الهيئة العامة للاعتماد والرقابة الصحية

GAHAR

GAHAR Handbook for Hospital Standards

Edition 2019

TABLE OF CONTENTS

Foreword

As an essential step towards implementing the comprehensive healthcare recovery in Egypt, here is the first edition of the Egyptian Accreditation Standards for Hospitals. This edition has been developed by the newly-established accrediting and regulatory body the General Authority for Healthcare Accreditation and Regulation (GAHAR). It supersedes the third edition of Egyptian Hospital Accreditation Standards released by the Ministry of Health in 2017, and is a continuation of the efforts started earlier 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, but not limited to, the Ministry of Health and Population (MOHP), university hospitals, specialized hospitals, and private hospitals.

This book of standards handles healthcare delivery from two main different perspectives; the patient-centered perspective and the organization-centered perspective. Each of the two main sections of this book adopts one of these perspectives and discusses in details the minimum requirement for accrediting organizations based on them. The second section “Patient-Centered Standards” adopts the Picker’s model for patient-centered care to ensure responsiveness of organizations to patients’ needs. On the other hand, the third section “Organization Centered Standards” highlights many aspects needed for workplace suitability to provide safe, efficient and learning healthcare; it adopts the HealthWISE concepts.

While these standards were carefully tailored to steer the current situation of Egyptian healthcare towards the targeted vision, they have been finely compared to international standards and found to meet the basic intent of all international standards that apply to Egyptian laws, regulations, and culture. In addition, these standards correspond with the new trends in the healthcare industry in Egypt. It is expected that the standards shall be a catalyst for change and improvement in both the culture and practice of healthcare in Egypt.

Introduction

Patient-centered care is healthcare that is respectful of, and responsive 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, involvement of family, and access to care. Surveys measuring patients' experience of healthcare 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 healthcare rise, costs decrease, provider satisfaction increases and patient care experience improves. 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 in its own right and is identified in the Institute of Medicine report, Crossing the Quality Chasm,1 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 healthcare industry worldwide. Three major aspects may affect workers' well-being; Safety, Stress and Organizational Structure.

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

How to read this book?

- This book is divided in four sections, in addition to a foreword, introduction, acknowledgments, acronyms, and glossary.
- Each section is divided into chapters when applicable.
- Each chapter has an introduction that contains an intent, objectives, and important implementation guiding documents.
- Chapter objectives' details follow the introduction, and each one has a standard or more.
- Each standard has a standard statement. Some standards include essential components that need to be addressed during implementation.
- Each standard is followed with a *non-black-scripted statement* that describes the most essential quality dimension(s) addressed with the standard.

Useful implementation concepts

- Egyptian Hospital Accreditation Program evaluates organization structure, process and/or outcome by setting standards that address these concepts.
- Egyptian Hospital Accreditation Program uses each standard as a measurable unit of compliance.
- A standard is a level of quality or achievement, especially a level that is thought to be acceptable. In this book, each standard is written as a standard statement preceded with a code. Some standard requires minimum components of processes to be documented, implemented, and/or recorded. These components are usually preceded with the phrase “At least the following.” Hence, these components are considered essential indivisible parts of compliance to the minimum acceptable standard.
- Standards are categorized and grouped into 3 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:
        - First group: Standards requiring development and implementation of a structure or process. These standards usually start with the following statement “The organization develops and implements a policy/plan.” Usually, review of these documents occurs during the survey “document review session.” Evaluation of these standards include interviewing staff and observing implementation as well
        - Second group: Standards requiring ensuring the implementation of a structure or process. This group includes the majority of standards.
        - Third group: Standards requiring monitoring or evaluation of a structure or process. Usually these are the standards that require evaluation of safety plans in EFS chapter, community involvement plan in CAI chapter, strategic and management plans in OGM chapter and monitoring of measures in QPI chapter.
- During the survey visit, each standard is scored as one of the following:
    - Met,
    - Partially Met,
    - Not Met, or
    - Not Applicable.
- While most standards are independent stand-alone units of measurement that represent structure, process and/or outcome, few standards are dependent on each other. Dependence means that compliance to one standard cannot be achieved (or scored) without ensuring compliance to another standard (for example; compliance with fire drill requirement is dependent on compliance with fire safety plan, non-compliance with fire safety plan shall not ensure proper fire drill, and standard shall be scored as not met without review).

- Egyptian Hospital Accreditation Program ensures that 50%-80% of the evaluation score motivates implementation of quality programs.(in the 3 standard groups mentioned earlier)
    - For First group standards that require certain documentation requirements, a surveyor shall review the requirements and score the standard according to the following:
        - 20% on the availability of valid approved documents including policy, procedures, plan, or others.
        - 60% on the evidence of implementation by either observation or document review.
        - 20% on staff knowledge during staff interview.
    - For Second group standards, a surveyor shall review the requirements and score the standard according to the following:
        - 80% on the evidence of implementation by either observation or document review.
        - 20% on staff knowledge during staff interview.
    - For Third group standards, a surveyor shall review the requirements and score the standard according to the following:
        - 50% on the methodology of monitoring and evaluation used.
        - 50% on the action taken in response to monitoring or process evaluation.
- 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 organization is obliged to comply with the Egyptian accreditation standards. Failure to comply with this rule shall affect the decision of standard scoring.

- Look back period varies from one organization to another depending on accreditation and registration status
    - Registered organization seeking accreditation shall:
        - Comply with the NSR during the whole period between receiving the approval of registration and the actual accreditation survey visit.
        - Comply with the rest of standards for at least 4 months before the surveyors visit.
    - Organization seeking Re-accreditation :
        - For GAHAR accredited organizations: Compliance with all NSR and Egyptian standards for hospitals between receiving the approval of previous accreditation and the actual accreditation survey visit is required.
        - For accredited organization with the previous Egyptian accreditation system, A look back period of 4 months shall be considered including all hospital registration requirements and current Egyptian standards for hospitals.
- An organization can achieve accreditation by demonstrating compliance to certain accreditation decision rules. These rules mandate achieving certain scores on standard level, chapter level and overall level.

- Accreditation Decision Rules: These are mathematical rules that depend on summation and percentage calculation of scores of each applicable standard as follows:
  - Scoring of each standard
    - Met score when the organization shows 80% or more compliance with requirements during the required look back period.
    - Partially Met score when the organization shows.
      - Less than 80% but more than or equal to 50% compliance with requirements during the required look back period.
    - Not Met score when the organization shows
      - Less than 50% compliance with requirements during the required look back period.
    - Not Applicable score
      - When the surveyor determine that the requirements of the standard is out of the scope of the organization.
  - Scoring of each chapter
    - Each chapter should pass at least 70% of score.

- Final Decision Rules
  - Status of Accredited Organization
    - Overall compliance of 80% or more.
    - No single not met NSR standard.
    - Chapter compliance 70% or more.
  - Conditioned Accreditation (need a follow up visit within 4 to 6 months)
    - Overall compliance of 75% or more.
    - One or two not met NSR standard.
    - Chapter compliance 60% or more.
  - Rejection of Accreditation
    - Overall compliance less than 75%.
    - Three or more not met NSR standard.
    - Chapter compliance less than 60%.

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
	PCC.01	New standard
	PCC.02	New standard
	PCC.03	New standard
PR.1	PCC.04	Added second opinion
PR.2	PCC.04	
	PCC.06	New standard
	PCC.07	New standard
	PCC.09	New standard
PR.3	PCC.21	
PR.4	PCC.20	
PR.5	PCC.05	
PR.6	PCC.05	
PR.7	Deleted	
PR.8	PCC.14	
PR.9	PCC.14	
PR.10	PCC.14	
PR.11	PCC.14	
PR.12	PCC.25	
PR.13	PCC.25	
PR.14	PCC.12 PCC.13	
PR.15	PCC.12 PCC.13	
PR.16	PCC.12 PCC.13	
PR.17	PCC.12 PCC.13	
PR.18	PCC.12 PCC.13	
PR.19	PCC.12 PCC.13	
PR.20	PCC.12 PCC.13	
PR.21	OGM.19	
PR.22	Deleted	
PR.23	PCC.15	New standard
	PCC.16	New standard
	PCC.17	New standard
	PCC.18	New standard
	PCC.19	New standard
PR.24	Deleted	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
PR.25	PCC.23	New standard
	PCC.24	New standard
	PCC.26	New standard
PR.26	Deleted	
PR.27	Deleted	
PR.28	Deleted	
PR.29	ADD	
PR.30	ADD	
PR.31	ADD	
PR.32	ADD	
PR.33	ADD	
PR.34	ADD	
PR.35	ADD	
PE.1	PCC.10 PCC.11	
PE.2	PCC.10 PCC.11	
PE.3	PCC.10 PCC.11	
PE.4	PCC.10 PCC.11	
PE.5	PCC.10 PCC.11	
PE.6	PCC.10 PCC.11	
PE.7	PCC.10 PCC.11	
PA.1	ACT.01	
PA.2	ACT.02	
	ACT.03	New standard
	ACT.04	New standard
	ACT.05	New standard
	ACT.06	New standard
	ACT.08	New standard
	ACT.09	New standard
PA.3	Deleted	
PA.4	Deleted	
PA.5	Deleted	
PA.6	ACT.07	
PA.7	Deleted	
PA.8	Deleted	
PA.9	ACT.07	
PA.10	ACT.07	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
PA.11	ACT.07	
	ACT.11	New standard
PA.12	ACT.12	
PA.13	ACT.12	
PA.14	ACT.12	
PA.15	ACT.12	
PA.16	ACT.12	
PA.17	ACT.12	
PA.18	ACT.12	
AP. 1	ICD.02	
AP. 2		
	ICD.03	New standard: Pre hospital services
		New standards ICD.04 ICD.05 ICD.06 ICD.07describing assessment and provision of care for Emergency services
AP. 2.1	ICD.09 ICD.10	added approved guidelines
AP. 2.2	ICD.09 ICD.10	Merged
AP. 2.3	ICD.09 ICD.10	Merged
AP. 3	ICD.09	Merged
AP. 4	ICD.12	Merged
AP.5	ICD.12	Merged
AP.6	ICD.12	Merged
AP.7	ICD.12	Merged
AP.8	ICD.12	Merged
AP.9	ICD.12	Merged
AP.10	ICD.12	Merged
AP.11	ICD.12	Merged
AP.12	ICD.12	Merged
AP.13	ICD.13	
AP.14	ICD.10	
AP.15	ICD.21	
AP.16	ICD.22	
AP.17	ICD.23	
AP.18	ICD.24	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
AP.19	ICD.25	
AP.20	ICD.11	
AP.20.10	ICD.15	
AP.20.11	ICD.16	
AP.21	ICD.09	Merged
AP.22	ICD.13 ICD.14	
AP.23	ICD.09	Merged
AP.24	ICD.08	Merged
AP.25	ICD.08	Merged
AP.26	ICD.08	Merged
AP.27	ICD.08	Merged
AP.28	ICD.08	Merged
AP.29	ICD.08	Merged
AP.30	ICD.08	Merged
AP.31	ICD.29 ICD.30	
AP.32	ICD.29 ICD.30	
AP.33	ICD.29 ICD.30	
	ICD.31	New standard: Women in Labour
AP.34	ICD.32	Baby friendly initiative moved to CAI
AP.35	ICD.32	
AP.36	ICD.32	
AP.37	ICD.34	Merged
AP.38	ICD.34	
AP.39	ICD.34	
AP.40	ICD.34	
AP.41	ICD.34	
AP.42	ICD.34	
AP.43	ICD.34	
AP.44	ICD.35 ICD. 36	Merged
AP.45	ICD.35 ICD. 36	Merged
AP.46	ICD.35 ICD. 36	Merged
AP.47	ICD.35 ICD. 36	Merged
AP.48	ICD.35 ICD. 36	Merged
AP.49	ICD.35 ICD. 36	Merged
AP.50	ICD.35 ICD. 36	Merged

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
AP.51	ICD.35 ICD. 36	Merged
AP.52	ICD.35 ICD. 36	Merged
AP.53	ICD.35 ICD. 36	Merged
AP.54	ICD.35 ICD. 36	Merged
AP.55	ICD.35 ICD. 36	Merged
AP.56	ICD.35 ICD. 36	Merged
AP.57	ICD.35 ICD. 36	Merged
AP.58	ICD.35 ICD. 36	Merged
AP.59	ICD.35 ICD. 36	Merged
AP.60	ICD.35 ICD. 36	Merged
AP.61	ICD.35 ICD. 36	Merged
AP.62	ICD.35 ICD. 36	Merged
PC.1	ICD.01	
PC.2	Removed	This standard is covered in chapter PCC
PC.3	ICD.17	Merged and included in ICD.17
PC.4	ICD.17	Merged and included in ICD.17
PC.5	ICD.17	Merged and included in ICD.17
PC.6	ICD.17	Merged and included in ICD.17
PC.7	ICD.17	Merged and included in ICD.17
PC.8	ICD.17	Merged and included in ICD.17
PC.9	ICD.17	Merged and included in ICD.17
PC.10	ICD.18	
PC.11	ICD.19	
PC.12	ICD.18	Merged and included in ICD.18
PC.13	ICD.17	Merged and included in ICD.17 , Plan of care includes: interventions and desired outcomes with time frames, Time frame for diagnostic services is covered in chapter DAS
PC.14	ICD.20	Included in ICD.20
PC.15	ICD.20	Merged and included in ICD.20
PC.16	Removed	This standard is covered in NSR chapter
PC.17	ICD.26	Merged and included in ICD.26

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
PC.18	ICD.26	Merged and included in ICD.26
PC.19	ICD.26	Merged and included in ICD.26
PC.19.1,	ICD.26	
PC.19.2,	ICD.26	
PC.19.3	ICD.26	
PC.19.4,	Removed from chapter ICD	Transferred to chapter IPC
PC.19.5	ICD.26	
PC.20	ICD.26	Merged and included in ICD.26
PC.21	ICD.26	Merged and included in ICD.26
PC.22	ICD.26	Merged and included in ICD.26
PC.23	Removed from chapter ICD	Transferred to chapter IPC
PC.24	Removed from chapter ICD	Transferred to chapter IPC
PC.25	ICD.26	Merged and included in ICD.26
PC.26	ICD.26	Merged and included in ICD.26
PC.27	Removed from chapter ICD	Transferred to MMS
PC.28	Removed from chapter ICD	Transferred to MMS
PC.29	ICD.33	Merged in ICD.33
PC.29.1,		
PC.29.2		
PC.30	ICD.33	Merged and included in ICD.33
PC.31	Removed from chapter ICD	Transferred to ACT
PC.32	Removed from chapter ICD	Transferred to ACT
PC.33	Removed from chapter ICD	Transferred to ACT
PC.34	Removed from chapter ICD	Transferred to ACT
PC.35	ICD.38	Merged in ICD.38
PC.35.1,	ICD.38	
PC.35.2,	ICD.38	
PC.35.3,	ICD.38	
PC.35.4	ICD.38	
PC.36	ICD.38	Merged and included in ICD.38
PC.37	ICD.38	Merged and included in ICD.38

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
PC.38	ICD.38	Merged and included in ICD.38
PC.39	ICD.38	Merged and included in ICD.34
PC.40	ICD.38	Merged and included in ICD.38
PC.41	ICD.38	Merged and included in ICD.34
PC.42	ICD.38	Merged and included in ICD.38
----	ICD.39	New standard
PC.43	ICD.40	Adds the policy addresses at least the following: a) to f)
PC.44	ICD.41	
PC.45	ICD.40	Merged and included in ICD.40
PC.46	ICD.42	
PC.47	ICD.41	Merged and included in ICD.41
PC.48	ICD.41	Merged and included in ICD.41
PC.49	ICD.04	
PC.50	ICD.04	Merged and included in ICD.04
PC.51	ICD.04	Merged and included in ICD.04
PC.52	ICD.04	Merged and included in ICD.04
PC.53	ICD.05	Merged in ICD.05
PC.53.1,	ICD.05	
PC.53.2,	ICD.05	
PC.53.3,	ICD.05	
PC.53.4	ICD.05	
PC.54	ICD.05	Merged and included in ICD.05
PC.55	ICD.05	Merged and included in ICD.05
----	ICD.43	New standard: Organ transplant service
----	ICD.44	New standard: Assessment and care of dialysis patients
----	ICD.45	New standard: Dialysis unit water testing
----	ICD.46	New standard: grey zone dialysis unit

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
----	ICD.47	New standard: Assessment and care of oncology patients
----	ICD.48	New standard: Mortality and Morbidity committee
DS.1	DAS.1	Added: plans
	DAS.2	
	DAS.3	
DS.2.	DAS.4	
DS.3		
DS. 4		
DS. 5	DAS.7	
DS. 6	DAS.5	
DS.7	DAS.6	Rephrasing
DS.8	DAS.8	Added handling of contrast media and radio pharmaceuticals
DS.9	DAS.9	
DS.10		
DS.11		
DS.12	DAS.10	Added: components of Report
DS.13		
DS. 14	DAS. 11	Added details
DS.15		
DS.16		
DS. 17	Mentioned in NSR	
DS.18	DAS.12- DAS.13	
DS.19	DAS.14	
DS.20	DAS.12- DAS.24	
DS. 21	DAS.12- DAS.24	
DS. 22	DAS.12- DAS.24	
DS. 23	DAS.12- DAS.24	
DS. 24	DAS.12- DAS.24	
DS. 25	DAS.12- DAS.24	
DS. 26	DAS.12- DAS.24	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
DS. 27	DAS.12- DAS.24	
DS.28	DAS.12- DAS.24	
DS. 29	DAS.12- DAS.24	
DS.30	DAS.12- DAS.24	
DS.31	DAS.12- DAS.24	
DS.32	DAS.12- DAS.24	
DS.33	DAS.12- DAS.24	
DS.34	DAS.12- DAS.24	
DS.35	DAS.12- DAS.24	
DS.36	DAS.12- DAS.24	
DS.37	DAS.12- DAS.24	
DS.38	DAS.12- DAS.24	
DS.39	DAS.12- DAS.24	
DS.40	DAS.12- DAS.24	
DS.41	DAS.12- DAS.24	
DS.42	DAS.12- DAS.24	
DS. 43	DAS.12- DAS.24	
DS. 44	DAS.12- DAS.24	
DS.45	DAS.12- DAS.24	
DS. 46		Mentioned in NSR
	DAS.25 DAS.26	Added: other diagnostic tests
DS.47	DAS.27	Merged
DS.47.1	DAS.27	Merged
DS. 47.2	DAS.27	Merged
DS. 47.3	DAS.27	Merged
DS. 47.4	DAS.27	Merged
DS.48		
BB.1	DAS.28	
BB.2	DS.32	Merged
	DAS.29	Added qualified individuals
BB.2.1	DAS .30	rephrasing, added: traceability
	DAS.31	Added Quality control program
BB.2.2	DAS.32	Merged and added selection / deferring criteria
BB.3		Merged
BB.4	DAS.33	Merged

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
BB.5		Merged
BB.6	DAS.34	
BB.7		
BB.8		
	DAS.35	New standard for evaluating contracted blood banks
BB.9	DAS. 30	
BB.10	DAS. 39	added contents of the policy
BB.11	DAS.37 DAS.38	role of physician and blood compatibility testing
	SAS.01	New standard
	SAS.02	New standard
IP.1	SAS.03	Reworded, renumbered to SAS.03
IP.2	SAS.04	Reworded, renumbered to SAS.04
IP.3	SAS.05	Reworded, renumbered to SAS.05
IP.4		Deleted for repetition.
	SAS.06	New standard
	SAS.07	New standard
	SAS.08	New standard
	SAS.09	Reworded, transferred from PS chapter
	SAS.10	New standard
IP.5	SAS.11	Merged and renumbered to SAS.11
IP.6	SAS.11	Merged and renumbered to SAS.11
IP.7	SAS.11	Merged and renumbered to SAS.11
IP.8	SAS.11	Merged and renumbered to SAS.11
IP.9	SAS.11	Merged and renumbered to SAS.11
IP.10	SAS.11	Merged and renumbered to SAS.11
IP.11	SAS.11	Merged and renumbered to SAS.11
IP.12	SAS.11	Merged and renumbered to SAS.11
	SAS.12	New standard
IP.13	SAS.13	Reworded
	SAS.14	New standard

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
	SAS.15	New standard
	SAS.16	New standard
	SAS.17	New standard
	SAS.18	New standard
IP.14	SAS.19	Reworded, and renumbered to SAS.19
	SAS.20	New standard
IP.15		Deleted
IP.16	SAS.21	Reworded, and renumbered to SAS.21
IP.17	SAS.21	Merged with IP.16 to SAS.21
IP.18	SAS.22	Reworded, and renumbered to SAS.22
IP.19	SAS.23	Reworded, and renumbered to SAS.23
IP.20	SAS.24	Merged and renumbered to SAS.24
IP.21	SAS.24	Merged and renumbered to SAS.24
IP.22	SAS.24	Merged and renumbered to SAS.24
IP.23	SAS.24	Merged and renumbered to SAS.24
IP.24	SAS.24	Merged and renumbered to SAS.24
IP.25	SAS.24	Merged and renumbered to SAS.24
IP.26	SAS.24	Merged and renumbered to SAS.24
IP.27	SAS.24	Merged and renumbered to SAS.24
IP.28	SAS.24	Merged and renumbered to SAS.24
IP.29	SAS.24	Merged and renumbered to SAS.26

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
IP.30	SAS.26	Merged and renumbered to SAS.26
IP.31	SAS.26	Merged and renumbered to SAS.26
IP.32	SAS.25	Reworded, and renumbered to SAS.25
IP.33	SAS.26	Merged and renumbered to SAS.26
IP.34	SAS.27	Reworded, and renumbered to SAS.27
	SAS.28	New standard
	SAS.29	New standard
	SAS.30	New standard
	SAS.31	New standard
	SAS.32	New standard
	SAS.33	New standard
	SAS.34	New standard
	SAS.35	New standard
	SAS.36	New standard
MM.1	MMS.01	Rephrase
-	MMS.02	New as it is part of resources management
MM.2	MMS.03	Rephrase for more clarity
-	MMS.03.01	New - Added to highlighting critical thinking in different possible situation
MM.3	MMS.04	Merged and Rephrase - Transform the scope of the committee to meet the changes needs
MM.4		
-	MMS.05	New requirements in safe managing antibiotics use
		Transferred to IM chapter
MM.5		
-	MMS.06	New requirements in drug information and patient education

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
MM.7	MMS.08	Rephrase -To introduce the concept of supply chain management
MM.8, MM.9	MMS.09	Merged and highlights the different lists of medications to support medication plan and budget
MM.10, MM.11, MM.12		
MM.13, MM.14, MM.15 , MM.16 , MM.17,	MMS.10	Merged, rephrase with new requirements to add clarity more in classification of medication type that could be considered in the requirements
MM.18, MM.24		Deleted and replaced by NSR.16 and NSR.17
MM.19	Deleted and replaced by NSR.16 and NSR.17	
-	MMS.11 - MMS.12	New NSR requirements in medication safety (NSR.16 and NSR .17)
MM.20 - MM. 21- MM .28	MMS.13	Merged and rephrase
MM.22 - MM.23	MMS.14	Merged.
MM.25	MMS.15	Rephrase with new requirements have been added for more control and safety
MM.26,	Deleted -merged with MMS.12	
MM.27,		
MM.28		

