tissue procurement process is defined.

Equity

Keywords:

Organ/Tissue donation choice

Intent:

The World Health Assembly has endorsed a set of guiding principles addressing ethical aspects of organ transplantation such as the voluntary and unpaid donation, but also the issues of universal access to transplant services, the availability, safety, and quality of the procedures.

Efforts need to be exerted in order to ensure banning of organ trafficking and transplant tourism.

The hospital should promote donation motivated by the need of the recipient and the benefit for the community.

In any event, all practices to encourage the procurement of cells, tissues and organs for

transplantation should be defined explicitly

Any measures to encourage donation should respect the dignity of the donor and foster societal recognition of the nature of cell, tissue, and organ donation.

The hospital develops a policy and procedures that cover the following:

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

Survey process guide:

- GAHAR surveyor may assess organ donation activities during hospital tours and tracers followed by interviewing staff members who are involved in organ/tissue donation process
- GAHAR surveyor may also perform a patient's medical record review for a donor.

Evidence of compliance:

1. The hospital approved a document for organ donor recruitment that includes all points mentioned in the intent from a) through f).
2. Promotion of donation of human cells, tissues, or organs by means of advertisement or public appeal are undertaken according to laws and regulation.
3. Physicians and other health professionals do not engage in transplantation procedures, if the cells, tissues, or organs concerned have been obtained through exploitation or coercion of, or payment to, the donor.
4. Specific measures are in place to protect donating minors.
5. Consent is taken from tissue/organ donor and is recorded in patient's medical record.

Related standards:
PCC.11 Informed consent; PCC.04 Patient and family rights.

ADD.09 Organ and tissue transplant services are performed according to applicable laws and regulations and approved organization policy and clinical guideline/ protocol.

Safety

Keywords:
Organ and Tissue Transplantation services.

Intent:
Organ transplantation is considered nowadays acknowledged as the best and frequently the only life-saving therapy for end-stage organ failure.
Most recent data from the WHO Global Observatory on Donation and Transplantation (GODT) indicate that over 130,000 solid organ transplants are performed worldwide, and although impressive, it is estimated that this number represents less than 10% of the global need.
Moreover, there is a huge discrepancy in the availability and access to services as rates of organ donation and transplantation vary widely between WHO regions. The situation of acute organ shortage causes high mortality rates of people that are on waiting lists or leads people (usually the wealthy) to obtain an organ through illegal and unethical pathways (usually from the poor and vulnerable).
The hospital has an approved policy and procedures that describe mechanisms addressing procurement and transplantation of organs and other tissues; the policy includes at least the following:

a) Criteria for identifying potential organ and tissue donors.
b) Pre-transplantation tissue/organ evaluation criteria that includes: initial screening, macro and microscopic tests when required and compatibility matching.
c) Post-Transplantation hospital stay, care plans, recovery plans and health instructions.

Survey process guide:

- GAHAR surveyor may assess organ/tissue procurement and transplantation activities during hospital tours and tracers followed by interviewing staff members who are involved in this process.
- GAHAR surveyor may perform a document review for procurement/transplantation policy.
- GAHAR surveyor may also perform a patient's medical record review for a recipient.

Evidence of compliance:

1. The hospital approves a document that covers all points mentioned in the intent from a) through c).
2. All staff involved in tissue/organ transplantation processes are aware of hospital policy.
3. Pre-transplantation evaluation criteria are assessed for all patients and are recorded in patient's medical record.
4. Post-transplantation care plans and health instructions are recorded in the patient's medical record.

Related standards:

ACT.08 Patient care responsibility; ICD.14 Plan of care; ICD.08 Medical patient assessments.

Survey Activities and Readiness

Introduction:

- GAHAR survey process involves performing building tours, observations of patient's medical records, staff member files, credential files, and interviews with staff and patients.
- The survey is an information gathering activity to determine organization's compliance with the GAHAR standards.

Readiness Tips:

- To facilitate the completion of the survey within the allotted time, all information and documents should be readily available for the surveyors to review during survey
- If certain staff members are missing, the team will continue to perform the survey; the appropriate missing staff members may join when they are available.
- Files may be in paper or in electronic format; however, the information should, at all times, be safe and secure from unauthorized access, up-to-date, accessible, and readily retrievable by authorized staff members.

	Activity	Timeframe	Location in survey agenda
1	Arrival and Coordination	minutes 30-60	1st day, upon arrival
2	Opening Conference	minutes 15	1st day, as early as possible
3	Hospital Orientation	minutes 30-60	1st day, as early as possible
4	Survey Planning	minutes 30-60	1st day, as early as possible
5	Document Review Session	minutes 60-180	
6	Patient Journey Tracer	minutes 60-120	Individual Tracer activity occurs throughout the survey; the number of individuals who surveyors trace varies by organization
7	Break	minutes 30	At a time negotiated with the organization Team Meeting/Surveyor Planning

8	Daily Briefing	minutes 15-30	Start of each survey day except the first day; can be scheduled at other times as necessary
9	Staff members file review	minutes 30-60	After some individual tracer activity has occurred; at a time negotiated with the hospital
10	Environment and facility safety plans review	minutes 45-90	After some individual tracer activity has occurred; at a time negotiated with the hospital
11	Environment of care evaluation tour	minutes 60-240	After document review
12	Leadership interview	minutes 60	During early or middle of survey
13	Financial Stewardship Review	minutes 60	After leadership interview
14	Patient's medical record review	minutes 60-120	Towards the end of survey
15	Medication Management Review	minutes 60-120	In the middle of survey
16	Infection Prevention and Control Review	minutes 60-120	In the middle of survey
17	Quality Program Review	minutes 60	Towards the end of survey
18	Report Preparation	minutes 60-120	Last day of survey
19	Executive Report	minutes 15	Last day of survey
20	Exit Conference	minutes 30	Last day, final activity of survey

Arrival and coordination

Why will it happen?

