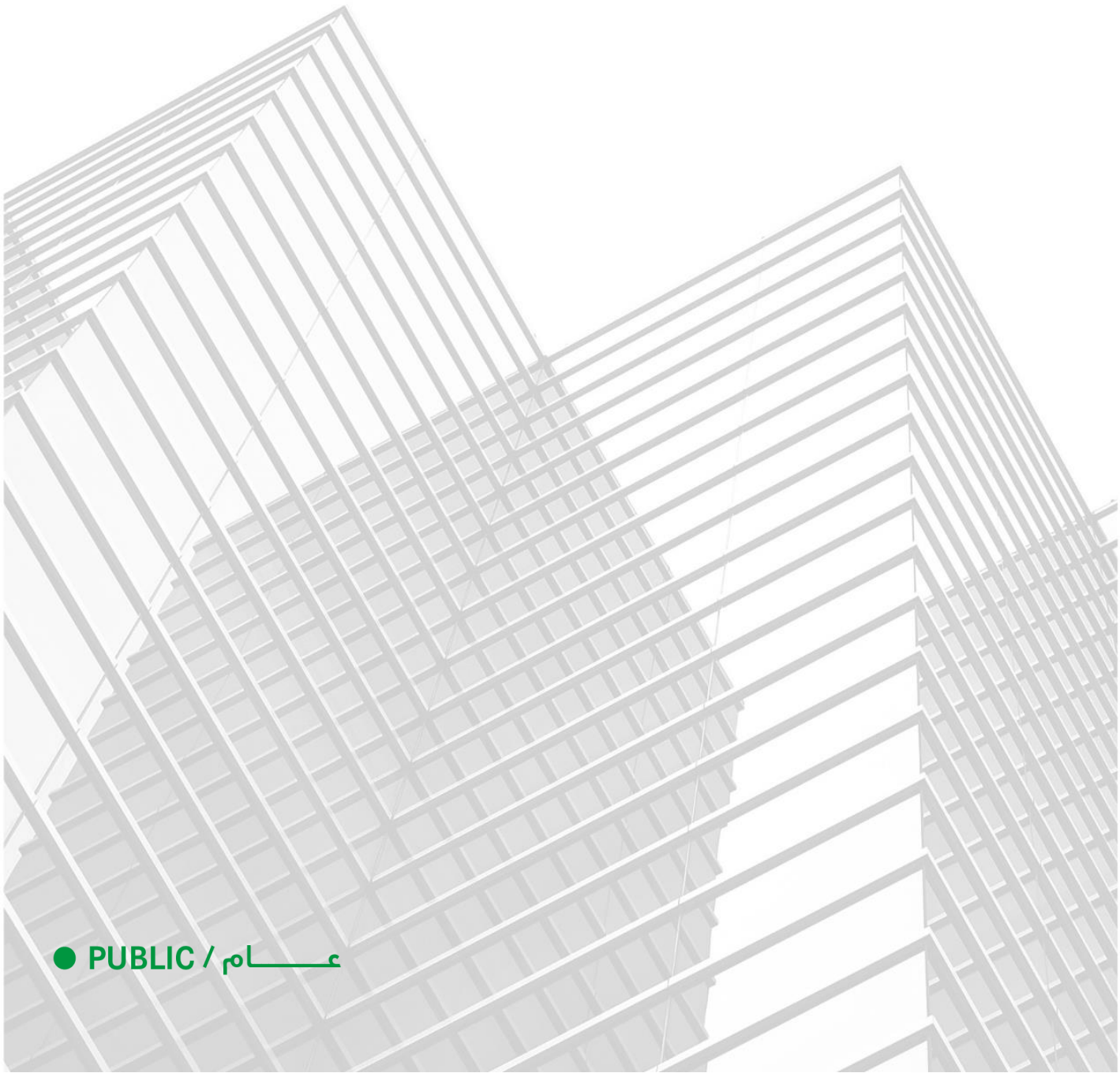
دائـــرة الـصـحـــة
DEPARTMENT OF HEALTH

Accreditation Standards for Healthcare Facilities (Hospitals)



PUBLIC / عـــــام

Document Title:	Accreditation Standards for Healthcare Facilities (Hospitals)		
Document Ref. Number:	DOH/STD/ASHFH/V1	Version:	V1
New / Revised:	New		
Publication Date:	April, 2024		
Effective Date:	April, 2024		
Document Control:	DOH Strategy Sector		
Applies To:	DOH licensed Healthcare Facilities (Hospitals)		
Owner:	Healthcare Facilities Quality Division | Healthcare Facilities Sector		
Revision Date:	March 2026		
Revision Period:	2 Years after publication		
Contact:	healthaudit@doh.gov.ae		

CONTENTS

1. STANDARD SCOPE

The Accreditation Standards for Healthcare Facilities are applicable to all licensed healthcare facilities (type hospital) within the Emirate of Abu Dhabi. The standards have been developed in consultation with internal and external stakeholders, piloted and tested to ensure applicability and in accordance with the requirements of the International Society for Quality in Healthcare (ISQua) Principles for the Development of Health and Social Care Standards, 5th Edition, V1.1, March 2022.

The standards are to be used to assess healthcare facilities and award accreditation based on compliance with the standards. The standards are for use by the whole facility focusing on the range of services included in the standard requirements with Chapter B Patient Centered Care to be used by all clinical services and units. The standards link to DOH Abu Dhabi regulations and publications in order to assess compliance with these and also refer to international practice to give guidance on quality improvement.

2. DEFINITIONS AND ABBREVIATIONS

No.	Term / Abbreviation	Definition
2.1	**ADPHC**	Abu Dhabi Public Health Center
2.2	**Biological indicators or spore tests**	Biological indicators, or spore tests, are the most accepted means of monitoring sterilization because they assess the sterilization process directly by killing known highly resistant microorganisms (e.g., Geobacillus or Bacillus species).
2.3	**Care Pathway**	A care pathway is a complex intervention for the mutual decision making and organization of care processes for a well-defined group of patients during a well-defined period.[1]
2.4	**Chaperone**	A female (nurse) who is in the same room when a female patient is examined by a male physician. [2]
2.5	**Clinical Governance**	A system through which hospitals are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish [3]
2.6	**Competency Framework**	A competency framework is a means by which organizations communicate which behaviors are required, valued, recognized, and rewarded with respect to specific occupational roles.
2.7	**Core Standard (C)**	Links to good working practice, a percentage is allowed not to be fully achieved.
2.8	**Corporate risk**	Risks associated with the running and management of a healthcare facility, not limited to governance, finance, information technology, workforce, performance, regulation, inability to provide a service.

[1] European Pathway Association, About care pathways, care pathway
[2] Cambridge Dictionary | English Dictionary, Translations & Thesaurus
[3] NHS England - Governance, patient safety and quality

2.9	**Driver Measurable Elements (D)**	Measurable elements to drive quality improvement, not mandatory to implement.
2.10	**DOH**	Department of Health Abu Dhabi
2.11	**Estate**	Environment, buildings, plant, equipment, and grounds that make up the physical organization.
2.12	**Family**	A family member is a near relative who enjoys the patient's trust, and can be spouse, children, parents, siblings or grandparents. A near relative can also be a legal guardian or a committee having custody of patient under law.
2.13	**Framework**	The ideas, information, and principles that form the structure of an organization or plan. [1]
2.14	**Governing Body**	A group that manages or controls the activities of country, region, or organization.
2.15	**High-risk procedures / treatment**	High-risk operations can be defined as those that carry a mortality rate of 5% or more. This high mortality rate can be attributed to a number of factors related not just to the nature of the surgery, but also to the physiological status of the patient, such as procedures with possible significant effect on hemodynamics, blood loss, i.e., emergency aortic surgery, major surgery on the large intestine or major abdominal surgery of all types in patients aged seventy or higher[2].
2.16	**Incident**	Any deviation from usual medical care that causes an injury to the patient or poses a risk of harm. Includes errors, preventable adverse events, and hazards. [3]
2.17	**Information assets**	Information assets include information/data in all its form, as well as the underlying application, technology, and physical infrastructure to support its processing, storing, communicating and sharing. The following are considered information assets:[4] • Information (in physical and digital forms) • Medical device and equipment • Applications and Software • Information System • Physical Infrastructure (Data Centre, access barriers, electrical facilities, HVAC systems, etc.) • Human resources (in support of care delivery)
2.18	**Interventional imaging**	a medical sub-specialty of radiology utilizing minimally invasive image-guided procedures to diagnose and treat diseases in nearly every organ system.
2.19	**Intrathecal administration**	Intrathecal administration is where a drug is injected into the cerebrospinal fluid (e.g., epidural anesthetics, administration of some cytotoxic drugs to treat brain tumors).

[1] Cambridge Dictionary | English Dictionary, Translations & Thesaurus

[2] Cancer Therapy Advisor, Critical Care Medicine, High-risk operations

[3] WHO: Patient Safety Incident Reporting and Learning Systems, Technical report and guidance, 2020

[4] DOH Abu Dhabi, Healthcare Information and Cyber Security Standard, February 2019

2.20	**Ionization chambers**	Radiation detector used for determining the intensity of a beam of radiation or for counting individual charged particles.
2.21	**Jargon**	Special words and phrases that are used by particular groups of people, especially in their work.[1]
2.22	**Just culture**	An environment which seeks to balance the need to learn from mistakes and the need to take disciplinary action.[2]
2.23	**Local rules**	Document which sets out the safe working arrangements and administrative controls required to comply with laws and regulations. This includes the protection of staff and patients from harm.
2.24	**Mandatory Standard (M)**	Links to legislation, laws and regulations, expected to be achieved.
2.25	**Mechanical monitoring**	Mechanical monitoring involves checking the sterilizer gauges, computer displays, or printouts, and documenting in your sterilization records that pressure, temperature, and exposure time have reached the levels recommended by the sterilizer manufacturer. Since these parameters can be observed during the sterilization cycle, this might be the first indication of a problem.
2.26	**Medication omission**	Failure to give medication according to the prescribed regimen.
2.27	**Medicines Management**	The clinical, cost-effective, and safe use of medicines to ensure patients get the maximum benefit from the medicines they need, while at the same time minimizing potential harm. [3]
2.28	**Measurable Element**	How the standard is measured and rated for compliance
2.29	**Near Miss (or close call)**	Circumstances or events that had the capacity to cause an adverse event, but which did not reach the patient. [4]
2.30	**Never event**	Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.[5]
2.31	**Patient Safety event**	An event, incident, or condition that could have resulted or did result in harm to a patient
2.32	**People of Determination (POD)**	The term "People of Determination (POD)" refers to individuals who need assistance because of a disability that limits their intellectual and/or physical abilities. (ADPHC)
2.33	**Philosophy**	Values, ethics, and beliefs
2.34	**Policy**	The policy document is a formal document that is regarded as a high-level statement of intent of a defined topic, for example, a patient admission

[1] Cambridge Dictionary | English Dictionary, Translations & Thesaurus.
[2] WHO: Global Patient Safety Action Plan, 2021-2030
[3] Medicines and Healthcare products Regulatory Agency - GOV.UK (www.gov.uk)
[4] HAAD Standard for Adverse Events Management and Reporting, 2012
[5] NHS, Never Events policy and framework, 2018

policy. These documents are approved by Senior Individuals or Senior Managers and may be included as an initial statement in a document that incorporates the procedure or process.

2.35 Procedure

How to carry out a task or guide individuals, links to the policy on the topic. Procedures set out how work processes are to be carried out. Procedures may be linked to a statement of policy, but this is not necessary for every procedure. While some procedures may be approved at executive management or corporate level, it is likely that the majority will be created at service or departmental level.

2.36 Protocols

A detailed set of instructions / descriptions of a sequence of activities taken to deliver care.

2.37 Safeguarding

'The protection of children and adults who could be easily hurt emotionally and physically'. [1]

Safeguarding means protecting a citizen's health, wellbeing, and human rights; enabling them to live free from harm, abuse, and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.[2]

2.38 Safety walk arounds

A safety walk-around is when a line manager or supervisor observes work taking place, inspects the workplace, and discusses safety performance with staff based on their observations. It is not to be confused with a safety inspection, which is a formalized process of documenting safety hazards and unsafe work practices.

2.39 Secondary standard

An instrument calibrated by comparison with a primary standard (an instrument of the highest metrological quality) against which clinical ionization chambers are calibrated.

2.40 Self-management

The ways that health and care services encourage, support and empower people to manage their ongoing physical and mental health conditions themselves.

2.41 Senior Individuals

Team of senior staff (directors) who manage the hospital on a daily basis, may also be known as the Leadership Team.[3]

2.42 Senior manager

A person with designated responsibilities and accountabilities who is able to take decisions.

2.43 Sentinel event

Any unanticipated adverse event or 'Near Miss' event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not arising from the natural course of the patient's illness. [4]

2.44 Stakeholder

A person such as an employee, customer, or citizen who is involved with an organization, society, etc. and therefore has responsibilities towards it and an interest in its success.

[1] Cambridge Dictionary | English Dictionary, Translations & Thesaurus
[2] NHS England.
[3] DOH Healthcare Providers Manual, November 2017
[4] HAAD Standard for Adverse Events Management and Reporting, 2012

2.45	**Tissue viability**	A specialty that considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and all forms of leg ulceration.[1]
2.46	**Waste Hierarchy**	The waste management hierarchy is a conceptual framework designed to guide and rank waste management decisions at both the individual and organizational level. It gives top priority to waste prevention, followed by re-use, recycling, recovery and finally disposal.

[1] Society of Tissue Viability | Formerly known as the TVS

3. STANDARD REQUIREMENTS AND SPECIFICATIONS

INTRODUCTION TO THE ACCREDITATION PROGRAM STANDARDS

These standards are designed to provide a framework for quality assurance and accreditation of healthcare facilities in the Emirate of Abu Dhabi.

These standards build upon the Ranking Hospital standards and take into account existing good practices, laws, rules and regulations within the Emirate and international practice. It should be noted that these standards are only for accreditation purposes with the aim of improving quality of services to patients. They are **not** for inspection and licensing but may be linked to insurance in the future.

Quality improvement

The accreditation program is a powerful tool for healthcare facilities to put in place systems for continuous quality improvement. That is, making sure that at all levels, staff within the services are questioning what is done, how they do it, and how better results could be achieved, more efficiently and more effectively. The accreditation program enables the facility to examine itself critically against a framework of organizational standards. The submission of a self-assessment report together with the external peer review highlights good practice, whilst setting an agenda for service and team development.