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
MM.45	MMS.16	Moved under storage section, rephrase with new requirements New requirements have been added for more control and safety
MM.29	MMS.17	Rephrase Adding more clarity
-	MMS.18	NSR requirements in medication safety (NSR.14 and NSR .12.2)
		And moving related standards from chapter PS (PS.27 , PS.28)
MM.30,	MMS.19	Merged
MM.31		
MM.32	MMS.20	Changed to cover NSR.03 requirements in medication safety
MM.33,	MMS.21	Merged with additions
MM.34		
MM.35	Deleted for repetition	
MM.37,	MMS.23	Merged and rephrase with new requirements -To highlight the safe and patient centred requirements related to the subject
MM.38		MMS.24
MM.39	MMS.24	Rephrase with new requirements -To highlight the appropriateness review required
MM.40	Deleted for repetition	
MM.41	MMS.25	Replaced by NSR.15 requirements in medication safety
MM.42- MM.43- MM.49	MMS.26	Merged with rephrase
MM.44	MMS.27	Rephrase with new requirements new requirements have been added to the standard
MM.46	Deleted for repetition	
MM.48,	MMS.28	Merged
MM.50	Merged	Deleted for repetition

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
MM.49		
MM.51,	MMS.29	Merged Under the same subject
MM.52		
MM.54, MM.55, MM.56	MMS.31	Merged with new requirements
MM.57,	MMS.32	Merged for clarity
MM.58, MM.59		
MM.60,	MMS.33	Merged for clarity
MM.61		
IC.1	IPC.01	IPC.01 rephrasing
IC.2	IPC.02	Merged all to IPC.02
IC.3	IPC.02	With new element added (Action plan based on risk assessment)
IC.4	IPC.02	
IC.5	IPC.02	
IC.6	IPC.02	
IC.7	IPC.03	Merged all to IPC.03
IC.8	IPC.03	Rephrasing. Details for terms of reference removed as it is mentioned in the national guidelines for infection control
IC.9	IPC.03	
IC.10	IPC.04	IPC.04
IC.11.1	IPC.05	Merged all with IC.11.7 to IPC.05
IC.11.2	IPC.05	Aseptic techniques , safe injection newly added
IC.11.3	IPC.05	
----------	IPC.09	IPC.09 newly added
IC.11.4	IPC.10	Moved to IPC.10
IC.11.5	IPC.10	Moved to IPC.10
IC.11.6		Deleted
IC.11.7	IPC.05	Merged with IC.11.1 IC.11.2 IC.11.3

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
IC.11.8	IPC.12	Merged with IC.16 and moved to IPC.12
IC.11.9	IPC.12	Merged with IC.47 and moved to IPC.12
IC.11.10	IPC.12 and IPC.13	Moved to IPC.12 and IPC.13
		New element added to IPC.12 regarding implements evidence-based interventions to reduce the burden of epidemiologically significant organisms (MDROs).
----------		IPC.16 newly added (MDROs)
IC.11.11	WFM	Moved to WFM
IC.11.12	MMS	Moved to MMS
IC.12	IPC.07	Merged all to IPC.07
IC.13	IPC.07	
IC.14	IPC.06	IPC.06
IC.15	IPC.08	IPC.8 rephrasing with more details added
IC.16	IPC.12	Merged with IC.11.8 and moved to IPC.12
IC.17	IPC.10	Merged with IC.11.5 and moved to IPC.10 with removal of haemorrhagic patients
IC.18	EFS	Moved to EFS
IC.19	IPC.10	Moved to IPC.10 rephrasing
IC.20	IPC.11	Moved to IPC.11 rephrasing with more details added
IC.21		Deleted as summarised to follow national guidelines
IC.22	IMT	Moved to IMT
IC.23	IPC.17	Merged together to IPC.17 and rephrasing
IC.24	IPC.17	
IC.25	IPC.17	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
IC.26	IPC.17	
IC.27	IPC.19	IPC.19 rephrasing
IC.28	IPC.18	Merged to IPC.18 and rephrasing
IC.29	IPC.18	
IC.30	IPC.18	
IC.31	IPC.18	
IC.32	IPC.18	
IC.33	IPC.18	
IC.34	IPC.20	Merged to IPC.20 and rephrasing
IC.35	IPC.20	
IC.36	IPC.22	Rephrasing to IPC.22
IC.37		Deleted because of repetition
IC.38	IPC.22	Merged with IC.36 to IPC.22
IC.39	IPC.22	Merged in IPC.22
IC.40	IPC.21	Rephrasing with adding more details to IPC.21
IC.41	IPC.14	Merged all together , moved to IPC.14 and rephrasing
IC.42	IPC.14	
IC.43	IPC.14	
IC.44	IPC.14	
IC.45	IPC.15	Moved to IPC.15
IC.46		Deleted because of repetition
IC.47	IPC.12	Moved to IPC.12
IC48		Deleted because of repetition
----------	IPC.23	IPC.23 moved from patient care with more details added regarding food safety
----------	IPC.24	IPC.24 newly added standard regarding IC procedures during construction and renovation
PS.1	NSR.01	
PS.2	NSR.03	
PS.3	NSR.03	
PS.4	Deleted	
PS.5	Deleted	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
PS.6	NSR.02	
PS.7	NSR.04	
PS.8	Deleted	
PS.9	NSR.03	
PS.10	NSR.05	
PS.11	NSR.06	
PS.12	NSR.06	
PS.13	NSR.07	
PS.14	NSR.07	
PS.15	NSR.09	
PS.16	NSR.09	
PS.17	NSR.08	
ES.1	EFS.01	Reworded
ES.2	EFS.03	Reworded, added requirements
ES.3	EFS.02	Merged and renumbered to EFS.02
ES.4	EFS.02	Merged and renumbered to EFS.02
ES.5	EFS.02	Merged and renumbered to EFS.02
ES.6		Deleted
ES.7	EFS.04	Reworded
	EFS.05	New standard
ES.8	EFS.06	Reworded
ES.9		Transferred to ACT.
ES.10	EFS.07	Merged with ES.13-18 and renumbered to EFS.07
ES.11	EFS.10	Merged with ES.19 and renumbered to EFS.10
ES.12		Deleted
ES.13	EFS.07	Merged and renumbered to EFS.07
ES.14	EFS.07	Merged and renumbered to EFS.07
ES.15	EFS.07	Merged and renumbered to EFS.07
ES.16	EFS.07	Merged and renumbered to EFS.07
ES.17	EFS.07	Merged and renumbered to EFS.07
ES.18	EFS.07	Merged and renumbered to EFS.07
	EFS.08	New standard
	EFS.09	New standard

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
ES.19	EFS.10	Merged with ES.11 and renumbered to EFS.10.
ES.20	EFS.05	Merged and renumbered to EFS.05.
ES.21	EFS.11	Reworded
ES.22	EFS.12	Reworded, merged with ES.24 and ES.26 and renumbered to EFS.12.
ES.23	EFS.14	Merged with ES.28 and renumbered to EFS.14
ES.24	EFS.12	Merged with ES.22 and renumbered to EFS.12
ES.25	EFS.13	Reworded
ES.26	EFS.12	Merged with ES.22 and renumbered to EFS.12
ES.27		Deleted
ES.28	EFS.14	Merged with ES.23 and renumbered to EFS.14.
ES.29	EFS.05	Merged and renumbered and renumbered to EFS.05
ES.30	EFS.15	Reworded
ES.31	EFS.16	Reworded, merged with ES.34 and ES.35 and renumbered to EFS.16
ES.32		Deleted
ES.33	EFS.17	Merged with ES.36 and renumbered to EFS.17
ES.34	EFS.16	Merged with ES.31 and renumbered to EFS.16
ES.35	EFS.16	Merged with ES.31 and renumbered to EFS.16
ES.36	EFS.17	Merged with ES.33
ES.37	EFS.05	Merged to EFS.05.
ES.38	EFS.18	Reworded
ES.39	EFS.19	Merged with ES.44 and renumbered to EFS.19
ES.40		Deleted

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
ES.41	EFS.22	Merged with ES.46 and renumbered to EFS.22
ES.42	EFS.20	Renumbered to EFS.20
ES.43		Deleted
ES.44	EFS.19	Merged with ES.39 and renumbered to EFS.19
ES.45	EFS.21	Renumbered
ES.46	EFS.22	Merged with ES.41 and renumbered to EFS.22
ES.47	EFS.05	Merged and renumbered to EFS.05
ES.48	EFS.23	Reworded
ES.49	EFS.24	Merged with ES.52, ES.53 and ES.58 and renumbered to EFS.24
ES.50		Deleted
ES.51	EFS.27	Merged with ES.59 and renumbered to EFS.27
ES.52	EFS.24	Merged with ES.49 and renumbered to EFS.24
ES.53	EFS.24	Merged with ES.49 and renumbered to EFS.24
ES.54		Transferred to ICD.
ES.55	EFS.25	Merged with ES.56 & ES.57 and renumbered to EFS.25.
ES.56	EFS.25	Merged with ES.55 and renumbered to EFS.25
	EFS.26	New standard
ES.57	EFS.25	Merged with ES.55 and renumbered to EFS.25
ES.58	EFS.24	Merged to ES.49 and renumbered to EFS.24
ES.59	EFS.27	Merged with ES.51 and renumbered to EFS.27
ES.60	EFS.05	Merged and renumbered to EFS.05
ES.61	EFS.28	Reworded

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
ES.62	EFS.29	Merged with ES.65 – 70 and renumbered to EFS.29
ES.63		Deleted
ES.64	EFS.31	Merged with ES.71 and renumbered to EFS.31
ES.65	EFS.29	Merged with ES.62 and renumbered to EFS.29
ES.66	EFS.29	Merged with ES.62 and renumbered to EFS.29
ES.67	EFS.29	Merged with ES.62 and renumbered to EFS.29
ES.68	EFS.29	Merged with ES.62 and renumbered to EFS.29
ES.69	EFS.29	Merged with ES.62 and renumbered to EFS.29
ES.70	EFS.29	Merged with ES.62 and renumbered to EFS.29
	EFS.30	New standard
ES.71	EFS.31	Merged with ES.64 and renumbered to EFS.31
ES.72	EFS.05	Merged, renumbered to EFS.05
ES.73	EFS.32	Reworded
---	IMT.01	New standard
IM.1	IMT.05	Merged and included in the standard IMT.5
IM.1.1,	IMT.05	
IM.1.2,	IMT.05	
IM.1.3,	IMT.05	
IM.1.4	IMT.05	
IM.2	IMT.05	Merged and included in the standard IMT.5
IM.3	IMT.06	
IM.4	IMT.06	Merged and included in the standard IMT.6
IM.5	IMT.08	
IM.6	IMT.03	Adds items from a) to e)

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
	IMT.03	Change the review and update of policies from at least two years to 3 years
IM.7	IMT.03	Merged and included in IMT.03
IM.8	IMT.02	Merged and included in IMT.02
IM.8.1,	IMT.02	
IM.8.2	IMT.02	
IM.9	IMT.02	Merged and included in IMT.02
IM.10	IMT.02	Merged and included in IMT.02
IM.11	IMT.07	
IM.12	IMT.07	Merged and included in IMT.07
IM.13	IMT.04	Adds approved and not-to use abbreviations list (mentioned in chapter MM in the previous version)
	IMT.04	Example of referenced not-to-use abbreviations is mentioned in the chapter intent.
	IMT.04	Adds e) approved symbols and abbreviation not allowed to be used in documents received by patient/family.
IM.14	IMT.09	
IM.16,	ACT	These standards are covered in ACT and ICD chapters
IM.16.1,	ACT	
IM.16. 2,	ACT	
IM.16.3,	ACT	
IM.16.4,	ACT	
IM.16.5,	ACT	
IM.16.6	IMT.09	Merged and included in IMT.09
IM.16.6.1,	IMT.09	
IM.16.1.6.2	IMT.09	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
IM.17	NSR	This standard is covered in NSR chapter
IM.18	IMT.10	Merged and included in IMT.10
IM.19	IMT.10	Merged and included in IMT.10
IM.20	IMT.10	Merged and included in IMT.10
IM.21	IMT.10	Merged and included in IMT.10
IM.22	IMT.10	Merged and included in IMT.10
IM.23	Removed	This standard is covered in NSR chapter
IM.24	IMT.10	Merged and included in IMT.10
IM.25	Removed	This standard is covered in ICD chapter
IM.26	IMT.10	Merged and included in IMT.10
IM.27,	Removed from chapter IMT	Transferred to chapter ICD
IM.27.1,	ICD	ICD.7
IM.27.2,	ICD	
IM.27.3,	ICD	
IM.27.4,	ICD	
IM.27.5,	ICD	
IM.27.6	ICD	
IM.28	IMT.11	
IM.29	IMT.10	
IM.30	Removed from chapter IMT	Transferred to chapter ACT
	ACT	The closed medical record must contain a discharge summary
IM.31,	Removed from chapter IMT	Transferred to chapter ACT
IM.31.1,	ACT.13	ACT.13
IM.31.2,	ACT.13	
IM.31.3,	ACT.13	
IM.31.4,	ACT.13	
IM.31.5,	ACT.13	
IM.31.6,	ACT.13	
IM.31.7,	ACT.13	
IM.31.8,	ACT.13	
IM.31.9	ACT.13	
IM.32	Removed from chapter IMT	Transferred to chapter ACT

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
		A copy of the discharge instructions and discharge summary is given to the patient on discharge
IM.33	Removed from chapter IMT	Transferred to chapter ACT
	ACT	A copy of the discharge instructions and discharge summary is given to the patient on discharge
IM.34,	Removed from chapter IMT	Transferred to chapter ACT
IM.34.1,	ACT	ACT.14
IM.34.2,	ACT	
IM.34.3,	ACT	
IM.34.4,	ACT	
IM.34.5,	ACT	
IM.34.6	ACT	
IM.35	Removed from chapter IMT	Transferred to chapter ACT
	ACT	A copy of the referral sheet is retained in the patient's medical record
		Please review
IM.36,	IMT.12	Adds e) The results of review shall be reported to the organization leaders.
IM.36.1,	IMT.12	
IM.36.2,	IMT.12	
IM.36.3,	IMT.12	
IM.36.4	IMT.12	
IM.37	IMT.12	Merged and included in IMT.12
IM.38	IMT.12	Merged and included in IMT.12
---	IMT.13	New standard
---	IMT.14	New standard
---	IMT.15	New standard
PI.1 -PI.2 -PI.4- PI.5 -PI.6	QPI.01 - QPI.02	Rephrase, merged with additional requirements for clarity

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
PI.7	QPI.03	Rephrase and merged for clarity
PI.9		
PI.10 - PI.11 -PI.12	QPI.04	Merged to avoid repetition
PI.13- PI.14	QPI.05	Merged for clarity
PI.15 to PI.25	QPI.06	Merged for clarity
PI.27 to PI.37	QPI.07	Merged for clarity
PI.38 to PI,42	QPI.08	Merged for clarity
-	QPI.09	New requirements in quality program
PI.44 to PI.48	QPI.16	Merged for clarity
PI.50	QPI.13	Rephrase with new requirements, to highlight the important content of the system
PI.51 -PI.52	Deleted	
PI.54 to PI.61	QPI.14 - QPI.15	Modify, the original standard divided into two standards cover two main subjects in reporting system
OM.1	OGM.01	OGM.1 Merged with new element added (d. meetings)
OM.2	OGM.01	
OM.3	OGM.01	
OM.4	OGM.01	
OM.5	OGM.02	OGM.2 Rephrasing, adding mission to be aligned with 2030 vision
OM.6	OGM.02	

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
OM.7	OGM.03	OGM.3 Rephrasing and Merged with OM.7
OM.8	OGM.07	
OM.9	OGM.04	OGM.4
OM.10		Removed
OM.11	OGM.5	OGM.5
OM.12	OGM.06	OGM.6
OM.13	OGM.06	
OM.14		--
OM.15	OGM.07	OGM.7 Rephrasing and merged with OM.16
OM.16	OGM.07	
OM.16.1	OGM.08	
OM.16.2	OGM.08	
OM.16.3	OGM.08	
OM.16.4	OGM.08	
OM.16.5	OGM.08	
OM.16.6	OGM.08	
OM.16.7	OGM.08	
OM.17	OGM.09	OGM.9
OM.18		Removed
OM.19		Removed
OM.20		Removed
OM.21		Removed
OM.21.1		Removed
OM.21.2		Removed
OM.21.3		Removed
OM.22		Removed
OM.23	OGM.10	OGM.10
OM.24		--
OM.25		--
OM.26	OGM.11	OGM.11
OM.27	OGM.12	OGM.12
OM.28	OGM.12	Merged with OM.27
OM.29	OGM.12	Merged with OM.27
OM.30		

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
OM.31		
OM.32		
OM.33		
OM.34		
OM35		
OM.36		
OM.37		
OM.38		
OM.39		
OM.40		
OM.41		
OM.42		
OM.43		
OM.44		Removed
OM.45		Moved to OGM.18
OM.46		
OM.47		--
OM.48		Removed
OM.49		Removed
OM.50		--
OM.51	OGM.13	
OM.51.1	OGM.13	
OM.51.2	OGM.13	
OM.51.3	OGM.13	
OM.51.4	OGM.13	
OM.51.5	OGM.13	
OM.51.6	OGM.13	
OM.51.7	OGM.13	
OM.52	OGM.13	
OM.53	OGM.13	Removed
OM.53.1	OGM.13	
OM.53.2	OGM.13	
OM.53.3	OGM.13	
OM54	OGM.13	
	OGM.14	New standard
	OGM.15	New standard

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
	OGM.16	New standard
	OGM.17	New standard
	OGM.18	New standard
	OGM.19	New standard
	OGM.20	New standard
	OGM.21	New standard
	OGM.22	New standard
	OGM.23	
	OGM.24	New standard
HR.1	WFM.01	Rephrasing to use laws and regulations
HR.2	WFM.02	Merge HR.2 & HR.3 to WFM02
HR.3	WFM.02	Merge HR.2 & HR.3 to WFM02
HR.4	WFM.03	Merged and Rephrased to WFM.03
HR.5	WFM.03	Merged and Rephrased to WFM.03
HR.6	WFM.05	Merged and Rephrased HR.6 & HR.7 to WFM05
HR.7	WFM.04	
HR.8	WFM.06	Rephrased to WFM.06
HR.9	WFM.06	Rephrased to WFM.06
HR.10	WFM.05	Rephrased to WFM.05
HR.11	WFM.04	Rephrased to WFM.04
HR.12	WFM.10	Rephrased to WFM.10
HR.13	WFM.05	Rephrased to WFM.05
HR.14	WFM.05	Rephrased to WFM.05
HR.15	WFM.05	Rephrased to WFM.05
HR.15.1	WFM.05	Rephrased to WFM.05
HR.15.2	WFM.05	Rephrased to WFM.05
HR.15.3	WFM.06	Rephrased to WFM.06
HR.15.4	WFM.06	Rephrased to WFM.06
HR.15.5	WFM.06	Rephrased to WFM.06
HR.15.6	WFM.06	Rephrased to WFM.06
HR.15.7	WFM.06	Rephrased to WFM.06

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
HR.15.8	WFM.01	Rephrased to WFM.01 with more details
HR.16	WFM.06	Rephrased and merged with HR.17 & HR.18 & HR.19 & HR.20 & HR.21& HR.22 to WFM.06
HR.17	WFM.06	Rephrased and merged with HR.17 & HR.18 & HR.19 & HR.20 & HR.21& HR.22 to WFM.06
HR.18	WFM.06	Rephrased and merged with HR.17 & HR.18 & HR.19 & HR.20 & HR.21& HR.22 to WFM.06
HR.19	WFM.06	Rephrased and merged with HR.17 & HR.18 & HR.19 & HR.20 & HR.21& HR.22 to WFM.06
HR.20	WFM.06	Rephrased and merged with HR.17 & HR.18 & HR.19 & HR.20 & HR.21& HR.22 to WFM.06
HR.21	WFM.06	Rephrased and merged with HR.17 & HR.18 & HR.19 & HR.20 & HR.21& HR.22 to WFM.06
HR.22	WFM.09	Rephrased and merged with HR.22 to HR.56 to WFM.09
HR.23	WFM.09	Rephrased and merged with HR.22 to HR.56 to WFM.09
HR.24	WFM.09	Rephrased and merged with HR.22 to HR.56 to WFM.09
HR.25	WFM.09	Rephrased and merged with HR.22 to HR.56 to WFM.09
HR.26	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.27	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.28	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.29	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
HR.30	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.31	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.32	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.33	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.34	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.35	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.36	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.37	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.38	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.39	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.40	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.41	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.42	WFM.09	Rephrased and merged from HR.22 to HR.42 to WFM.09
HR.43	WFM.10	Rephrased and merged from HR.42 to HR.48 to WFM.10
HR.44	WFM.10	Rephrased and merged from HR.42 to HR.48 to WFM.10
HR.45	WFM.10	Rephrased and merged from HR.42 to HR.48 to WFM.10
HR.46	WFM.10	Rephrased and merged from HR.42 to HR.48 to WFM.10
HR.47	WFM.10	Rephrased and merged from HR.42 to HR.48 to WFM.10

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
HR.48	WFM.10	Rephrased and merged from HR.42 to HR.48 to WFM.10
HR.49	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.50	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.51	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.52	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.53	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.54	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.55	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.56	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
HR.57	OGM.23	Rephrased and merged from HR.49 to HR.57 to OGM.23
NS.1	WFM.22	Rephrased to WFM.22
NS.2	WFM.23	Rephrased to WFM.23 to clarify the meaning
NS.3	WFM.23	Merged and Rephrased to WFM.23
NS.4	WFM.23	Merged and Rephrased to WFM.23
NS.5	WFM.26	Merged and Rephrased to WFM.26
NS.6	WFM.24	Merged and Rephrased to WFM.24
NS.7	WFM.25	Merged and Rephrased to WFM.25
MS.1	WFM.11	Rephrased
MS.2	WFM.12	Merged together and rephrased
MS.3	WFM.13	
MS.4	WFM.13	Merged together and rephrased with adding more details
MS.5	WFM.13	
MS.6	WFM.13	
MS.7		Deleted because of repetition

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
MS.8	WFM.14	Merged together and rephrased
MS.9	WFM.14	
MS.10	WFM.06	Merged ,rephrased and moved
MS.11	WFM.06	
MS.12	WFM.15	Merge together and rephrased
MS.13	WFM.15	
MS.14	WFM.16	Merged together and rephrased
MS.15	WFM.16	
MS.16	WFM.16	
MS.17	WFM.16	
MS.18	WFM.16	
MS.19	WFM.16	
MS.20		Deleted because of repetition
MS.21	WFM.17	Merged together and rephrased
MS.22	WFM.17	
MS.23	WFM.17	
MS.24	WFM.17	
MS.25	WFM.17	
MS.26	WFM.17	
MS.27	WFM.18	Merged together and rephrased
MS.28	WFM.18	
MS.29	WFM.18	
MS.30	WFM.18	
MS.31	WFM.18	
MS.32	WFM.19	Merged together, rephrased with more details added
MS.33	WFM.19	
MS.34	WFM.19	
----------		Separated from MS.4.6 and MS.19 with more focus on other healthcare providers privileges
		Rephrased
MS.35		Moved to ADD
MS.36		Moved to ADD
MS.37		Moved to ADD
MS.38		Moved to ADD

Differences between 2017 and 2019 editions		
2017 standards 3rd Edition	**2019 standards 4th Edition**	**Change Summary**
MS.39		Moved to ADD
CI.1	CAI.02	
CI.2	CAI.02	
CI.3	CAI.02	
CI.4	CAI.02	
CI.5	CAI.02	
CI.6	CAI.03 CAI.04	
CI.7	CAI.03 CAI.04	
CI.8	CAI.03 CAI.04	
CI.9	CAI.03 CAI.04	
CI.10	CAI.06	
CI.11	CAI.02	
CI.12	CAI.05	
CI.13	Deleted	
CI.14	Deleted	

+ Additional Requirements for research, academic activities and organ transplantation

Acknowledgements

Hospital Standards Development and Review Working Group:

- Dr. Ahmed Algamal, International Healthcare Quality Consultant
- Dr. Zakaria Abdelhameed, Healthcare Quality Consultant
- Dr. Nahla Badr, Healthcare Quality Expert
- Ms. Hanan Ibrahim Matiboly, Nurse Specialist and Healthcare Quality Expert
- Ms. Nagia Sharf El Din, Nursing and Quality Expert
- Dr. Eman Ahmed Darwish, FISQua, PhD, Healthcare Quality Expert
- Dr. Soha Al Marsfy, Infection Control Consultant
- Dr. Samah El Azab, Healthcare Quality Consultant

Special appreciation for the support of:

- GAHAR Higher committee for standards development, led by Dr Ahmed Safwat

Special appreciation for the efforts of:

- *Primary Care working group leader, Dr Khaled Omran*
- *Facility Management working group led by Dr Sayed ElOkda*
- *Infection Control Working Group led by Dr Walaa Abd El-Latif*
- *Medication Working Group led by Dr Nirmeen Ahmed Sabry*
- *Blood Bank Working Group represented by Dr Ehab Serag Eldin Ahmed*
- *Radiology Working Group led by Dr Seham ElSaadany*

Special Thanks to;

- *Sheikh Zayed Specialized Hospital and the quality team for hospitality and discussions*
- *AsSalam International Hospital and the medical administration team for hospitality and discussions*
- *Misr University for Science and Technology and quality team for hospitality and support*

ACRONYMS

Code	Meaning
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
EFS	Environment and Facility Safety
ICP	Infection control and Prevention
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 Process Requirements

SECTION 1: ACCREDITATION PROCESS REQUIREMENTS

Section Intent:

This chapter aims at providing a clear ethical framework that an organization shall follow in order to comply with GAHAR survey process. These standards are not going to be scored; however, compliance to them is crucial for survey process.