To start survey process on time, GAHAR surveyors shall use the time to review the focus of the survey in the light of submitted application

What will happen?

GAHAR surveyors shall arrive to the hospital and may present themselves to hospital security or desk. Hospital survey coordinator shall be available to welcome GAHAR surveyors

How to prepare?

Identify a location where surveyors can wait for organization staff to greet them and a location where surveyors can consider as their base throughout the survey.
The suggested duration of this step is approximately 30 to 60 minutes. Surveyors need a workspace they can use as their base for the duration of the survey. This area should have a desk or table, internet and phone coverage, and access to an electrical outlet, if possible. Provide the surveyors with the name and phone number of the survey coordinator

Who should collaborate?

Suggested participants include hospital staff and leaders

Opening conference

Why will it happen?

This is an opportunity to share uniform understanding of the survey structure, answer questions about survey activities and create common expectations

What will happen?

GAHAR surveyors shall introduce themselves and describe each component of the survey agenda.
Questions about the survey visit, schedule of activities, availability of documents or people and any other related topics should be raised at this time.

How to prepare?

Designate a room or space that will hold all participants and will allow for an interactive discussion.
Who should collaborate?

Suggested participants include members of the governing body and senior leadership. Attendees should be able to address leadership's responsibilities for planning, resource allocation, management, oversight, performance improvement, and support in carrying out your organization's mission and strategic objectives.

Hospital orientation

Why will it happen?

GAHAR surveyors shall learn about the hospital through a presentation or an interactive dialogue to help focus subsequent survey activities

What will happen?

Hospital representative (usually hospital director or his/her designee) shall present information about the hospital

How to prepare?

Prepare a brief summary (or a presentation) about the hospital that includes at least information about:

- Hospital mission, vision, and strategic goals
- Organization structure and geographic locations
- Information management, especially the format and maintenance of medical records
- Contracted services
- Compliance with National Safety Requirements
- Summary of Community involvement
- Hospital's patient population, most common 5 diagnoses and most common 5 procedures
- Whether the hospital has any academic, research or transplantation activities
- Whether the hospital provides any home care or services outside the boundaries of hospital facility
- Compliance to GAHAR reports and recommendations during the pre-accreditation visit period

Who should collaborate?

Suggested participants include the same participants as the Opening Conference.

Survey planning

Why will it happen?

To ensure efficiency of survey time

What will happen?

Surveyors shall begin selecting patients for tracers based on the care, treatment, and services the hospital provides

How to prepare?

Survey coordinator need to ensure that the following information are available for surveyors.

- List of sites where deep or moderate sedation is in use
- List of sites where high-level disinfection and sterilization is in use
- List of departments/units/ areas/programs/services within the hospital, if applicable
- List of patients that includes: name, location, age, diagnosis, and length of stay, admit date, point of admission
- Lists of scheduled surgeries and special procedures, e.g. cardiac catheterization, endoscopy lab, electroconvulsive therapy, caesarian sections, including location of procedure and time

Who should collaborate?

GAHAR surveyors only.

Document review session

Why will it happen?

To help GAHAR surveyors understand hospital operations

What will happen?

GAHAR surveyors shall review required policies (or other quality management system documents) and policy components based on GAHAR standards

How to prepare?

Survey coordinator shall ensure that all valid current and approved quality management system documents are available for review either in paper or electronic format (approval should be visible, clear and authentic)

Use of bookmarks or notes is advisable to help surveyors find the elements being looked for

1. List of unapproved abbreviations
2. Performance improvement data from the past 12 months
3. Documentation of performance improvement projects being performed, including the reasons for performing the projects and the measurable progress achieved (this can be documentation in governing body minutes or other minutes)
4. Patient flow documentation: Dashboards and other reports reviewed by hospital leadership; documentation of any patient flow projects being performed (including reasons for performing the projects); internal throughput data collected by emergency department, inpatient units, diagnostic services, and support services such as patient transport and housekeeping
5. Analysis from a high-risk process
6. Emergency Management Policy
7. Emergency management protocols
8. Annual risk assessment and Annual Review of the Program
9. Assessment-based, prioritized goals
10. Infection Control surveillance data from the past 12 months

Who should collaborate?

Survey coordinator and policy stakeholders

Patient journey tracer

Why will it happen?

Patient journey tracer are defined as an assessment, made by surveyors shadowing the sequential steps of a patient's clinical care, of the processes in an organization that guide the quality and safety of care delivered (Greenfield et al., 2012a: 495).

GAHAR surveyors shall follow course of care and services provided to the patient to assess relationships among disciplines and important functions and evaluate performance of processes relevant to the individual

What will happen?