The standards framework

The standards have been designed for use by the whole healthcare facility and link to inclusivity of all patients, high-risk treatments, the safety of patients and the disease prevalence within the Emirate. They have been developed with international representatives and in consultation with the DOH, healthcare professionals representing the interests of healthcare within the Emirate, and in accordance with the requirements of the International Society for Quality in Healthcare (ISQua). The standards are set out in five Chapters:

A. Organizational Management
B. Patient Centered Care
C. Safety
D. Clinical Support Services
E. Clinical Services

Each Chapter includes an Overview of the content, Guidance on what should be considered for implementation and assessment; the Standard and the Measurable Elements required to implement and assess the standard. References are listed to guide the users and further guidance on the Suggested personnel to work with the standards is also included.

Each Standard has a 'Tag' to indicate if it is a **M**andatory requirement or a **C**ore requirement. Mandatory requirements link to laws, regulations, rules and safety and Core to good working practice. To drive quality improvement some Measurable Elements are tagged as **D**rivers.

People of Determination (POD)

People who require assistance due to a condition that restricts their intellectual and/or physical skills are referred to as "People of Determination (POD)". The standard addressed factors to be taken into account in healthcare settings when providing treatment for POD in order to guarantee that they have access to appropriate healthcare services and facilities in all healthcare settings in the Emirates of Abu Dhabi:

- **Accessibility**: Healthcare facilities should be designed and equipped to ensure easy access for people of determination. This includes ramps, elevators, widened doorways, accessible parking spaces, and properly designed waiting areas to accommodate individuals with different types of disabilities.
- **Communication:** Healthcare professionals should adopt effective communication strategies to engage with people of determination. This may involve using clear and simple language, providing written information in accessible formats (such as braille, large print, or electronic formats), or utilizing sign language interpreters or other communication aids.
- **Staff Training:** Healthcare providers should receive training on disability awareness, communication techniques, and how to accommodate the specific needs of people of determination. This training can help foster a more inclusive and understanding environment within healthcare settings.
- **Sensory Considerations:** Healthcare facilities should be designed with sensory considerations in mind. For example, individuals with visual impairments may benefit from tactile markers or audio cues, while those with hearing impairments may require visual alerts or the availability of sign language interpreters.
- **Assistive Devices and Aids:** Healthcare providers should be familiar with and have access to appropriate assistive devices and aids, such as wheelchairs, hearing aids, or communication devices, to support the specific needs of people of determination.
- **Privacy and Dignity:** Healthcare professionals should respect the privacy and dignity of people of determination. They should provide support in a compassionate and respectful manner, ensuring that individuals are involved in decision-making processes and that their autonomy is respected.
- **Inclusive Policies and Practices:** Healthcare institutions should establish policies and practices that promote inclusivity and equal access to healthcare services for people of determination. This may involve developing guidelines for reasonable accommodation, appointment scheduling, or ensuring that diagnostic and treatment equipment is accessible to individuals with disabilities.
- **Collaboration and Multidisciplinary Approach:** Collaborative efforts among healthcare professionals, caregivers, and relevant stakeholders are essential for providing comprehensive care to people of determination. A multidisciplinary approach allows for a holistic assessment and management of their healthcare needs.

CHAPTER A. ORGANIZATIONAL MANAGEMENT

For any healthcare facility, quality and patient safety depend on effective leadership and good organizational management. **(For the purposes of these standards the top management team will be called the Senior Individuals).**

There is a group of Senior Individuals (governing body or board of directors) who are responsible for setting the strategic direction of the healthcare facility and its goals, direction, limitations, and accountability frameworks. This is different to management which has the responsibility for the allocation of resources and overseeing the day-to-day operations of the organization.

It is important for all healthcare facilities to have a clearly stated mission. It is the responsibility of the top management team or governing body of the healthcare facility to develop the mission and provide the resources to fulfil this. To ensure quality and safety of healthcare services, the Senior Individuals work collaboratively, communicate effectively through clear lines of authority, and coordinate and integrate services provided.

This section addresses the roles and responsibilities of the Senior Individuals and the management processes required, including the following processes and activities:

SECTION A1 LEADERSHIP

Overview

Leadership and Governance are not the same. The role of the governing body as leaders is to: formulate strategy by providing vision and a clear statement of the facility's purpose; ensure accountability for the delivery of the services; shape the culture of the facility and its staff.[1]

Governance, section A2, has been defined as "Systems, processes and behaviors by which trusts lead, direct and control their functions in order to achieve organizational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organizations."[2]

The healthcare facility needs to be led by a competent and innovative team who set the vision and mission and values of the organization and are able to share and engage others in the vision. The healthcare facility has a clear purpose which is communicated to and shared by staff and stakeholders.

A1.1 Leadership and Organizational Management

(C) A1.1.1 The healthcare facility has Senior Individuals and structures in place to provide oversight and management of the facility. [3]

Guidance

Depending on the size of the facility, the Senior Individuals may be a governing body, a Board of Directors, executive committee, or a leadership group of designated senior personnel, both clinical and non-clinical, such as the chief executive officer, medical and nursing directors, the finance director, quality manager, human resource manager, administrators and service heads as appropriate, such as the head of facilities. An organizational chart demonstrates how the sections of the facility interact with each other. The chart includes all the services within the facility and their lines of accountability and management. Alongside this chart is an organogram (see A2.1.1.3) which demonstrates how the various clinical and non-clinical teams and committees

[1] The Healthy NHS Board Principles for Good Governance

[2] UK Department of Health 2006

[3] **Reference for A1.1.1:** Abu Dhabi Department of Health, Healthcare Providers Manual, 2017

are established and their interactions. This will include, for example, the Drugs and Therapeutics and Radiation Safety committees, the risk management team, the quality team.

A set of rules for the governing body defines its composition and responsibilities, its established committees, and the code of conduct to which members shall comply. The documented rules set out how the governing body's business is conducted, scheme of delegations and will contain the rules for the management of facility.

The day-to-day operational management of the facility is delegated by the Chief Executive Officer (or equivalent) to senior managers in a defined organizational management structure with lines showing responsibilities and accountability.

The healthcare facility has developed a scheme of delegation which sets out the lowest level that day to day operational decisions are delegated to or defines delegated limits where appropriate. This is to ensure business continuity in the absence of senior personnel. The scheme of delegation provides a framework defining the delegated issues and to whom delegation falls.

The Senior Individuals may establish subgroups or committees to support its operational management functions, these might include for example, a Finance committee and an Ethics committee.

Measurable elements

A1.1.1.1 There is a committee of Senior Individuals (or governing body or equivalent) for the healthcare facility with documented terms of reference and standing meeting agendas.

A1.1.1.2 There is an up-to-date organizational chart for the healthcare facility that reflects the current management structure with lines of responsibilities and authorities.

A1.1.1.3 There is a documented scheme of delegation for the Senior Individuals and directors (or equivalent) with defined limits of authorisation.

(D) A1.1.1.4 There is a documented set of rules, or equivalent, for the practice and procedure of the Senior Individuals (or governing body) (see guidance).

A1.1.1.5 The Senior Individuals (or governing body or equivalent) hold formal, minuted meetings no less than four times per year to review progress against the strategic objectives and governance assurance.

A1.1.1.6 All management and leadership committees which support the management of the healthcare facility have documented terms of reference.

(C) A1.1.2 The leaders of the healthcare facility have developed and implemented a strategy and vision (see overview).[1]

Guidance

The Senior Individuals have a documented strategy that includes a published mission and vision and has a set of values that the facility works within. The values may be encapsulated within an ethical code, which is a statement of the ethical principles which guide the behaviors and moral conduct of the healthcare facility and its staff. (Healthcare facilities may wish to consider Lord Nolan's Seven Principles of Public Life -Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership - when developing their ethical code). Part of the values and ethics of the healthcare facility is that ideally no senior staff have any conflict of interest that may be detrimental to the values of the organization. Any potential conflict shall be declared and managed.

The Senior Individuals define the strategic aims for the facility, which are reviewed. The strategic aims do not just focus on financial aims but include meeting national requirements and a focus on health improvements and clinical quality. The strategy has measurable objectives that are for a defined period of time and subject to formal review within the timeframe.

[1] **Reference for A1.1.2**: Department of Health, Standard for Centers of Excellence in the Emirate of Abu Dhabi.

Measurable elements

A1.1.2.1 There is a documented statement of the healthcare facility's mission, vision, values, approved by the Senior Individuals which is publicly displayed and made available for all staff, patients, visitors and contractors.

(D) A1.1.2.2 There is evidence that the mission and values are embedded in the healthcare facility.

A1.1.2.3 There is a published strategy outlining the healthcare facility's' strategic objectives and aims and providing a clear statement of the facility's purpose and scope of services.

A1.1.2.4 The strategic aims include an assurance to providing quality clinical care and health improvement.

A1.1.2.5 There is an implementation plan for the strategy which includes measurable objectives.

A1.1.2.6 There is evidence that the Senior Individuals monitor progress towards meeting the strategic aims.

A1.1.2.7 There is a published ethical code which guides the behaviors and moral conduct of the healthcare facility's staff.

A1.1.2.8 There is a policy on conflict of interest defining the process of avoiding, disclosing and managing ethical, legal, or financial conflicts.

(M) A1.1.3 The healthcare facility can demonstrate that the scope of services is approved by the Senior Individuals. [1]

Guidance

The scope of services shall be in accordance with the approved Department of Health licenses and may not be exceeded. The scope of services is in accordance with the strategic aims of the facility and states that the services offered are diagnostic, therapeutic, preventative, rehabilitative or for health-promotion.

Measurable elements

A1.1.3.1 There is a defined scope of services approved by the Senior Individuals.

(D) A1.1.3.2 The current scope of services, for which the healthcare facility is licensed, is prominently and publicly displayed

A.1.1.3.3 A copy of the current healthcare facility license is prominently and publicly displayed.

A1.1.3.4 There is evidence that the services offered by the healthcare facility do not exceed the granted license.

(C) A1.1.4 The healthcare facility can demonstrate how it plans to meet its strategic aims. [2]

Guidance

The facility needs to develop and document operational and business plans which detail how the strategic aims and business directives are to be implemented, including potential budgetary requirements. It will include for example, how capacity will meet demand, service developments, quality priorities and workforce planning. All individual service requirements are reviewed annually and be in accordance with the healthcare facility's strategic objectives and financial budget.

There is also a business plan which sets out the financial requirements to meet the strategic aims. The business plan includes the health improvement plans and the financial plans needed to meet the objectives as well as other resources that need to be considered such as workforce development.

The financial implementation plan includes proposals for capital and revenue; and is based on market intelligence, forecasting and assumptions of national and local changes. The results of the plan are reported on. The report includes progress against previously set objectives, and this informs the objectives for the following year based on the performance monitoring undertaken throughout the year. As part of the business planning

[1] **Reference for A1.1.3**: Abu Dhabi Department of Health, Healthcare Providers Manual, 2017

[2] **Reference for A1.1.4**: Abu Dhabi Department of Health, Healthcare Providers Manual, 2017

process there are documented procedures to help inform the budget and contracting process. They include timescales and responsibilities including frequency of reporting and monitoring and how the departmental budgets are set and how managers are involved in order to enable an overall view of requirements.

Measurable elements

A1.1.4.1 The healthcare facility has a documented and current operational plan, reviewed annually.

A1.1.4.2 The annual operational plan includes any specific requirements of individual services.

A1.1.4.3 A business plan is developed to meet the strategic objectives and includes an assessment of the significant risks to achieving those objectives.

A1.1.4.4 There is a current financial strategy and implementation plan which includes levels of authority and delegation.

(D) A1.1.4.5 There is a policy and procedure to guide the business planning process and cycle (see guidance).

A1.1.4.6 The business plan and operating plan are monitored and progress in achieving objectives is measured, reported, and acted upon.

A1.1.4.7 An annual financial report is produced and approved by the Senior Individuals.

(D) A1.1.4.8 There is a policy and procedure that sets out how all plans are subject to ongoing monitoring to measure progress, how slippages are reported and responsibility for approving changes to the plans.

(M) A1.1.5 The healthcare facility has developed a systematic process of managing change in the facility. [1]

Guidance

Organizational requirements frequently need to change to meet changes to operational necessities. These may include, for example, extending or decreasing or closing a service, the introduction of new technologies, and outsourcing services. Resistance to some changes may occur because of staff fears about adapting to and coping with new methods. It is therefore the role of the healthcare facility's leaders to ensure that the change is managed with minimum disruption and with respect for the workforce. Change management policies include for example, the scope of change, responsibilities, employees at risk if necessary, training requirements, if necessary, support for employees and how change is to be communicated.

Measurable elements

A1.1.5.1 There is a documented and implemented policy and procedures for managing organizational change in the healthcare facility.

A1.1.5.2 There is evidence that the healthcare facility analyzes the impacts and requirements when considering any organizational change.

(D) A1.1.5.3 There is evidence of communication with stakeholders when considering an organizational change.

[1] **Reference for A1.1.5**:

- Abu Dhabi Occupational Safety and Health System Framework (OSHAD – SF), Manual, V3.1, 2017

(M) A1.1.6 Occupational Safety and Health roles, responsibilities, authorizations, and accountabilities are defined, established and documented. [1]

Guidance

Whilst the Senior Individuals have overall responsibility for Occupational Safety and Health across the facility, every member of staff has a responsibility towards maintaining a safe and secure environment. To manage this, there are delegated roles throughout the facility with clear accountabilities and responsibilities. Staff who have a departmental responsibility for OSH are trained and supported in their role. Other staff with OSH roles might include an administrative officer and advisor.

Measurable elements

A1.1.6.1 There is a documented framework of OSH roles defining accountabilities and responsibilities. This may be demonstrated as an organizational chart which is publicly displayed.

(D) A1.1.6.2 Staff with delegated OSH roles collaborate as a network to share practice and learning.

A1.2 Communication

(C) A1.2.1 The healthcare facility has established methods of communication with patients, staff, and visitors. [2]

Guidance

The ever-increasing pace and scope of changes facing healthcare means that all those involved in providing healthcare and related services need to work together in a culture of mutual trust, to achieve the mission, and strategic aims The need to communicate well with the public, patients, users of services, partners and other organizations (key stakeholders) is central not only to the success of achieving the strategic aims but is also an integral part of delivering safe, quality healthcare. Effective communications can enable management, motivation, influence, explain and create conditions for change and therefore a senior member of staff who either is a member of the Senior Individuals or reports directly to a member of the Senior Individuals has responsibility for the management of communication.