APR.01 The organization complies with all registration requirements and provide continuous and accurate monitoring of compliance.

APR.02 The organization maintains current and valid licensure for all required services.

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

APR.04 The organization reports within 30 days any structural changes in the organization scope of work, building or governance that require adding, modification or deletion of licenses.

APR.05 The organization provides GAHAR access to evaluation results and reports of any evaluating governmental organization.

APR.06 The organization accurately represents its registration and accreditation status and scope.

APR.07 The organization informs staff and patients on mechanisms to report safety issues to GAHAR.

APR.08 During surveys, the organization maintains professional standards on dealing with surveyors and prevent safety or security risks.

APR.09 During surveys, the organization avoids media or social media releases without approval of GAHAR.

Section 2

Patient-Centered Standards

SECTION 2: PATIENT CENTERED CARE

Patient-centered care represents a paradigm shift in how patients, providers, 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 • equitable.

The report set 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 family advisers should participate in the overall design of the service, department or program.
3. The organizational level refers to the organization as a whole. Patients and families should participate as full members of key organizational 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 organizations could readily put patient's medical file 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 is 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 providers 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 providers 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. Providers 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; 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. Providers shall cooperate in the interest of the patient's overall well-being

7) Access to Care

To the extent that it is possible, patients should have access to all the care they need, when they need it, in a manner that's convenient and doesn't inflict too much added 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.

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 provider'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 provider's communication, soft skills and on-time schedules.

This requires that healthcare providers develop good communication skills and address patient needs effectively and timely. Patient-centered care also requires that the healthcare provider becomes a patient advocate and strives to provide care that not only is 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. Patient-centered care is described and enforced on multiple levels.

Globally, the universal declaration of human rights article 25 emphasized the human right to a standard of living adequate for the health and well-being of himself and of his family that includes medical care and the right to security in the event of sickness or disability. In 1990, Cairo declaration on human rights in Islam clearly stated in article 20 that no human should be a subject to a 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 Egyptian constitution, comprehensive quality-standardized healthcare is a right for Egyptians. Egyptian codes of medical, nursing, pharmaceutical and other healthcare providers' ethics emphasized multiple aspects of patient's rights and healthcare provider'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 the Egyptian society such as women, children, and handicapped and elderly. Egyptian government identified multiple methods for public to voice complaints from healthcare organizations, including hotlines in the ministry of health and population.

Practically, Healthcare organizations need to ensure an 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 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 Objectives:

This chapter corresponds to the “Patient Rights and Responsibilities” chapter in the previous versions of Egyptian standards.

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

Implementation guiding documents:

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

1) Egyptian Constitution
2) Universal declaration on Human Rights year 1964
3) Cairo declaration on Human Rights in Islam, 1990
4) Law 126/2008 on 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 / 2001 Management of emergency cases
15) MOH Ministerial decree number 216 / 1982 Healthcare facilities organization
16) MOH Ministerial 186/2001 Patient right to know expected cost of care

Planning and Protecting Patient-Centeredness Culture

PCC.01 The organization plans services and advertises honestly in accordance to applicable laws and regulations, approved organization policy, and ethical codes of the healthcare providers' Syndicates.

Patient-Centeredness

PCC.02 The organization establishes an interdisciplinary committee for Patient Centered practices

a) The committee has terms of reference; they include at least the following features:
   1. Work to plan and assist with implementation and maintenance of patient-centered practices.
   2. Membership includes a mix of bed side nurses and doctors, administrative and management staff, and patient representatives.
b) The committee meets on regular basis.
c) The committee's meetings are recorded.

Patient-Centeredness

PCC.03 The organization management team adopts mechanisms to ensure patient-centered initiatives are supported by the organization staff:

a) Staff are oriented, educated and trained on patient-centered initiatives.
b) The organization develops mechanisms to evaluate patient-centeredness performance of staff; these mechanisms may include patient education activities, patient engagement in making care decisions and/or providing emotional support.

Patient-Centeredness

PCC.04 The organization develops and implements a policy and procedures that defines patients and family rights, mechanisms to protect these rights and to inform patients and families of these rights; the policy addresses at least the following:

a) Patient and family rights as defined by laws and regulations, and the ethical code of Healthcare Providers' Syndicates.
b) Patient and family right to access care if provided by the organization.
c) Patient and family right to know the name of the treating, supervising and/or responsible physician.
d) Patient and family right to care that respects the patient's personal values and beliefs.

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

Patient-Centeredness

PCC.05 The organization develops and implements a policy and procedures that defines patient and family responsibilities, mechanisms to empower patients and their families to assume them; the policy addresses at least the following:

a) Patients and their families have the responsibility to comply with the policies and procedures of the organization.
b) Patients and their families have the responsibility to comply with financial obligation according to laws and regulations and organization policy.
c) Patients and their families have the responsibility to show respect to other patients and healthcare workers.
d) Patients and their families have the responsibility to follow the recommended treatment plan.

Equity

PCC.06 The organization defines a process for reporting violations for patient's and family's rights and responsibilities.

Patient-Centeredness

Empowerment and Involvement of Patient and Family

PCC.07 The organization ensures that admission consent is obtained from the patient or a legal representative before patient hospitalization after discussing the patient needs and obligations.

Patient-Centeredness

PCC.08 The organization ensures that all patients and families have opportunities to meet with multiple members of healthcare team (including the nurse and physician) at one time. Opportunities maybe used to ask questions and to have answers in a manner that they understand.

Patient-Centeredness

PCC.09 The organization ensures that patient education materials are:

a) Readily available.
b) Appropriate for readers of varying literacy levels.
c) Translated in different languages for foreigner patient groups, if applicable.

Patient-Centeredness

PCC.10 The organization develops and implements a policy and procedures for patients and families education; the policy addresses at least the following:

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

Patient-Centeredness

PCC.11 The organization develops and implements a policy and procedures for providing education and recording in the patient's medical file about at least the following:

a) Diagnosis and condition.
b) Plan of care.
c) Discharge instructions.

Patient-Centeredness

PCC.12 The organization develops and implements a policy and procedures for obtaining informed consent for certain medical processes as required by laws and regulations; the policy defines at least:

a) The list of medical processes when an informed consent is needed, this list shall include:
   1) Surgery and invasive procedures.
   2) Anesthesia, moderate or deep sedation.
   3) Use of blood.
   4) High-risk procedures or treatments (including, but not limited to, Electro Convulsive Treatment, radiation therapy, chemotherapy).
   5) Family planning interventions.
   6) Research.
b) The risks, benefits, and alternatives of performing that particular medical process.
c) Certain situations when a consent can be given by someone other than the patient, and mechanisms for obtaining and recording it in accordance to applicable laws and regulations and approved organization policies.
d) Consent forms availability in all applicable locations.

Patient-Centeredness

PCC.13 The organization defines the validity period of signed informed consents and the potential situations when a new consent is required i.e. a patient already signed a consent but his/her condition has changed.

Timeliness

PCC.14 The organization develops and implements a policy and procedures to define the process of informing patients and families 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; 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 document patient and/or family refusal of the medical care process step.
d) How to follow up with the patient/family after leaving the organization.

Patient-Centeredness

PCC.15 The organization implements a process to educate and support patients and families through the billing (or other administrative) process.

Patient-Centeredness

Ensuring Patient Physical Comfort

PCC.16 The organization works in collaboration with other community stakeholders to provide physical comfort and easy physical access to the organization; such as public transportation access, ramps and paths for wheel chairs and trollies, and adequate parking space.

Equity

PCC.17 The organization provides appropriate and clear wayfinding signage inside the organization to help patients and their families to reach their destination.

Effectiveness

PCC.18 The organization provides waiting spaces for various services that are:

a) Well-lit, well-ventilated, clean and safe.
b) Adequate for the expected number of patients.
c) Suitable for basic human needs such as toilets, potable water and food.
d) Providing information on how long patients may wait.

Patient-Centeredness

PCC.19 During hospitalization, the organization ensures at least the following:

a) Patients are allowed to control their space environment such as ventilation, temperature and lighting.
b) Comfortable spaces and equipment are available for patient use.
c) Healthy food is available for patients and families 24 hours a day and 7 days a week.
d) Visiting hours are convenient for patients and their families.

Patient-Centeredness

Protecting Patient Belongings, Privacy and Confidentiality

PCC.20 The organization implements a process to identify communicate and honor patient emotional, religious and spiritual needs and other preferences.

Patient-Centeredness

PCC.21 The organization ensures that patient's dignity, privacy and confidentiality are protected during all medical care processes; such as screening, assessments, care and treatments.

Patient-Centeredness

PCC.22 Patients are allowed to decide who can attend their screening, assessment or care processes.

Patient-Centeredness

PCC.23 The organization develops and implements a policy and procedures that defines the organization's responsibility towards patient's belongings. The policy addresses at least the following:

a) Who is responsible for securing patient belongings?
b) When responsibility for these belongings begin?
c) How belongings shall be protected?
d) How patients and families shall be informed about the organization's responsibility for belongings?
e) "Loss and found" situations.

Patient-Centeredness

Responsiveness to Patients' and Families' Voices

PCC.24 The organization develops and implements a policy and procedures to measure patient's and family's feedback on provided services; The policy addresses at least the following:

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

Patient-Centeredness

PCC.25 The organization develops and implements a policy and procedures to define the process for patients and families to make oral or written complaints or suggestions; the policy addresses at least the following:

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

Patient-Centeredness

PCC.26 The organization ensures that data obtained from patients' and families' feedback are used to improve the quality of services.

Patient-Centeredness

Access, Continuity and Transition of Care

Chapter Intent:

Access is the process by which a patient can start receiving the 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. Transitional care refers to the coordination and continuity of healthcare during a movement from one healthcare setting to either another one or to home, between healthcare providers and settings as their condition and care needs change during the course of a chronic or acute illness. Continuity of care becomes increasingly important for patients as community ages, develops multiple morbidities and complex problems, or include more patients who become socially or psychologically vulnerable.

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, 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 healthcare organizations defined the minimum requirements for licensure and for access pathways. 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. Also, Egyptian government has announced a major initiative to transform the healthcare industry in Egypt, Where payors 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 "Comprehensive Health Insurance" where eligibility criteria is set for patient access and referral mechanisms shall be established.

Practically, Healthcare organizations need to consider all the accesses to services, even on 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 patient from/to the organization 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 Objectives:

This chapter corresponds to chapter “Patient Access” in the previous version.

The main objective is to ensure that organizations provides and maintains an equitable effective access to patient care services in a safe efficient way. Patient may start accessing healthcare services through emergency room, outpatient department, admission office, dialysis unit, and day care unit or registration/admission offices. Upon hospitalization and all through the patient journey, someone shall be responsible for the patient plan of care, even if the patient is lying on a board waiting for transfer from emergency room to a patient room. Sometimes, care plans change and another doctor need to be called in for consultation or even become completely responsible for the patient care. These situations also need to be addressed by the organizations 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 organization, clear information need 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) 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) MOH Ministerial decree number 216 / 1982 Healthcare facilities organization
10) MOH Ministerial decree 254/2001 Discharge summary requirements
11) Publications of Central Administration of Emergency and Critical Care, Egyptian ministry of health and population

Effective Patient Flow in the organization

ACT.01 The organization develops and implements a policy and procedures to grant patients access to its services in accordance to applicable laws and regulations, approved organization policy, and pre-set eligibility criteria. The policy addresses at least the following:

a) Process to screen patients to determine that the organization scope of services can meet their healthcare needs.

b) Access through emergency areas is safe and appropriate for patients' conditions.

c) Access through outpatient areas include a clearly defined scheduling and queuing process for patients that ensures appropriate identification, clear sufficient information exchange, safety and comfort.

Patient-Centeredness

ACT.02 The organization develops a policy and procedures to ensure coordination and continuity of care; The policy addresses at least the following:

a) A competent staff member performs an initial screening process.

b) A screening process is used to determine the priority of the patient's medical and nursing care needs in emergency, outpatient, interventional units and referral to the organization.

Equity

ACT.03 The organization develops and implements a policy and procedures to ensure safe and comfortable hospitalization process; the policy addresses at least the following:

a) Hospitalization procedures of patients, including those coming from outpatient area, emergency areas and other hospitalization routes.

b) A defined care plan and time frame for hospitalization process.

c) Information to be given to the patient and family at the time of hospitalization.

d) Management of patients when bed is not available.

e) Management of patients whose care needs cannot be met by the organization including care at emergency rooms, outpatient clinics or inpatient services.

Equity

Effective and Safe Patients Flow within the organization

ACT.04 The organization develops a risk assessment and management plan for patient flow; the plan addresses at least the following:

a) Define multiple scenarios of patient flow.
b) Identify bottlenecks and crowding areas.
c) Develop improvement projects for more efficient patient flow.

Effectiveness

ACT.05 The organization develops and implements a policy and procedures to ensure a safe and clear responsibility of patient care; The policy addresses at least the following:

a) Each hospitalized patient is assigned to one Most Responsible Physician (MRP) as relevant to patient clinical condition.
b) Conditions to request and grant transfer of care responsibility.
c) How information about assessment and care plan including pending steps shall be transferred from the first most responsible physician to the next one.
d) Process to ensure clear identification of responsibility between “transfer of responsibility” parties.

Safety

ACT.06 The organization develops a policy and procedures to ensure a safe and effective second opinion processes. The policy addresses at least the following:

a) Defined criteria for getting second opinion for patients.
b) Clear process of communicating second opinion requests to concerned healthcare providers.
c) Clear process of communicating essential information to the second opinion healthcare providers.
d) Timeframe to respond to second opinion requests.
e) Response details to ensure safe and appropriate care planning.

Patient-Centeredness

ACT.07 The organization develops a policy and procedures to ensure a safe and appropriate consultation process. The policy addresses at least the following:

a) Defined criteria for getting consultation for patients.
b) Expected outcome and urgency of consultation.
c) Clear process of communicating consultation requests to concerned healthcare providers.
d) Timeframe to respond to consultation requests.
e) Response details to ensure safe and appropriate care planning.

Safety

ACT.08 The organization develops and implements a policy and procedures to ensure a safe and appropriate process of "Multidisciplinary management". The policy addresses at least the following:

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

Safety

ACT.09 The organization develops and implements a policy and procedure to ensure a safe and clear process of transporting patients; the policy addresses at least the following:

a) Safe patient handling to and from patient bed, trolley, wheelchair, and other transportation means.
b) Staff safety while lifting and handling patients.
c) Competence of responsible staff for transportation of patients.
d) Defined criteria to determine the appropriateness of transportation within the organization.

Safety

ACT.10 The organization develops and implements a policy and procedures for admission and discharge from intensive care and specialized units; that includes at least the following:

e) Defined physiologic based admission criteria for the intensive care and specialized units and /or specific conditions defined by appropriate healthcare providers in the organization.
f) Defined discharge physiologic based criteria for the intensive care and specialized units and /or specific conditions defined by appropriate healthcare providers in the organization.

Equity

Safe and Effective Patients Flow out of the organization

ACT.11 The organization develops and implements a policy and procedures that defines patients' temporary discharges. The policy addresses at least the following:

a) Safe and effective patient referral out to do a diagnostic examination or to receive care outside the organization then return.
b) Efficient patient education if patient is allowed to leave the organization for non-medical reasons.
c) Required support to ensure safe patient discharge and return.

Patient-Centeredness

ACT.12 The organization develops and implements a policy and procedures for transfer outside the organization, referral and discharge of patients; The policy addresses at least the following:

a) Planning for transfer, referral and discharge begins once diagnosis or assessment is settled and when appropriate includes the patient and family.
b) The reason for the transfer or referral is recorded in the patient's medical file.
c) Responsible staff for transfer, referral and discharge of patients.
d) Defined criteria determine the appropriateness of transfers outside the organization based on organization scope and patient's needs for continuing care.
e) Coordination with referral agencies, if applicable, other levels of health service and other organizations.

Patient-Centeredness

ACT.13 The organization implements a process for completing the discharge summary; A copy of the discharge summary is stored in the patient's medical file; The discharge summary shall include 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 physician who discharged the patient.

Patient-Centeredness

ACT.14 The organization implements a process for completing the referral/transfer sheet; A copy of the referral/transfer sheet is stored in the patient's medical file; The referral/transfer sheet shall include at least the following:

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

Patient-Centeredness

Integrated Care Delivery

Chapter Intent:

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

Usually, patients are screened whenever full assessments is 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 further deeper assessment is required. It is a crucial step to save recourses and time.

Assessment is a structured deeper process, when a patient is looked at holistically by listening to patient 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 assessment required. Healthcare organizations define the minimum contents of initial and subsequent assessments. This process starts with collecting enough relevant information to allow healthcare providers to draw pertinent conclusions about patient's strengths, deficits, risks, and problems. In addition to understanding the meaning of signs and symptoms, 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 collection of patient’s needs. Literature shows that this concept helps to coordinate care, improve healthcare service utilization, and reduce costs at healthcare organizations. It also improves patient satisfaction and engagement.

The assessment and management of certain categories of patients may differ in its content and scope from the regular processes. Healthcare organizations 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.

Egyptian government has announced a major initiative to transform the healthcare industry in Egypt, Where payors 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 “Comprehensive Health Insurance” where defined eligibility criteria is set for patient access and referral mechanisms shall be developed.

Healthcare organizations need to comply to a number of laws and regulations that maintains and organizes the new healthcare initiative, the main guide is a vast collection of patient and family centered national laws and regulations, national and international evidence-based guidelines and several governmental initiatives.

Chapter Objectives:

This chapter corresponds to Assessment of Patient (AP) and Provision of Care (PC) in previous versions.

This chapter “Integrated Care Delivery” includes multiple sectors; the main theme is that 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 organization “presentation site” then 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 special 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 care of psychiatric patients
6) Law 126/2008 on Egyptian Child
7) Law 10/2018 on the rights of handicapped
8) MOH Ministerial decree 63/ 1996 for dialysis units
9) Regulation for care of psychiatric patients 128/2010
10) Publications of Central Administration of Emergency and Critical Care, 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 MOH law and regulation
14) National cancer treatment guidelines, High committee of cancer. Egyptian ministry of health and population
15) Law 51/1981 for healthcare organizations
16) Managing victims of social abuse guidelines – ministry of health, UNFPA

Sustaining Uniform Care

ICD.01 Care delivery is uniform when similar care is needed regardless location or time of care.

Equity

ICD.02 The organization defines a process to ensure qualified healthcare providers shall screen and assess patients in order to identify all their needs according to laws and regulations and based on the services provided. This multidisciplinary team may include physicians, nurses, social workers, physiotherapists, nutritionists and pharmacists.

Effectiveness

Screening, Assessment and Care upon access to healthcare services

ICD.03 When applicable, The organization develops and implements a policy and procedures that guides the delivery of pre-hospital services according to applicable laws and regulations. The policy addresses at least the following:

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

Effectiveness, Equity, Timeliness

ICD.04 The organization develops and implements a policy and procedures that guides the delivery of urgent and emergency services according to applicable laws and regulations. The policy addresses at least the following:

a) A qualified staff is available 24 hours a day and 7 days a week.
b) Defined criteria are developed to determine priority of care according to a recognized triage process.
c) Assessment, reassessment and care management follows approved clinical guidelines and protocols.

Effectiveness, Equity, Timeliness

ICD.05 The organization develops/adapts and implements clinical guidelines/protocols for emergency care that are appropriate for the organization scope of service; the clinical guidelines/protocols addresses at least the following:

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.

Effectiveness

ICD.06 The organization implements a process for recording information in the patient's medical file of every patient receiving emergency care; The record includes at least the following:

a) Time of arrival and time of discharge.

b) Conclusions at termination of treatment.

c) Patient's condition at discharge.

d) Patient's disposition at discharge.

e) Follow-up care instructions.

f) Discharge order by the treating physician.

Patient-centeredness

ICD.07 The organization develops and implements a policy and procedures to define the following for all outpatient services:

a) Scope and content of the initial assessment including history and physical examination.

b) Time frame for completing and recording initial assessment for each discipline.

c) Responsibility for completion of assessment.

d) Frequency of reassessments of patients whenever applicable.

e) Recording care plans.

Patient-centeredness

Basic screening, assessment and care for hospitalized patients

ICD.08

The organization develops and implements a policy and procedures to define the following for all patients upon hospitalization:

a) Responsibility and scope of performing the initial assessment.

b) Time frame for completion of initial assessment for each discipline.

c) Minimum frequency and content of reassessments of patients by diagnosis and/or level of care.

Effectiveness, Timeliness

ICD.09

The organization ensures that nursing initial assessments and subsequent reassessments are performed in accordance to approved clinical guidelines/protocols and recorded in the patient's medical file within an approved timeframe.

Effectiveness, Timeliness

ICD.10

The organization develops and implements a policy and procedures to define the contents of the medical staff comprehensive history and physical examination upon patient hospitalization; The policy addresses 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.

Effectiveness, Timeliness

ICD.11

The organization develops and implements a policy and procedures to ensure that patient's healthcare needs are identified according to defined screening processes; The policy addresses at least the following:

a) All screens are completed and recorded within an approved timeframe.

b) Patients are referred for further assessment by the specific service when defined criteria are met.

c) Qualified healthcare providers define screening criteria for assessing the following patients' risks and needs.

d) Screening occurs for at least the following:

1. Nutritional status.
2. Functional status.
3. Psychosocial status.
4. Discharge needs.
5. Victims of abuse and neglect.

e) Screening occurs in accordance to applicable laws and regulations, approved organization policy and clinical guidelines/protocols.

Patient-Centeredness

ICD.12 The organization defines a policy and procedures to verify and/or accept the results of patient's assessments performed outside the organization.

Patient-Centeredness

ICD.13 The organization develops and implements a policy and procedures to define whenever history and physical examination completed prior to hospitalization may be used.

Patient-Centeredness

ICD.14 The medical staff reaches conclusion or impressions drawn from the history and physical examination, including diagnoses and records the findings in the patient's medical file.

Patient-Centeredness

ICD.15 On hospitalization, the healthcare provider records in the patient's medical file subsequent changes to the initial assessment, based on reassessment of the patient accurately and within approved timeframe.

Patient-Centeredness

ICD.16 Individualized Plan of care is developed for every patient, which is:

a) Developed by all relevant disciplines providing care.
b) Based on assessments of patient performed by the various healthcare disciplines and providers.
c) Developed with participation by the patient and/or family.
d) Includes identified needs, interventions, and desired outcomes with time frames.
e) Updated as appropriate based on reassessment of the patient.