- The tracer process takes surveyors across a wide variety of services.
- The tracer methodology's use of face-to-face discussions with healthcare professionals, staff members and patients, combined with review of patient's medical records and the observations of surveyors
- Quality, timeliness of entries and legibility of recording in patient's medical record is also crucial to safe, effective care because healthcare professionals rely on it to communicate with each other about treatment needs and decisions

- This shall help guide surveyors as they trace a patient's progress.
- The individual tracer begins in the location where the patient and his/her medical record are located. The surveyor starts the tracer by reviewing a file of care with the staff person responsible for the individual's care, treatment, or services. The surveyor then begins the tracer by following the course of care, treatment, or services provided to the patient from preadmission through post discharge, assessing the interrelationships between disciplines, departments, programs, services, or units (where applicable), and the important functions in the care, treatment or services provided which may lead to identifying issues related to care processes
- Most of GAHAR standards can be triggered during a patient journey tracer activity which may also include interviewing staff, patients or family members
    - Staff members may be interviewed to assess organization processes that support or may be a barrier to patient treatment and services, Communications and coordination with other staff members, Discharge planning, or other transitions-related resources and processes available through the hospital, Awareness of roles and responsibilities related to the various policies
    - Patients or family members may be interviewed to assess coordination and timeliness of services provided, Education, including discharge instructions, Perception of care, treatment or services, Understanding of instructions (e.g., diet or movement restrictions, medications, discharge and healthcare professional follow-up), as applicable

How to prepare?

- Every effort needs to be exerted to assure confidentiality and privacy of patients during tracers including no video or audio recording and no crowdedness
- A surveyor may arrive in a department and need to wait for staff to become available. If this happens, the surveyor may use this time to evaluate environment of care issues or observe the care, treatment, or services being assessed.
- All efforts will be done to avoid having multiple tracers or tours in the same place at the same time.

Who should collaborate?

Survey Coordinator and any staff member (when relevant)

Break

Why will it happen?
To allow time for surveyor and for hospital staff to use the information learned

What will happen?
GAHAR surveyor shall meet in their base alone

How to prepare?
Make sure that the place is not going to be used during the break time

Who should collaborate?
GAHAR surveyors only.

Daily briefing

Why will it happen?
GAHAR surveyor shall summarize the events of the previous day and communicate observations according to standards areas

What will happen?
GAHAR surveyors briefly summarize the survey activities completed the previous day.
GAHAR surveyors shall make general comments regarding significant issues from the previous day and note potential noncompliance, with a focus on patient safety.
GAHAR surveyors shall allow time to provide information that they may have missed or that they requested during the previous survey day.
***Note:** Hospital staff may present to surveyors information related to corrective actions being implemented for any issues of non-compliance. Surveyors may still record the observations and findings.

How to prepare?
A room shall be available to accommodate all attendees

Who should collaborate?
Suggested participants include representative(s) from governance, Hospital Director, Hospital leaders, individual coordinating the GAHAR survey, and other staff at the discretion of hospital leaders

Staff members file review

Why will it happen?

The review of files, in itself, is not the primary focus of this session; however, the surveyor shall verify process-related information through recorded in staff member's files. The surveyor shall identify specific staff whose files they would like to review.

What will happen?

- GAHAR surveyor may ensure that a random sample of staff files is reviewed.
- The minimum number of records selected for review is 5 staff member files
- The minimum number of case file records required to be selected by the surveyor for review is no more than 5 (five) records total.
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Throughout the review process, if a big number of findings are observed, the survey team may document whether the findings constitute a level of non-compliance
- The total number of records within the six-month case period Should be recorded on the review form.
- Surveyor may focus on orientation of staff, job responsibilities, and/or clinical responsibilities, Experience, education, and abilities assessment, Ongoing education and training, performance evaluation, credentialing and privileging, and competency assessment

How to prepare?

The hospital shall produce a complete list of all staff members including outsourced, contracted, full-timers, fixed-timers, part-timers, visitors, volunteers, and others

Who should collaborate?

Representatives from medical management, nursing management and human resources management teams

Environment and facility safety plans review

Why will it happen?

GAHAR surveyor may assess the hospital degree of compliance with relevant standards and identify vulnerabilities and strengths in the environment and facility safety plans

What will happen?

There shall be a group discussion. Surveyors are not the primary speakers during this

time; they are listeners to the discussion. the surveyor shall review the Environment of Care risk categories as indicated in the hospital risk assessment and safety data analysis and actions taken by the hospital.

How to prepare?

Make sure that those responsible for environment and facility safety plans are available for discussion

Also, the following documents have to be available

- Hospital licenses, or equivalent
- An organization chart
- A map of the organization, if available
- List of all sites that are eligible for survey
- Environment and facility safety data
- Environment and facility safety Plans and annual evaluations
- Environment and facility safety multidisciplinary team meeting minutes prior to survey
- Emergency Operations Plan (EOP) and documented annual review and update, including communications plans
- Annual training

Who should collaborate?

Environment and facility safety responsible staff members such as safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, and the person responsible for emergency management.

Environment of care tour

Why will it happen?

GAHAR surveyor observes and evaluate the hospital actual performance in managing environment and facility risks.

What will happen?

GAHAR surveyor may Begin where the risk is encountered, first occurs or take a top-down/bottom-up approach.

GAHAR surveyor may interview staff to describe or demonstrate their roles and responsibilities for minimizing the risk, what they are to do if a problem or incident occurs, and how to report the problem or incident

GAHAR surveyor may assess any physical controls for minimizing the risk (i.e., equipment, alarms, building features), Assess the emergency plan for responding to utility system disruptions or failures(e.g., alternative source of utilities, notifying staff, how and when to perform emergency clinical interventions when utility systems fail, and obtaining repair services), assess If equipment, alarms, or building features are present for controlling the particular risk, reviewing implementation of relevant inspection, testing, or maintenance procedures
GAHAR surveyor may also assess hazardous materials management, waste management, safety or security measures.