The communication strategy includes reference to: public relations; managing the reputation of the healthcare facility and protecting its corporate identity; promoting the facility and the services offered in an ethical manner; reporting key performance results, developing links with key stakeholders and local community; communication with staff, patients and visitors; links with local media; use of information technology to promote communications including the world-wide web and the intranet. Leadership decides on the key performance results that are publicly reported, these may include, but not limited to: complaints, compliments and concerns, nationally required patient reported outcome measures, incidents and adverse events, patient satisfaction and staff satisfaction.

The procedure for advertising is developed in accordance with the MOHAP Advertising Guidelines and includes how consent is obtained from patients/staff/users who are filmed or photographed for marketing purposes.

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[1] **References for A1.1.6**:

- OSHAD-SF Mechanism 8.0, Version 3, July 2016
- OSHAD-SF Guidance Document: OSH Roles and Responsibilities, Version 3.0, July 2016
- Institution of Occupational Safety and Health, Competency framework Professional standards for safety and health at work

[2] **References for A1.2.1**:

- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- DOH Resolution No. (37) of 2019 regarding the regulations for health media and advertising

Measurable elements

A1.2.1.1 There is a senior member of staff who is responsible for communication which is included in their job description.

A1.2.1.2 There is a documented strategy for managing internal and external communications including ethical marketing of the healthcare facility's services, the list of performance results (see guidance) and how these are made publicly available.

A1.2.1.3 There is a procedure on the use of promotional initiatives and advertising.

(D) A1.2.1.4 The healthcare facility's leaders keep staff up to date on key information through defined communication channels. This may be through newsletters, meetings, noticeboards and an intranet.

A1.2.1.5 An up-to-date staff contact list is maintained with the names of staff in post and their job titles, department extension numbers, mobile phone numbers and has restricted access.

A1.2.1.6 There are procedures for the management of telecommunications equipment.

A1.2.1.7 There is a documented communication plan in the event of a major incident (also A1.4).

A1.3 Complaints Management

(M) A1.3.1 The healthcare facility has a process for the management of complaints.[1]

Guidance

A complaint is 'an expression of dissatisfaction made to an organization, either written or spoken, and whether justified or not, which requires a response. There is no difference between a 'formal' complaint and an 'informal' complaint. Both are expressions of dissatisfaction', (The Patient's Association, 2013).

Complaint management is a process that requires a structured mechanism to investigate, identify causes, resolve and communicate the findings. The complaint management process is focused on patient satisfaction and internal improvement. All complaints, whether clinical or non-clinical in nature, are investigated by staff who have received training and involves the use of expertise in the area of the complaint. Good complaint management is essential to maintain the public's trust in the healthcare facility, to provide learning, to reduce the risk of escalation to litigation and to provide support to all those involved, including staff, patients and their families.

Complaints need to be reviewed by a senior manager who can make decisions and take the required actions to resolve complaints. Complex complaints are investigated by a multidisciplinary team, which includes experts in the main field or specialism in which the complaint was raised. When complaints are registered and graded this allows for trend analysis and patterns to be viewed, this analysis may assist with planning and ensuring that lessons learnt are put into practice.

Measurable elements

A1.3.1.1 There is a designated senior member of staff who is responsible for complaints management.

A1.3.1.2 There is a complaints management policy and procedure which includes:

a) How stakeholders are made aware of the right to complain which includes published information in Arabic and English,
b) Assigning a reference number and informing the complainant of this number,
c) Acknowledging the complaint in writing within 3 working days,

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[1] **References for A1.3.1**:

- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- DOH Standard for Clinical Complaints Management in Healthcare Facilities, 2018
- DOH Circular No. 162/2022
- The Patient's Association, Good Practice Standards for NHS Complaints Handling, 2013

d) Timeframes for response,
e) Keeping complainants informed of progress,
f) How the complaint is recorded, graded, and risk assessed,
g) Record-keeping (including the time for retention),
h) Handling complex complaints,
i) Internal complaint investigation methodologies,
j) The internal and external appeals process, and mediation,
k) The systems that are in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

A1.3.1.3 Complaints are recorded in a complaints register which includes the grade, the severity, and the potential future risk to patients and to the facility.

A1.3.1.4 The complaints register includes the names of the staff undertaking the complaint investigation.

A1.3.1.5 All complaints are trended, aggregated and analyzed on a quarterly basis and a summary report is presented to the integrated governance committee (see A2.1.1.2) for discussion and action.

(D) A1.3.1.6 There is evidence that complaints are reviewed in combination with incident report data and information on claims made to look for links.

A1.3.1.7 There is a process for referral of unresolved complaints to be monitored for potential resolution and how the complainants are kept informed.

A1.3.1.8 Staff members with responsibility for investigating complaints have received training in investigative techniques.

(D) A1.3.1.9 A multidisciplinary approach is used for the investigation of complex complaints.

A1.3.1.10 The analysis of complaints and outcomes ensure that lessons from previous complaints are being learned.

A1.4 Management of Major Incidents

Overview

Emergencies, disasters and other crises majorly affect people's health, including the loss of many lives. In recent years, new threats have emerged, and they reveal the challenge of managing new health risks and effects of emergencies and disasters.

Emergency preparedness is the shared responsibility of all levels of government, the private and nonprofit sectors, and individual citizens. The healthcare sector is a key player and contributes immensely to dealing with disasters. The healthcare system provides core capacities for emergency risk management for health.[1]

(M) A1.4.1 The healthcare facility has plans and processes in place to manage a major incident or periods of huge or fluctuating demand (such as pandemics) and which meet the Department of Health requirements.[2]

Guidance

The plans and processes shall follow the Department of Health Standards for Major Incident and Disaster Preparedness in Healthcare. The main requirements of this standard are included. The Major Incident and disaster planning team has wide representation including a representative of the Senior Individuals, staff from:

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[1] DOH Policy on Healthcare, Emergency & Disaster Management for the Emirate of Abu Dhabi, 2017

[2] **References for A1.4.1**:

- DOH Policy on Healthcare, Emergency & Disaster Management for the Emirate of Abu Dhabi, 2017
- Health Authority-Abu Dhabi, Standards for Major Incident and Disaster Preparedness in Healthcare, 2012
- Health Authority-Abu Dhabi, Standard for Medical Emergency Preparedness at Mass Gatherings, 2013
- NHS, Clinical guidelines for major incidents and mass casualty events, Version 2, 2020
- Centers for Disease Control and Prevention, Office of Emergency Preparedness and Response, Hospital All-Hazards Self-Assessment

The Emergency Department (if there is one within the facility), support services such as the pharmacy, laboratory and radiology, chief medical and nursing officers, OSH officer. A command and control system empowers designated personnel to exercise authority and direction over assigned resources to manage the emergency situation.

The Major Incident and Disaster Preparedness shall be written in accordance with Appendix 2 of the Department of Health Standards for Major Incident and Disaster Preparedness in Healthcare. A Business Continuity plan shall also take into account how the healthcare will continue to function in the case of an internal major disaster, for example, loss of electrical power or water, internal threats. An all-hazards approach to risk assessment is required and a self-assessment may be of use in analyzing risks.

A set of clinical guidelines for managing casualty events will prepare emergency staff in the case of a major incident. These might include the management of crush, and blast injuries, and exposure to radiation and hazardous substances. This should consider internal major incidents, for example, fire, explosions, and other such incidents.

Measurable elements

A1.4.1.1 The healthcare facility has established a Major Incident and Disaster team.

A1.4.1.2 The healthcare facility has established a system to command and control resources in the event of a major incident.

A1.4.1.3 There are designated individuals available at all times to take control and to manage a major incident.

A1.4.1.4 There are designated individuals available to assume delegated responsibilities to manage a major incident.

A1.4.1.5 There is a documented Major Incident and Disaster Preparedness plan.

A1.4.1.6 There is a documented Business Continuity plan.

A1.4.1.7 There is evidence that the healthcare facility has undertaken an all-hazards risk assessment.

A1.4.1.8 The Major Incident and Business Continuity plans include the management of internal major incidents such as a major plant failure (see also C3.1.1.8).

(D) A1.4.1.9 There is a set of clinical guidelines for managing mass casualty events.

A1.4.1.10 There is evidence that the healthcare facility has undertaken a Major Incident exercise in the past 12 months.

A1.4.1.11 An evaluation report is written after every Major Incident exercise.

Documentary evidence required:

A1.1.1.2 Organizational chart that reflects the current structure and delegated authorities.

A1.1.1.3 Scheme of delegation.

A1.1.1.4 Set of rules for the practice and procedure of the Senior Individuals.

A1.1.2.1 Statement of the healthcare facility's mission, vision, values and ethical code.

A1.1.2.3 Strategy outlining the healthcare facility's' strategic objectives and aims and providing a clear statement of the facility's purpose and scope of service.

A1.1.2.7 Ethical code which guides the behaviors and moral conduct of the healthcare facility staff.

A1.1.2.8 Policy on conflict of interest.

A1.1.4.1 Current operational plan.

A1.1.4.3 Business plan is developed to meet the strategic objectives.

A1.1.4.4 Current financial strategy and implementation plan.

A1.1.4.5 Policy and procedure to guide the business planning process and cycle.

A1.1.4.7 Annual financial report.

A1.1.5.1 Policy and procedures for managing organizational change.

A1.1.6.1 Framework of Occupational Safety and Health management roles.

A1.2.1.2 Strategy for managing internal and external communications.

A1.2.1.3 Procedure on the use of promotional initiatives and advertising.

A1.2.1.6 Procedures for the management of telecommunications equipment.

A1.2.1.7 Communication plan in the event of a major incident.

A1.3.1.2 Complaints management policy and procedures.

A1.4.1.5 Major Incident and Disaster Preparedness plan.

A1.4.1.6 Business Continuity plan.

A1.4.1.6 Evaluation report after a Major Incident exercise.

Personnel to work with the standard:
Senior Individuals
Finance director
Major incident and disaster team lead
Quality manager

SECTION A2 INTEGRATED GOVERNANCE

Overview

Integrated Governance is defined as: "Systems, processes and behaviors by which hospitals lead, direct and control their functions to achieve organizational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organizations".[1]

Integrated Governance allows members of the Senior Individuals to deliver the facility's objectives on behalf of the governing body in a comprehensible way and review the support structures that enable them to govern effectively. This facilitates a focus on the patient and safety.

Having an integrated governance framework will help leaders to understand and demonstrate where the healthcare facility is in terms of risk management and governance.

Integrated governance involves:

- **Corporate governance**: the system of rules, practices and processes by which an organization is directed and controlled to achieve its objectives.
- **Clinical Governance**: a system through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
- **Risk Governance**:(section A3) the set of rules and guidance the healthcare facility has in place to identify, assess, manage and communicate all types of risk.
- **Financial Governance**: the stringent set of rules and guidance issued by regulators to check that financial processes are well.
- governed. This includes the healthcare facility's reporting capabilities which include everything from internal controls, to audits, to process workflows, to financial controls, data tracking and security and reporting integrity.
- **Information Governance: is included in section A6.**

[1] UK Department of Health, Integrated Governance Handbook, A handbook for executives and non-executives in healthcare organizations, 2006

Those leading the healthcare facility are accountable for the quality of services provided through quality and governance systems which enable the facility to achieve its stated objectives which include delivering safe, high quality patient care and continual quality improvement.

Good governance enables those leaders to provide assurance to patients, service users, carers, citizens, and stakeholders around quality and safety, and the effective use of resources.

A2.1 Corporate governance

(M) A2.1.1 The healthcare facility has established an integrated governance framework.[1]

Guidance

The integrated governance framework is described in a strategy, policies and procedures and includes the scope and objectives of governance, the committees involved and how they interact with each other, for example, clinical governance team, drugs and therapeutic and risk management teams, roles and responsibilities, and how the governing body receives assurances that the facility is operating according to regulations and that patient and staff are monitored and managed effectively. This strategy may include other strategies such as risk, clinical governance etc.

The implementation of the strategy shall be overseen and be undertaken by an integrated governance committee. Members of the Senior Individuals will be part of this committee along with senior managers. The primary objective of the committee is to provide assurance to the governing body that the key objectives of the governance strategy are being met. This will be achieved through monitoring of data and performance.

Measurable elements

A2.1.1.1 There is a current, implemented integrated governance strategy, approved by the Senior Individuals.

A2.1.1.2 There is a multi-professional integrated governance committee, with documented terms of reference, the membership includes, as a minimum the medical director (or equivalent), nursing director (or equivalent) and a representative of the Senior Individuals. Members have documented roles and responsibilities.

A2.1.1.3 There is an organogram which sets out the framework for governance and how the governance committees and teams interact and share information.

A2.1.1.4 The committee presents to the Senior Individuals a review (at least bi-annually) of the governance of care provided.

(D) A2.1.1.5 There is a process for service performance to be reported to the Senior Individuals.

(M) A2.1.2 The Senior Individuals establish a 'just culture' as part of the integrated governance framework.

Guidance

To encourage staff to be able to report concerns and incidents, the healthcare facility promotes a 'just culture' of 'no blame.' 'A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution'. (Promoting a Culture of Safety as a Patient Safety Strategy: A Systematic Review, Weaver et al, 2013.).

Staff involved in incidents and sentinel events are often the 'second victims' and may be traumatised, have feelings of guilt and may require specialist support such as counselling.

[1] **References for A2.1.1**:

- Salisbury NHS Foundation Trust, Integrated Governance Framework, March 2022
- The Royal Marsden NHS Foundation Trust, Integrated Governance Monitoring Report April - September 2021

Measurable Elements

A2.1.2.1 The healthcare facility promotes 'just culture' through:

a) Training managers in the concept of 'just culture'
b) Implementation of a process for defining boundaries and distinctions between medical errors and medical negligence
c) Training staff on the concept of 'just culture'

A2.1.2.2 The healthcare facility supports staff involved who have been involved or affected by an incident or sentinel event.

Documentary evidence required:

A2.1.1.1 Current integrated governance strategy

A2.1.1.2 Terms of reference for integrated governance committee

A2.1.1.3 Organogram of the framework for governance

A2.1.1.4 Integrated governance committee report

A2.1.2.1 Just culture training programme

Suggested personnel to work with the standards:

Medical director (or equivalent)

Nursing director (or equivalent)

Member of the Senior Individuals

Senior manager

A2.2 Clinical Governance

Overview

Clinical governance is the system through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish. [1]

(C) A2.2.1 The healthcare facility has established a clinical governance framework.[2]

Guidance

Clinical governance has a framework which mirrors the integrated governance framework to which it belongs. There is a strategy defining what it is, a committee to oversee its implementation and policies and procedures to support the process of governance, inclusivity, equal access to treatment and care to all people regardless of their individual circumstances to support the person-centered care approach as outlined in Chapter B.

The strategy identifies all the leads with responsibility for clinical governance and clinical quality, for example medical and nursing directors, and who can make key decisions regarding priorities.