Patient-Centeredness

ICD.17 The organization develops and implements policy for clinical guidelines/protocols, that includes at least the following:

a) Defines how clinical practice guidelines/protocols are developed/adapted, reviewed, evaluated, and updated based on evidence-based literature.
b) The organization should develop/adapt guidelines/protocol for the most common/high risk three diagnosis managed in the organization annually.
c) Clinical practice guidelines developed/adapted by the organization are evaluated at least annually or when needed.

Efficiency

ICD.18 Clinical practice guidelines are used when required by law and regulation and when applicable to patient condition.

Patient-Centeredness

ICD.19 The organization ensures that information are available to support physician's orders and requests; 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 physician.
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.

Patient-Centeredness

Special Patient Screening, Assessments, and Care Processes

ICD.20 The organization defines a program that ensures all inpatients and outpatients are screened for pain, assessed whenever pain is present and managed accordingly.

Patient-Centeredness

ICD.21 All hospitalized patients are screened for pain Initially and every 12 hours or according to the physician's order.

Patient-Centeredness

ICD.22 If pain is present, a complete assessment is performed including the nature, site and severity.

Patient-Centeredness

ICD.23 Qualified Individuals are responsible for managing the pain and recording the management plan in the patient's medical file.

Patient-Centeredness

ICD.24 Pain is reassessed and recorded to determine the effectiveness of treatment, in accordance to approved organization policy and clinical guidelines/protocols.

Patient-Centeredness

ICD.25 The organization develops and implements a policy and procedures for assessment and care management of nutritional patient needs. The policy addresses at least the following:

a) Availability of competent individual for assessment and management of patient's nutritional needs.
b) Defined criteria for involvement of nutritional services into patient care process.
c) Components of nutritional assessment.
d) Management and care for patient's nutritional needs:
    1. A list of all special diets is available and accommodated.
    2. Ordering of food is appropriate to the patient's clinical condition.
    3. Ordering for food or other nutrients is recorded in the medical file.
    4. 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.

Patient-Centeredness

ICD.26 The organization develops and implements a policy and procedure for assessment and care management of social patient needs. The policy addresses at least the following:

a) Availability of competent individual for assessment and management of patient's social needs.
b) Defined criteria for involvement of social services into patient care process.
c) Components of social assessment.
d) Management and care of patient's social needs:
    1. A list of community resources for health promotion and vulnerability support is available.
    2. Education of patients and/or their families on available community resources when needed.
    3. Field and home visits for assessment and support.
    4. Management and support in case of patient's disability, infectiousness, and inability to afford payment of care costs.

Patient-Centeredness

ICD.27 The organization develops and implements a policy and procedures for assessment and care management of functional patient needs; The process 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 individualized plan of care that addresses at least the following:
    1. Management, care and support for independent activities of daily life such as eating, drinking, walking and moving.
    2. Management, care and support for communication for those with limited hearing, vision, cognitive or intellectual abilities.
    3. 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 involvement of rehabilitative services into patient care process.

Patient-Centeredness

ICD.28 The Organization develops and implements a policy and procedure to specify special screening, assessment, reassessment and care components for special patient populations including at least the following:

a) Adolescents.
b) Elderly.
c) Disabled.
d) Immunocompromised.
e) Patients with communicable diseases.
f) Patients with chronic pain.
g) Victims of abuse and neglect.

Patient-Centeredness

ICD.29 The organization ensures qualified healthcare providers with the appropriate experience are available to provide care for special populations in accordance to laws and regulations.

Patient-Centeredness

ICD.30 For women in labor, The organization develops and implements a policy and procedure that guide assessment and management of childbirth process in accordance to WHO safe childbirth checklist.

Safety

ICD.31 For pediatric patients, clinical guidelines are used to define the assessment and care management that includes 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 in accordance to national child law and regulations.
f) Growth charts.

Patient-Centeredness

ICD.32 The organization develops and implements a policy and procedures to guide the assessment and care management of terminally ill patients and includes at least the following:

a) Management of symptoms, including pain and depression.
b) Provision of patient and family support for psychosocial, emotional and spiritual needs.

Patient-Centeredness

ICD.33 The organization develops and implements a policy and procedures to ensure psychiatric patients' rights during assessments and care plans are maintained in accordance to applicable laws and regulations, 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.

Patient-Centeredness

ICD.34 The organization ensures qualified healthcare providers are available to perform assessment for patients with drug abuse and addiction according to national laws and guidelines.

Effectiveness

ICD.35 The organization develops and implements a policy and procedures that guide the assessment and care management of victims of drug abuse and addiction in in accordance to applicable laws and regulations and approved organization policies and clinical guidelines/protocols; The policy addresses at least the following:

a) Assessment of history of drug use, including age of onset, duration, intensity, patterns of use, used drugs, consequences and complications.

b) Types of previous treatment and responses to the treatment.

c) History of mental, emotional, and behavioral problems, plus results of previous treatments used.

d) Treatment acceptance or motivation for treatment is assessed and recorded.

e) Features of the environment that promote compliance and wellness or obstacles to recovery are assessed and recorded.

Patient-Centeredness

ICD.36 The organization develops and implements a policy and procedures to ensure qualified healthcare providers perform the addiction patient psychosocial assessment and management according to laws and regulations, that includes at least the following:

a) Assessment of:

1. Leisure and recreation activities and preferences.
2. Childhood and family history for psychiatric disease.
3. Military service history.
4. Financial status.
5. Sexual history, including abuse, either as abuser or abused.
6. Physical abuse, either as abuser or abused.
7. Current living situation and family circumstances.
8. Social, ethnic, cultural, emotional, religious and health factors.
9. Need for family participation in the patient's care.

b) Care and management of patients based on identified needs

Patient-Centeredness

ICD.37 The organization develops and implements a policy and procedures that defines the appropriate and safe use of restraint and seclusion, The policy addresses at least the following:

a) 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.

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.

Patient-Centeredness

ICD.38

NSR.10 The organization develops and implements a policy and procedures to ensure organization-wide 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 on the defined criteria.

c) Identification of involved staff to respond.

d) Mechanisms to call staff to respond; including code(s) that may be used for calling emergency.

e) Time frame of response.

f) The response is uniform 24 hours a day and 7 days a week.

g) Recording of response and management.

Safety

ICD.39 The organization develops and implements a policy and procedures that define the response to medical emergencies and cardio-pulmonary arrest in the organization for both adult and pediatric patients; The policy addresses at least the following:

a) Defined criteria of recognition of emergencies and cardio-pulmonary arrest.
b) Education of staff on the defined criteria.
c) Identification of involved staff to respond.
d) Mechanisms to call staff to respond; including code(s) that may be used for calling emergency.
e) Time frame of response.
f) The response is uniform 24 hours a day and 7 days a week.
g) Recording of response and management.

Safety

ICD.40 The organization develops and implements a policy and procedures that define emergency equipment and supplies required according to law, regulations and guidelines; The policy addresses at least the following:

a) Identification of required emergency equipment and supplies in accordance to laws, regulations and standards of practice.
b) Emergency equipment and supplies are available all over the organization.
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.

Safety

ICD.41 The organization develops and implements a policy and procedures for dialysis services according to laws and regulations; 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:
    1. Management of clotted access.
    2. Anticoagulation usage.
    3. Dialysis-induced complications.
    4. Cardiopulmonary collapse and urgent medical conditions during dialysis.

Patient-Centeredness

ICD.41.01 The organization develops and implements policy and procedures to define regular testing of water and machinery used in chronic renal dialysis unit in accordance to laws, regulations and manufacturer's recommendations.

Safety

ICD.41.02 The organization implements a process for safety and prevention of sero-conversion for patients with positive HCV (Ab) and negative PCR (grey zone dialysis machines).

Safety

ICD.42 The organization develops and implements a policy and procedures for chemotherapy and/or radiotherapy services in accordance to laws and regulations; The policy addresses at least the following:

a) Initial assessment requirements.
b) Reassessment requirements.
c) Clinical guidelines/protocols for at least the following:
    1. Extravasations and anaphylaxis management guidelines.
    2. Neutropenia and other related complications.

Patient-Centeredness

Monitoring safe care practices

ICD.43 The organization establishes an interdisciplinary committee for mortality and morbidity:

d) The committee has terms of reference.
e) The committee meets on regular basis.
f) The committee's meetings are recorded.

Safety, Effectiveness

ICD.44
NSR.11 The hospital implements guidelines to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).

Safety

Diagnostic and Ancillary Services

Chapter Intent:
Patients seek medical help for determination and treatment of various health problems. Sometimes a combination of the patient's history and a clinical examination by a primary level 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
- Neuro diagnostics
  - Electroencephalography (EEG)
  - Electromyography (EMG)
  - Nerve conduction studies (NCS) and evoked potentials (EP)
- Pulmonary Function
- Polysomnography
- Laboratory Medicine
  - Sample collection
  - Chemistry and Immunology
  - Microbiology
  - Hematology
  - Anatomic pathology and cytology
  - Molecular Biology
  - Cytogenetics
- Point-of-care testing
- Transfusion medicine

There are three phases in the process of diagnostic investigation:

- Preanalytical
- Analytical
- Post analytical

The pre-analytical phase comprises the time and all processes for the preparation of a patient for a diagnostic investigation to the moment when the investigation is performed. The analytical phase comprises the time and all processes of a diagnostic 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 analytical phase is under the control of the diagnostic service, which has the responsibility for accurately performing the investigations. In contrast, during the pre-analytical and post-analytical phases, other personnel, including the medical doctor and paramedical personnel who are not working with the diagnostic service are involved in the process; and made errors in these two phases influence the results such that they may no longer be clinically relevant.

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

The chapter covers also 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; as described in the WHO Blood Safety Initiative; WHO core medical equipment, Laboratory biosafety, Laboratory quality control and other publications.

From the national perspective, laws, regulations and guidelines are covering most of the critical processes and offers guidance to the healthcare providers for provision of appropriate safe care specially in the Medical Imaging and transfusion services, In the laboratory and other diagnostic services international guidelines are available to ensure effective analysis. GAHAR surveyors shall be focusing on the timely communication of the patient information to ensure correct and effective patient management plans. The accuracy and precision of the results reported to clinicians is 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, and radioactive or others.

Chapter Objectives:

This chapter corresponds to chapters DS and BB in the previous version

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

1) Safe and effective medical imaging services.
2) Safe and effective clinical laboratory and pathology services.
3) Safe and effective other diagnostic tests.
4) Safe and effective point of care testing.
5) 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) MOH Ministerial decree 385/1975 for management of blood banks
6) MOH Ministerial decree 420/1994 for blood donor incentives
7) Law 192/2001 for Hazardous waste management
8) National Blood transfusion Policy, MOH, 2007
9) Anatomic pathology and Microbiology checklists, CAP accreditation program, 2014
10) ISO 15189, 2012
11) Requirements of blood bank staff, Egyptian MOH
12) Requirements and equipment of blood bank, Egyptian MOH
13) Requirements of sub-blood bank, Egyptian MOH
14) Tuberculosis Labs manual, Egyptian MOH 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, MOH
19) List of essential invitro diagnostic tests, WHO, 2018
20) Law 51/1981 for healthcare organizations

Medical Imaging

Appropriate Planning and Management

DAS.01 The organization plans, provides and operates all medical Imaging services in accordance to applicable laws and regulations and approved organization policy and clinical guideline/protocol.

Effectiveness

DAS.02 The organization leaders plan and periodically evaluate the medical imaging services in accordance to organization scope and available resources, this may include:

a) Selection of equipment and technology used.
b) Required space.
c) Special human expertise.

Effectiveness- efficiency- patient-centeredness

DAS.03 The organization ensures licensed competent healthcare providers are available to operate uninterrupted medical Imaging services, and specific duties are assigned in accordance to applicable laws and regulations and assessed competencies.

Effectiveness- Safety

DAS.04 The organization develops and implements radiology procedure manuals in accordance to applicable laws and regulations and approved organization policy and clinical guideline/protocol and manufacturer's recommendation.

Effectiveness- Safety

DAS.05 The organization develops and implements a plan to ensure that all medical Imaging equipment are regularly inspected, maintained and calibrated and appropriate records are maintained.

Safety- Effectiveness

Effective processes before radiological study

DAS.06 The organization implements and records physicians' orders for diagnostic services; each record includes at least the following:

a) All requested elements as per standard physician order.
b) Site and laterality.

Safety- Efficiency

DAS.07 The organization develops and implements a quality assurance and control program for all its medical imaging services.

Safety- Efficiency- Effectiveness

Safe Radiological Studies:

DAS.08 The organization develops and implements a policy and procedures for administering contrast media and radiopharmaceuticals; the policy addresses at least the following:

a) Requirements for complete safe ordering.
b) Requirements for safe administration.
c) Monitoring and handling patients receiving medications during and after the examination.
d) Management, care and reporting in case of occurrence of adverse reactions or complications.

Safety

Timely and Safe processes after radiological studies

DAS.09 The organization develops and implements a policy and procedures for reporting of medical Imaging investigations; The policy addresses at least the following:

a) Time frames for reporting various types of images.
b) Emergency and routine reports.
c) Accountabilities on the medical Imaging services across the organization.
d) Qualified licensed physician is responsible for interpretation and reporting.

Timeliness- Patient-centeredness

DAS.10 The organization ensures that copies of the medical Imaging results are recorded in the patient's medical file, the report includes at least the following:

a) The organization's 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 physician.

Patient-centeredness- safety

Effective Radiation Safety Program

DAS.11

NSR.27

The organization develops and implements radiation safety program to ensure facility environment, staff, patients, families and vendors are safe from radiation hazards. The program includes at least the following:

a) Compliance to national laws, regulations and guidelines.
b) All ionizing and non- ionizing radiation equipment are maintained and calibrated.
c) Staff self-monitoring tools.
d) Appropriate and safe waste disposal for radioactive materials.
e) Staff suitable personal protective equipment.
f) Patients safety precautions.
g) Radiation doses measured and monitored for patients in imaging areas.
h) MRI safety plan.
i) Laser safety plan.

Safety

Clinical Laboratory/ Pathology

Effective Planning and management

DAS.12 The organization plans, provides and operates the laboratory and pathology services in accordance to applicable laws and regulations and approved organization policy.

Effectiveness

DAS.13 The organization plans and periodically evaluates the laboratory and pathology services in accordance to the organization scope and available resources, this may include:

a) Selection of equipment and technology used.
b) Required space area and preparation.
c) Special human expertise.

Effectiveness- Patient-centeredness

DAS.14 The organization ensures licensed competent healthcare providers are available and assigned to operate uninterrupted laboratory and pathology services and duties. Organization ensures assignment of duties occurs in accordance to applicable laws and regulations, approved organization policy, and assessed competencies.

Effectiveness- Safety

DAS.15 The organization develops and implements procedure manuals; Manuals address at least the following:

a) All laboratory and pathology tests.
b) Summarized operational information in an easily understood language.

Effectiveness- Safety

DAS.16 The organization develops and implements a plan to ensure all laboratory and pathology equipment are regularly inspected, maintained and calibrated, and appropriate records are maintained.

Effectiveness- Efficiency

DAS.17 The organization develops and implements a policy and procedures to select contracted services; the policy addresses periodic monitoring and evaluation of compliance to the contract terms including at least the following:

a) Compliance to laws and regulations including MOH licensure.
b) Precautions for specimen collection, handling and transportation to contracted referral laboratory.
c) Reference intervals in accordance to age and sex with each report.

Safety

Safe and Effective Pre-analytical Phase

DAS.18 The organization develops and implements a policy and procedures to ensure the following updated information is readily available to laboratory and pathology staff whether covering outpatient or inpatient services:

a) Types of clinical services offered by the laboratory.
b) Defined criteria for a complete laboratory/pathology order.
c) Instructions for patient preparation, when applicable.
d) Defined specimen acceptance and rejection criteria.

Safety- Efficiency

DAS.19 The Laboratory/ Pathology department develops and implements a policy and procedures to cover the laboratory cycle including the following:

a) Receiving specimens/ lab tests orders including patient's age, sex and provisional diagnosis.
b) Collecting, identifying and processing specimens.
c) Safe transportation of specimens.
d) Retention and disposal of specimens.
e) Handling precious suboptimal specimens.
f) Pathology laboratory: Records of the number of blocks, slides, and stains prepared.

Effectiveness- safety

Safe and Effective Analytical Phase

DAS.20 The organization implements and records validation studies for test methods to ensure achieving the required performance in accordance to the manufacturer's recommendation and approved guidelines.

Effectiveness- Safety

DAS.21 The laboratory/ Pathology department develops and implements a quality control program for all tests and reagents. Quality control data are reviewed and assessed at least monthly by the laboratory director or designee. The program includes:

a) Periodic quality control and recording of corrective action when results exceed defined acceptability limits.
b) Internal quality control procedures.
c) Quality control for tests that require "microscopic examination".
d) Proficiency testing and/ or alternate proficiency testing.
e) Managing reagents and supplies, including availability, receiving, storage, labeling, inspecting and testing for accuracy.
f) Histochemical stains adequate quality.

Effectiveness- Efficiency –safety

Safe and Effective Post-analytical Phase

DAS.22 The organization develops and implements a policy and procedures to ensure reporting of verified laboratory and pathology tests; the policy addresses at least the following:

a) Approved time frame for reporting.
b) Emergency and routine reports.
c) Uninterrupted reporting services for critical disciplines.

Timeliness- safety

DAS.23 The organization ensures test reports are generated and copies are retained in the patient's medical file includes the following:

a) For all laboratory report:
   1. Name of the organization.
   2. Type of the test.
   3. Method used.
   4. Patient identifiers on each page.
   5. Date and time of primary sample collection.
   6. Examination results.
   7. Reference interval that is gender and age based updated and authorized.
   8. Interpretation of results when applicable.
   9. Time of reporting.
   10. Name and signature of the reporting physician.

b) The Pathology test reports additionally include the following:
   1. Description of specimen on receipt (e.g. bloody fluid).
   2. Interpretation of gross and microscopic findings, and, as appropriate, standard descriptive terminology.
   3. When significant disparity exists between initial intra-operative consultation (e.g. frozen section, intra-operative cytology, gross evaluation) and final pathology diagnosis, it is reconciled and recorded in the pathology report and in the departmental quality management file.

Patient-Centeredness

Effective Laboratory Safety Program

DAS.24

NSR.28

The organization develops and implements a laboratory and pathology safety program based upon the biosafety level of the laboratory; the program addresses at least the following:

a) Handling, segregating and disposing of biological hazards including engineering controls.
b) Engineering and work practice controls appropriate to the biosafety level of the laboratory are defined and implemented.
c) Identifying, handling, storing and disposing chemical hazards.
d) Handling, disposing anatomical hazards.
e) Formaldehyde and Xylene vapor levels.
f) Microtome knives safe handling.

Safety

Other Diagnostic test

DAS.25 The organization ensures licensed competent healthcare providers are available to operate diagnostic services and report its results; specific duties are assigned in accordance to applicable laws and regulations, approved organization policy, and assessed competencies

Effectiveness

DAS.26 The organization develops and implements a policy and procedures to control risks to patients, staff and organization whenever operating a diagnostic test; the policy addresses at least the following:

a) Instructions for proper patient preparation and positioning.
b) Instructions to avoid noise, artifacts or other risks that may lead to misinterpretation.
c) Quality control requirements are fulfilled in accordance to applicable laws and regulations, and approved organization policy and clinical guideline/protocol, and manufacturer's recommendation.
d) Manuals are created accordingly to minimize risks and ensure accuracy of results.

Safety

Point of care testing

DAS.27 The organization develops and implements a policy and procedures for point of care testing; the policy addresses at least the following:

a) List of tests that can be performed in the organization at the patient bedside.
b) Required staff competence to perform the test.
c) Personal protective equipment.
d) Calibration of equipment.
e) Quality control.
f) Identifying critical values.

Effectiveness- safety

Blood transfusion Services

Effective Management and planning:

DAS.28 The organization plans, operates and provides blood bank and transfusion services according to national laws and guidelines.

Effectiveness

DAS.29 The organization ensures licensed competent healthcare providers are available to operate the blood bank and supervise donation process, specific duties are assigned in accordance to applicable laws and regulations, approved organization policy, and assessed competencies.

Effectiveness- safety

DAS.30 The organization develops and implements a policy and a procedure to ensure traceability of blood/ blood components from donation until transfusion.

Safety

DAS.31 The organization develops and implements a quality control program for blood transfusion services.

Safety

Safe and Effective Blood Donation

DAS.32 The organization develops and implements a policy and procedures for screening of donors through previously defined selection/ deferring criteria, screening is through physical and laboratory testing including specified communicable diseases, Blood grouping and RH typing.

Effectiveness

DAS.33 The organization develops and implements a policy and procedures to ensure safe collection, handling, testing of blood and blood components.

Safety- Effectiveness

Safe Blood storage

DAS.34 The organization develops and implements a policy and procedures for storage and labeling of all blood and blood components in the blood bank that meet the national requirements; labels should include at least the following:

a) Traceable Number.
b) Name of Blood bank.
c) Blood group and RH.
d) Volume of the product.
e) Required storage conditions.
f) Date of collection.
g) Date of expiry.

Safety

DAS.35 The organization develops and implements a policy and procedures to select, contract services and evaluate blood banks whenever blood is obtained from outside the organization, contracted blood banks provide at least the following:

a) License of MOH.
b) Precautions for transportation of blood and blood components.

Safety

Safe Transfusion Process

DAS. 36 The organization ensures that the attending physician is responsible for the following:

a) Assessment of patient's clinical need for blood.
b) Education of patient and family about proposed transfusion and recording in patient's medical file.
c) Recording indication for transfusion in the patient's medical file.
d) Selecting blood product and quantity required (i.e. whole blood/PRBC/FFP/PC) and completing the request form accurately and legibly.
e) Recording the reason for transfusion on the form, so that the blood bank can check that t he product ordered is the most suitable with regard to diagnosis.
f) Sending the blood request form with a blood sample to the blood bank
g) Clearly communicate whether the blood is emergently or routinely needed.

Safety

DAS.37 The blood bank develops and implements a policy and procedures for blood compatibility testing of all whole blood and red cells transfused even if, in life-threatening emergencies.

Safety- Timeliness

DAS.38 The organization develops and implements a policy and procedures for administration of blood/ blood products. The policy addresses at least the following:

a) Visually checking the bag for integrity.
b) Conditions when the bag shall be discarded.
c) Rate for blood transfusion.
d) Recording the transfusion.
e) Monitoring and reporting any adverse event.

Safety

Surgery, Anesthesia and Sedation

Chapter Intent:

Generally, surgery and invasive procedure refers 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:

1) Take out or eliminate all or a portion of a body part through excision, resection, extraction, destruction or detachment
2) Putting in or on, putting back, or moving living body parts through transplantation, reattachment, reposition and transfer
3) Take out or eliminate solid matters, fluids or gases from body parts
4) Bypass, dilation, Occlusion or restriction of a tubular body part
5) Insertion, replacement, supplement, removal, change or revision of a device attached in/to the body
6) Cutting revision, release, alteration, creation, fusion of a body part
7) Stopping or attempting to stop post-procedural bleeding
8) Restoring a body part to its normal anatomic structure and function
9) 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 organization 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 endoscopic assistance

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 Objectives:

This chapter corresponds to chapter Invasive procedures in the previous version.

The main objective is to ensure that organizations provides/ maintains safe, timeliness, patient-centeredness and effective surgical, procedural, anesthesia care and sedation services.