How to prepare?
Ensure that keys, communication tools and contacts are available, so GAHAR surveyor may be able to access all hospital facilities smoothly

Who should collaborate?
Environment and facility safety responsible staff members such as safety management coordinator, security management coordinator, facility manager, building utility systems manager, information technology (IT) representative, and the person responsible for emergency management.

Leadership interview

Why will it happen?
The surveyor will learn about hospital governance and management structure and processes

What will happen?
GAHAR surveyor addresses the following issues

- The structure and composition of the governing body
- The functioning, participation, and involvement of the governing body in the oversight and operation
- The governing body's perception and implementation of its role in the hospital
- Governing body members understanding of performance improvement approaches and methods
- Pertinent GAHAR Leadership standards relevant to the governing body, direction and leadership in the hospital including organization culture
- Surveyors may explore, through hospital-specific examples, Leadership commitment to improvement of quality and safety, creating a culture of safety, Robust process improvement and Observations that may be indicative of system-level concerns

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with hospital leaders.

The following documents may be reviewed during this session

- Hospital structure
- Hospital strategic plan
- Hospital ethical framework
- Governing Body minutes for the last 12 months
- Leadership safety rounds
- Safety culture assessment
- Patient centeredness initiatives Medical Staff Bylaws and Rules and Regulations
- Medical Executive Committee meeting minutes
- Peer Review process and results

Who should collaborate?

Required participants include at least the following: hospital director, governing body representative, clinical responsible leaders, Human resources management leader, performance improvement coordinator

Financial stewardship review

Why will it happen?

The surveyor will learn about hospital financial stewardship structure and processes

What will happen?

GAHAR surveyor addresses topics related to financial stewardship such as observations noted during hospital tours and tracers, billing process, contractor's performance, availability of staff, supplies and equipment

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with financial stewardship representatives

The following documents may be reviewed during this session

- List of all contracted services
- Agreement with outside blood supplier, referral laboratory, radiology, and other services
- Contractor monitoring data
- Feedback reports from payers

- Cost reduction projects
- Financial audit schedules, focus and major findings

Who should collaborate?

Required participants include at least the following: hospital director, procurement responsible leader, clinical responsible leader, finance responsible leader

Patient's medical record review

Why will it happen?

The review of files, in itself, is not the primary focus of this session; however, the surveyor verifies process-related information through recording in patients' medical records. The surveyor identifies specific patients whose files they would like to review.

What will happen?

- GAHAR surveyor may ensure that a random sample of patient's medical record is reviewed.
- A sample of both open and closed cases Should be reviewed. Record review should include a random sample from each of active and discharged cases.
- The sample selected represents a cross section of the cases performed at the hospital.
- The minimum number of case file records required to be selected by the surveyor for review is no more than 5 (five) records total.
- If findings are observed during the file review, the survey team may request additional file samples to substantiate the findings recorded from the initial sample.
- Throughout the review process, if a big number of findings are observed, the survey team may document whether the findings constitute a level of non-compliance
- The total number of records within the six-month case period Should be recorded on the review form.

How to prepare?

The hospital is required to produce a log or other record of closed cases for the previous six-month period and the surveyor will select a sample of medical records to review.

Who should collaborate?

Representatives from hospital medical, nursing, and other healthcare teams in addition to information management representatives.

Medication management review

Why will it happen?

GAHAR surveyor will Learn about the planning, implementation, and evaluation of medication management program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce medication errors and antibiotics stewardship

What will happen?

GAHAR surveyor will evaluate hospital medication management systems by performing system tracers. Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities and communication among staff/units involved in the process with a focus on management of high-risk medications, look-alike sound-alike, concentrated electrolytes and medication errors
- Strengths in the processes and possible actions to be taken in areas needing improvement; with a special focus on:
    - Antimicrobial Stewardship including: A document that describes how the hospital uses Antibiotic Stewardship Program, Hospital-approved antimicrobial stewardship protocols (e.g. policies, procedures or order sets are acceptable), Antimicrobial stewardship multidisciplinary team
    - Process for reporting errors, system breakdowns, near misses, or override, Data collection, analysis, systems evaluation, and performance improvement initiatives

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the medication management program. Then time may be spent where the medication is received, stored, dispensed, prepared, or administered

The following documents may be reviewed during this session

- Medication management policies
- Core Elements of Hospital Antibiotic Stewardship Programs
- Antimicrobial stewardship data
- Antimicrobial stewardship reports documenting improvement

Who should collaborate?

Suggested participants include clinical and support staff responsible for medication management processes.

Infection prevention and control program review

Why will it happen?

GAHAR surveyor will Learn about the planning, implementation, and evaluation of infection prevention and control program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce infection

What will happen?

GAHAR surveyor will evaluate hospital IPC systems by performing system tracers.
Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities and communication among staff/units involved in the process; How individuals with infections are identified, Laboratory testing and confirmation process, if applicable, Staff orientation and training activities, Current and past surveillance activity
- Strengths in the processes and possible actions to be taken in areas needing improvement; Analysis of infection control data, Reporting of infection control data, Prevention and control activities (for example, staff training, staff vaccinations and other health-related requirements, housekeeping procedures, organization-wide hand hygiene, food sanitation, and the storage, cleaning, disinfection, sterilization and/or disposal of supplies and equipment), staff exposure, Physical facility changes that can impact infection control and Actions taken as a result of surveillance and outcomes of those actions.