The strategy defines the visions and values for clinical care and quality. It includes quality objectives and quality indicators, their monitoring of achievement and progress throughout the facility. The strategy also addresses how clinical risk will be managed through, for example, the seven pillars of clinical governance i.e. clinical risk assessments, clinical audit, clinical effectiveness and outcomes, training, staff management and patient and public involvement.

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[1] UK Department of Health

[2] **Reference for A2.2.1**: Abu Dhabi Department of Health, JAWDA Quarterly Guidelines for (Specialized and General Hospitals), 2022

The primary objective of the committee overseeing clinical governance is to provide assurance to the Senior Individuals through the integrated governance committee that the key critical clinical systems and processes are effective and robust. The committee will set and review systems of care and key performance indicators. The indicators will include the mandatory JAWDA quality indicators as well as ones set for the facility.

Measurable elements

A2.2.1.1 There is a current documented and implemented clinical governance strategy that is monitored and reviewed.

A2.2.1.2 There is a multi-professional committee, with documented terms of reference that oversees clinical governance. Members have documented roles and responsibilities.

A2.2.1.3 There is evidence that the committee reviews the following clinical governance systems as a minimum:

a) Clinical incident management and reporting including any trend analysis,
b) Clinical outcomes to check that care is effective,
c) Review of JAWDA quality indicators that are not being met so see where improvements need to be made.
d) Compliance with the Abu Dhabi laws and regulations,
e) Medical record review and audit,
f) Clinical audit,
g) Patient experience and results of feedback,
h) Research and development (if undertaken),
i) Issues with maintaining clinical competence and licensure.

A2.2.1.4 The committee overseeing clinical governance reviews the JAWDA quality indicators and any other clinical indicators that the committee deems pertinent to the facility.

(D) A2.2.1.5 The committee presents to the Senior Individuals a review (at least bi-annually) of the governance of care provided.

A2.3 Clinical Guidelines

(C) A2.3.1 Health professionals utilize evidence-based guidelines to maximize patient safety and patient outcomes.[1]

Guidance

Clinical guidelines reflect current guidance, be evidenced based and referenced. The guidelines may be transcribed into pathways of care which are developed around systems of care which may cross internal and external organizational boundaries. The treatment guidelines and/or care pathways set out criteria for selection of patients for different care options, based on risk factors such as age, general health, associated conditions and other factors in accordance with clinical judgement. When new clinical guidelines and care pathways are introduced, this may be due to new guidance received from professional bodies and governmental departments, these are evaluated for applicability, risk and gap analyses, for example, is there sufficient equipment do staff have the required competencies.

Some clinical guidelines and care pathways may be associated with high-risk clinical procedures, it is recommended that these are easily identifiable and that the associated risks are noted and include mitigation measures, for example the use of two-person checks for high-risk medication.

Measurable elements

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[1] **References for A2.3.1:**

- DOH Standard for Centers of Excellence in the Emirate of Abu Dhabi, 2019
- NHS UK, Pathways, policies, referral criteria & standards

A2.3.1.1 The clinical guidelines and/or care pathways cover the range of common variances from the care pathway, options for treatment and/or care.

A2.3.1.2 There is a planned program for the development and review of clinical guidelines and/or care pathways by the multi-disciplinary teams.

A2.3.1.3 There are systems so that all staff working in the healthcare facility are aware of, and know how to access, relevant treatment guidelines and/or care pathways in current use**.**

A2.3.1.4 There is evidence that new guidelines are evaluated for applicability, risk and gap analyses.

A2.3.1.5 Clinical guidelines and care pathways are produced to a set style and format. They include reference to any published best practice and national guidance (see also A6.4 Document Control).

A2.3.1.6 Individual procedures and treatment protocols include the risk level to identify and mitigate the associated risks.

Documentary evidence required:

A2.2.1.1 Clinical governance strategy.

A2.2.1.2 Terms of reference of the clinical governance committee.

A2.2.1.5 Clinical governance committee report.

A2.3.1.2 Planned programme for the development and review of clinical guidelines.

Suggested personnel to work with the standards:

Representative of clinical governance committee

Medical staff

Nursing staff

Department managers

A2.4 Financial Governance

Overview

Financial governance refers to the way an organization collects, manages, monitors and controls its finances and financial information. Financial governance includes how financial transactions are tracked, how financial performance is managed and the identification and review of financial risk. Financial governance also includes how financial performance and controls are reviewed; how stock and assets are managed in order to support the strategy, business and operational plans.

(C) A2.4.1 The healthcare facility has established a financial governance framework.[1]

Guidance

There is a structure of financial control and accountability with delegated authority throughout the healthcare facility. This structure defines who may sign off financial transactions and how much they may approve, these processes are subject to annual audit. Financial instructions are designed so that any financial transactions are carried out in accordance with the law, regulations, and government policy. The aim is to achieve probity, accuracy, economy, efficiency, and effectiveness.

Management of capital assets includes a register to identify the requirements for capital replacement, purchasing, selling and other disposal of capital equipment and fixed assets, responsibilities and accountabilities for the capital assets and the specific capital accounting procedures and monitoring arrangements.

[1] **Reference for A2.4.1:** Abu Dhabi Department of Health, Healthcare Providers Manual, 2017

Measurable elements

A2.4.1.1 There is a financial director (or equivalent status), reporting to the Senior Individuals, who has documented responsibility for managing the control and accountability of finance.

A2.4.1.2 There is a set of financial instructions which detail the financial responsibilities, policies, and procedures to be adopted by the healthcare facility.

A2.4.1.3 There is a policy with procedures for the management of capital assets and investments that defines how the capital investment program is managed.

(D) A2.4.1.4 There is capital assets register.

A2.4.1.5 There is a process for the review and assessment of financial risks which includes reports on the facility's financial performance and any identified financial risks that might affect the running of the healthcare facility. These are recorded in the facility wide risk register (see A3.2.1.5).

A2.4.1.6 An annual financial audit report is presented to the Senior Individuals.

(C) A2.4.2 There are processes to govern the procurement of goods and services.[1]

Guidance

The policies and procedures are in place to define the requirements for purchase orders and include who can request and authorize these. The policy also defines who needs to be involved in contract negotiations and how services tendered for patients are competitively priced and of good value with consideration given to quality as well as price. Contracts are monitored to ensure that any key performance indicators are being met and actions taken if not. See C4. Equipment Management (Including Medical Devices).

Measurable Elements

A2.4.2.1 There is a policy and procedures for purchasing supplies and commissioning services.

A2.4.2.2 There is a standardized contract format which maintains consistency of wording and terms. A2.4.2.3 The contracts include, as a minimum:

a) The period of the contract,
b) How the service/goods received will be checked to ensure they meet the specifications agreed within the contract,
c) Defined activity levels,
d) Specification of equipment,
e) If clinical services are commissioned the contracts specify staffing levels and qualifications,
f) Costs or pricing including payment methods,
g) Notice required if contract is to be extended or terminated,
h) KPIS and how these are monitored.

A2.4.2.4 There is evidence that the healthcare facility monitors the contracts for goods or services.

A2.4.2.5 The contracts include arrangements for review and mediation if problems with delivery arise.

A2.4.2.6 The healthcare facility maintains an up-to-date register of all major contracts and contractors.

Documentary evidence required:

A2.4.2.1 Policy and procedures for purchasing supplies and commissioning service.

A2.4.2.2 Standardized contract.

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[1] **Reference for A2.4.2:**

- OSHAD-SF Element 3: Management of contractors

A2.4.2.6 Register of major contractors.

Suggested personnel to work with the standards:

Finance

Departmental managers

SECTION A3 RISK MANAGEMENT

Overview

Risk management is the systematic processes and procedures that an organization puts in place to ensure that it identifies, assesses, prioritizes and takes action to manage these risks to ensure it continues to deliver its objectives. It therefore involves responsibilities, risk assessments, incident reporting and investigating, and training staff.

This sub-section is required to be addressed together with Section D1

A3.1 Risk Management General

(M) A3.1.1 The healthcare facility has established a risk management system.[1]

Guidance

An effective risk management system is essential to the delivery of high quality and safe healthcare services. The system involves having established multi-professional structures and accountabilities for both clinical and non-clinical risks, such as financial, environmental, workforce and so on, as risk is everyone's responsibility. The structures would include those professional committees that provide oversight for the governance of functions, for example, Drugs and Therapeutics, Medical Exposure, Infection Control, and an over-arching committee with oversight of risk management, for example the Occupational Safety and Health committee. The committee is responsible for the development and implementation of the risk management strategy and for monitoring the systems of internal control in relation to risk management across the facility. The committee reports on risk management on a regular basis, ideally monthly, to the Senior Individuals with formal reports at least twice per year. It is important that the Senior Individuals are aware of any significant risks that have been identified.

An overarching risk management framework supports the risk strategy that sets out how risk is managed by the healthcare facility and includes the objectives for managing risk, accountabilities and national requirements. A risk framework may be in the form of a diagram that sets out how risk is integrated, implemented, evaluated and how improvements are made – see also ISO31100:2021 Risk management — Code of practice and guidance for the implementation of BS ISO 31000:2018.

Measurable Elements

A3.1.1.1 There is a member of the Senior Individuals with documented responsibility for risk management in the healthcare facility.

A3.1.1.2 There is a risk management framework designed to meet the requirements of the healthcare facility.

A3.1.1.3 There is a risk management strategy that sets out how the framework is implemented and includes:

[1] **References for A3.1.1:**

- Abu Dhabi Occupational Safety and Health System Framework, Management System Elements,
- OSHAD – SF, 2017, Element 2 Risk Management.
- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17

a) the types of risk i.e., clinical and non-clinical,
b) the committee structures and accountabilities,
c) the legislative framework in which the healthcare facility shall operate,
d) the risk framework is monitored to give assurance of its effectiveness and the healthcare facility's performance in the management of risk,
e) the identification of how risk is measured proactively and reactively through a planned program,
f) the requirements for reporting on significant risks and incidents within the facility and to regulatory bodies,
g) training requirements.

A3.1.1.4 There is a multi-professional overarching committee with documented terms of reference for the oversight of risk management. The committee is chaired by a member of the Senior Individuals with responsibility for risk management.

A3.1.1.5 There is an organogram of the structures and accountabilities of the risk management system.

A3.1.1.6 The committee reports on risk management to the Senior Individuals at least twice per year or more frequently if new or high risks are identified.

A3.2 Risk Management Processes

(C) A3.2.1 The healthcare facility has established risk assessment processes and a program of implementation.[1]

Guidance

A risk assessment is the process of identifying what hazards currently exist or may appear in the workplace. A risk assessment defines which workplace hazards are likely to cause harm to patients, staff, visitors and contractors. Policies and procedures set out how risks are assessed, managed and recorded, risk recording may be through an electronic system.

Risk management is proactive and reactive and therefore is continuous. Proactive risk management means that risks are identified before they happen, and controls are put in place to avoid or alleviate the risk. Reactive risk management is a response-based risk approach, which is dependent on incident evaluation, including near misses, and audit findings. It seeks to stop incidents re-occurring or getting worse. Risk assessment findings are collated into a risk register. Risk registers may be service specific or organizational wide. They are dynamic documents and need to be regularly reviewed and updated.

High risk procedures are varied and may be clinical or non-clinical and include, for example, any interventional procedure including surgery, cytotoxic chemotherapy, testing radioactive or contaminated material. Each service will have a list of high-risk procedures relating to the patient profile and treatments offered.

Training programs on risk management include how risks are assessed, analyzed, recorded, involving different disciplines to implement control measures and re-evaluation.

Measurable Elements

A3.2.1.1 There are implemented policies and procedures for the assessment, management and recording of risks.

A3.2.1.2 There is evidence of a systematic and proactive planned program for the identification, assessment, prioritization and management of all types of risk within the healthcare facility.

A3.2.1.3 Reactive risk management measures are implemented, in consultation with stakeholders who are involved or affected by the identified risk.

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[1] **Reference for A3.2.1:**

- OSHAD – SF Mechanism 11. Incident Notification, Investigation and Reporting, 2017

A3.2.1.4 There is evidence that risks are re-evaluated after control measures have been implemented.

A3.2.1.5 Risks are recorded in a risk register.

A3.2.1.6 There is a procedure for the maintenance of risk registers which includes:

a) Defining the severity of the risk,
b) Risk matrix ranking of the risk to set priorities for action,
c) Control measures in place or required including responsibility for this,
d) Monitoring arrangements,
e) All actions with dates, timescales and responsibilities.

A3.2.1.7 The healthcare facility has a process to identify those procedures and treatments that are considered to be high risk.

A3.2.1.8 There is evidence of controls in place to mitigate risks, including clinical risks, corporate risks and other non-clinical risks.

A3.2.1.9 There is a system for informing the committee responsible for risk management and the Senior Individuals when risks identified at service level have the potential to impact on the healthcare facility's strategic objectives.

A3.3 Management of Incidents

(M) A3.3.1 The healthcare facility has an incident reporting system.[1]

Guidance

An incident can occur as a result of failures of systems, processes, staff, equipment and utilities and can affect patients, staff, visitors and contractors. Whenever an incident occurs it is reported so that the causes can be identified, and measures implemented to stop reoccurrence.

When an incident occurs, the immediate effects, and the aftermath, are managed promptly and efficiently to protect life, prevent suffering and reduce damage. An appropriate investigation is carried out to identify the causative factors, and plans put in place to prevent or reduce the likelihood of a reoccurrence. All staff are aware of the incident reporting system and are trained in its use. However, not all staff will be required to be trained in investigation techniques and it may be appropriate to have a core team to carry out these using a variety of techniques. An open incident reporting system includes disclosure to all involved including patients. See Section C2: Patient Safety for the management of patient related incidents.

An incident and adverse effect reporting system may be electronic, or paper based. The system encompasses the reporting of all types of incidents and near misses.

Measurable Elements

A3.3.1.1 There is a healthcare facility wide standardized incident reporting system.

A3.3.1.2 There is a policy and procedure detailing how incidents, adverse events and near misses are managed and reported in accordance with the Risk Management Strategy and includes:

a) Definition of an incident, adverse event and near miss,
b) Severity grading,
c) Definition of a serious event, sentinel event.