The first part includes standards related to implementation of laws and regulations, booking and patient care, followed by required processes before, during and after procedure. The second part includes standards related to anesthesia care, stated by laws and regulations, about anesthesia leadership, followed by preanesthesia, 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) MOH Ministerial Decree 216 for operation procedures
4) Prime Minister decree, 1063/2014 Management of Emergency cases
5) MOH Ministerial decree 236/2004 on anaesthesia service requirements
6) MOH Ministerial Decree 153/2004 on minimum requirements for anaesthesia services
7) MOH Ministerial decree 244/2001 on competencies of surgeons
8) MOH Ministerial decree 34/2001 on surgery and anaesthesia services
9) Patient Safety during operation procedure committee recommendations, 2003
10) Egyptian code of medical ethics 238/2003 (Medical Syndicate Publications)
11) MOH 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 MOH law and regulation
15) ICD-10-PCS
16) WHO Surgical Safety

Safe and Effective Surgical and Invasive Procedures Care

SAS.01 The organization ensures that the provision of surgery and invasive procedure services is in accordance to applicable laws and regulations and clinical guideline/protocol.

Safety

SAS.02 The organization develops and implements a policy and procedures for booking surgery and invasive procedure; the policy addresses at least the following:

a) Surgeries and invasive procedures are booked in accordance to granted clinical privileges.
b) Organization records surgeries and invasive procedures whether they are scheduled, performed or cancelled.
c) Clear and safe mechanism to identify patients in the records.
d) Clear and safe mechanism to call patients for surgeries or invasive procedures.

Efficiency

SAS.03 The organization develops and implements a policy and procedures to describe preoperative, operative and postoperative patient surgical care.

Patient-Centeredness

SAS.04 The organization ensures that patient assessment is performed by physician(s) and nurse(s) before surgery and invasive procedure, results of requested investigations are reported, and all are recorded in the patient's medical file.

Patient-centeredness

SAS.05 In life-threatening emergencies, a brief assessment and planning is performed and recorded in the patient's medical file; The record includes at least the following:

a) Patient needs and condition.
b) Preoperative diagnosis.
c) Plan for surgery (and invasive procedure).

Timeliness - Patient-Centeredness

SAS.06
NSR.18.1
NSR.19

The organization develops and implements a policy and procedures to ensure that the precise site where the surgery or invasive procedure shall be performed is clearly marked by the physician with the involvement of the patient.

Safety

SAS.07
NSR.18.2
NSR.20

The organization develops and implements a policy and procedures to verify that all documents and equipment needed for procedures and anesthesia or sedation are on hand, correct and properly functioning before call for the patient.

Safety

SAS.08
NSR.18.3
NSR.21

The organization develops and implements a policy and procedures to ensure accurate patient identification preoperatively and just before starting a surgical or invasive procedure (time out), to ensure the correct patient, procedure, and body part.

Safety

SAS.09

The organization implements and records a process for monitoring of patient's physiologic status before and during surgeries and invasive procedures by a competent staff.

Patient-Centeredness

SAS.10

The organization implements and records a process for procedure reporting immediately after procedure, the record includes at least the following:

a) Time of start and time of end of 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 occurrence of complication or not.
f) Any removed specimen or not.
g) Signature of the performing physician.

Effectiveness

SAS.11 The organization develops and implements a policy and procedures to verify an accurate counting of sponges, needles and instruments pre and post procedure.

NSR.18.4

NSR.22

Safety

SAS.12 The organization ensures that surgically removed tissue is sent to the organization's laboratory and pathology services for pathological examination unless present in the list of exempted tissues from pathological examination.

Effectiveness

SAS.13 The organization develops implements and records a process to track and/or recall any implantable device.

Safety

SAS.14 The organization ensures that the postoperative care plan is determined and recorded in the patient's medical file before patient transfer.

Patient-centeredness

Safe and Effective Anesthesia Care

SAS.15 The organization ensures that the provision of anesthesia and sedation services is in accordance to applicable laws and regulations and approved organization policies and clinical guideline/protocol.

Safety

SAS.16 The organization ensures that anesthesia and sedation services are under the direction of a qualified anesthesiologist.

Safety

SAS.17 The organization ensures that anesthesia and sedation services are uniform throughout the organization and readily available 24 hours a day, 7 days a week.

Safety

SAS.18 The organization develops and implements a policy and procedures for anesthesia care including pre-anesthesia assessment, during and postoperative anesthesia care.

Patient-centeredness

SAS.19 The organization develops clinical protocols for all anesthesia techniques and serious anesthesia emergencies or complications.

Patient-centeredness

SAS.20 The organization implements and records a process for determining the patients' anesthesia plan after pre-anesthesia assessment by a qualified anesthesiologist.

Patient-centeredness

SAS.21 The organization implements and records a process for patient re-assessment by the anesthesiologist immediately prior to induction of anesthesia.

Patient-centeredness

SAS.22 The organization implements and records a process for continuously monitoring of patient's physiologic status before and during anesthesia by a competent anesthesiologist.

Safety

SAS.23 The organization implements and records a process for patient care during anesthesia, 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 product.
g) The occurrence of any unusual event.
h) The patient condition before leaving the theatre.
i) Patient disposition.
j) Time of transfer.
k) Signature of the anesthesiologist.

Patient-centeredness

SAS.24 The organization ensures that the post-anesthesia care unit is equipped in accordance to applicable laws and regulations and approved organization policy and clinical guideline/protocol.

Patient-centeredness

SAS.25 The organization implements and records a process for continuous monitoring of patient's physiologic status in the post-anesthesia care unit by a qualified healthcare provider, the records 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 product.
g) The occurrence of any unusual event.
h) The patient condition before leaving in accordance to defined criteria
i) Patient disposition.
j) Time of transfer from the post-anesthesia care unit.
k) Signature of the anesthesiologist.

Patient-centeredness

SAS.26 The organization implements and records a process to ensure that a qualified anesthesiologist makes the decision of patient transfer/discharge from post-anesthesia care unit in accordance to defined criteria.

Safety

Safe and Effective Sedation Service

SAS.27 The organization develops and implements a policy and procedures for sedation care including pre sedation assessment, during and post sedation care.

Patient-centeredness

SAS.28 The organization develops protocols for sedation techniques including management of complications.

Patient-centeredness

SAS.29 The organization implements and records a process for determining the patients' sedation plan after pre sedation assessment by a competent physician.

Patient-centeredness

SAS.30 The organization implements and records a process for patient reassessment by a competent physician immediately prior to start of sedation.

Patient-centeredness

SAS.31 The organization implements and records a process for continuous monitoring of patient's physiological status before and during sedation by a competent physician.

Patient-centeredness

SAS.32 The organization implements and records a process for patient care during sedation, the record 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.

Patient-centeredness

SAS.33 The organization ensures that the patient receives the post sedation care by a qualified healthcare provider in an appropriate equipped place.

Safety

SAS.34 The organization implements and records a process for continuous monitoring of patient's physiological status during post sedation care by a qualified healthcare provider, the 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 condition before leaving in accordance to a defined score.
e) Patient disposition.
f) Time of transfer.
g) Signature of the physician.

Patient-centeredness

SAS.35 The organization implements and records a process to ensure that a competent physician decides on patient's transfer/discharge from procedural sedation area according to defined criteria.

Safety

Medication Management and Safety

Chapter Intent:

Medication management and safety is an evidence-based approach to manage medications, which balances the safety, tolerability, and cost-effectiveness of treatments. Good medications management means that patients shall receive better, safer and more convenient care. The Medications Management Team supports the organization objectives to improve the health of the population by optimizing the use of medications through: Promoting the safe and evidence-based approaches.

Globally, multiple international organizations focuses on medication safety measures. WHO, for instance, adopts the “5 Moments” technique for ensuring medication safety. Institute of safe medication practices “ISMP” periodically announces updated high risk medications lists, tools to assess safe medications practices and updates on trends of medication risks.

Locally, Egypt has built various organizations to oversee parts of the process of national medication management. National essential medication list has been issued, Clinical pharmacy role has been clarified and pharmacovigilance unit has been established. In August 2019, The Egyptian government issued the decree number 151/2019 to establish the Egyptian Drug Authority which shall be a major controller in the Egyptian medication market.

Healthcare organizations need to consider the complexity of medication management processes and the severity of not complying with medication safety measures. Medication management team should be aware of the MMS standards and the related standards in other chapters such as in Organization and Governance Management (OGM), Infection Prevention and Control (IPC), Environment and Facility Safety (EFS), National Safety Requirements (NSRs), Quality and Performance Improvement (QPI), Workforce Management (WFM), Integrated Care Delivery (ICD), and Information Management and Technology (IMT).

During GAHAR Survey, the surveyor is going to assess medication management system by using leaders and staff interview and document review, as well as by using tracer methodology to assure uniform implementation and understanding.

Chapter Objectives:

This chapter corresponds to the “Medication Management” chapter in previous versions.

This chapter aims at supporting healthcare providers and patients to make best use of medications, and minimizing the harm caused by medications considering adopting applicable practice standards and guidelines of ASHP, ISMP and Egyptian standards for medication management and use.

This chapter addresses the different activities under medication management. This shall help each one in the organization to understand his/her role in maintaining efficient and safe medication practice. The chapter focuses on the following domains and their technologies:

a) Leadership and management
b) Selection and Procurement
c) Storage
d) Prescribing/Ordering and Transcribing
e) Preparing, Dispensing and distribution
f) Administration
g) Monitoring and Evaluation

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. Presidential decree 151/2019 for Egyptian Drug Authority
2. Law 127/1955 on practicing the profession of pharmacy
3. Law182/1960 on combating narcotics and regulating their use and trafficking, amendments, and regulatory decrees.
4. Regulation of tenders and auctions law promulgated by Law 89/1998 and its implementing regulations issued by the Minister of Finance decree 1367/1998.
5. MOH Ministerial decree 172/2011 on the re-regulation of handling of the pharmaceutical substances and products affecting the mental state.
6. The publication issued by the Central Administration for Pharmaceutical Affairs 13/2012 on the custody of narcotics and drugs affecting the mental state.
7. MOH Ministerial decree 380/2009 on the re-regulation of the health requirements for pharmaceutical institutions.
8. MOH Ministerial decree 391/2012 on the establishment of a Clinical Pharmacy Unit and a Drug Information Center within the hospital.
9. MOH Ministerial decree 368/2012 for developing a pharmacovigilance center
10. MOH Ministerial decree 487/1985 for management of psychiatric medications

11. MOH Ministerial decree 306/2002 on medication storage spaces
12. Jeddah Declaration on Patient Safety 2019
13. Central pharmacy role and scope
14. Egyptian Clinical pharmacy standards of practice
15. Pharmacist code of ethics
16. Regulation of tenders and auctions law and law 89/998 and its regulations issued by the Minister of Finance decree 1367/1998.
17. Regulation of tenders and actions law promulgated by Law 182/2018
18. Rational Drug Use Publication 2/2017: Local Drug and Therapeutics Committee in Hospitals Working Paper.
19. Rational Drug Use Publication 3/ 2017: Drug Formulary Working Paper.
20. Rational Drug Use Publication 4/2017: Antimicrobial Stewardship Program (ASP) in Hospitals Working Paper
21. Pharmaceutical Care Development Publication (2) for Clinical Pharmacist Job Description
22. Pharmaceutical Care Development Publication (3) for Documentation of Clinical Pharmacy Work.
23. American Society of Health-System Pharmacists (ASHP) standards for 2019
24. WHO guidelines on medication safety in high risk situation
25. WHO guidelines on medication safety in transition of care
26. WHO guidelines on medication safety in poly pharmacy
27. WHO five moments for medication safety.

Safe and Effective Leadership and Management

MMS.01 The organization plans, manages and provides medications in accordance to applicable laws and regulations and patients' needs.

Safety, Effectiveness

MMS.02 The organization develops and implements a "Medication Management" program; the program covers at least the following:

a) All medication management steps such as selection, purchasing, storing, ordering, transcribing, dispensing, distributing, preparing, administering, monitoring and reporting.
b) Emergency Preparedness/Contingency Plans.
c) Medical Emergencies.
d) Program annual evaluation.

Effectiveness, Efficiency

MMS.03 The organization ensures that a licensed qualified pharmacist is available to supervise medication use in the organization in accordance to applicable laws and regulations at all time, when applicable.

Safety

MMS.04 The organization develops and implements a policy and procedures that ensure uninterrupted availability of medication supply at least in the following situations:

a) During operating hours.
b) When 24-hour pharmacy services are not feasible.
c) When a shortage of organization-approved (formulary) medications.
d) When non-organization-approved (non-formulary) medication is required.

Effectiveness

MMS.05 The organization establishes an interdisciplinary Pharmacy and Therapeutics (PT) committee.

a) The Committee has terms of reference that cover medication management and technology used in medication management.
b) The committee meets on regular basis.
c) The committee meetings are recorded.

Efficiency

MMS.06 The organization develops and implements a policy and procedures that describe the system for "Antibiotic Stewardship Program", the policy shall be in accordance to applicable laws and regulations and approved organization policies and clinical guidelines/protocols. The policy addresses at least the following:

a) Antimicrobial stewardship programs should be the organization priority with leadership commitment and support.
b) Center of Disease Prevention and Control (CDC) core elements.
c) Education of staff, patients, and families who are involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial stewardship practices and the appropriate use of antimicrobials.
d) Use of organization-approved interdisciplinary protocols, e.g., Antimicrobial Formulary Restrictions, Guidelines for Antimicrobial Use, Parenteral to Oral Antimicrobial Conversion, Preauthorization.
e) Tracking, collection, analysis, and reporting of data on antimicrobial stewardship program.
f) Actions on improvement opportunities identified in antimicrobial stewardship program.

Safety

MMS.07 The organization ensures that reliable source of information is accessible for medical staff, nurses, pharmacists and patients on the medications use, administration, and side effects, including potential adverse reactions.

Effectiveness

MMS.08 The organization develops and implements a policy and procedures to define the proactive and uniform education of patients when required; The policy addresses at least the following cases:

a) When some medications are used for the first time.
b) Medications for chronic diseases.
c) High – alert medications.
d) Existence of more than one medical complaint.
e) Risk of not taking the medicine.
f) If there is more than one prescription and there is a duplication.
g) In the case of an anticipated medication-allergic symptoms such as from antibiotics.

Efficiency

Safe and Efficient Selection and Procurement Processes

MMS.09 The organization ensures that medications are selected and procured in accordance to applicable laws and regulations and approved organization policy.

Safety

MMS.10 The organization develops and implements a policy and procedures that define the selection and procurement of medications. The policy addresses at least the following:

a) Suppliers identification and selection process.
b) Suppliers are monitored and evaluated to ensure that the purchased medications are provided from reliable sources that refrain from dealing with counterfeit, smuggled or damaged medicines.
c) Supplies are monitored and evaluated to ensure that no recalled medications, samples medications are provided.
d) Transportation of medication supplies is monitored to ensure that it occurs in accordance to applicable laws and regulations, approved organization policy, and manufacturer's recommendations.

Safety, Efficiency

MMS.11

The organization develops and implements medication formulary, which is available, accessible for medication prescribers and annually updated, updated. Medication formulary includes a list of vital medications, Essential and desirable medication lists that are approved by PT committee.

Efficiency, Safety

Safe Storage of Medications

MMS.12 The organization develops and implements a policy and procedures to ensure medication security at all the time, safe storage and handling procedure, the policy addresses at least the following:

a) Regular medications.
b) Emergency Medication.
c) Medication stocked in Patient care areas stock.
d) Sample medications.
e) Nutritional products.

Safety

MMS.13

NSR.16

NSR12.4

The organization develops and implements a policy and procedures to prevent errors from high risk medications and concentrated electrolytes; the policy addresses at least the following:

a) Defined process to prevent errors associated with high risk medications
b) Concentrated electrolytes; including, but not limited to, potassium chloride (2 meq/L or greater concentration), potassium phosphate, sodium chloride (>0.9% concentration), magnesium sulfate (50% or greater concentration) are removed from all patient care areas, whenever possible.
c) Concentrated electrolytes, which cannot be removed, are segregated from other medications with additional warnings to remind staff to dilute before use.

Safety

MMS.14

NSR.17

NSR12.5

The organization develops and implements a policy and procedures to prevent errors from look-alike and sound-alike medication; The policy addresses at least the following:

a) Identified list of look-alike and sound-alike medications.
b) look-alike and sound-alike medications are stored and dispensed in a way which assures that risk is minimized.

Safety

MMS.15

The organization develops and implements a policy and procedures to ensure that medication storage is checked and maintained periodically; The policy addresses at least the following:

a) Defined proper storage conditions, such as identification of storage temperature and humidity ranges and continuous temperature/humidity monitoring procedures.
b) The pharmacist inspects all medication storage areas at least monthly.
c) Expired, nearly expired, outdated and damaged medications are clearly labeled. Expired, outdated and damaged are separated from other medications until removal and proper destruction.
d) Light sensitive medication to be defined and stored properly.
e) Protocols for stability of medications based on manufacturer's recommendation.

Effectiveness

MMS.16

The organization develops and implements a policy and procedures to manage the storage, distribution and disposal of controlled-medication and narcotics that complies with law and regulations.

Safety

MMS.17

The organization develops and implements a policy and procedures to ensure accessibility, availability, monitoring, and security of emergency medications at all time; The policy addresses at least the following:

a) Development and maintenance of a standardized set of emergency medications to be included in the crash carts and emergency medical bags in accordance to approved clinical guidelines.
b) Emergency medications are available in the patient care units and accessible.
c) Emergency medications are protected from loss or theft.
d) A process for monitoring emergency medications and replenishing used, damaged, expired medication within an approved time frame.
e) Emergency medications are regularly inspected by those stocking them and by pharmacy department.

Safety, Effectiveness

MMS.18 The organization develops and implements policy and procedures for "Medication recall"; The policy addresses at least the following:

a) Process to retrieve recalled medications.
b) labeling, separation, disposal or removal of recalled medications.
c) When and how patients are contacted.

Safety

Safe Prescribing/Ordering

MMS.19 The organization identifies those qualified healthcare providers who are permitted to prescribe or order medications including those with approved special privileges, in accordance to applicable laws and regulations, approved organization policy, and healthcare provider's licensure.

Safety

MMS.20 The organization develops and implements a policy and procedures for recording and communication of patient's current medications and discharge medication.

NSR.14 The organization implements a process to obtain and record a complete list of the patient's current medications upon admission to the organization and with the involvement of the patient.

NSR.12.2

Safety

MMS.21 The organization develops and implements a policy and procedures that define safe prescribing, ordering and transcribing of medications in the organization; the policy addresses at least the following:

a) Where medication orders are uniformly written in the patient's medical file.
b) Definition of elements of a complete order: medication name , dosage form , strength , concentration , dosage , route of administration , frequency ,and duration, Requirements for prescriber's signature (date and time).
c) Clear indication for writing as needed orders (PRN).
d) Other types of orders that are acceptable (range, sliding scale, etc.).
e) Actions to take if prescriptions/orders are incomplete, illegible, unclear, or potentially unsafe.

Safety, Effectiveness

MMS.22 The organization develops and implements a policy and procedures to define at least the following:

a) Use of weight-based or otherwise adjusted, dose calculations for pediatrics, infants, chemotherapy patients and others as scientifically relevant.
b) Using, reviewing and updating of preprinted order sets.

Effectiveness

Safe Preparation; Dispensing and Distribution of Medication

MMS.23 The organization identifies those licensed competent healthcare providers who are permitted to prepare and dispense medications in accordance to applicable laws and regulations, approved organization policy, and healthcare provider's licensure.

Safety

MMS.24 The organization develops and implements a policy and procedures that define the uniform safe medication preparation; dispensing and distribution, the policy addresses at least the following:

a) Right medication.
b) Right dose.
c) Right route of administration.
d) Right time.
e) Right patient.
f) Uniform system for dispensing and distribution of medications in the most ready-to-administer form possible and in accordance to patient needs.
g) Implementation of independent double check.

Safety, Timeliness

MMS.25 The organization develops and Implements a policy and procedures to define the appropriateness review; the policy addresses at least the following:

a) Review of each prescription/order.
b) Minimum requirements for appropriateness review.
c) Communication mechanism with the prescriber in case of inappropriate prescription.
d) Role of clinical pharmacists in high risk situation, transition of care and in poly pharmacy.
e) Recording of intervention.

Safety

MMS.26

NSR.15

NSR.12.3

The organization develops and implements a policy and procedures for labelling of medications, medication containers and other solutions; The organization ensures that all medications and medication containers (e.g., syringes, medicine cups, basins, multi-dose containers, unit dose sterile preparation or mixed preparation) are labeled with at least the following:

a) The two approved patient identifiers.
b) The name of the medication and its concentration/strength, dose; frequency and duration.
c) The expiration date; if not clearly displayed on the package or the container.
d) Open date and discard date in multi-dose container.
e) Written instructions for use/administration; organization may use preprints. appropriate auxiliary labels (e.g., take with food, for topical use, store temperature. etc.).

Safety

MMS.27 The organization develops and implements a policy and procedures that describe the prescription, preparation, dispensing and administration of parenteral therapy.

Effectiveness

Safe Medication Administration

MMS.28 The organization identifies those qualified healthcare providers who are permitted to administer medications, in accordance to applicable laws and regulations, approved organization policy, and healthcare provider's licensure.

Safety

MMS.29 The organization develops and implements a policy and procedures that define safe and accurate administration of medications; the policy addresses at least the following:

a) The medication administration five rights.
b) Recording of each administered dose.
c) Patient education regarding potential side effects.
d) Medication self-administration.
e) Pediatric medication dosing.

Safety

MMS.30 The organization develops and implements a policy and procedures to manage medications brought by patient or patient's family; The policy addresses at least the following:

a) When to accept medications brought by patient or patient's family.
b) Process to assure safety of the brought medications.
c) Process to store these medication.

Safety

Monitoring and Evaluation of Medication Management Processes

MMS.31 The organization ensures that pharmacists are actively involved in the development, implementation and monitoring of all aspects of the medication management system.

Safety

MMS.32 The organization develops and implements a policy and procedures that define monitoring and recording of the response to medications; The policy addresses at least:

a) First dose response of certain medication when newly started.
b) High risk medications.
c) Antibiotics are monitored for appropriate use.
d) Other medications in accordance to organization PT recommendations.

Effectiveness

MMS.33 The organization develops and implements a policy and procedures for dealing with medication errors, near misses and adverse drug reaction; the policy addresses at least the following:

a) Definition of medication errors; near-miss and adverse drug reactions.
b) Development of reporting systems.
c) Timeframe for reporting.
d) Recording in patient's medical file.
e) Mechanism for external reporting; when applicable.

Effectiveness

MMS.34 The organization quality management program uses data to improve medication management processes; the program addresses at least the following:

a) Aggregation of data about medication errors; near-misses and adverse drug reactions.
b) Reports analysis to identify patterns and trends.
c) Improvement of medication management processes based on data.

Effectiveness

MMS.35 The organization defines a process to engage and empower patients to be involved in their own care through promoting the use of WHO 5 moments in medication safety.

Safety

National Safety Requirements

Chapter Intent:

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

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

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

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

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

Chapter objectives:

This chapter corresponds to Patient Safety chapter in previous versions.

The main objective is to ensure that organizations provide and maintain patient safety program effectively. To achieve this, 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

General Patient Safety Standards:

NSR.01.1

NSR.02

The organization develops and implements a policy and procedure for safe patient identification; the policy addresses at least the following:

a) At least two (2) ways are used to identify a patient.
b) Identification occurs upon administering medications, blood, or blood. products, taking blood samples and other specimens for clinical testing, and/or providing any other treatments or procedures.

Safety

NSR.03

NSR.01.2

NSR.01.3

The organization develops and implements a policy and procedure for communication among healthcare providers; the policy addresses at least the following:

a) A process for taking verbal or telephone orders.
b) A process for the reporting of critical test results.
c) Verification of communicated message by writing down and "reading-back" of the complete order or test result by the person receiving the information.

Safety

NSR.04

NSR.01.4

The organization develops and implements a policy and procedure for Hand Hygiene; the policy addresses at least the following:

a) Current published and generally accepted hand hygiene guidelines.
b) Guidelines are implemented to prevent healthcare-associated infections.

Safety

NSR.05

NSR.01.5

The organization develops and implements a policy and procedure to prevent catheter and tubing misconnections.