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the infection prevention and control process. Then time is spent where the care is provided
The following documents may be reviewed during this session

- Infection prevention and control policies
- Infection control education and training records
- Infection control measures data

Who should collaborate?

Suggested participants include the infection control coordinator; physician member of the infection control team; healthcare professionals from the laboratory; Safety

management staff; organization leadership; and staff involved in the direct provision of care, treatment, or services.

Activity quality program review

Why will it happen?

GAHAR surveyor will Learn about the planning, implementation, and evaluation of quality management program, identify who is responsible for its day-to-day implementation, evaluate its outcome and Understand the processes used by the hospital to reduce risks

What will happen?

Discussions in this interactive session with staff include:

- The flow of the processes, including identification and management of risk points, integration of key activities and communication among staff/units involved in the process;
- Strengths in the processes and possible actions to be taken in areas needing improvement; Use of data
- Issues requiring further exploration in other survey activities;
- A baseline assessment of standards compliance.

How to prepare?

GAHAR surveyor may need a quiet area for brief interactive discussion with staff who oversee the quality management program. Then time may be spent where improvement was implemented

The following documents may be reviewed during this session

- Quality management program
- Performance Improvement projects
- Performance management measures
- Risk Management registers, records and logs

Who should collaborate?

Suggested staff members include quality management staff, healthcare professionals involved in data collection, aggregation and interpretation, performance improvement teams

Report preparation

Why will it happen?
To provide an opportunity of clarification and consolidation of any findings

What will happen?
Surveyors use this session to compile, analyze, and organize the data collected during the survey into a report reflecting the hospital compliance with the standards.
Surveyors may also ask organization representatives for additional information during this session

How to prepare?
GAHAR surveyors may need a room that includes a conference table, power outlets, telephone, and internet coverage.
Who should collaborate?
GAHAR surveyors only.

Executive report

Why will it happen?
To give an opportunity to brief the most relevant outcomes of the survey and help prioritization of post-accreditation activities

What will happen?
GAHAR surveyors will review the survey findings with the most senior leader and discuss any concerns about the report

How to prepare?
GAHAR surveyor may need a quiet private area for brief interactive discussion with the most senior leader

Who should collaborate?
Hospital available most senior leader and others at his/her discretion

Exit conference

Why will it happen?
To thank the hospital team for participation and share the important findings in the accreditation journey

What will happen?

Surveyors will verbally review the survey findings summary, if desired by the most senior leader and review identified standards compliance issues

How to prepare?

Hospital available most senior leader may invite staff to attend, an area that can accommodate attending staff is required

Who should collaborate?

Suggested participants include the hospital available most senior leader (or designee), senior leaders and staff as identified by the most senior leader or designee.

Glossary

ABC analysis The analysis of annual medication consumption and cost in order to determine which items account for the greatest proportion of the budget.

Adherence to medication The degree to which the person's behavior corresponds with the agreed recommendations from a healthcare professional.

Adverse drug event (ADE) This is an injury resulting from medication intervention related to a drug

Adverse drug reaction (ADR) A response to a medication which is noxious and unintended, and which occurs at doses normally used in man for the prophylaxis, diagnosis, or therapy of disease, or for the modifications of physiological function

Adverse effect Medical occurrence temporally associated with the use of a medicinal product, but not necessarily causally related

AII Airborne Infection Isolation (AII) rooms, commonly called negative pressure rooms, are single-occupancy patient care spaces designed to isolate patients with airborne pathogens.

Airborne They are particles ≤ 5μ in size that remain suspended in the air and travel great distances.

Antimicrobial stewardship Is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

Antiseptics They are substances that reduce or stop the growth of potentially harmful microorganisms on the skin and mucous membranes. Or Antimicrobial substances that are applied to the skin to reduce the number of microbial flora.

Appointment The process of reviewing an initial applicant's credentials to decide if the applicant is qualified to provide patient care services that the hospital's patients need and that the hospital can support with qualified staff and technical capabilities

Aseptic technique It is a method designed to reduce the risk of microbial contamination in a vulnerable body site. This may include procedures like undertaking a wound dressing or performing an invasive procedure such as inserting a urinary catheter or preparing an intravenous infusion.

Beyond use date The date or time after which a compounded sterile preparation (CSP) or compounded nonsterile preparation (CNSP) may not be stored or transported or used and are calculated from the date or time of compounding.

Biohazardous it is a biological agent or condition that is carries a risk of danger to humans or the environment.

Certification The procedure and action by which an authorized organization evaluates and certifies that a person, institution, or program meets requirements.

Certified person Someone who has passed exams from an accredited organization related to the work that they shall perform.

Cleaning It is the process of removing foreign material (e.g. soil, organic material, micro-organisms) from an object.

Clinical pathway An agreed-upon treatment regime that includes all elements of care.

Clinical pharmacist Clinical pharmacists work directly with physicians, other health professionals, and patients to ensure that the medications prescribed for patients contribute to the best possible health outcomes. Clinical pharmacists practice in healthcare settings where they have frequent and regular interactions with physicians and other health professionals, contributing to better coordination of care.