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[1] **Reference for A3.3.1:**

- OSHAD – SF, Management System Manual, 2017
- WHO: Patient Safety Incident Reporting and Learning Systems, Technical report and guidance, 2020
- Abu Dhabi Department of Health, Standard on Reporting Medication Errors, March 2019 Abu Dhabi Occupational Safety and Health System Framework (OSHAD-SF), Mechanism 11.0 Incident Notification, Investigation and Reporting, Version 3.0 July 2016
- Promoting a Culture of Safety as a Patient Safety Strategy: A Systematic Review, Weaver et al. Document Title (england.nhs.uk) https://www.england.nhs.uk/wp-content/uploads/2021/02/justcultureinpractice.pdf

d) Investigation processes and methodologies including the tools used,
e) Timescales for reporting and relevant investigations,
f) Incidents and adverse events to be reported to regulatory authorities.

A3.3.1.3 There is evidence that there is learning from analysis of incident and adverse event reporting.

A3.3.1.4 There is evidence that the healthcare facility demonstrates an active cycle of monitoring and closure of risks identified from analysis of incident reporting.

A3.3.1.5 Summary reports of incidents and adverse events are produced and presented to the committee with oversight of risk management and Senior Individuals (see also A3.1.1.3 f).

A3.4 Staff training

(C) A3.4.1 There is evidence that staff receive training on risk management and the incident reporting systems.[1]

Guidance

Training programs are developed to suit the needs of different requirements, for example, those staff who will undertake risk assessments may need different skills to those staff dealing with investigations. All staff are trained in understanding the basics of the risk management system, including what incidents, adverse events and near misses are and how to report them.

Measurable elements

A3.4.1.1 There is a healthcare facility wide, mandatory, risk management training programme.

A3.4.1.2 The risk management training is held annually.

A3.4.1.3 There is evidence of a training program on proactive and reactive risk management for staff undertaking risk assessments.

A3.4.1.4 Records of attendance to the risk management training are maintained.

A3.4.1.5 Staff are trained on using the incident reporting system.

A3.4.1.6 Staff responsible for carrying out investigations are trained in the techniques used in the healthcare facility.

Documentary evidence required:

A3.1.1.3 Risk management strategy

A3.1.1 Terms of reference of committee with oversight of risk management.

A3.1.1.5 Organogram of the structures and accountabilities of the risk management system.

A3.2.1.1 Policies and procedures for the assessment, management and recording of risks.

A3.2.1.5 Procedure for the maintenance of risk registers.

A3.3.1.2 Policy and procedure for the reporting of incidents, adverse events and near misses.

Suggested personnel to work with the standards:

Senior manager

General staff

SECTION A4 HUMAN RESOURCES

[1] **Reference for A3.4.1:**

- OSHAD – SF, 2017, Element 2 Risk Management.

Overview

Staff are the key resource for the efficient and effective management and running of a healthcare facility. They are essential to good patient care, and their costs make up a large part of the budget. It is therefore necessary to ensure that the healthcare facility is able to recruit and keep professional and experienced people to meet its strategic objectives. Supporting a healthy lifestyle, including physical and emotional health, is essential for promoting a good staff experience.

A4.1 Human resource management

(M) A4.1.1 The healthcare facility has strategies and plans for the management of its human resources.[1]

Guidance

The Human Resource department has a wide range of roles that it fulfils to recruit and maintain staff. The main roles include recruitment, training and development, development of workplace policies, retention, staff protection and wellbeing.

A human resource strategy defines the objectives for managing staff and is in accordance with the healthcare facility's strategic objectives. It outlines the workforce planning, training needs and retention initiatives required to meet the objectives. As the largest group of staff in a healthcare facility is likely to be nurses there is a nursing strategy which defines the planning needs, how nursing skills will be developed, in-service training, supervision and how a patient centered care will be provided.

Workforce planning is essential to meet the healthcare facility's strategic objectives. It involves analysis of the needs of all sectors within the facility with consideration given to the requirements for skills, qualifications and experience required, as well as shift patterns, working hours on-call arrangements pay and reward and staff welfare.

The development of the human resource policies and procedures are written in accordance with local, national legislation and employment regulations. They include (but not limited to) recruitment, staff leave and sickness, disciplinary and grievance procedures, staff performance, credentialing and privileges, training and development and employee relations.

During excessive demand on the staff, such as experienced during pandemics, there is a need to support their well-being and particularly those staff working in areas where patients have life-threatening conditions. Staff are provided with basic facilities, including restrooms but also have access to specialist help as required (see also C3.7). Supporting a healthy lifestyle is important and the healthcare facility identifies ways to do this, and this might include providing easy access to, for example, smoking cessation, weight management classes and gym memberships.

Measurable elements

A4.1.1.1 There is a current human resources strategy that defines the staffing requirements to meet the healthcare facility's strategic objectives.

A4.1.1.2 There is a current nursing strategy which defines the strategic objectives for the management of the nursing staff.

A4.1.1.3 There is a current staffing plan written in accordance with the healthcare facility's strategic objectives and business plan.

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[1] **References for A4.1.1:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17
- Abu Dhabi Department of Health, Standard for Centers of Excellence in the Emirate of Abu Dhabi, March 2019
- https://www.nhsemployers.org/publications/nhs-health-and-wellbeing-framework

A4.1.1.4 Human resource management policies and procedures are implemented to meet the needs of the services provided by the healthcare facility (see guidance).

A4.1.1.5 The healthcare facility maintains a personnel file for each member of staff.

A4.1.1.6 The personnel file is kept in a strictly confidential manner.

A4.1.1.7 There is a documented strategy for supporting the health and wellbeing of staff, which includes:

a) Access to services providing stress management,
b) Initiatives to provide emotional support,
c) Initiatives to promote a healthy lifestyle and
d) Support for those involved in incidents, adverse events and near misses.

A4.1.1.8 Staff are provided with basic hygiene facilities which include:

a) changing rooms,
b) staff rooms and rest areas
c) access to hot food at night.

A4.2 Recruitment and Credentialing

(M) A4.2.1 Staff are recruited with the correct skills, experience and credentials to carry out their role.[1]

Guidance

In order to maintain efficiency and the safety of its patients the healthcare facility shall ensure that its staff have the right skills, qualifications and are licensed in accordance with the local and national legislation. This needs to be addressed and checked at the recruitment stage. The recruitment procedure includes, for example, guidelines for advertising posts, writing job descriptions/role profiles or equivalent, determining person specifications, deciding selection criteria, probity declaration appropriate to the job, pre-employment checks and issuing the letter of appointment.

There is a system for checking that staff who require are required to be licensed maintain a current license and that they only work within the scope of practice as defined by that license and with the privileges granted. This may be by maintaining a register of all licensed professionals.

Job descriptions/role profiles specify the job title and grade, job purpose, objectives and accountability and responsibilities, responsibility for self-development and the requirement for the relevant staff to abide by their professional codes of practice. The person specification states the necessary and desirable skills, experience, qualifications, personal attributes and criteria for selection, or gives a competency framework that includes an indicator of roles and responsibilities. Job descriptions are dated and issued to staff on appointment and reviewed subsequently in accordance with appraisals or changes in terms and conditions of their employment.

Measurable elements

A4.2.1.1 There is a current procedure for the recruitment and selection of staff.

A4.2.1.2 The recruitment procedure includes the pre-employment checks required as per local regulations for all new recruits and include (but not limited to):

a) Verification of identity,
b) Professional license,
c) Professional registration and training certificates,
d) Employment history and references,

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[1] **References for A4.2.1:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17
- UAE Ministry of Health and Prevention, Unified Healthcare Professional Qualifications Requirements, Version 3, 2022

e) Occupational health checks.

A4.2.1.3 There is a policy and procedures on credentialing and granting of privileges which is in accordance with Abu Dhabi regulations.

A4.2.1.4 All healthcare professionals have their license and scope of practice verified prior to contracting.

A4.2.1.5 All staff have a signed contract which includes the terms and conditions of their employment.

A4.2.1.6 All staff have a job description (see guidance).

A4.2.1.7 There is evidence that all professional staff maintain a current license to practice.

A4.2.1.8 There is evidence that clinical privileges are reviewed.

A4.3 Orientation and training

(M) A4.3.1 There are orientation and training programs in place to support staff to perform their roles effectively.[1]

Guidance

Orientation into the healthcare facility is essential for staff to understand the internal workings of the facility. Attendance at a mandatory orientation course is made as soon after the employee's start date as possible. Managers will decide which of the orientation sessions the new employee is required to attend. Departmental orientation may take place over a period of time with a plan of completion when the employee demonstrates the required competencies associated with their role.

All staff are required to attend an on-going training program to maintain their basic skills and knowledge, and this will include safety and health, person-centered care, confidentiality, manual handling and basic life support.

The training plan addresses the needs associated with the healthcare facility's overall objectives and might include the mandatory training requirements; professional updating; the training needs in response to changes in practice, the law and new technology; the results of a training needs analysis and meeting individuals' training needs as identified within the performance review system. Competency based packages of training, supervision e-learning, providing financial support, protected time, on the job training and study leave are all methods of training and updating.

Measurable elements

A4.3.1.1 The healthcare facility has an organizational orientation program for staff which includes but may not be limited to:

a) The healthcare facility's values and objectives,
b) Ethical conduct expected of staff,
c) Quality,
d) Patient safety,
e) The occupational safety and health systems including infection control and manual handling,
f) Child protection and the protection of vulnerable adults,
g) Patient confidentiality and the management of medical records,
h) Access to shared portals including access to policies and procedures,
i) Accident and incident reporting,
j) Risk management including clinical risk,
k) Medicines management,
l) Personnel policies including performance assessment,

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[1] **References for A4.3.1:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017

m) Security,
n) Dress code.

A4.3.1.2 Records of attendance are maintained.

A4.3.1.3 All new employees complete a departmental orientation program based on their role.

A4.3.1.4 There is an on-going mandatory training program.

(D) A4.3.1.5 There are processes for checking staff knowledge of safety and patient experience issues.

A4.3.1.6 There is a mandatory training program on person-centered care, which includes but not limited to,

a) The Patients' Rights,
b) Patient choice and preferences,
c) Diversity,
d) Consent,
e) Dignity and privacy.

A4.3.1.7 There is a current training and development plan to meet the needs of the human resource strategy (see guidance).

(D) A4.3.1.8 There is a current policy on protected time for study leave to support continuing professional development and professional registration.

A4.3.1.9 All staff who participate directly in the care of patients have Basic Life Support training.

A4.3.1.10 Advanced Life Support training is made available to those who require it. This includes Pediatric, Advanced Cardiac and Advanced Trauma Life Support skills.

(M) A4.3.2 There are Occupational Safety and Health (OSH) training programs for staff who work within the healthcare facility.[1]

Guidance

Different training will be required for those staff with delegated OSH roles, all other staff including contracted and outsourced staff. The healthcare facility needs to evaluate the needs of the different groups of staff and devise programs to suit these groups accordingly. The frequency of the training provided shall also be assessed. The training needs are prioritized through documented evaluation of risk levels of tasks, monitoring of OSH performance indicators of all employees or other means of evaluations by the healthcare facility that reflects the OSH training needs.

Measurable elements

A4.3.2.1 There is evidence that OSH training needs have been assessed for different staff groups working within the healthcare facility.

A4.3.2.2 Attendance at OSH training is mandatory, and records of attendance maintained.

A4.3.2.3 There is an annual planning matrix of OSH trainings.

(D) A4.3.2.4 The healthcare facility monitors the effectiveness of training at least annually.

A4.4 Performance Appraisal

(C) A4.4.1 All staff undergo an annual review of their performance.[2]

Guidance

A performance appraisal is an annual discussion between employee and line manager and covers a number of aspects to gauge the performance and needs of each employee. Line managers who undertake employee appraisals receive training in how to do such appraisals.

Supervision is different in that it allows staff to discuss their particular issues on a one-to-one basis. It is led by the employee not the line manager. It is an opportunity for employees to spend some time with their manager to discuss how things are going with work and wellbeing. There are different types of supervision including clinical, managerial, professional and safeguarding supervision. Staff with direct clinical care have clinical supervision whenever they need this. It allows for reflective practice and provides support to staff. The supervision policy describes the types of supervision available, the roles requiring the different types of supervision, responsibilities and processes.

Measurable elements

A4.4.1.1 There is evidence that all staff have received a performance appraisal in the previous 12 months that includes:

a) Employee's competence,
b) Behaviors,
c) Positive and challenging aspects,
d) Training attended and future training needs,
e) Maintaining continuing professional development, and

[1] **References for A4.3.2:**

- OSHAD-SF, 2017, Element 5: Training, Awareness and Competency

[2] **References for A4.4.1:**

- https://www.england.nhs.uk/professional-standards/medical-revalidation/appraisers/
- Sheffield Health and Social Care NHS Foundation Trust, NP 019 Supervision Policy, 2020-23

f) Career aspirations.

A4.4.1.2 An individual training and development plan is agreed as part of the appraisal process.

A4.4.1.3 The annual performance appraisal of medical staff includes (but not limited to):

a) Mortality and morbidity,
b) Outcomes of surgery or procedures,
c) Medication usage and errors,
d) Medical records review for completeness and timeliness,
e) Patient assessments,
f) Adverse events,
g) Utilization of resources.

A4.4.1.4 Findings of the medical and nursing appraisals are used to improve patient care.

A4.4.1.5 The result of performance appraisals is given to the employee.

A4.4.1.6 The performance appraisal documents are kept in the employee's personnel file.

(D) A4.4.1.7 There is a supervision policy and procedure that is developed in accordance with the above guidance.

(D) A4.4.1.8 Staff are able to access a supervision meeting when required.

Documentary evidence required:

A4.1.1.1 Human resource strategy.

A4.1.1.2 Nursing strategy.

A4.1.1.3 Staffing plan.

A4.1.1.4 Human resources policies and procedures.

A4.1.1.7 Strategy for supporting staff health and wellbeing.

A4.2.1.1 Procedure for the recruitment and selection of staff.

A4.2.1.3 Policy and procedures on credentialing and granting of privileges.

A4.3.1.7 Training and development plan.

A4.3.1.8 Policy on protected time for study leave.

Suggested personnel to work with the standards:

Human resource manager

Medical and Nursing directors

Staff representatives

SECTION A5 QUALITY MANAGEMENT

Overview

Quality is everyone's responsibility, but structure and processes need to be in place to enable continuous quality improvement in both clinical and non-clinical services; to allow reflection and learning to enable improvements to be made which benefit staff and patients. Quality assurance includes the processes and procedures for assuring quality controls are maintained.

This sub-section addresses how quality is managed and addressed including knowledge from accidents, incidents, complaints and feedback.

It also includes how documents are controlled within the healthcare facility.

A5.1 Quality Improvement

(M) A5.1.1 There are policies and processes to support quality improvement and assurance in the healthcare facility.[1]

Guidance

Quality improvement activities are aligned with the healthcare facility's vision and strategic objectives and include the identified actions from staff feedback, learning from complaints, risks, audit results and incidents and accidents.