Safety

NSR.06

NSR.01.7

The organization develops and implements a policy and procedure for patient fall prevention; the policy addresses at least the following:

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

Safety

NSR.07

NSR.01.6

The organization develops and implements a policy and procedure for pressure ulcer prevention; the policy addresses at least the following:

a) Each patient's risk of developing pressure ulcers is assessed and recorded.
b) Action is taken to decrease or eliminate any identified risks of developing pressure ulcers.

Safety

NSR.08

NSR.01.8

The organization develops and implements a policy and procedure for safe handover communication; the policy addresses at least that an opportunity to ask and respond to questions exists.

Safety

NSR.09

The organization develops and implements a policy and procedure for managing critical alarms; the policy addresses at least the following:

a) Preventive maintenance.
b) Testing of critical alarm systems.
c) Alarms are tested and activated with appropriate settings.
d) Alarms are sufficiently audible with respect to distances and competing noise within the unit.

Safety

Other National Safety Requirements	
NSR.10 - NSR.30	NSR.10 Clinical deterioration, Please read ICD.38 NSR.11 VTE prophylaxis; Please read ICD.44 NSR.12 – NSR.17 Medication Management Safety Standards; Please read MMS 13,14,20,26 and IMT.04 NSR.18 - NSR.22 Operative and Invasive Procedure Safety; Please read SAS.06,07,08,09,12 NSR.23 – NSR.27 Environmental Safety Standards; Please read EFS.07,16,19,20,24,29 and DAS.11,24

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 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 healthcare industry worldwide. Three major aspects may affect worker's wellbeing; Safety, Stress and Organizational 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 workers 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.

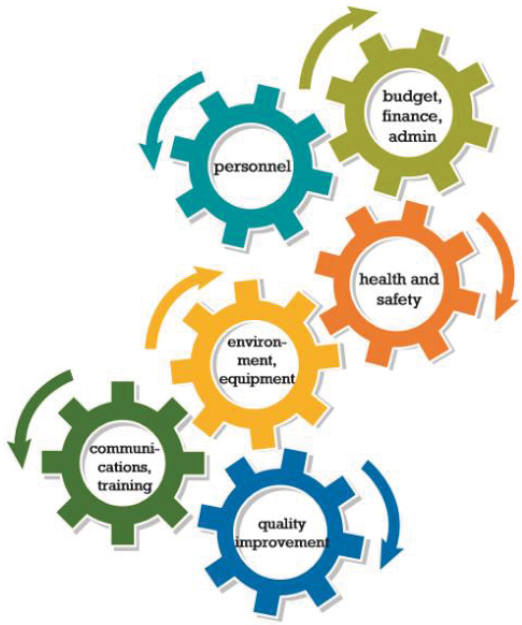
On the other hand, being exposed to stress for too long, may lower a person's efficiency and could trigger negative consequences on one's health or family and social life. Nevertheless, not every manifestation of stress is always workplace stress. Workplace stress may be caused by various factors. Some 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 maybe the most important stress source.

Organizational structure provides guidance to all staff by laying out the official reporting relationships that govern the workflow of the company. A formal outline of an organization structure makes it easier to add new positions in the organization, as well, providing a flexible and ready means for growth. Organization management need to be in accordance to a clear ethical framework that is responsive to community needs. Organizations have an obligation to act for the benefit of community at large. Workers, as community members, need to be engaged into assessing community needs and responding to them in addition to be protected from safety and stress hazards while working in the organization.

Nevertheless, both the organization and the staff have 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 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 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 the traditional thinking about patient safety and improvement more generally. It describes a process and structure that may lead to improved safety in a variety of healthcare settings.

The aim of HealthWISE is to provide health-care 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 health-care environment appreciated by patients and the community.



Elements for safe healthcare workplace

As organization management is responsible for providing an efficient organizational structure, where a governing body is well defined and responsive to the organizational needs, Leaders work collaboratively to run the organization towards preset approved strategic directions. A well-established structure includes defining capacity and roles of organization 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.

Environment and Facility Safety

Chapter intent:

Environment and Facility safety (EFS) is a specialty that studies and implements practical aspects of environmental protection and safe facility at work for all available humans including patients, families, staff, and visitors.

From an environmental standpoint, it involves creating a systematic approach to complying 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 personnel in accident prevention, accident response, emergency preparedness, and use of protective clothing and equipment.

Globally, Healthcare design standards were developed to maintain proper healthcare facility 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 organization 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 organization, 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 an organization.

Chapter objectives:

This chapter corresponds to Facility and Environmental Safety in the previous version

This chapter started by planning and effective management of the organization 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:

1. Safety and security
   - Safety—The degree to which the organization's buildings, construction areas, grounds, and equipment do not pose a hazard or risk to patients, staff, or visitors.
   - Security—Protection from loss, destruction, tampering, or unauthorized access or use.
2. Hazardous materials—Handling, storage, and use of radioactive and other materials are controlled, and hazardous waste is safely disposed including Infectious waste, Pathological waste, Sharps, Pharmaceutical waste, Genotoxic waste, Chemical waste, Wastes with high content of heavy metals, Pressurized containers, and Radioactive waste.
3. Emergency management—Risks are identified and response to epidemics, disasters, and emergencies is planned and effective, including the evaluation of the structural integrity of patient care environments.
4. Fire safety—Performing of ongoing assessment of risks to enhance protection of property and occupants from fire and smoke.
5. Medical equipment—Equipment is selected, maintained, and used in a manner to reduce risks. Special consideration was given to control of temperature and humidity either in fridges, freezers or rooms. Temperature controls apply anywhere in the organization including laboratory reagents, pharmacy, blood bank, radiology, ER, nursing stocks, vaccine rooms and other patient care areas.
6. Utility systems—Electrical, water, medical gases and other utility systems are maintained to minimize the risks of operating failures.

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) MOH regulation in NICU, 2007
4) MOH requirements in the website www.mohp.org.eg
5) MOH Ministerial decree 34/2001 on surgery and anaesthesia services
6) Law 192/2001 for Hazardous waste management
7) Presidential decree number 3185/2016
8) MOH Ministerial decree 284/1985 on requirements for OR
9) MOH 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 and Safe Planning and Management

EFS.01 The organization follows laws, regulations, and facility inspection requirements that relate to the structure and management of the physical environment.

Safety

EFS.02 The organization establishes an interdisciplinary committee for Environment and Facility Safety responsible for planning, implementing and monitoring of all environmental and facility safety requirements as required by laws and regulations.

a) The committee has terms of reference.
b) The committee meets on regular basis.
c) The committee meetings are recorded.

Safety

EFS.03 The organization ensures availability of a qualified safety officer(s) responsible for oversight of the facility maintenance and environmental safety in addition to a designated staff to oversee the implementation of each environmental safety plan. Staff are available in accordance to applicable laws and regulations and approved organization policy.

Safety

EFS.04 The organization ensures that interdisciplinary hazardous surveillance rounds are conducted in all organization areas at least twice annually.

Safety

EFS.05 There is a biannual report submitted to the board of the organization with the significant observations during the hazardous surveillance rounds with corrective actions taken or needed.

Safety

EFS.06 The organization ensures that clinical and diagnostic services have adequate space in accordance to applicable laws and regulations and approved organization scope of service.

Safety

Effective Safety and Security Plan

EFS.07

NSR.26

There is a well-structured and implemented safety and security plan/s. that includes at least the following:

a) Risk assessment.

b) Identification of patients, visitors and staff in the organization.

c) Protection of patients, visitors and staff from harm, including assault, violence and aggression.

d) Protection against infant/child abduction.

e) Monitoring of remote and isolated areas.

Safety

EFS.08 The organization develops and implements a construction or renovation plan that includes a preconstruction risk assessment.

Safety

EFS.09 The organization develops and implement a process for pest and rodents control.

Safety

EFS.10 The safety and security plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement and at least one performance improvement initiative for an identified area for improvement annually.

Safety

EFS.11 The plan objectives are evaluated annually followed by updating the plan for the coming year.

Effectiveness

Effective Emergency/Disaster Management Plan

EFS.12 There is a well-structured and implemented emergency/disaster management plan for internal and external emergencies including response to likely community emergencies, epidemics, natural or other disasters, that addresses risk assessment, personnel recall system; alternate care sites, if needed; and alternate sources of medical supplies, utilities, and communication.

Safety

EFS.13 The organization ensures testing of the external emergency/disaster plan at least once annually.

Safety

EFS.14 The emergency/disaster management plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement and at least one performance improvement initiative for an identified area for improvement annually.

Safety

EFS.15 The plan objectives are evaluated annually followed by updating the plan for the coming year.

Effectiveness

Effective Hazardous Materials and Waste Management Plan

EFS.16

NSR.25 There is a well-structured and implemented hazardous materials and waste management plan for the use, handling, storage, and disposal of hazardous materials and waste that addresses at least the following:

a) Risk assessment.
b) Safety and security requirements for handling and storage.
c) Requirements for personal protective equipment.
d) Procedures and interventions to take after occurrence of spills and accidental contact or exposures.
e) Disposal in in accordance to applicable laws and regulations and approved organization policy.
f) Labeling of hazardous materials and waste.
g) Monitoring data on incidents to allow corrective action.

Safety

EFS.17 The hazardous materials and waste management plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement and at least one performance improvement initiative for an identified area for improvement annually.

Safety

EFS.18 The plan objectives are evaluated annually followed by updating the plan for the coming year.

Effectiveness

Effective Fire and Smoke Safety Plan

EFS.19

NSR.23 There is a well-structured, implemented fire and smoke safety plan that addresses prevention, early detection, response, and safe evacuation in case of fire or other internal emergencies and includes at least the following:

a) Risk assessment.
b) Frequency of inspecting fire detection and suppression systems, including recording of inspections.
c) Maintenance and testing of fire protection and abatement systems in all areas.
d) Documentation requirements for staff training in fire response and evacuation.
e) The assessment of fire risks when construction is present in or adjacent to the Facility.

Safety

EFS.20

NSR.24 Fire drills are conducted at least quarterly in different clinical areas and different shifts, including at least one unannounced annually.

Safety

EFS.21 The organization develops and implements policy and procedures to restrict smoking within organization premises, in accordance to applicable laws and regulations and approved organization policy.

Safety

EFS.22 The fire safety plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement and at least one performance improvement initiative for an identified area for improvement annually.

Safety

EFS.23 The plan objectives are evaluated annually followed by updating the plan for the coming year.

Effectiveness

Effective Medical Equipment Plan

EFS.24

NSR.29 There is a well-structured and implemented plan for selecting, inspecting, maintaining, testing, and safe usage of medical equipment that addresses at least the following:

a) Risk assessment.
b) Inventory of all medical equipment.
c) Schedule for inspection and preventive maintenance in accordance to applicable laws and regulations, approved organization policy, manufacturer's recommendations and frequency of repair and breakdown.
d) Testing of all new equipment before use and repeat testing, as part of the preventive maintenance.
e) Verification and Calibration.
f) Testing of alarm systems.
g) Qualified healthcare providers who can provide these services.
h) Data monitoring for frequency of repair or equipment failure.
i) Ensure only trained and competent people handle specialized equipment.

Safety

EFS.25 The organization develops and implements a policy and procedures for temperature control of all fridges and freezers in the organization.

Safety

EFS.26 The organization develops and implements a policy and procedures for temperature and humidity control in critical environment areas.

Safety

EFS.27 The medical equipment plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement and at least one performance improvement initiative for an identified area for improvement annually.

Safety

EFS.28 The plan objectives are evaluated annually followed by updating the plan for the coming year.

Effectiveness

Effective Utility Management Plan

EFS.29

NSR.30 There is a well-structured and implemented plan for regular inspection, maintenance, testing and repair of essential utilities addresses at least the following:

a) Risk assessment.
b) Electricity, including stand-by generators.
c) Water.
d) Heating, ventilation, air conditioning, appropriate temperature, humidity and eliminates odors.
e) Medical gases.
f) Communications systems.
g) Sewage disposal.
h) Regular inspections.
i) Regular testing.
j) Regularly scheduled maintenance.
k) Correction of identified risks and deficiencies.

Safety

EFS.30 The utility plan includes a process for regular maintenance and repair of the facility building(s) including the furniture and elevators.

Safety

EFS.31 The utility plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement and at least one performance improvement initiative for an identified area for improvement annually.

Safety

EFS.32 The plan objectives are evaluated annually followed by updating the plan for the coming year.

Effectiveness

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 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.

Infection prevention and control (IPC) program aims at identifying and reducing or eliminating the risks of acquisition and transmission of infections among patients, healthcare workers, volunteers, students, visitors, and the community. Usually, IPC program is risk based. This means that a risk assessment is needed 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 organization's clinical activities, scope of services and served patient population.

One or more staff members oversee the IPC program whether on full-time or part-time basis; with a detailed job description. The staff member(s) shall be qualified enough to meet the organization needs. These needs are driven by the organization 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.

IPC program and activities is based on current scientific knowledge, the national guide- line, accepted international practice guidelines (CDC, APIC, IFIC), besides applicable laws and regulations. The program shall need to be planned, disseminated, taught and monitored. A committee shall be a good tool to ensure all these points. All relevant disciplines are represented on the infection control committee including representatives of the clinical departments, nursing, engineering, food services, housekeeping, laboratory, medication, and sterilization service as well as the purchasing department.

The organization ensures evidence-based interventions to prevent hospital acquired infections including the implementation of bundles for prevention of CLABSI (center line associated blood stream infection), CAUTI (catheter associated urinary tract infection), VAP (ventilator associated pneumonia) and SSI (surgical site infection), then data on the care bundles for preventions are regularly collected, analyzed, and evaluated with improvement interventions are taken accordingly.

Chapter objectives:

This chapter corresponds to Infection Control chapter in the previous versions.

Important processes and activities addressed in this chapter include the following:

1) Effective structure of infection prevention and control.
2) Standard precautions
3) Transmission based isolation precautions and protective isolation for immunocompromised
4) Efficient epidemiological activities of infection prevention and control program.
5) Efficient supportive services for the infection prevention and control program; in Laundry, Sterilization and food services
6) Preventive measures during construction and renovation by addressing risk assessment matrix, Implementation and monitoring of preventive measures.

I**mplementation guiding documents:**
(*All mentioned references needs to be read in the context of its conditions, amendments, substitutes, updates and annexes)*

1) National guidelines for infection control
2) MOH Ministerial decree for developing infection prevention and control departments
3) MOH Ministerial decree 187/2004 for infection control personnel
4) Presidential decree 14/2014 for performance evaluation
5) MOH Ministerial decree 753 / 2015 for medical waste management
6) MOH Ministerial decree 458 / 2007 for potable water
7) MOH Ministerial decree 63/ 1996 for dialysis units
8) MOH Ministerial decree 153 / 2004 for prevention of viral hepatitis
9) MOH Ministerial decree 523 / 2015 for reuse of single used devices and instruments
10) The Egyptian code for healthcare facilities design
11) Egyptian law of environment

Efficient Structure of the infection prevention and control Program

IPC.01 The organization ensures one or more qualified healthcare provider(s) (physician/dentist/pharmacist) and at least one qualified nurse are available to jointly oversee the infection prevention and control activities in accordance to applicable laws and regulations, approved organization policy, and healthcare provider's assessed competencies.

Effectiveness

IPC.02 The organization develops and implements a comprehensive infection prevention and control program that addresses at least the following:

a) The program describes the scope, objectives, expectations, and surveillance methods.
b) The program covers patients, staff, and visitors.
c) All areas of the organization are included in the program.
d) The program is based on current scientific knowledge, accepted practice guidelines and applicable laws and regulations.
e) Action plan based on risk assessment.
f) The program is evaluated, updated at least annually.

Effectiveness

IPC.03 The organization establishes an interdisciplinary IPC committee. The committee meets at least the following:

a) The committee has terms of reference.
b) The committee meets at least monthly.
c) The committee meetings are recorded.

Effectiveness

IPC.04 The organization identifies those procedures and processes associated with increased risk of infection.

Safety

Safe Standard precautions

IPC.05 The organization develops and implements a policies and procedures that define “Standard precautions” needed for infection prevention and control practices, the policy addresses at least the following:

a) Hand hygiene and washing techniques.

b) Selection and uses of antiseptics and disinfectants.

c) Availability of personal protective equipment and using it properly.

d) All cleaning activities, including environment, equipment, supplies, furniture, etc.

e) Aseptic techniques and safe injection.

f) Handling and disposal of sharps safely.

Safety

IPC.06 Hand hygiene , washing techniques are used correctly in the organization.

Effectiveness

IPC.07 Personal protective equipment , soap, washing detergents, antiseptics and disinfectants are available and used correctly when required.

Effectiveness, safety

IPC.08 The organization implements cleaning activities at least through:

a) Listing all environmental services that require cleaning.

b) Scheduling of cleaning times.

c) Identification of proper procedures to be used.

d) Proper choice of disinfecting agents to be used.

e) Handling blood /body fluids spills.

Safety

IPC.09 The organization ensures safe injection practices; through adoption of at least the following mechanisms:

a) Intravenous bottles are not used interchangeably between patients.

b) Usage of multi-dose vials is appropriately performed.

c) Usage of single dose vials whenever possible.

Safety

Transmission based isolation precautions and immune compromised protection

IPC.10 The organization develops and implements a policy and procedures that defines "Transmission based isolation precautions" and immunocompromised protective isolation, the policies address at least the following:

a) Transmission based precautions (contact, droplet, airborne and extended if needed).

b) Precautions for immune compromised patient.

Safety

IPC.11 The organization ensures the availability of isolation room(s) that is/are a least :

a) The number of isolation rooms matches the organization capacity and scope of service.
b) The isolation room fits the Egyptian design standards for healthcare facility.
c) There is a protective environment if needed.
d) National guidelines for the care of infectious patients are followed when there is no isolation room available.

Safety

Effective Epidemiological Infection Control

IPC.12 The organization develops and implements a policy and procedures that defines epidemiological infection prevention and control practices, the policy addresses at least the following:

a) Identification and proper management of organization-acquired infections.
b) Reporting of patients with suspected communicable diseases as required by law and regulation.
c) Investigation, Management and reporting of outbreaks of infections.
d) The organization implements evidence-based interventions to reduce the burden of epidemiologically significant organisms (MDROs).

Safety

IPC.13 The organization ensures that results of outbreak investigations are used to prevent recurrence with monitoring and tacking of the proper preventive measures.

Effectiveness

IPC.14 The organization develops and implements a policy and procedures to define "Surveillance" process, the policy addresses at least the following:

a) All areas in the organization are included.
b) The surveillance data are regularly aggregated and analyzed.
c) The surveillance and data collection and results are disseminated to the stakeholders.
d) Results of the surveillance program are reported at a minimum quarterly to the infection prevention and control committee and to organization leadership

Safety

IPC.15 The organization ensures that surveillance results when relevant are utilized for improving the quality of care

Effectiveness

IPC.16 The organization develops and implements bundles approach for prevention of healthcare associated infections, with periodical monitoring of the compliance and corrective actions are promptly taken whenever needed

Efficiency

Safe Sterilization Service

IPC.17 The organization ensures central sterilization processing and supply department, that address at least the following:

a) The functions of cleaning, processing, storage and distribution.
b) The functions are physically separated with -unidirectional airflow.
c) There is at least one functioning pre-vacuum class B sterilizer.

Safety

IPC.18 The organization develops and implements a policy and procedures for sterilization processing that address at least the following:

a) Processing guided by the laws and regulations, Spaulding classification and manufacturers requirements and recommendations.
b) Receiving and cleaning of used items.
c) Preparation, processing and labeling of sterile packs.
d) Storage of sterile supplies.
e) Inventory levels.
f) Expiration dates for sterilized items.
g) Use of emergency flash sterilization.

Safety

IPC.19 The organization maintains recorded evidences that complete sterilization has been accomplished (mechanical, chemical and biological).

Safety

IPC.20 The organization ensures that quality control processes and quality control tests are implemented using indicators as recommended by the manufacturer; This process is monitored and reported to the infection control committee at least quarterly.

Safety

Safe Laundry and Linen management

IPC.21 The organization ensures a functioning laundry service, that addresses at least the following:

a) The functions of pre-cleaning, processing, storage and distribution.
b) These functions are physically separated.
c) There is at least one functioning washing machine with a pre-cleaning cycle.

Safety

IPC.22 The organization develops and implements a policy and procedures for linen management ,the policy addresses at least the following:

a) Definition of contaminated linen.
b) Collection, transportation and storage of contaminated linen.
c) Cleaning and disinfection of contaminated linen.
d) Storage and distribution of clean linen.
e) Quality control program, including water temperatures.

Safety

Safe Food Services

IPC.23 The organization develops and implements a policy and procedures to reduces the risk of infections associated with the operations of food services, the policy addresses at least the following:

a) Flow and time frame of the following steps: handling, storage, preparation and distribution of food and nutrition products.
b) Sanitation measures during all receiving, storage, preparation and distribution.
c) Sanitation measures regarding cleaning leafy vegetables (lettuce, cabbage…).

Safety

Safe Construction and Renovation

IPC.24 The organization develops and implements a policy and procedures that addresses infection prevention and control considerations during demolition, renovation, and construction projects, the policy addresses at least the following:

a) Mechanism to ensure involvement of infection prevention and control team prior to any demolition, renovation, and construction projects.
b) Defined risk criteria to assess the impact of renovation or new construction take place.
c) Preventive measures that needs implementation.
d) Monitoring and follow-up.

Safety

Safe Mortuary Management

IPC.25 The organization develops and implements a policy and procedures for mortuary; The policy addresses at least the following:

a) Temperature and humidity levels.
b) Cleaning and disinfection.
c) Handling bodies and body parts.
d) Identification of cases that require special isolation precautions.

Safety

Organization Governance and Management

Chapter intent:

This chapter is concerned with structures for governance and accountability that may differ according to the organization and its size, mandate, and whether it is publicly or privately owned. Possible structures include an individual or group owner, government committee or ministry, or Board of Directors. Having a defined governance structure provides clarity for everyone in the organization, including managers, clinical leadership, and staff regarding who is accountable for making final decisions and oversight of the organization's overall direction. While governance provides oversight and support, it is the commitment and planning efforts of the organization leadership as well as the departments and services leaders that ensures the smooth and efficient management of the organization.

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 healthcare organizations 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 organization's plan should be continuously aligned with the governmental initiated campaigns addressing therapeutic, prophylactic, social and nutritional aspects of healthcare. The chapter guides the organization 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 governance and leadership structure. The ability of leaders to motivate and drive the staff is instrumental for the success of an organization and can be assessed throughout the survey.

Chapter Objectives:

This chapter corresponds to the “Organization Management” chapter in previous versions.

The chapter focuses on checking the organization structure resilience by looking into the following:

1) Effectiveness of governing body.
2) Effectiveness of direction.
3) Effectiveness of leadership.
4) Effectiveness of financial stewardship.
5) Efficient contract management.
6) Ethical management.
7) Effective staff engagement, health and safety.

Implementation guiding documents:

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

1) Egyptian Constitution
2) Egypt 2030 vision, Ministry of Planning
3) Law 51/1981 organization healthcare facilities
4) MOH Ministerial 186/2001 Patient right to know 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, 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

Effective Governing Body

OGM.01 The organization has a defined governance structure that is characterized by the following:

a) The structure is represented in the organization chart.
b) Governance responsibilities and accountabilities are defined in a written document.
c) Members of the governing body are identified by title and name.
d) The governing body meets regularly, and minutes of meetings are recorded.

Effectiveness

OGM.02 The governing body works with the organization leaders to create the mission statement; the organization's mission statement fulfills the following:

a) Aligned with the national healthcare mission and 2030 vision.
b) Approved by the governing body.
c) Evaluated annually.
d) Visible in public areas to staff, patients and visitors.

Effectiveness- patient-centeredness

OGM.03 The governing body approves, receives reports and regularly evaluates and updates the following:

a) The organizational strategic plan.
b) The operational plan and budget, capital investments.
c) The quality improvement, patient safety and risk management programs.
d) Community involvement and relationship program.