Clinical practice guidelines Statements that help healthcare professionals and patients choose appropriate healthcare for specific clinical conditions (for example, recommendations on the case management of diarrhea in children under the age of five years). The healthcare professional is guided through all steps of consultation (questions to ask, physical signs to look for, lab exams to prescribe, assessment of the situation, and treatment to prescribe).

Communicable disease it is a disease that is capable of spreading from one person to another through a variety of ways, including contact with blood and bodily fluids, breathing, etc.

Competence or competency A determination of the staff's job knowledge, skills, and behaviors to meet defined expectations. Knowledge is the understanding of facts and procedures. Skill is the ability to perform specific actions, behaviors, such as the ability to work in teams, are frequently considered as a part of competence.

Competent safety person One who is capable of identifying existing and predictable hazards in the surroundings or working conditions which are unsanitary, hazardous, or dangerous to staff.

Contamination The presence of unwanted material or organism, such as an infectious agent, bacteria, parasite, or another contaminant, that is introduced to an environment, surface, object, or substance, such as water, food, or sterile medical supplies.

Credentialing The process of obtaining, verifying, assessing, and attesting the qualifications of a physician. The process determines if a staff member can provide patient care services in or for a healthcare organization. The process of periodically checking the physician's qualifications is called re-credentialing.

Credentials Evidence of competence, current and relevant licensure, education, training, and experience. Other defined criteria may be added by a healthcare organization.

Defined daily dose (DDD) The assumed average maintenance dose per day for a medication used for its main indication in adults.

Desirable medication list Lowest criticality needed from medication and items; shortage may not pose a threat to the health of the patients.

Discharge summary A section of the patient's medical record that summarizes the reasons for hospitalization, significant findings, procedures performed, treatment rendered, patient's condition on discharge, and any specific instructions given to the patient or family

Disinfectants they are substances that are applied to the surface of non-living objects in order to destroy microorganisms but not necessarily bacterial spores.

Disinfection It is the process of reducing the number of pathogenic microorganisms, but not necessarily bacterial spores to a level which is no longer harmful to health. It may be high level, intermediate level or low level disinfection depending on the level of probable risk.

Dispensing preparing, packaging, and distributing to a patient a course of therapy on the basis of a prescription.

Droplet it is a large respiratory particle ≥ 5μ, which is generated when an infected person coughs, sneezes, or talks, or during procedures such as suctioning, endotracheal intubation, cough induction by chest physiotherapy or cardiopulmonary resuscitation; with possible transmission within 2 meters from the patient source.

Drug and therapeutic committee (DTC) The committee that evaluates the clinical use of medications, policies for managing pharmaceutical use and administration and manages the formulary system

Drug Formulary A manual containing a clinically oriented summary of pharmacological information about a selected number of medications. The manual may also include administrative and regulatory information pertaining to medication prescribing and dispensing.

Drug Recall Is action taken at any time to call back or remove a defective or harmful drug product from the market when it is being discovered to be in violation of laws and regulations. This includes expired, outdated, damaged, dispensed but not used, and/or contaminated medications.

Drug Recall System A system defined that alerts appropriate individuals when a company/manufacturer is calling back a drug product due to a defect in manufacturing, contamination, or being discovered to be in violation of laws and regulations.

Endemic The usual incidence of disease within a geographic area during a specified time period.

Epidemic infection A higher than expected level of infection by a common agent in a defined population during a defined period.

Expired medication is one that is past the expiry date listed on the original packaging from the manufacturer.

External Refers to the outside of the organization, such as comparing data with other organizations or contributing to Egypt's required database.

Failure mode and effects analysis (FMEA) A systematic approach to examining a design prospectively for possible ways failure may occur. The ways failure may occur are then prioritized to help organizations create design improvements that shall have the most benefit. This tool assumes that no matter how knowledgeable or careful people are, errors shall occur in some situations and may even be likely to occur.

Formulary A formulary contained a collection of formulas for the compounding and testing of medication (a resource closer to what would be referred to as a pharmacopeia today). Today, the main function of a prescription formulary is to specify particular medications that are approved to be prescribed at a particular organization, in a particular health system, or under a particular health insurance policy. The development of prescription formularies is based on evaluations of efficacy, safety, and cost-effectiveness of medications. Depending on the formulary, it may also contain additional clinical information, such as side effects, contraindications, and doses. The hospital formulary list should be according to the national essential medicines list.

Governing body The individual(s) or group that has ultimate authority and responsibility for developing policy, maintaining the quality of care, and providing for organization management and planning for the organization.

Hand hygiene A general term that applies to handwashing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis.

Handover The transfer of responsibility for a patient and patient care that occurs in the healthcare setting. For example, in the hospital from one healthcare professional to another, from one level of care to another level, from an inpatient unit to a diagnostic or another treatment unit, and from staff to patients/families at discharge.

Hazardous materials and waste plan The hospital written document that describes the process it would implement for managing the hazardous materials and waste from source to disposal. The plan describes activities selected and implemented by the hospital to assess and control occupational and environmental hazards of materials and waste (anything that can cause harm, injury, ill-health, or damage) that require special handling. Hazardous materials include radioactive or chemical materials. Hazardous wastes include the biologic waste that can transmit disease (for example, blood, and tissues), radioactive materials, toxic chemicals, and infectious waste, such as used needles and used bandages.

Head of department The staff member who manages and directs the subgroups of the organization, commonly referred to as departments, services, units, or wards.