The quality improvement plan outlines methodologies to achieve its objectives together with a timetable for achieving these. The objectives are aimed at improving safety, quality of care, patient experience, clinical effectiveness and efficiency. The plan is reviewed and evaluated to ensure that improvement initiatives are feasible, relevant and useful.

Although quality is the responsibility of every employee, there needs to be personnel to co-ordinate and monitor quality activities. Such personnel have experience of quality improvement and may have a clinical or non-clinical background.

A fundamental part of continuous quality improvement is audit, and the healthcare facility needs to know what audits are taking place, including re-audits, the main findings, timescales and responsibilities. In addition to audit, improvements can be made as a result of patient and staff feedback, suggestions and opinions. This may be in the form of a patient experience questionnaire, suggestion boxes, complaints, appreciation, staff leaving interviews and informal discussions with staff and patients.

Quality assurance supports quality improvements but is different. Quality assurance's main purpose is to verify that control is maintained. It includes the system of procedures, checks, audits and corrective actions to ensure that all testing, sampling, analysis, monitoring and other technical and reporting activities are of the highest achievable quality. Quality assurance is of particular importance in the clinical support services, particularly the laboratories and radiology.

Measurable elements

A5.1.1.1 There is a designated person within the organization who coordinates and leads quality concepts and principles.

A5.1.1.2 There is a current, implemented facility-wide, both clinical and non-clinical, quality improvement plan with objectives. The plan includes input from individual departments/services.

A5.1.1.3 Each department/service with involvement in the quality plan reports on progress to the designated person. report based on the specific requirements of the department/service.

A5.1.1.4 There is evidence that progress towards meeting the objectives of the quality improvement plan is reported to the Senior Individuals at least three times per year.

A5.1.1.5 There is a documented audit schedule based on the objectives of the quality improvement plan. The audit schedule includes clinical and non-clinical audits.

A5.1.1.6 There is a register of all audits completed and includes corrective action plans carried out in the healthcare facility.

A5.1.1.7 There is a training program which covers, but not limited to:

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[1] **References for A5.1.1:**

- https://www.clinicalauditsupport.com/what-is-clinical-audit.html
- https://www.bmj.com/content/368/bmj.m213
- https://evidence.nihr.ac.uk/themedreview/improving-care-by-using-patient-feedback/
- Healthcare Improvement Scotland, Moving from Quality Improvement to Quality Management, January 2022
- https://qi.elft.nhs.uk/elfts-quality-management-system/
- Healthcare Quality Improvement Partnership: Best Practice in Clinical Audit, 2020
- Healthcare Quality Improvement Partnership: Best Practice in Clinical Audit, checklist 3 - Assessing completed clinical audits
- Abu Dhabi Department of Health, Policy for Quality and Patient Safety, 2017

a) Audit,
b) Quality improvement methodologies,
c) Quality improvement planning,
d) Data management.

A5.1.1.8 There is evidence that the healthcare facility continually seeks the opinions and suggestions of patients and their families to improve quality of care given.

A5.1.1.9 There is evidence that the healthcare facility continually seeks the opinions and suggestions of staff on how to improve the patient and staff care experience.

A5.1.1.10 Results of patient and staff feedback processes are collated, analyzed and the results reported to the Senior Individuals.

A5.1.1.11 There is evidence that the healthcare facility reports indicators as required by performance according to the JAWDA indicator guidelines.

A5.1.1.12 There is evidence that each service/department has a set of key performance indicators against which it is monitored.

A5.1.1.13 Improvement plans are in place for any key performance indicators which do not meet the required performance level.

Documentary evidence required:

A5.1.1.2 Quality improvement plan

A5.1.1.5 Audit schedule

Suggested personnel to work with the standards:

Quality manager

Auditors

Department managers

SECTION A6 DATA AND INFORMATION MANAGEMENT

A6.1 Information Governance

Overview

Information Governance is implemented to enable the healthcare facility to set the standards it follows to check it carries out its duty to maintain full and accurate information and keep that information confidential and secure.

(M) A6.1.1 The healthcare facility has established an information governance framework.[1]

Guidance

Information governance has a framework which mirrors the integrated governance framework to which it belongs. There is a strategy defining what information governance is, a committee to oversee its implementation and policies and procedures to support the process of governance.

The Senior Individuals have overall responsibility for the security, integrity, and confidentiality of patient and corporate information but there are delegated responsibilities throughout the healthcare facility such as a senior manager and information owners throughout the whole organization.

There is an information governance committee that links with the integrated governance committee.

The information governance policy describes the responsibilities and schemes in place for managing information risk and for maintaining the security, integrity, accessibility and confidentiality of data handles by the facility. An access log is maintained and include a list of staff with access to the information systems, where they work, when they started working, job role, level of access permitted, applications and server access, when access rights are rescinded, for example, when a person leaves the organization.

Information technology systems and equipment in used throughout the healthcare facility purchased through the central service and purchased against documented specifications drawn up between the information technology service and the service end-user. A central log of all purchases of hardware and software is maintained.

Procurement of information technology systems needs to be controlled to stop the risk of malware being introduced through hardware or software bought randomly.

Measurable elements

A6.1.1.1 There is an information governance committee with documented terms of reference responsible for the development and implementation of the information governance policies and procedures.

A6.1.1.2 There is a current information governance policy, written in accordance with national guidance and legislation and includes:

a) Who has access to all different types and categories of information and describes the penalties for the staff that violate the security and confidentiality of data and information,
b) The levels of access to patient information on a need-to-know basis,
c) The access to confidential patient information by parental and family members
d) Usage and downloading from the internet,
e) Restrictions on the use of removable hardware devices.

A6.1.1.3 Information technology systems and equipment in use throughout the facility are purchased through the central service against documented specifications drawn up between the information technology service and the service end-user.

(D) A6.1.1.4 A central log of all purchases of hardware and software is maintained.

A6.1.1.5 There are information systems to support integrated governance through the collation of information used to monitor and improve business and clinical objectives.

A6.1.1.6 There is an education and training program for staff who have access to information and information systems on the principles of data management for decision-making and includes data analytics, setting metrics, and aspects of data quality.

A6.1.1.7 Software Licenses are held centrally by a designated person in the healthcare facility. Copies of the purchase orders for the software are maintained.

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[1] **References for A6.1.1:**

- Department of Health Abu Dhabi, Policy on Digital Health, 2020
- DOH Abu Dhabi, Healthcare Information and Cyber Security Standard, February 2019
- Abu Dhabi Healthcare Information and Cyber Security Workforce Guideline, September 2022

A6.1.1.8 There is a register of access rights given to staff which is maintained and kept up to date.

A6.2 Information risk management

Overview

Information Risk Management (IRM) and cybersecurity involves the protection of computer systems and networks from information disclosure, theft or damage. Insufficiently protected data risks breaches of sensitive patient data and the healthcare facility has a duty of care to protect this information. Threats can be categorized as either external or internal. External threats may include, for example, state-sponsored Cyber activities, disruption, denial of service, malware attacks, etc. Internal threats may include malicious insiders and system issues caused by inadequate IT design, lack of physical / IT controls, lack of procedural controls or training.

(M) A6.2.1 There is a collaborative approach to risk as it relates to all information obtained and processed within the healthcare facility held in electronic, paper-based and other formats, whether stored in automated or manual systems.[1]

Guidance

The management of Information Risk is an integral part of management and clinical practice. Every individual within the healthcare facility is therefore responsible for identifying and managing risk and for keeping information about patients, staff and the healthcare facility safe and confidential. The policy and procedures for managing information risk are in accordance with the Abu Dhabi Healthcare Information and Cyber Security Workforce Guideline.

Measurable elements

A6.2.1.1 There is an information security officer who is responsible for the planning, development and implementation of cybersecurity policies, procedures, standards, and controls.

A6.2.1.2 There is a policy and procedures for maintaining cybersecurity and includes (but not limited to):

a) Identify and deal with the risk of threats from malicious software, cyber-attacks and ransomware,
b) The steps to take when there is an incident involving data security breaches, including when a report needs to be made to relevant authorities.

A6.2.1.3 There are documented procedures to follow in the event of failures of information technology systems.

A6.2.1.4 There are systems and documented procedures for routine back up or preservation of key information technology systems and data and restoring this information in the case of an emergency in accordance with The Major Incident and Business Continuity plans (see also A1.4).

A6.2.1.5 There are documented procedures for the installation of new software and the removal and upgrade of old versions and includes:

a) Who may request new software,
b) Who may install software,
c) The risk assessment of introducing new software to the facility's information system.

A6.3 Data management

Overview

[1] **References for A6.2.1:**

- DOH Abu Dhabi, Healthcare Information and Cyber Security Standard, February 2019
- Abu Dhabi Healthcare Information and Cyber Security Workforce Guideline, September 2022

Data management is the practice of collecting, keeping, and using data securely, efficiently, and confidentially. The goal of data management is to optimize the use of data within the bounds of policy and regulation so that information can be shared to assist in the care of patients and the healthcare facility.

(M) A6.3.1 Data is managed to be confidential and secure.[1]

Guidance

A robust data management policy is important as healthcare facilities become increasingly dependent on digital systems. The policy sets out the healthcare facility's standards of data management that individual departments work within. The quality of data used is essential as decisions, whether clinical, managerial or financial, need to be based on information which is of the highest quality. Data quality may be assured by training staff who need to input data, processes to update data and audits. When patient information is used for audit or shared with other bodies this should be anonymized, for example, only using the patient record number.

Measurable elements

A6.3.1.1 There is a data management officer who is responsible for providing advice and monitoring compliance.

A6.3.1.2 There is a data management policy which includes but is not limited to:

a) How data is obtained and used within a lawful framework,
b) How the personal data obtained is justified, relevant and not excessive,
c) How security and confidentiality are maintained,
d) How the anonymity of patient identifiable information is ensured,
e) Data quality assurance,
f) Data file storage,
g) Destruction of digital information,
h) Responsibilities,
i) The legal framework within which the healthcare facility shall operate.

A6.3.1.3 There is a policy and procedures for the design and control of data, data transfer and information sharing which includes:

a) The roles and responsibilities for data entry,
b) The definition of a data entry,
c) Design of data entry formats for data entry,
d) Data collection,
e) Restrictions for displaying and analyzing data using software programs to maintain patient confidentiality,
f) Restrictions on transfer methods of sensitive material e.g., email, facsimile, telephone,
g) Restrictions on the transfer of patient identifiable data.

A6.3.1.4 There is a procedure for checking data quality and validity.

[1] **References for A6.3.1:**

- Abu Dhabi Department of Health, Standard on Patient Healthcare Data Privacy, September 2020
- DOH Policy on The Abu Dhabi Health Information Exchange, April 2020
- DOH Abu Dhabi, Healthcare Information and Cyber Security Standard, February 2019

A6.4 Document Control

Overview

Documents and information may be found in many different formats including paper, computer records, compact and magnetic discs, photographs, emails, internet and intranet. They need to be accurate, current and accessible. Any information containing personal data also needs to be kept confidential. Document control therefore falls within the remit of the Information Governance committee.

(C) A6.4.1 There is a process for the control of documents and information.[1]

Guidance

It is important that the healthcare facility has in place a robust process for the creation, ratification, approval, dissemination, revision, and review of all documentation. A robust document control process will ensure consistency of approach across the facility. A standard format and approved structure for documents helps to ensure that policies and procedures are up to date to a professional and consistent standard and reflects the organizational approach.

A document control policy defines the different types of documents used in the healthcare facility, for example, a strategy, a policy standard operating procedure, plan etc. It explains the steps involved in document development, version control, templates, ratification and approval, review timeframes which may be different depending on the criticality of the document, archiving and responsibilities against activities.

Documentation includes information that may or may not be vital to the business continuity of the healthcare facility and for patient care a risk level added to the document guides users and those responsible for review to easily identify those which are of high risk/importance. High risk/importance documents may require to be reviewed and updated on a more frequent basis. An information asset is a body of information which has value to an organization, for example care records in a filing cabinet, care records on planning software, employee training records. The healthcare facility decides what information, whether paper, CD, electronic, tape etc. is recorded and whether the information is of value to the facility, is there a risk if it is lost or disclosed. Examples might include manuals and training materials, contracts and agreements, business continuity plans and audit data.

The register of all documents in use and archived with published and review dates, author and version helps keep track of the documentation cycle. It will include the information asset owner i.e., the person responsible for ensuring that specific information assets are handled and managed appropriately, what it is, its value to the facility, its sensitivity, where it is kept and how it is accessed.

Measurable elements

A6.4.1.1 There is a document control policy which includes but not is limited to:

a) Definitions of the types of documents covered by the policy and in use in the healthcare facility,
b) Responsibilities,
c) Development, approval, and revision processes including timeframes,
d) Document control,
e) Monitoring of clinical and non-clinical policies and procedures,
f) Format,
g) Withdrawal of clinical and non-clinical policies and procedures,
h) Archiving and archive retrieval of obsolete and superseded versions,

[1] **References for A6.4.1:**

- DOH Abu Dhabi, Healthcare Information and Cyber Security Standard, February 2019
- Abu Dhabi Department of Health, Standard on Patient Healthcare Data Privacy, 2020
- Sussex Partnership NHS Foundation Trust, Information Asset Framework Policy, 2022-2025

i) Destruction.

A6.4.1.2 There is a policy for the management of information assets which includes:

a) Responsibilities for owning information,
b) Identification of an information asset,
c) What is required for the maintenance of an information asset register,
d) Audit,
e) How personal data is processed to remain confidential and secure,
f) The requirements for sharing personal information outside the healthcare facility.

(D) A6.4.1.3 The information asset register contains all healthcare facility wide clinical and non-clinical policies and procedures.

(D) A6.4.1.4 Individual policies and procedures include the risk level to identify the associated risks.

A6.5 Management of medical records

Overview

A medical record relates to the physical or mental health of an individual, made by or on behalf of a health professional in connection with the case of that individual. It contains personal and sensitive material and is therefore kept up-to date, accurate, confidential and secure, whether it is in paper or electronic format.

(M) A6.5.1 There are systems in place to maintain medical records.[1]

Guidance

The Healthcare Facility is required to create a medical record for every patient receiving care in the Healthcare Facility or treated in the emergency or attending the out-patients department. The record contains patient identifiable information, including a unique identifier as well as their name, age, and next of kin. Clinical staff have a duty to input the clinical information as soon after the event as possible, be factual and consistent, and using terminology accepted by the healthcare facility i.e., use of abbreviations, ensuring comments are related to the patient's clinical condition and are completed in language for readers to understand the requirements for continuity of care and are comprehensive for legal use, if so required. Regular audits of the medical records are undertaken to ensure that staff adhere to the required standards of accuracy and completeness.