Effectiveness

OGM.04 The governing body evaluates its performance annually versus the strategic plan.

Effectiveness

OGM.05 The organization leaders ensure effective communication with the governing body.

Effectiveness

OGM.06 The governing body supports the organization in achieving its goals through appointing director, allocating resources, providing expertise, effective financial planning, and responsiveness to internal and regulatory inspection reports.

Effectiveness- Efficiency

Effective Organization Direction

OGM.07 A full-time qualified director is appointed by the governing body to manage the organization in accordance to applicable laws and regulations and approved organization policies. The organizational director has appropriate training and/or experience in healthcare management, as defined in the job description.

Effectiveness

OGM.08 The organizational director is responsible for the following:

a) Providing oversight of day-to-day operations.
b) Ensuring clear and accurate posting of the organization'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 organization's committees performance.
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.

Effectiveness

OGM.09 The organization ensures a clear process for coordination and communication between the director and the following structures:

a) Leadership.
b) Staff.
c) Organization's committees/structures.

Effectiveness

OGM.10 The organization's leaders develops and implements a strategic plan under oversight and guidance of the governing body; the plan is monitored and evaluated through:

a) Measurable, goals/desired outcomes and defined achievable timelines.
b) Progress review reports, at least annually.
c) Participation of staff, community and other identified stakeholders.

Effectiveness

OGM.11 The organization leaders develop and implement operational plans to achieve the strategic plan goals and objectives, and meet identified input from staff, service providers, and other stakeholders. The plans are communicated throughout the organization.

Efficiency

OGM.12 The organizations leadership is responsible for:

a) Sustaining firm organizational structure:
   1. Planning for upgrading or replacing of systems, buildings, or components needed for continued, safe and effective operation.
   2. Collaboratively developing a plan for staffing the organization that identifies the numbers, types and desired qualifications of staff.
   3. Providing appropriate facilities and time for staff education and training.
   4. Ensuring all required policies, procedures and plans have been developed and implemented.
   5. Providing adequate space, equipment, and other resources based on strategic and operational plans, and needed services.
   6. Selecting equipment and supplies based on defined criteria that include quality and cost effectiveness.

b) Running smooth directed operations:
   1. 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.
   2. Designing and implementing processes that support continuity, coordination of care and risk reduction.
   3. Ensuring that services are developed and delivered safely in accordance to applicable laws and regulations and approved organization strategic plan with input from the users/staff.

c) Continuous monitoring and evaluation:
   1. Ensuring that all quality control monitoring is implemented, monitored and action is taken when necessary.
   2. Ensuring the organization meets the conditions of facility inspection reports or citations.
   3. Annually assessing the operational plans of the services provided to determine required facility and equipment needs for the next operational cycle.
   4. Annually reporting to the organization governance or authority on system or process failures and near misses, and actions taken to improve safety, both proactively and in response to actual occurrences. The organization data are reviewed, analyzed and used by management for decision-making.

d) Continuous Improvement.

Effectiveness- Safety- Efficiency

Effective Departmental Leadership

OGM.13 A designated qualified staff member is assigned to supervise each department and service. 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 work load 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).

Effectiveness- Efficiency

Efficient Financial Stewardship

OGM.14 The organization develops and implements a policy and procedures for managing its storage, stock and inventory. The policy 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.

Efficiency

OGM.15 The organization develops at least one cost reduction improvement project that addresses at least the following:

a) Identification of high frequency and high cost processes, either clinical or non-clinical.
b) Eliminate wastes and redundancies in these processes.
c) Measurements are monitored to ensure sustainability.

Efficiency

OGM. 16 The organization develops and implements a policy and procedure for carrying out internal and/or external financial audits.

a) Audits are performed in accordance to applicable laws and regulations and approved organization policies.
b) Frequency of audits is identified.
c) There's an evidence that the organization responded to the audit reports.

Efficiency

OGM.17 The organization develops and implements a policy and procedures for billing patients; the policy 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) Process to ensure accurate billing.
d) Use of accurate and approved codes for diagnoses, interventions, and diagnostics.
e) In case of a 3rd party payer (or health insurance), the organization ensures that:
    1. The timeliness of approval processes is monitored.
    2. Billing staff are oriented on various health insurance processes.

Efficiency

Efficient Contract Management

OGM.18 The organization develops and implements a policy and procedures for 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.

Safety- Efficiency

Ethical Management

OGM.19 The organization develops and implements a policy and procedures for ethical management; The policy addresses at least the following:

a) Developing and implementing the code of ethics.
b) Handling Medical errors and medico-legal cases.
c) Managing clinical research.
d) Identifying conflict of interest.
e) Gender equality.

Safety- Equity

Effective Staff Engagement, Safety and Health

OGM.20 The organization develops and implements a policy and procedures to ensure 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 organization leaders.
d) Staff feedback measurement.
e) Planning for staff development.

Effectiveness

OGM.21 The organization ensures that staff rest areas are provided for staff for sanitary needs, change clothes, rest and eat when applicable, areas should be:

a) Well- ventilated, Well-lit and clean.
b) Not overcrowded.
c) Reachable through communication tools.
d) Secured and not readily-accessible for non-staff members.
e) With access to healthy staff food and water supply.

Effectiveness

OGM.22 The organization develops and implements a policy and procedures to ensure safe and efficient working hours; The policy addresses at least the following:

a) Measures to avoid staff burnout.
b) Planned rest times.
c) Maternity protection and arrangements for breast-feeding.

Safety

OGM.23 The organization develops and implements a staff health program that is monitored and evaluated annually in conformance with laws, regulations and national initiatives. 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
    1. Ergonomic hazards that arise from the lifting and transfer of patients or equipment, strain, repetitive movements, and poor posture.
    2. Physical hazards such as lighting, noise, ventilation, electrical and others.
    3. Biological hazards from blood borne and air borne pathogens and others.

e) Staff education on the risks within the organization 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) There is appropriate record keeping and management (e.g., staff health records that are filed separately).

Safety effectiveness

OGM.24 The organization ensures that multidisciplinary staff participate in all relevant committees.

Efficiency

Community Assessment and Involvement

Chapter 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 an organization. Communities are always dynamic and live. Changes occur in community structure, function, conditions or behaviors may result in changes in community health needs and risks. Dynamic healthcare organizations can clearly define their communities, frequently assess their needs and respond to those needs. Response can be in the form of widening organization scope, improving certain internal issues that form patient perception or even by reaching out to the community and working with community leaders to engage and involve communities into 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 organization.

Globally, WHO has identified multiple factors as “social determinants of health” Those factors are responsible for health inequalities within and among communities. During late 1990s, the term “Social Accountability” came to 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, 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, 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 on health and its link to health inequalities. Accordingly, during the period of 2018-2019, Egyptian authorities announced multiple initiatives such as “Comprehensive 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 sufficint

Practically, A healthcare organization 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 GAHAR survey, Surveyors shall evaluate the efficiency of the community assessment and involvement program of healthcare organization. The ability of leaders to motivate and drive the community involvement practices and evaluate the outcome.

Chapter Objectives:

This chapter corresponds to chapters Community involvement in the previous version

The main objective is to ensure that organization provides community involvement effectively; The chapter discusses the following objectives:

1) Effective community needs assessment.
2) Alignment with international, national, regional or local community initiatives.

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) MOH Social services webpage:
   http://www.mohp.gov.eg/SectorServices.aspx?Deptcode=7andandSectorCode=4
   Including:
   a. scope of practice as approved by MOHP
   b. Quality measurement for a “social services specialist” in healthcare organizations
   c. Implementation of quality standards
   d. Social services role in control of infectious diseases
3) WHO/UNICEF Baby friendly hospital initiative

Ensuring alignment with healthcare eco-system changes

CAI.01 The organization plans and implements its services in line with international, national, regional or local community initiatives and in accordance to applicable laws and regulations and approved organization policies; Initiatives may include:

a) Implementation of international baby-friendly initiatives.
b) National initiatives of “Comprehensive Health Insurance”, “100 Million Healthy Lives”, “Reduction of Waiting Lists for critical conditions” or others.
c) Others.

Effectiveness

Ensuring Effective Community Services

CAI.02 The organization develops and implements a community involvement and relations program in collaboration with community representatives; The program addresses at least the following:

a) A designated person (s) to coordinate community involvement activities and public relations.
b) Identification and description of catchment area.
c) Gap analysis process involving at least the following:
    1. Accessibility and timeliness of services.
    2. Risk assessment of the community hazards including environmental problems.
    3. Healthcare needs.
    4. Healthcare education needs.
    5. Healthcare expectation.
d) Planning for interventions.
e) Identifying potential solutions.
f) Announcing or posting selected solutions to the community.
g) Training tools and information provided for the community education program.

Patient-Centeredness

CAI.03 The organization ensures that community activities whether educational, cultural, recreational, outreach or other activities meet the identified learning needs and educational level of the community. Topics of social activities may cover smoking cessation, nutrition, exercise and fitness, sexual and reproductive health and mental health including depression and addiction.

Effectiveness

CAI.04 The organization ensures that outcomes of community involvement and relations program is monitored and evaluated as follows:

a) Reassessment of community needs and risks at least every two years.
b) Effectiveness of interventions.
c) Community satisfaction of provided social activities is measured.
d) Complaints from the community and external customers are addressed.

Effectiveness

CAI.05 The organization develops and implements a policy and procedures to guide the process for dealing with at least the following:

a) External business customers.
b) Internal or External customer complaints.
c) Situations to call police help including aggressive behavior.
d) Media.

Equity

CAI.06 Accredited organization is sharing experience with neighboring (or other) healthcare organization(s) to understand, achieve or maintain accreditation.

Patient-centeredness

Workforce Management

Chapter Intent:

The healthcare organization needs an appropriate variety of skilled, qualified people to fulfil its mission and to meet patient needs. The organization's workforce refers to the staff within the organization. Planning the appropriate number and skill mix of workforce is essential. Developing clear job descriptions, strong orientation and training programs help staff in delivering proper healthcare. A good organization should always have a clear structure of its medical staff, including departments, divisions, and medical committees. This chapter defines the medical staff leaders' roles and responsibilities in credentialing, privileging, bylaws development, committees and departments' management (head), as well as performance improvement. The medical staff includes licensed physicians and licensed dentists, it's particularly important to carefully review the credentials of all medical staff and other healthcare providers, The organization should provide medical staff with opportunities to learn and to advance personally and professionally Independent practitioners are other licensed healthcare providers as (pharmacists, physiotherapist, nutritionist…) that are permitted by law and regulation to provide patient care services independently in the organization, those special group of healthcare providers shall be identified by the organization and their clinical privileges shall be clarified and reviewed.

Law and regulation shall license nurses because their role is critical in nearly all aspects of patient assessment and care, in evaluating patients and monitoring their response to treatment and outcomes of care.

Globally, Shortage of healthcare providers is seen in multiple places in the world. In some countries, licenses are renewable which means that physicians, nurses and other providers need to go through a renewal process periodically and prove their competence and continuous development. National bodies that govern medical and nursing education is established in different countries. National performance evaluation and ranking of healthcare providers is on the rise with many healthcare systems moving towards pay-per-performance concept.

Locally, Egypt also has experienced migration of healthcare providers to other countries. The new Universal Health Insurance system tackled the pay-per-performance concept in its initial phases. Licenses are not linked to frequent evaluation of professional development yet, but discussions are established to build a system for monitoring this process. MOH licensing body requires specific lists of documents for almost all healthcare providers, 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 bylaw, nursing bylaws, Policies, procedures and plans reflecting processes of human resources department through interviews with leadership and staff and reviewing different healthcare provider's personnel files.

Chapter objectives:

This chapter corresponds to chapter Human Resources**,** Nursing Services and Medical staff in the previous version.
The main objective is to ensure that organizations maintain effective Workforce Management program;
The chapter addresses the following objectives:

1) Effective workforce planning.
2) Effective orientation, continuous medical education and training program
3) Efficient mix of staff.
4) Periodic evaluation of the 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 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) MOH ministerial decree 70/1996 work of foreign experts
15) MOH ministerial decree 90/1999 for the use of foreign experts
16) MOH Ministerial decree 236/2004 on anaesthesia service requirements
17) MOH Ministerial Decree 153/2004 on minimum requirements for anaesthesia services
18) Law 213/2017 of trade unions and protection
19) MOH Ministerial decree 25/2002 for medical responsibility and suspension of medical practice
20) MOH Ministerial decree 293/2000 on promotion of doctors
21) MOH Ministerial decree 62/2004 on promotion of healthcare providers
22) MOH Ministerial decree 244/2001 on competencies of surgeons

Efficient Workforce Planning

WFM.01 The organization complies with the laws and regulations on recruitment, planning, education, training and staff appraisal.

Efficiency

WFM.02 The organization develops and implements a staffing plan; The plan has at least the following features:

a) Staffing plan matches the strategic and operational plan.
b) Skill levels, needed qualification and estimated needed staff numbers versus staff assignments.
c) Personnel to meet the needs of the organization.
d) Staffing plan is monitored and reviewed at least annually.

Efficiency

WFM.03 The organization develops job descriptions, which include required licenses, certification, registration, education, skills, knowledge, and experience, responsibility and other requirements for each position.

Efficiency

WFM.04 The organization implements recruitment processes that have at least the following features:

a) The recruitment process is uniformly applied.
b) Appropriate leaders participate in the recruitment process.

Equity

WFM.05 The organization implements and records a process for verifying credentials and evaluating the qualifications of new and current staff that is uniformly applied.

Safety

WFM.06 The organization develops and implements a policy and procedures that guide the development of a staff file for each workforce member, the policy 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 organization, 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.

Effectiveness

Effective Orientation Program

WFM.07 The organization develops and implements a formal orientation program for all staff, volunteers and contracted workers. The orientation program addresses at least the following:

a) General orientation course addresses at least the following: review of the organization mission, structure, policies for environment of care ,infection control, and performance improvement ,patient safety, risk management.
b) Departmental Orientation includes the review of relevant policies and procedures, operational processes and work relations.
c) Orientation skills needed for specific job.
d) Staff Manual which includes at least description of the following processes: appointment and reappointment, staff appraisal, Staff complaints, staff satisfaction measurement process, code of ethics, disciplinary actions and termination.
e) The orientation completion is recorded.

Effectiveness

Effective Training and Education

WFM.08 The organization develops and implements a continuing education and training program for all staff. 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.

Effectiveness

WFM.09 The organization 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 file requirements as appropriate to responsibilities or job description.
f) Pain assessment and treatment.
g) Restraint use and seclusion.
h) Moderate sedation.
i) clinical guidelines used in the organization.
j) Basic cardiopulmonary resuscitation training at least every two years for all staff that provides direct patient care.
k) Quality concept, performance improvement, patient safety, and risk management.
l) Patient rights, Patient satisfaction and the complaint process.
m) Interpersonal communication between patients and other staff cultural beliefs, needs and activities of different groups served.
n) Defined abuse and neglect criteria.
o) Medical equipment and utility systems operations and maintenance.

Effectiveness

Equitable Staff Performance Evaluation

WFM.10 The organization develops and implements a policy and procedures that define the process for staff performance review. The policy addresses at least the following features:

a) The policy is uniformly applied for all categories/ levels of staff.
b) Review is based upon the staff job functions as described in the job description.
c) Review when indicated by the findings of quality improvement activities and appropriate education and training provided.
d) Reviews are performed at least annually for each staff member.

Equity

Efficient Medical Staff Structure

WFM.11 The organization has an organized medical staff structure to provide oversight to ensure uniform quality of care, treatment and services.

Equity

WFM.12 The organization establishes an interdisciplinary committee for medical staff management

a) The committee has terms of reference.
b) The committee meets on regular basis.
c) The committee's meetings are recorded.

Effectiveness

WFM.13 The organization develops a document to define medical staff bylaws that addresses at least the following:

a) The structure of the entire medical staff.
b) The structure and function of medical staff committee.
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 organization are verified and kept current.
e) The medical staff bylaws are in accordance to applicable laws and regulations, approved organization policies and approved by the organization leader(s).
f) The privileging (application, granting, revision, renewal).
g) The organization 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.

Safety

WFM.14 Each medical department has a designated head that is certified in an appropriate specialty, certified in a management field and has appropriate documented experience as required by the job description.

Effectiveness

WFM.15 Appointment of medical staff members is performed in accordance to applicable laws and regulations, approved organization medical staff bylaws and approved by the organization leader(s).

Safety

WFM.16 All medical staff members have current and specific delineated clinical privileges approved by the medical staff committee. The privileges address the following:

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

Safety

WFM.17 The performance of each medical staff members is reviewed and recorded at least annually to determine continued competence to provide patient care services; In addition to regular performance evaluation of all staff, Data includes at least:

a) Patient's medical record review for completeness and timeliness.
b) Utilization practice, blood utilization and medication use.
c) Compliance with approved clinical guideline.
d) Complications, outcomes of care, mortality and morbidity.
e) Professional development.

Safety

WFM.18 The organization develops and implements a policy and procedures to ensure an ongoing peer review process. The policy addresses at least the following:

a) There are defined criteria for referring clinical cases for peer review.
b) There are defined criteria for referring clinical cases for external peer review.
c) Internal and external peer reviews are performed as per defined criteria.
d) The date and information from peer review are used for competency assessment. and considered at the time of re-appointment and re-privileging.

Safety

WFM.19 The organization develops and implements a policy and procedures to identify and facilitate continuous medical education activities; the activities follow the general requirements for all workforce members in addition to the following features:

a) Based on defined and desired education, skills, knowledge, and other requirements of all medical staff members.
b) Based on organization scope and strategic plan.
c) Medical staff members participate in continuing medical education, related to their practices.
d) Medical Education and training completion is recorded and evaluated.

Effectiveness

Safe Independent Practitioners Practices

WFM.20 The organization develops and implements a policy and procedures for granting clinical privileges to these providers. The policy addresses at least the following:

a) Identification of healthcare providers who are not medical staff and who can plan patient care independently.
b) Privileges are determined based on documented evidence of competency (experience- qualifications – certifications-skills).
c) Privileges are reviewed and renewed at least every three years.
d) Privileges are available in areas where independent practitioners shall provide services pertinent to granted privileges.
e) Independent Practitioners with privileges do not practice outside the scope of their privileges.

Safety

Organized Nursing Structure

WFM.21 The organization ensures that legal requirements governing the professional regulation of nurses and allied health professionals are followed.

Equity

WFM.22 The organization has a nurse director, that is licensed nurse, qualified by education and managerial experience; the nurse director has the following responsibilities:

a) Responsible for developing and implementing written nursing standards of practice and recording for nursing assessment ,nursing care plan ,nursing reassessment and treatments.

b) Responsible for evaluating the effectiveness of nursing treatments.

a) Member of the senior leadership team of the organization and attending the senior leadership staff meetings.

b) Ensuring that schedules and assigned tasks to the staff are completed.

Effectiveness

WFM.23 The organization develops and implements nursing staff bylaws; Bylaws address at least the following:

a) The structure of the entire nursing staff.

b) The structure and function of the nursing staff committee.

c) Nurse credentialing process including the process for validating required licensure, education, registration and/or certification of all nursing staff.

d) Nurse staff bylaws are in accordance to applicable laws and regulations and approved organization policy, and approved by the organization leader(s).

e) Defined criteria and process for suspension.

f) Mechanism for a fair hearing and appeal process.

Safety

WFM.24 The nurse director ensures that all nurse trainees are supervised by a qualified member of the nursing staff.

Effectiveness

WFM.25 The organization develops and implements a policy and procedures guiding nursing care and specifies type of care they are permitted to provide.

Effectiveness

Information Management and Technology

Chapter intent:

Information management is the process by which relevant information is provided to decision-makers in a timely manner. Effective information management system is a vital component of the healthcare service. Information management and Technology in healthcare organizations 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 breech of patient confidentiality. Patient confidentiality means that personal and medical information given to a healthcare provider 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 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 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 encourage that movement.

Locally, The 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, Healthcare organizations need to provide resources for implementation of 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 Objectives:

This chapter corresponds to Information Management chapter in previous versions.

This chapter addresses the main concepts of information management in the organization

a) Effective Information Management Processes.
b) Maintaining Information Confidentiality and Security.
c) Availability of patient's medical file.
d) Effective **i**nformation Technology in Healthcare.

Standards included in this chapter shall apply on 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) MOH - 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) MOH 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 The organization implements information management processes in accordance to applicable laws and regulations and approved organization policies.

Equity

IMT.02 The organization develops and implements an information plan to meet information needs based on at least the following:

a) The identified information needs of clinical and managerial leaders of the organization.
b) The information needs and requirements of external authorities and agencies.
c) The size and the types of services provided by the organization.

Effectiveness

IMT.03 The organization develops and implements a policy and procedures to define the requirements for developing, approving, tracking and revising quality management system documents such as policies, plans, programs, procedures and others
The policy addresses at least the following:

a) Standardized formatting.
b) Document control system for tracking of issues and tracking of changes; The system allows each document to be identified by title, date of issue, edition and/or current revision date, number of pages, who authorized issue and/or reviewed the document and identification of changes of version.
c) Required policies are available and disseminated to relevant staff
d) Staff understand how to access those policies relevant to their responsibilities.
e) Retirement of documents.
f) Policies are revised at least every 3 years.

Effectiveness

IMT.04 The organization develops and implements a policy and procedures to define standardized diagnosis codes, procedure codes, definitions, symbols and abbreviations in accordance to
NSR.12.1 the organization's scope of service and approved official language of communication inside the organization; The policy addresses at least the following:
NSR.13

a) Approved symbols/abbreviation list.
b) Not-to-use symbols/abbreviations list.
c) Symbols and abbreviations are not used in informed consents and any record that patients and families receive from the organization about the patient's care.

Safety

Ensuring Confidentiality and Security of Information

IMT.05 The organization develops and implements a policy and procedures to define the confidentiality and security of data and information. The policy addresses at least the following:

a) Determination of who can access what type of data and information for decision making.

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 privacy or security of information has been breached.

Patient-centeredness

IMT.06 The organization ensures that patient's medical file and information are protected from loss, destruction, tampering, and unauthorized access or use.

Patient-centeredness

IMT.07 The organization develops and implements a policy and procedures to define the retention time of records, data and information; The policy is in accordance to applicable laws and regulations and approved organization policy.

Timeliness

IMT.08 The organization ensures that patient's medical file, data and information are destroyed as defined by law, regulation and policy.

Patient-centeredness

Availability of Patient-Specific Information

IMT.09 The organization develops and implements a policy and procedure to define the mechanism of managing patient's medical file in the organization; the policy addresses at least the following:

a) Initiation of a patient's medical file with unique identifiers for each assessed or treated patient.
b) Contents and organization.
c) Uniformity and standardization of use.
d) Patient's medical file release.
e) Tracking.
f) Storing.
g) Management of voluminous patient's medical file.
h) Patient's medical file destruction.

Patient-centeredness

IMT.10 The organization develops and implements a policy and procedures to guide the process of "Using patient's medical file"; the policy addresses at least the following:

a) Availability of patient's medical file when needed by care providers.
b) who is authorized to make entries in the patient's medical file.
c) Physicians, nurses and other healthcare providers record directly in the patient's medical file to promote continuity and integrity of care.
d) All entries are dated, legible and authors are clearly identified by name and title.

Safety

IMT.11 The organization implements a process for completion of patient's medical file of discharged patients within maximum 30 days.

Timeliness

IMT.12 The organization develops and implements a policy and procedures to define the review process of patient's medical file. The policy 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 in the patient's medical file.
d) Review of the completeness and legibility of entries.
e) Review occurs at least quarterly.
f) The results of review shall be reported to the organization leaders.

Effectiveness

Effective Information Technology in Healthcare

IMT.13 The organization implements a process for health information technology systems assessment and testing prior to implementation within the organization and evaluation for quality and patient safety following implementation.