Healthcare professional He is any person working in a hospital or healthcare centre, whether he is a physician, nurse, technician, housekeeper, administrator etc.

HEPA filter High-efficiency particulate air filter is defined as a filter with efficiency of 99.97% in removing particles 0.3 microns or more in size, which makes it suitable for prevention of airborne pathogens.

High-risk medication Medications that bear a heightened risk of causing significant patient harm when they are used in error.

Hospital director (chief executive of the organization) A job as a hospital director falls under the broader career that plan, direct, or coordinate medical and health services in hospitals, clinics, managed care organizations, public health agencies, or similar organizations.

Hospital-Acquired Infection (HAI) Any infection(s) acquired by a patient while receiving care or services in a healthcare organization. Common HAIs are urinary infections,

surgical wound infections, pneumonia, and bloodstream infections.

Hygiene The practice that serves to keep people and environments clean and prevent infection.

Immunization is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine (active immunisation) or serum containing desired antibodies (passive immunisation). Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease.Infection control practitioner

Infection control program An organized system of services designed to meet the needs of the hospital in relation to the surveillance, prevention, and control of infection, which impacts patients, staff, physicians, and/or visitors.

Infection The transmission of a pathogenic microorganism.

Inventory A written list of all the objects, abilities, assets, or resources in a particular place.

Investigational drug A chemical or biological substance that has been tested in the laboratory and approved for testing in people during clinical trials.

IPC committee The Infection Control Committee is generally comprised of members from a variety of disciplines within the healthcare facility; bringing together individuals with expertise in different areas of healthcare. It should be

Job description Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.

Performance measures it is a quantifiable measure used to evaluate the success of a hospital, employee, etc.

Laws and regulations Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.

Leader A person who sets expectations plans and implements procedures to assess and improve the quality of the hospital governance, management, clinical, and support functions and processes.

Legibility The possibility to read or decipher. The writing is clearly written so that every letter or number cannot be misinterpreted. It is legible when any ONE individual can

read the handwritten documentation or physician order.

Look-alike Sound-Alike medications These are medications that are visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics.

Medical staff bylaws Regulations and/or rules adopted by the medical staff and the governing body of the hospital for governance, defining rights and obligations of various officers, persons, or groups within the medical staff's structure.

Medical staff Licensed physician and licensed dentist.

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

Medication error Any preventable event that may cause inappropriate medication use or endangers patient safety. Examples are wrong patient, medication, dose, time, and the route; incorrect ordering, dispensing, or transcribing; missed or delayed treatments. Any professional/discipline/staff who handle medications can be involved in the error.

Medication reconciliation Medication reconciliation is a formal process that has been demonstrated to improve the continuity of medicines management,

Medication sample A unit of a prescription medication that is not intended to be sold and is intended to promote the sale of the medication. A medication sample is given to the patient in very limited circumstances that should be defined in the hospital policy.

Medication samples Medications packaged as one or more dosage units by a manufacturer or distributor according to laws and regulations, and they are provided by a pharmaceutical company to a licensed practitioner free of charge.

Medication-related problem is an event or circumstance involving medication therapy that actually or potentially interferes with desired health outcomes.

N95 respirator it is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small

(0.3 micron) test particles.

Near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so.

Nonclinical staff Those who provide indirect patient care (hospitalization, food service, etc.)

Non-ionizing radiation Non-ionizing radiation is any kind of radiation in the electromagnetic spectrum that does not have enough energy to remove an electron from an atom and turn it into an ion, so Non-ionizing radiation can generate heat.

Ordering is written directions provided by a prescribing practitioner for a specific medication to be administered to an individual. The prescribing practitioner may also give a medication order verbally to a licensed person such as a pharmacist or a nurse.

Outbreak An excess over the expected (usual) level of a disease within a geographic area; however, one case of an unusual disease may constitute an outbreak.

Outdated medication is one that is opened and is typically safe and effective to use for a short period of time after opening (shelf life)

Peer review A process whereby the performance of a hospital, staff or groups are evaluated by members of similar organizations or the same profession or discipline and status as those delivering the services

Personal protective equipment it is equipment worn to minimize exposure to hazards that cause serious workplace injuries and/or illnesses.

Plan of care A plan that identifies the patient's care needs lists the strategy to meet those needs, records treatment goals and objectives, defined criteria for ending interventions, and records the patient's progress in meeting specified goals and objectives. It is based on data gathered during patient assessment.

Plan A detailed method, formulated beforehand that identifies needs lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies, and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.

Policy is a guiding principle used to set direction in a hospital.

Post exposure prophylaxis it is a preventive medical treatment that is started after exposure to a pathogen in order to prevent the infection from taking place.

Practice guidelines Tools that describe processes found by clinical trials or by consensus

opinion of experts to be the most effective in evaluating and/or treating a patient who has a specific symptom, condition, or diagnosis, or describe a specific procedure. Synonyms include practice parameters, protocol, preferred practice pattern, and guideline. Also, see evidence- (scientific) - based guidelines and clinical practice guidelines.

Pre-printed orders Pre-Printed Medication Order Set (PMOS) is a formal record that includes a predetermined group of medication orders that work to standardize diagnosis and treatment choices applicable to a specific patient population

Prescribing advising and authorizing the use of a medication or treatment for someone, especially in writing.