The records are required to be stored securely at all times, for example, paper records are not left unattended, computer screens are not able to be seen by anyone other than the user.

There is a designated individual who is responsible for the management of medical records, and who is a member of the Information Governance committee.

Measurable elements

A6.5.1.1 There is a designated individual responsible for the medical records in the healthcare facility, and who is a member of the Information Governance committee.

A6.5.1.2 A medical record is initiated for all patients receiving care within the healthcare facility.

A6.5.1.3 There is a documented and implemented policy on the recording of entries in the medical records that include but not limited to:

a) Assigning a unique identifier,
b) Who is authorized to make entries into the record,

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[1] **References for A6.5.1:**

- Federal law No. 2, on the Use of The Information and Communication Technology (ICT) In Health Fields, 06/02/2019,
- Abu Dhabi Department of Health, Standard on Patient Healthcare Data Privacy, 2020
- Abu Dhabi Department of Health Policy on the Abu Dhabi Health Information Exchange, April 2020

c) Who is authorized to access medical records,
d) Requirements for dating, timing, and identification of the author, including registration number,
e) Use of abbreviations and symbols,
f) Advice on inappropriate comments,
g) Mandatory entries such as medication, diagnostic test results, allergies and alerts,
h) Physical structure of paper records,
i) The requirements for sharing medical information,
j) How records from different points of care are integrated into the main record.

A6.5.1.4 There is evidence of regular audit of the medical records with actions for improvement.

A6.5.1.5 There is evidence that medical records are kept secure and confidential.

A6.5.1.6 There is a documented policy and procedures for the confidential retention destruction or archiving of medical records, in accordance with the legal requirements.

A6.5.1.7 There is evidence that the healthcare facility undertakes clinical coding in accordance with the legal requirements.

A6.5.1.8 There is a process for patients to access their own medical records.

Documentary evidence required:

A6.1.1.1 Terms of reference for information governance committee.

A6.1.1.2 Information governance policy.

A6.2.1.2 Policy and procedures for maintaining cybersecurity.

A6.2.1.3 Procedures to follow in the event of failures of information technology systems.

A6.3.1.2 Data management policy.

A6.3.1.3 Policy and procedures for the design and control of data, data transfer and information sharing.

A6.4.1.1 Document control policy.

A6.4.1.2 Policy for the management of information assets.

A6.5.1.3 Policy on recording entries into medical records.

A6.5.1.4 Action plans from medical records audit.

A6.5.1.5 Policy and procedures for the confidential retention destruction or archiving of medical records.

Suggested personnel to work with the standards:

Information governance lead

Pharmacist

Radiology staff

Medical records staff

Clinical coders

SECTION A7 TELEMEDICINE

Overview

Telemedicine is medicine that is practiced at a distance. This may be through video-conferencing, transmission of images as in teleradiology, or the transmission of patient data such as blood pressures and respiratory rate for example.

The uses of telemedicine are growing and include follow up consultations, prescriptions, access to medical and nursing advice, long term condition management.

A7.1 Management of Telemedicine

(C) A7.1.1 Telemedicine is practiced in a safe and efficient manner.[1]

The Abu Dhabi Department of Health has published a comprehensive set of standards for telemedicine. Healthcare facilities undertaking telemedicine and/or digital health functions implement the requirements and audit the service provided.

Whilst it is convenient for patients to receive medical advice without leaving home there are risks associated with this media if staff do not undertake as thorough an assessment as they might with a face-to-face consultation. Very clear protocols are developed to gain as much information as possible and if the physician has any doubts as to the suitability of continuing with a digital consultation, then alternative means are sought.

Training is required to be provided to patients who take up telemedicine. Those using digital health devices are aware of whom they should contact should the device be faulty.

The healthcare facility obtains feedback from patients and their carers on how useful or not the system and the process is for them and how secure they feel their information is kept confidential.

Measurable elements

A7.1.1.2 The healthcare facility has a license to operate a telemedicine system.

A7.1.1.2 The healthcare facility can demonstrate that it complies with the requirements of the Abu Dhabi DOH Standard on Tele-Medicine.

A7.1.1.3 There is evidence that the telemedicine service has been audited against the DOH standards and has developed an action plan for improvement.

A7.1.1.4 The telemedicine service has a set of criteria for suitability to be included in digital health practices, either consultation or using devices.

A7.1.1.5 There is a documented policy and clinical protocols for the clinical assessment of patients having a digital consultation.

A7.1.1.6 There is a process to provide patients with training and support on the use of telemedicine and digital health devices.

A7.1.1.7 There is a process for the recall and replacement of faulty telemedicine devices provided to patients by the healthcare facility.

(D) A7.1.1.8 The healthcare facility monitors the uptake of telemedicine and digital health.

A7.1.1.9 The telemedicine service continuously seeks feedback from patients on the service provided.

A7.1.1.10 There is a documented procedure on the confidential retention and destruction of digital media obtained through the telemedicine process, in accordance with the healthcare facility's policy on the retention and destruction of medical records (see A6.5.1).

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[1] **References for A7.1.1:**

- Abu Dhabi Department of Health, Standard on Tele-Medicine, September 2020

A7.1.1.11 Consent is obtained from the patient and recorded in accordance with the policy for consent (see B4.2.1.1).

Documentary evidence required:

A7.1.1.5 Policy and clinical protocols for the clinical assessment of patients having a digital consultation.

A7.1.1.10 Policy and procedure for retention and destruction of digital media.

Suggested personnel to work with the standards:

Clinicians using telemedicine or digital health

CHAPTER B: PATIENT CENTERED CARE

Introduction

Patient-centered care is defined as "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 Institute of Medicine). Preferences and choices can be something as simple as how they wish to be addressed, if they need help with personal care as well as their treatment. It is important that staff are made aware of any preferences and choices so that they can deliver care with respect and maintain the patient's dignity. This model of care promotes a holistic approach to caring for the patient, developing individualized, comprehensive care plans in which the psychosocial needs of the patient receive equal attention to their medical treatment. Further guidance can be found online, and The Health Foundation in the UK has published an accessible guide Person-centered care made simple - The Health Foundation.

Patient centered care is inclusive of diversity and includes characteristics or factors such as age, race, ethnicity, language, gender, religion, beliefs, family and/or social structure, and ability, including varying levels of disability. The diverse needs of each person are complex, and staff require to be educated on the patient-centered care approach to ensure they understand the concept and how to put it into practice, see A4.3.1.6. Policies and procedures should reflect inclusivity and support staff in caring for the diverse population and people of determination.

Ministerial Resolution No 14 of 2021 of the Patient's Rights and Responsibilities Charter should be considered with this Chapter. For more information on terms used within this Chapter please see the Terms and Definitions Section.

SECTION B1 ADMISSION AND ASSESSMENT

Overview

Patients who are admitted for a planned procedure are informed and made aware of what is going to happen and what they need to do. Ideally all patients have multi-disciplinary assessments of their health care needs and preferences. Information is available to ensure that the healthcare professionals have all the required data to provide the correct care.

B1.1 Admission

(M) B.1.1.1 Patient admission to the healthcare facility is guided by clear processes.

Guidance

The admissions process is as standardized as possible but individual units, departments and services may have different criteria for accepting patients into their service, for example, admitting patients with a condition that requires emergency surgery. Such criteria are stated in a policy and include responsibilities for each step of the process. For both routine and emergency admissions, relevant patient information is collected and recorded in a standardized manner, either on a paper or electronic-based system, and includes as a minimum: name, date of birth, gender, next of kin and contact details. A bed allocation system promotes regular communication between units and clinical areas, such as accident and emergency, to ensure that bed usage is appropriate and to help avoid patients being held in emergency rooms and cancellations. Monitoring and assessing the number and ratio of planned and emergency admissions using standard tools such as statistical process control can be

used to demonstrate disruptive variations and admission patterns. This can also include times and days of admissions.

Measurable elements

B1.1.1.1 There is a documented policy and procedure for admission to the healthcare facility services which includes routine and emergency admissions including the timescale for them to be completed in.

B1.1.1.2 There is a standardized admission form, which is completed and is part of the patient's medical record.

B1.1.1.3 Prior to an elective inpatient admission, the patient receives information applicable to their condition explaining how to prepare for their stay, and includes:

a) Advice on taking drugs prescribed prior to admission,
b) What to bring including own medicines,
c) Specimens (if required),
d) Suitable clothes,
e) Instructions about fasting,
f) Anticipated length of stay, and
g) Is documented in the patient's medical record.

(D) B1.1.1.4 There are systems in place and a member of staff to manage and re-assess bed allocation to maintain an effective patient flow through available bed capacity and create bed capacity by supporting timely patient admission, transfer and discharge processes.

(D) B1.1.1.5 Cancelled admissions by either the healthcare facility or the patient are monitored and analyzed with results used for improvement.

B1.2 Assessment

(M) B1.2.1 Initial comprehensive patient's assessments are completed after patient's admission to the healthcare facility.

Guidance

A multi-disciplinary assessment is completed as soon as possible after admission and within 24 hours. A documented assessment procedure includes the roles and competencies of the staff (for example, trainees under supervision, multi-professional team) who are authorized to carry out assessments and how it is recorded. The assessment includes the assessment of the patient's clinical risks using standardized tools, for example, the Malnutrition Universal Screening Tool (MUST). Pain assessment tools are used that are suitable for a variety of ages and cognitive ability. The findings of the assessment are recorded in the patient's medical record together with a provisional or definite diagnosis.

Measurable elements

B1.2.1.1 There is a documented procedure for the assessment of patients which includes:

a) The timescale the assessment is to be undertaken within,
b) The roles and competencies of the staff who can carry out the assessment,
c) The assessment of clinical risks,
d) How the assessment is documented.

B1.2.1.2 The procedure for the assessment includes a physical examination and taking a health history relevant to the patient's symptoms, current condition and complaint.

B1.2.1.3 All patients are screened for pain and assessed when pain is present.

B1.2.1.4 Patients are screened for any existing long-term conditions which may impact on their well-being.

B1.2.1.5 The initial assessment includes screening the patient for the need for further functional assessments to address mobility, cognitive issues, continence and personal hygiene needs.

B1.2.1.6 The initial assessment includes the patient's psychosocial status and their emotional and social needs within their cultural and spiritual setting.
B1.2.1.7 Patients are screened for nutritional risk as part of the initial assessment.
B1.2.1.8 Patients are screened for tissue viability and existing pressure injury graded.
B1.2.1.9 There is a system for indicating an alert to significant risk factors or allergies which is used consistently in all patients' medical records.
B1.2.1.10 The assessment includes a provisional or definite diagnosis.
B1.2.1.11 The assessment documents the discussion and decisions of the patient and their family on the treatment options offered.

Documentary evidence required:
B1.1.1.1 Policy and procedure for admission to the healthcare facility services which includes routine and emergency admission.
B1.2.1.1 Procedure for the assessment of patients.

Suggested personnel to work with the standards:
Medical director
Nursing director
Unit doctors
Unit nurse

SECTION B2 TREATMENT AND CARE

Overview
After the initial multi-disciplinary assessment, the health care needs and preferences of the patient are reflected in care pathways or equivalents that are implemented and reviewed. Care and treatment are centered on the patient, who is involved in all aspects of their care process. These standards address the roles and responsibilities of those involved in the treatment and care of patients to encourage co-decision making, transparency of risks and ongoing monitoring of care required.

B2.1 Treatment Planning

(M) B2.1.1 A documented integrated coordinated and multi-professional care and treatment plan is developed for each patient, based on the assessment of the patient's health care needs, results of any diagnostic tests, their preferences and choices.[1]

Guidance
A care and treatment plan is a written record of a plan of action negotiated with the patient to meet their health, social and psychosocial needs. Care plans ideally are multi-professional, coordinated across services, departments and settings, and integrated to include the notes, findings and comments from all healthcare professionals involved in the patient's care. Ideally this is completed in chronological order. It sets out who is doing what, when, and why and the outlines the aims, actions, responsibilities and objectives. The objectives are based on the evidenced-based guidelines, for example, patient after surgery will be assessed for pain, will be eating and drinking within a set timescale, will be able to get out of bed etc. The plan describes in an easy, accessible way the needs of the patient, their views, preferences and choices. The plan is compiled and agreed with the patient throughout the process of care planning and review. The risks associated with planned

[1] **References for B2.1.1:**
- DOH Standard for Centres of Excellence in the Emirate of Abu Dhabi, 2019

interventions are considered with respect to the patient's condition and the type of intervention, particularly high-risk interventions such as surgery, cytotoxic chemotherapy.

Measurable elements

B2.1.1.1 The integrated and multi-professional care and treatment plans include the diagnosis.

B2.1.1.2 The evidence-based guidelines or protocols being used to plan the patient's treatment are named in the patient's care and treatment plan.

B2.1.1.3 The care and treatment plans have measurable objectives and desired outcome.

B2.1.1.4 The care and treatment plans include the actions, interventions and time frames required to achieve the objectives and desired outcome.

B2.1.1.5 The results of any diagnostic tests informing the care and treatment plan are documented.

B2.1.1.6 The risks associated with the planned treatment and the actions taken to mitigate these risks, are documented in the care plan as clinically indicated.

B2.1.1.7 The preferences and choices of the patient and their family regarding the availability of treatment options are discussed and documented in the patient record.

B2.1.1.8 As part of the care and treatment planning process patients are offered a choice of food in accordance with their nutritional needs, the outcome is recorded in their plan.

B2.1.1.9 Any special needs such as assisted feeding or help with personal care are documented, and the requirements made available.

(M) B2.1.2 All patients are reassessed at intervals to determine their response to treatment and re-evaluate their treatment and plan.[1]

Guidance

The frequency of the reassessment depends on the criticality of the patient's condition and the nature of the treatment. The frequency is noted in the plan and is in accordance with the relevant guidelines. The objective of the reassessment is to ensure the care and treatment plan is meeting the continuing needs of the patient including amendments if circumstances change and clinical risks. Every review, re-assessment and change to the plan is recorded.

Measurable elements

B2.1.2.1 There is evidence that the patient's response to treatment is evaluated.

B2.1.2.2 The treatment plan re-evaluation includes:

a) A re-assessment of the patient's medication,
b) A review of all diagnostic test results,
c) A review of progress towards meeting the plan's objectives,
d) A review of pain management (if applicable to the patient's condition),
e) Monitoring of any deterioration, including deterioration of tissue viability, mobility and cognitive functions,
f) An assessment of the patient's nutritional intake,
g) A review of the patient's preferences and decisions,
h) A review of clinical risks,
i) A readjustment of the plan, if required, after the re-assessment is completed.