Safety

IMT.14 The organization develops and implements a program for response to planned and unplanned downtime of data systems testing and evaluation of the response.

Safety

IMT.15 The organization develops and implements a policy and procedures for data backup.

Safety

Quality and Performance Improvement

Chapter intent:

It is essential for organizations to have a framework to support the continuous improvement and risk management activities. This requires leadership support, well established processes, active participation from all head of departments and staff. Performance improvement and risk management are parts of both strategic and departmental operational plan.

Globally, Healthcare organizations have adopted, adapted and even created improvement tools to help enhancing 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 quality of healthcare and medical outcome research. Multiple quality improvement methodologies were used in healthcare organizations such as PDCA, FOCUS PDCA, Six Sigma, Lean Methodology and others.

Locally, The Egyptian ministry of planning adopted the EFQM award for excellence to promote quality practices among governmental entities. Some Egyptian hospitals have participated in international conferences with Six Sigma and FOCUS PDCA projects. In 2013, Health Insurance Organization issued what was known as “Hospital Performance Indicators Guide”.

Practically, Healthcare organizations 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 organization understand his/her role in improving the healthcare quality and safety, by focusing on the leadership support, department level input and participation, measures and data collection and sustaining Improvement. Application of the standards should be in accordance to applicable Egyptian laws and regulations.

During 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 objectives:

This chapter corresponds to chapters Performance Improvement (PI) in the previous version

The main objective is to ensure that organization provides effective performance improvement program; The chapter discusses the following objectives:

1) Effective leadership support.
2) Effective Departmental participation.
3) Effective Performance Measurement and Data management.
4) Effective Improvement Sustain.

Implementation guiding documents:

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

1) MOH Quality and Safety Guide, 2019
2) Hospital Performance Indicators Guide by HIO, 2013
3) National EFQM based excellence award www.Egea.gov.eg
4) Law 35/1960 National census and statistics
5) Law 2915/1964 Establishment of CAPMAS

Effective Leadership support

QPI.01 The organization establishes an interdisciplinary performance improvement, patient safety and risk management committee(s).

a) The committee has terms of reference.
b) The committee meets on regular basis.
c) The meetings are recorded.

Efficiency

QPI.02 The organization develops and implements an organization-wide performance improvement, and patient safety plan that includes at least the following:

a) The goal(s) that fulfil the organization mission.
b) Defined criteria for prioritization and selection of performance indicators.
c) A description of the methodology to be used for data collection and analysis.
d) Defined criteria for prioritization and selection of performance improvement projects.
e) Valid and reliable data methods are utilized to measure improvements and include internal data as well as external data.
f) Quality Improvement model(s) used.
g) Information flow and reporting frequency.
h) Training on quality improvement and risk management approaches.
i) Regular evaluation of the plan (at least annually).

Effectiveness

QPI.03 The organization ensures that a qualified staff member is assigned as performance improvement coordinator/manager.

Efficiency

Efficient Department level input and participation

QPI.04 The organization staff including medical, nursing and others participate in performance improvement activities.

Efficiency

Efficient Data Management

QPI.05 Performance indicators are identified, defined and monitored for all significant processes.

Efficiency

QPI.06 Clinical Care Monitoring includes appropriate and relevant indicators for at least the following:

a) Waiting times in the relevant service areas.
b) Patient assessment is complete, accurate and within approved time frames.
c) Surgical and invasive procedures.
d) Use of anesthesia and moderate and deep sedation.
e) Use of medications.
f) Use of blood and blood products.
g) Patient's medical file, including availability and content.
h) Infection control, surveillance and reporting.
i) Medication errors, near-miss and adverse outcomes.
j) Use of restraints and seclusion.
k) Patient safety requirements.
l) Clinical effectiveness.

Effectiveness

QPI.07 Managerial monitoring includes appropriate and relevant indicators for at least the following:

a) Compliance with law and regulations.
b) Patient and family expectations and satisfaction.
c) Patient complaints.
d) Staff expectations and satisfaction.
e) Staff complaints.
f) Patient demographics, diagnoses and procedures.
g) Procurement of routinely required supplies and medications.
h) Financial management.
i) Risk management.
j) Staff and professional performance.
k) Utilization management.

Effectiveness

QPI.08 The organization assigns a staff member(s) with appropriate experience, knowledge, and skills for data review, aggregation and analysis within approved time frame.

Effectiveness

QPI.09 The organization develops and implements a policy and procedures for data validation in accordance to defined criteria.

Effectiveness

QPI.10 The organization uses internal and external reference databases, as available, for comparative purposes.

Effectiveness

Efficient Risk Management Program

QPI.11 The organization develops and implements a well-structured risk management plan that includes at least the following:

a) Scope and objective.
b) Risk identification.
c) Risk prioritization.
d) Risk reporting.
e) Risk Management.

Safety

QPI.12 The organization develops and implements a proactive risk reduction tool for at least one high-risk process annually.

Safety

QPI.13 The organization develops and implements a policy and procedures to defines an incident-reporting system that includes at least the following:

a) List of reportable incidents, near misses, adverse events and sentinel events.
b) Incident management process include 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.

Safety

QPI.14 The organization develops and implements a process for trend analysis and taking corrective actions in response to the following significant events:

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.

Safety

QPI.15 The organization develops and implements a policy and procedures for investigating and taking corrective actions in response to the following sentinel events:

a) Unexpected mortality or major permanent loss of function not related to the natural course of the patient' illness or underlying condition.
b) Wrong patient, wrong site, wrong procedure events.
c) Patient suicide, attempted suicide or violence leading to death or permanent loss of function.
d) Unintended retention of foreign object events in a patient after surgery or invasive procedure.
e) Wrong delivery of radiotherapy.
f) Any peri-partum maternal death.
g) Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.

Safety

Sustaining Improvement

QPI.16 The organization ensures that improvement activities are performed within approved time frame, appropriate and sustained.

Efficiency

Section 4

Additional Requirements

SECTION 4: 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: MOH- Research ethics committee guidelines,2013
2) Regulation 1002/1975 on teaching institutes
3) Law 5/2010 Egyptian Law for organ transplant
4) Law 310/2009 on Eye banks
5) Cairo declaration on Human Rights in Islam, 1990

Human Subject Research Compliance

ADD.01 The organization complies with the laws and regulations on recruitment, planning, education, training and staff appraisal.

Equity

ADD.02 An appropriate committee reviews and approves all research protocols that involve human subjects as required by law and regulation.

Efficiency

ADD.03 Research Policy and procedures is available and includes eligibility for enrollment in research projects or protocols.

Equity

ADD.04 A signed patient consent for participation in research is placed in the research file and in the patient's medical file.

Patient-Centeredness

ADD.05 Patient has the right to withdraw from a research protocol without fear of retribution.

Patient-Centeredness

ADD.06 Photographs and patient information included in the research are guaranteed confidentiality and names and identifiers shall not be published.

Patient-Centeredness

Efficient Medical Specialization and Education Program

ADD.07 The organization develops and implements a policy and procedures for arranging the activities of house officers and residents within the organization , the policy address at least the following:

a) Scope of house officer and resident assessment and treatment of patients.
b) House officers and residents are oriented to and comply with medical staff rules and regulations.

Effectiveness

ADD.08 The organization ensures that house officers and residents practice within their scope/job description.

Effectiveness

ADD.09 House officers and residents comply with policies and procedures of the organization.

Effectiveness

ADD.10 The organization participating in professional graduate education programs, physicians in training are supervised by a qualified medical staff member in carrying out their patient care responsibilities.

Effectiveness

ADD.11 There is a mechanism for communication between the committee/person who coordinates training activities and the medical staff committee.

Effectiveness

Patient Centered Organ and Tissue Donation and Transplantation Program

ADD.12 The organization develops and implements a policy and procedures to define how the organization informs patients and families about choosing to donate organs and other tissues.

Equity

ADD.13 The organization develops and implements a policy and procedures for organ and tissue transplant services in accordance to applicable laws and regulations and approved organization policy and clinical guideline/protocol; The policy addresses at least the following:

a) Organ procurement.
b) Defined selection criteria for donors and recipients.
c) Assessment of donors suitability.
d) Special consent as required by laws and regulations.
e) Organ transplant care guidelines/protocols.

Patient-Centeredness

Glossary

Antiseptics	An agent that eliminates many or all pathogenic microorganisms, except bacterial spores, on human skin.
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 the hospital can support with qualified staff and technical capabilities.
Aseptic technique	Using practices and procedures to prevent contamination from pathogens. it involves applying the strictest rules to minimize the risk of infection.
Certification	The procedure and action by which an authorized organization evaluates and certifies that a person, institution, or program meets requirements.
Certified person	Is someone who has passed exams from an accredited organization related to the work that he or she shall perform.
Cleaning	Removal of visible soil from objects and surfaces, which are normally, accomplished manually or mechanically using water with detergents or enzymatic products.
Clinical pathways	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 providers 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 provider 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).
Clinical staff	Those who provide direct patient care (physicians, nurses, etc.).
Communicable diseases	Some infectious diseases are contagious, that spread from one person to another.

Competence or competency	A determination of staff' 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 an unwanted material or organism, such as an infectious agent, bacteria, parasite, or other 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 are 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. See also competence; credentialing.
Discharge Summary	A section of a patient medical record that summarizes the reasons for hospitalization, the significant findings, the procedures performed, the treatment rendered, the patient's condition on discharge, and any specific instructions given to the patient or family.
Disciplines	Reference to the various members of the healthcare team, is a job category.
Disinfectants	An agent that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects,
Desirable Medication list	Lowest criticality needed from medication and items; shortage may not pose a threat to the health of the patients.
Medication sample	A medication sample is defined as a unit of a "prescription medication that is not intended to be sold and is intended to promote the sale of the medication. Medication sample is given to patient in very limited circumstances that should be defined in the organization policy.
Endemic infection	The usual level or presence of an agent or disease in a defined population during a defined period.
Epidemic infection	A higher than expected level of infection by a common agent in a defined population during a defined period.

Essential	Medication and Items having lesser criticality needs, Shortage can be afforded for a short period.
Essential medication list	Per WHO definition, people should have access at all times in sufficient amounts to these medications.
External	Refers to outside of the organization, such as comparing data with other organizations or contributing to Egypt 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 pharmacopoeia 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 organization formulary list should be in accordance to the national essential medicines list.
Governing body	The individual(s) or group that has ultimate authority and responsibility for developing policy, maintaining quality of care, and providing for organization management and planning for the organization.
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 provider to another, from one level of care to another level, from an inpatient unit to a diagnostic or other treatment unit, and from staff to patients/families at discharge.
Hazardous materials and waste plan	The organization's 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 organization 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 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, and/or wards.
Healthcare provider	any person, institution, or agency that provides health services to health.
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.
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 staff	personal working in the organization other than heath care providers, for example (housekeeping staff, administrative department, financial department, registration clerks, engineers, manual workers, drivers, etc.).
Hygiene	The practice that serves to keep people and environments clean and prevent infection.
Infection	The transmission of a pathogenic microorganism,
Infection Control Program	Organized system of services designed to meet the needs of the organization in relation to the surveillance, prevention, and control of infection which impacts patients, staff, physicians, and/or visitors.
Inventory	A written list of all the objects, abilities, assets, or resources in a particular place.
Job description	Statements or directions specifying required decisions and actions. Penalties, legal or otherwise, are normally assessed when laws and regulations are not followed.
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.
Leaders	A person, who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, clinical, and support functions and processes.

Medical staff	Licensed physician and licensed dentist.
Medical Staff Bylaws	Regulations and/or rules adopted by the medical staff and the governing body of the organization for governance, defining rights and obligations of various officers, persons, or groups within the medical staff's structure.
Medication Reconciliation	Medication reconciliation is a formal process that has been demonstrated to improve the continuity of medicines management,
Needs assessment	Alternative term for gab analysis.
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.
Outbreaks	Sudden increase in occurrences of disease in a particular time and place .it may affect a small and localized group or impact upon thousands of people across an entire continent.
Peer Review	A process whereby the performance of an organization, staff or groups are evaluated by members of similar organizations or the same profession or discipline and status as those delivering the services.
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.
Plan of care	A plan that identifies the patient's care needs, lists the strategy to meet those needs, records treatment goals and objectives, develops 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.
Policy	is a guiding principle used to set direction in an organization.
Procedure	is 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.

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 parameter, protocol, preferred practice pattern, and guideline. Also see evidence- (scientific) - based guidelines and clinical practice guidelines.
Preprinted orders	Pre-Printed Medication Order Set (PMOS) is a formal record that includes a pre-determined group of medication orders that work to standardize diagnosis and treatment choices applicable to a specific patient population.
Privileging	The process whereby specific scope and content of patient care services (clinical privileges) are authorized for a healthcare provider by the organization, based on evaluation of the physician's credentials and 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 develop an education strategy, develop educational materials, and deliver the education sessions.
Process	A natural phenomenon marked by gradual changes that lead toward a particular result.
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 labelling.
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	Planned set of interrelated tasks to be executed over a fixed period and within certain cost and other limitations.
Protocol	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 other resource.
Reliable resource	Resources of procurement of medications /paramedical supplies /pharmaceutical devices only from Authoritative sources and professional organization that can help to ensure avoidance of counterfeit, diverted, or stolen; Potentially intentionally adulterated; or 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.
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.
Scope (care or services)	The range and type of services offered by the organization and any conditions or limits to service coverage.
Scope of practice	The range of activities performed by a healthcare provider (physician, nurse) in the organization. The scope is determined by training, tradition, law or regulation, or the organization.
Side effect	Pharmacological effect of a medication, normally adverse, other than the one(s) for which the medication is prescribed.
Single Use Device	Are also referred to as a disposable device, 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	OSHA definition (linen that has been solid with blood or other infectious materials.
Staff	Personal who provide patient care, treatment, and/ or services in the organization ,for example(, medical staff, nursing staff).
Sterilization	The use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacterial endospores.
Stock	A quantity of something accumulated, as for future use, kept regularly on hand, as for use or sale; staple; standard.
Stocking	The activity of supplying a stock of something or items.
Storage	Space or 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	The ongoing systematic collection and analysis of data and the provision of information, which leads to action, being taken to prevent and control a disease, usually one of an infectious nature.
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.
Utilization	The use, patterns of use, or rates of use of a 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 favourable outcome for a patient. Misuse occurs when an appropriate service has been selected but a preventable complication occurs. All three reflect a problem in quality of healthcare. They can increase mortality risk and diminish 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.
Vital medication list	Is the list of critically needed as live saving and shall be available all the time. Shortage cannot be tolerated.

References

Egyptian Ethical Framework

1) Egyptian Constitution.
2) Universal Declaration on Human Rights, 1964.
3) Cairo Declaration on Human Rights in Islam, 1990.
4) Cairo Declaration on Woman Health.
5) Egyptian Code of Medical Ethics 238, 2003.
6) Egyptian Code of Nursing Ethics (Nursing Syndicate Publications).
7) Code of Ethics and Behavior for Civil Service Staff, 2019.
8) Pharmacist Code of Ethics

Egyptian Laws and Regulations

9) Law 10/2018, Rights of the Handicapped.
10) Law 181/2018, Egyptian Consumer Protection.
11) Law 206/2017, Advertisement for Healthcare Services.
12) Egyptian Consent laws.
13) Egyptian Standards for Accounting, 609/2016.
14) Presidential decree 151/2019 for Egyptian Drug Authority.
15) Ministry of finance decree 18/2019: Non-Monetary Payment.
16) Law 2/2018 on Universal Health Insurance.
17) MOH Ministerial decree 116/2017.
18) Law of Trade Unions and Protection 213/2017.
19) Presidential decree number 3185/2016.
20) MOH Ministerial decree number 523 / 2015 for reuse of single used devices and instruments.
21) MOH Ministerial decree number 753 / 2015 for medical waste management.
22) Presidential decree number 14 / 2014 for performance evaluation.
23) Prime Minister decree, 1063/2014 Management of Emergency cases.
24) MOH Ministerial decree 245/2012.
25) MOH Ministerial decree 368/2012.

26) MOH Ministerial decree 391/2012.
27) Regulation for Care of Psychiatric Patients 128/2010.
28) Law 5/2010 Egyptian Law for organ transplant.
29) Egyptian law for care of psychiatric patients 71/2009.
30) Ministry of finance decree 270/2009: Governmental Archives list.
31) Law 310/2009 on Eye Banks.
32) Law 126/2008 on Egyptian Children.
33) MOH regulation in NICU, 2007.
34) MOH Ministerial decree number 458/2007 for potable water.
35) Ministry of communication and information technology decree 109/2005: Electronic signature.
36) MOH Ministerial decree number 153/2004 for prevention of viral hepatitis.
37) MOH Ministerial decree number 187/2004 for infection control personnel.
38) MOH Ministerial decree 62/2004 on promotion of doctors.
39) MOH Ministerial decree 236/2004 on anesthesia service requirements.
40) MOH Ministerial Decree 153/2004 on minimum requirements for anesthesia services.
41) Patient Safety during operation procedure committee recommendations, 2003.
42) MOH Ministerial decree number 99/2002 for developing infection prevention and control department.
43) MOH Ministerial decree 25/2002 for medical responsibility and suspension of medical practice.
44) MOH Ministerial decree number 100/2002 for developing infection prevention and control departments.
45) MOH Ministerial decree 306/2002 on medication storage spaces.
46) MOH Ministerial decree 254/2001 Discharge summary requirements.
47) MOH Ministerial decree 186/2001 Management of emergency cases.
48) MOH Ministerial decree 186/2001 Patient right to know expected cost of care.
49) MOH Ministerial decree 244/2001 on competencies of surgeons.
50) Law 192/2001 for Hazardous waste management.
51) MOH Ministerial decree 293/2000 on promotion of doctors.
52) MOH ministerial decree of 90/1999 for the use of foreign experts.

53) MOH Ministerial Decree 216 for operation procedures.

54) Regulation of tenders and auctions law and law 89/998 and its regulations issued by the Minister of Finance decree 1367/1998.

55) MOH ministerial decree 70/1996 work of foreign experts.

56) MOH Ministerial decree number 63/1996 for dialysis units.

57) MOH Ministerial decree 420/1994 for blood donor incentives.

58) Law 4/1994 on Egyptian environment.

59) MOH Ministerial decree 284/1985 on requirements for OR.

60) Law 3/1985 practicing the profession of physiotherapy.

61) Law 104/1985 Blood banking services.

62) MOH Ministerial decree 284/1985 on requirements for OR.

63) MOH Ministerial decree 216/1982 Healthcare facilities organization.

64) Law 140/1981 on practicing midwifery.

65) MOH Ministerial decree 385/1975 for management of blood banks.

66) Law 2915/1964 Establishment of CAPMAS.

67) Law 35/1960 National census and statistics.

68) Law 59/1960 regulation of Medical Imaging work.

69) Law 178/1960 on organizing blood collection transport and storage.

70) Law 127/1955 on practicing the profession of pharmacy.

71) National law for laboratories, 367/ 1954.

72) Practicing the Human medicine profession law 415/1954.

73) Law 537/1954 on Practicing of dental profession.

74) Law 58/1937 on Egyptian Criminal code.

75) Drafted Egyptian Law for Elderly Care.

Egyptian Guidelines, Codes and References

76) Requirements of blood bank staff, Egyptian MOH.

77) Requirements and equipment of blood bank, Egyptian MOH.

78) Requirements of sub-blood bank, Egyptian MOH.

79) MOH - General Directorate of Technical Inspection. The administrative tool.

80) The Egyptian code for healthcare facilities design.

81) The Egyptian code of building for handicapped.

82) The Green Pyramid Rating System (GPRS).

83) Civil defense guidelines and instructions.

84) Egypt 2030 vision, Ministry of planning.

85) Abuse: Managing victims of social abuse guidelines – ministry of health, UNFPA.

86) Blood Transfusion: National Blood transfusion Policy, MOH, 2007.

87) Cancer: National cancer treatment guidelines, High committee of cancer. Egyptian ministry of health and population.

88) Environmental Safety: National strategy in disasters management.

89) Environmental Safety: Atomic Energy Commission rules.

90) Environmental Safety: The Egyptian Guideline for Medical Device Vigilance System

91) Emergency: Publications of Central Administration of Emergency and Critical Care, Egyptian ministry of health and population.

92) Emergency: Emergency Department unified protocol, Egyptian ministry of health and population curative and critical sector.

93) Food safety Egyptian Guidelines.

94) Infection Control: National guidelines for infection control.

95) Inspection: Requirements of inspection per MOH law and regulation.

96) Laboratory: Tuberculosis Labs manual, Egyptian MOH 2015.

97) Nursing: Nursing Syndicate Publications – Nursing Guidelines.

98) Pharmacy: Central pharmacy role and scope.

99) Pharmacy: Egyptian Clinical pharmacy standards of practice.

100) Radiology: Egyptian Swiss Radiology program, MOH.

101) Research: MOH- Research ethics committee guidelines,2013.

102) Quality: Hospital Performance Indicators Guide by HIO, 2013.

103) Social services: Social services scope of practice as approved by MOHP.

104) http://www.mohp.gov.eg/SectorServices.aspx?Deptcode=7andandSectorCode=4.

105) Social services: Quality measurement for a “social services specialist” in healthcare organizations.

106) Social services: Social services role in control of infectious diseases.

International References

107) American Society of Health System Pharmacists (ASHP) standards for 2019.

108) Anatomic pathology and Microbiology checklists, CAP accreditation program, 2014.

109) Guidance in environmental safety book – part 6.

110) HIPAA— Health Insurance Portability and Accountability Act Regulations1996.

111) Institute for Safe Medication Practices (ISMP): List of Error-Prone Abbreviations, Symbols, and Dose Designations.

112) ISO 15189, 2012.

113) Jeddah Declaration on Patient Safety 2019.

114) WHO Patient Safety Assessment Manual.

115) WHO Surgical Safety Checklist.

116) WHO Safe Childbirth Checklist.

117) WHO Core Medical equipment.

118) WHO Early Warning Alert and Response Network in emergencies.

119) WHO five moments for medication safety.

120) WHO Good clinical diagnostic practice, 2005.

121) WHO guidelines on medication safety in high risk situation.

122) WHO guidelines on medication safety in transition of care.

123) WHO International Health Regulation.

124) WHO guidelines on medication safety in poly pharmacy.

125) WHO List of essential in-vitro diagnostic tests, 2018.

126) WHO Lab quality management system, 2011.

127) WHO Laboratory biosafety manual, 2007.

128) WHO Transition of care, 2016.

129) WHO Surgical Safety Resources.

130) WHO Safe Childbirth Checklist.

131) WHO/UNICEF Baby friendly hospital initiative.

132) WHO-ILO HealthWISE action manual.

133) Planetree certification standards.

134) U.S. Department of Labor: Occupational Safety and Health Administration. (2016) Worker Safety in Hospitals: Caring for Our Caregivers. Retrieved from: https://www.osha.gov/dsg/hospitals/index.html.

135) The Joint Commission: Improving Patient and Worker Safety. Retrieved from: http://www.jointcommission.org/assets/1/18/tjc-improvingpatientandworkersafety-monograph.pdf.

136) U.S. Department of Labor: Occupational Safety and Health Administration. (2016) About OSHA. Retrieved from: https://www.osha.gov/about.html.

137) U.S. Department of Labor: Occupational Safety and Health Administration. (2016) Hospital eTools: Intensive Care Units. Https://www.osha.gov/SLTC/etools/hospital/icu/icu.html.

138) Centers for Disease Control and Prevention (2016). Cases of Ebola Diagnosed in the United States. http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/united-states-imported-case.html.

139) https://pdfs.semanticscholar.org/dce8/582215a272b0a1ee7d5fad43fb1e15a59e85.pdf

140) Joint Commission International Accreditation Standards for Hospitals Handbook, 6th Edition.

141) ICD-10-PCS.

142) Picker Institute. (1987). Principles of patient-centered care. Retrieved from http://pickerinstitute.org/about/picker-principles/.