Privileging The process whereby specific scope and content of patient care services (clinical privileges) are authorized for a healthcare professional by the organization, based on the evaluation of the physician's credentials and performance.

PRN Latin abbreviation Pro re nata Frequently used to denote whenever necessary or As needed.

Procedure a series of steps to be followed as a uniform and repetitive approach to accomplish an end result. Procedures provide a platform for uniform implementation to decrease process variation, which increases procedure control. Decreasing process variation is how we eliminate waste and increase performance.

Process A series of actions (or activities) that transform the inputs (resources) into outputs (services). For example, a rural health education program shall require that staff to develop an education strategy, develop educational materials, and deliver the education sessions.

Processing All operations performed to render a contaminated reusable or single-use (disposable) device ready again for patient use. The steps may include cleaning and disinfection/sterilization. The manufacturer of reusable devices and single-use devices that are marketed as non-sterile should provide validated reprocessing instructions in the labeling.

Procurement The process of acquiring supplies, including those obtained by purchase, donation, and manufacture. It involves efforts to quantify requirements, select appropriate procurement methods, and prequalify suppliers and products. It also involves managing tenders, establishing contract terms, assuring medications quality, obtaining the best prices, and ensuring adherence to contract terms.

Program A plan of action aimed at accomplishing a clear business objective, with details

on what work is to be performed, by whom, when, and what means or resources shall be used.

Project A planned set of interrelated tasks to be executed over a fixed period and within certain cost and other limitations.

Protocol A detailed scientific treatment plan for using a new treatment

Referral The sending of a patient from one clinician to another clinician or specialist or from one setting or service to another or another resource

Reliable resource Resources of procurement of medications /paramedical supplies / pharmaceutical devices only from Authoritative sources and professional organizations that can help to ensure avoidance of counterfeit, diverted, or stolen; Potentially intentionally adulterated, or the subject of a fraudulent transaction.

Repackaging The act of taking a finished medication product from the container in which it was distributed by the original manufacturer and placing it into a different container without further manipulation of the medication.

Respiratory hygiene This comprises infection prevention measures designed to limit the transmission of respiratory pathogens spread by droplet or airborne routes.

Risk assessment The identification, evaluation, and estimation of the levels of risks involved in a situation, their comparison against benchmarks or standards, and determination of an acceptable level of risk.

Root cause analysis A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

Safe injection It is a practice intended to prevent needle stick injuries and other possible contamination during syringe introduction in a patient; ultimately preventing transmission of blood borne infectious diseases between one patient and another, or between a patient and a healthcare professional.

Sanitation it is a condition concerning public health, especially indicating provision of clean drinking water, and adequate sewage disposal.

Scope (care or services) The range and type of services offered by the hospital and any conditions or limits to the service coverage.

Scope of practice The range of activities performed by a healthcare professional (physician, nurse) in the organization. The scope is determined by training, tradition,

law or regulation, or the organization.

Sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof.

Side effect The pharmacological effect of a medication, normally adverse, other than the one(s) for which the medication is prescribed.

Single-use device Also referred to as a disposable device it is intended for use on one patient during a single procedure. It is not intended to be reprocessed (cleaned and disinfected or sterilized) and used on another patient. Using disposable items improves patient safety by eliminating the risk of patient-to-patient contamination because the item is discarded and not used on another patient (According to the Food and Drug Administration).

Solid or contaminated linen Linen that has been solid with blood or other infectious materials (OSHA definition).

Spaulding classification it is a method of classification of the different medical instrumentation based on device usage and body contact into three categories, critical, semi-critical and non-critical dictated by the infection risk involved by using it.

Sterilisation It is a controlled process that destroys all microorganisms including bacterial spores.

Stock A quantity of something accumulated, as for future use, regularly kept on hand, as for use or sale; staple; standard.

Stocking The activity of supplying a stock of something or items.

Storage Space a place for storing, an amount stored, or the act of storing that it is kept in a special place until it is needed.

Surveillance A systemic and ongoing method of data collection, presentation and analysis, followed by dissemination of that information to those who can improve outcomes.

Tapering is defined as the gradual discontinuation or reduction of a therapeutic dose of a particular medication over a period of time.

Therapeutic duplication One person using two medications, usually unnecessarily, from the same therapeutic category at the same time.

Timeliness The time between the occurrence of an event and the availability of data about the event. Timeliness is related to the use of the data.

Titrating order Orders in which the medication dose is progressively increased or decreased in response to the patient's status.

Transcribing the legitimate copying of prescription information from one source to another without any alterations or additions

Transmissible it is a disease with the ability to be passed on from one person or organism to another.

Utilization The use, patterns of use, or rates of use of specified healthcare service. Overuse occurs when a healthcare service is provided under circumstances in which its potential for harm exceeds the possible benefits. Underuse is the failure to use a necessary healthcare service when it would have produced a favorable outcome for a patient. Misuse occurs when an appropriate service has been selected, but a preventable complication occurs. All three reflect a problem in the quality of healthcare. They can increase mortality risk and diminish the quality of life.

Variation The differences in results obtained in measuring the same event more than once. The sources of variation can be grouped into two major classes common causes and special causes. Too much variation often leads to waste and loss, such as the occurrence of undesirable patient health outcomes and increased cost of health services.

VEN analysis A known method to help set up priories for purchasing medications and keeping stock. Medications are divided according to their health impact into vital, essential, and non-essential categories. It allows medications of differing efficacy and usefulness to be compared.

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