B2.1.2.3 Every entry into the treatment plan can be traced to the person making the entry by the inclusion of name and designation (including in electronic records).

B2.1.2.4 All reassessments and any changes to the treatment plan are documented.

[1] **References for B2.1.2:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- DOH Standard for Centres of Excellence in the Emirate of Abu Dhabi, 2019

B2.1.2.5 Ongoing reassessments carried out during outpatient follow up appointments are documented in the patient record and the outcome communicated to the patient and those involved in the ongoing care.

B2.2 Care

(M) B2.2.1 There is a safe transition of care during staff shift changes.[1]

Guidance

Handover [or transfer of care] is 'the handover of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group, on a temporary or permanent basis' (Bhabra G et al. 2007). Effective communication is important when a task and its associated responsibilities are handed over to another person or work team. Poor communication between staff when handing over patient care is a recognizable risk factor. If the process is standardized, then staff know what information needs to be imparted to ensure the patient's safety and continuity of care. This supports staff who may work on different wards or services. The World Health Organization, Patient Safety Solution 3, 2007 'Communication During Patient Handovers' gives further information and guidance.

Handovers are given in locations where there is sufficient space for all those required to attend, at a time that allows for both shift staff to attend and to maintain patient confidentiality.

Measurable elements

B2.2.1.1 There are procedures for ensuring the implementation of a standardized approach to hand-over communications between staff at change of shift and between services, for example, from the emergency service to a unit.

B2.2.1.2 The procedure includes the guidance for handovers to be undertaken at a fixed point (time and location) to ensure consistency and be of sufficient length to ensure that all relevant information is imparted.

B2.2.1.3 The procedure includes that staff at handover are made aware of all patients that require further observation or interventions, particularly at night.

B2.2.1.4 There are procedures for ensuring the implementation of a standardized approach to hand-over communications between physicians.

B2.2.1.5 There are procedures for ensuring the implementation of a standardized approach for referring patients to another service or physician.

(M) B2.2.2 There is a system to respond rapidly to patients who demonstrate signs of imminent clinical deterioration.[2]

Guidance

Patients whose condition deteriorates acutely while hospitalized often exhibit warning signs (such as abnormal vital signs and these are the pre-determined criteria, for further information see https://psnet.ahrq.gov/primer/rapid-response-systems) in the hours before experiencing adverse clinical outcomes. Depending on the type of unit and situation the patient is being cared for, there may not be staff on duty with sufficient knowledge and skills to manage the deteriorating patient. The healthcare facility has a team in place who respond in these situations and are, known as a rapid response team or equivalent term, called to attend the patient, has the skills to immediately assess and treat the patient with the goal of preventing further

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[1] **References for B2.2.1:**

- World Health Organization, Patient Safety Solution 3, 2007
- Bhabra G, Mackeith S, Monteiro P, Pothier DD. An experimental comparison of handover methods. Ann R Coll Surg Engl. 2007
- Quality Improvement Clinic Ltd., Safe Communication, Design, implement and measure: A guide to improving transfers of care and handover

[2] **References for B2.2.2:**

- Agency for Healthcare Research and Quality (AHRQ), Rapid Response Systems, 2019

deterioration or decide to transfer to an intensive care unit. These teams are not the same as the resuscitation team called in suspecting or known cases of cardiopulmonary arrest, although they may be the same team members. To evaluate the effectiveness of the team, the healthcare facility needs to assess the likelihood that patients would have needed transfer to an intensive care unit or died without the timely intervention of the team. How the team supports unit staff is also to be assessed.

Measurable elements

B2.2.2.1 The healthcare facility has a rapid response team.

B2.2.2.2 There is a documented procedure for calling the rapid response team which includes the criteria for call-out and the method.

B2.2.2.3 After a call-out to the rapid response team, there is an evaluation of the call and the attendance.

(D) B2.2.2.4 There is evidence that the healthcare facility has evaluated the effectiveness of the rapid response team.

(C) B2.2.3 The healthcare facility works with primary care partners to develop a chronic disease program.[1]

Guidance

The WHO defines chronic diseases as "diseases of long duration and generally slow progression" , and the United States Centers for Disease Prevention and Control (www.cdc.gov) defines them as "conditions that are not cured once acquired … are considered chronic ….". Chronic diseases affect all countries, and the increase in their prevalence is largely attributable to changing demographics, increased life expectancy, changing lifestyles, better disease management and treatment and a better understanding of the factors that cause poor health and disease.

Chronic disease management is a systematic approach to coordinating health care interventions across levels (individual, organizational, local and national), and good evidence indicates that such coordination across care settings and providers is more effective than single or uncoordinated Interventions.

The most common chronic disease conditions presenting include patients suffering with asthma, diabetes, heart disease, stroke, respiratory conditions and mental health. Such long-term conditions are managed in primary care, but patients may need to be referred to secondary/tertiary care for further tests, more intensive care and for advice on self-management. Self-management groups may be led by a healthcare professional or an expert patient, if possible. Note: an expert patient is a patient living with a long-term condition who has undertaken training or a course on self-management.

A strategy for managing chronic disease (for example diabetes, heart disease and renal disorders) may include how cross boundary care is managed, for example, between primary and secondary care to provide continuous care for the patient, how chronic disease teams are structured and managed, provision for managing deterioration of patients and how information is shared between the different disciplines caring for the patient. The strategy includes how a program of care for patients with these long-term conditions are supported in their daily lives and may include running self-management groups that empower people to manage their ongoing physical and mental health conditions themselves, and to support patients and their families and the provision of care coordinators to work across the boundaries.

Care coordinators provide extra time, capacity, and expertise to support patients in preparing for clinical conversations or in following up discussions. They also provide support for families, and this may include training them to administer drugs, including the correct use of inhalers, advice on diet and nutrition, as well as coordinating and facilitating care with other facilities, long term care, ensuring safe transition of care, coordinating medical equipment and consumables before discharge, and communicating with other services such as finance, equipment stores.

[1] **References for B2.2.3:**

- World Health Organization: How can chronic disease management programs operate across care settings and providers, 2008
- The King's Fund, Co-ordinated care for people with complex chronic conditions, 2013

Measurable elements

B2.2.3.1 The healthcare facility can identify the main chronic disease conditions being managed within the scope of services offered.

B2.2.3.2 There is a strategy for the management of patients with chronic diseases, which includes how information is shared between the different disciplines caring for the patient.

(D) B2.2.3.3 There is evidence that the healthcare facility in conjunction with primary care has developed chronic disease management programs for the main chronic diseases within the Emirate of Abu Dhabi.

(D) B2.2.3.4 There are care coordinators working across the primary/secondary care boundary to provide support to patients.

(D) B2.2.3.5 The healthcare facility holds, or can refer to, self-management groups.

B2.2.3.6 The healthcare facility has a range of self-care information to support patients with chronic diseases.

B2.2.3.7 There is a process to fast-track patients with a chronic disease from primary to secondary/tertiary care when there is evidence of deterioration in their condition.

Documentary evidence required:

B2.1.1.1 An integrated and multi-professional care and treatment plan.

B2.2.1.1 Procedures for the standardized approach to hand-over communications between staff, change of shift and between services.

B2.2.2.2 Procedure for calling the rapid response team.

B2.2.3.2 Strategy for chronic disease management.

Suggested personnel to work with the standards:

Medical director

Nursing director

Unit doctors

Unit nurse

Rapid response team (if applicable)

Chronic disease care coordinator

SECTION B3 DISCHARGE AND TRANSFER

Overview

Ideally discharge planning should commence at the start of admission. Staff have standard processes to follow to ensure the safe and timely discharge to home or referral to another facility.

B3.1 Discharge planning

(C) B3.1.1 Patients are discharged from the healthcare facility with the required information and any medicines or dressings for a safe return home.[1]

Guidance

Individual units and services will need to develop service specific criteria. There is a commitment to the safe and timely discharge of all patients and appropriate communication, within defined timescales, to provide continuity of care between the healthcare facility and external services. Ideally discharge planning begins on the day of admission or before admission where possible and includes how continuing care will be arranged; the

[1] **References for B3.1.1:**

- DOH Standard for Centers of Excellence in the Emirate of Abu Dhabi, 2019
- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- WHO Patient Safety Solutions, volume 1, solution 3 May 2007, Communication During Patient Handovers.

information given to the patient concerning future management of their medical condition; management of their condition at home, and/or any advised changes in lifestyle. Discharge planning needs to take into account the needs of the individuals, their families and carers, especially where there is a dependency on others, for example, the elderly, children, those with special needs and people of determination.
The discharge checklist would include checking that the patient has the required education and information, knows when they are being discharged and to where, an escort is in attendance if required, has all the prescribed medication or dressings etc., if required, transportation is ready, the patient is able to access their house (have keys) and has their next appointment or follow up steps.
Patients may be discharged from one service but then required to be referred to another, possibly a more relevant service. The referral process is fully documented in the patient's medical record with the reason for the referral.

Measurable elements

B3.1.1.1 There is a written policy for referral and/or discharge of patients.
B3.1.1.2 Leaving a unit/service/discharge planning is started prior to, or within 24 hours of admission and involves, in addition to the patient, their patient's multi-disciplinary team and their family.
B3.1.1.3 A discharge summary is prepared at discharge by a qualified individual.
B3.1.1.4 The discharge summary contains:

a) Reason for admission,
b) Significant physical and other findings,
c) Significant diagnoses and co-morbidities,
d) Diagnostic and therapeutic procedures performed,
e) Significant medications and other treatments received,
f) The patient's condition at the time of discharge,
g) Discharge medications, including all of the medications to be taken at home,
h) Follow-up instructions and any appointments,
i) When and how to obtain urgent or emergency care.

B3.1.1.5 A copy of the discharge summary is placed in the patient record.
B3.1.1.6 A copy of the discharge summary is given to the patient.
B3.1.1.7 A copy of the discharge summary is accessible/provided to the referring or primary care physician.
B3.1.1.8 A standardized pre-discharge checklist (see guidance) is used to assess that the actions required to discharge the patient have been completed.
B3.1.1.9 There is a policy for the referral of patients from one healthcare professional to another.

B3.2 Patient transfer

(M) B3.2.1 Patients are transferred between services and facilities in a safe manner.

Guidance

The healthcare facility has a duty of care to transfer patients between services or facilities in a safe manner.
There are a number of reasons why a patient may need to be transferred to another service or facility, for example, if their care needs cannot be met in their current location. The transfer policy includes documenting the rationale for a patient transfer. The policy defines levels of escort required to accompany patients depending on patient needs, particularly for vulnerable patients and those with safeguarding issues. The procedures include how clinical risk is assessed for each patient, which includes the risk of moving patients with specific physical, sensory, mental or psychological health issues. The procedures also define what communication is required with the patient, their family and the destination service. The requirement for any medication and supplies necessary to accompany the patient, for example, oxygen, syringe drivers, mobility aids, as relevant to their condition and

linked to any identified risk. The transfer, where possible, should consider the needs of the patient, for example ensure that the transfer timing allows for nutrition and hydration beforehand.

Measurable elements

B3.2.1.1 There is a policy and procedures for the transfer of patients between units and services within the healthcare facility or to another facility which includes:

a) Rationale and criteria for transfer,
b) Responsibilities,
c) Communication with the patient and their family,
d) Communication with the destination,
e) Clinical risk assessments, including pain management and medical fitness for transfer,
f) Infection control requirements,
g) Information relating to any vulnerable patients and associated safeguarding risks,
h) Documentation in the medical record,
i) Handover information and documentation at the destination,
j) Medication and any supplies relevant to the patient's condition,
k) Equipment and mode of transport,
l) Level of escort requirements,
m) Personal belongings.

B3.2.1.2 The transfer policy and procedure include how communication is made with other agencies (for example, hospices, care homes etc.) that may be relevant in the care continuum.

B3.2.1.3 The transfer policy includes the times during which patients may be transferred or depending on the patient' criticality.

(M) B3.2.2 The transfer of critically ill patients is managed in a safe manner.[1]

Guidance

If a patient attends an emergency service or starts to deteriorate whilst admitted on a unit, they may need to be transferred to an intensive care unit (ICU). A transfer from a unit or service to an ICU has to be in accordance with a defined set of criteria (see Section E. 4) and if the healthcare facility does not have the capacity or cannot provide the level of care required then patients may have to be transferred to other facilities that can accommodate such patients.

The transfer of critically ill patients between healthcare facilities is a time critical high-risk episode, as the patient may be in an unstable condition and may require urgent lifesaving intervention.

Ideally all healthcare facilities will have a nominated privileged physician for critical care transfers who has knowledge of the transfer pathway, is responsible for competencies and staff training, and equipment provision. This may be an intensive care physician or a general consultant physician with the required privileges. A pre-transfer checklist would include checking that the patient, staff, equipment are ready to transfer, and organizations are ready to receive the patient.

Measurable elements

B3.2.2.1 There is a nominated lead privileged physician on duty with decision making responsibilities for the transfer of critically ill patients.

B.3.2.2.2 There is a set of parameters for assessing suitability for transfer to a critical care unit (see E4).

B3.2.2.3 There is policy and procedure for the safe transfer of patients to another facility if their needs exceed the healthcare facility's capability for care which includes but is not limited to:

[1] **References for B3.2.2:**

- Health Authority - Abu Dhabi Health Care Standards for Hospitals, 2008
- Faculty of Intensive Care Medicine Guidance On: The Transfer of The Critically Ill Adult, 2021

a) Rationale and criteria for transfer,
b) Responsibilities,
c) Communication with the patient and their family,
d) Communication with the destination,
e) Clinical risk assessments, including pain management and medical fitness for transfer,
f) Infection control requirements,
g) Information relating to any vulnerable patients and associated safeguarding risks,
h) Documentation in the medical record,
i) Handover information and documentation at the destination,
j) Medication and any supplies relevant to the patient's condition,
k) Equipment and mode of transport,
l) Level of escort requirements,
m) Personal belongings.

(D) B3.2.2.4 The healthcare facility develops a critical care transfer pathway in collaboration with other facilities with intensive care provision.

B3.2.2.5 There is a standardized pre-transfer checklist to assess the preparedness for transfer.

Documentary evidence required:

B3.1.1.1 Policy for discharge of patients.

B3.1.1.8 Standardized discharge checklist

B3.2.1.1 Policy and procedures for transfer of patients

B3.2.2.3 Policy and procedure for the safe transfer of critically ill patients to another facility

Suggested personnel to work with the standards:

Medical director:

Nursing director

Unit doctors

Unit nurse

SECTION B4 PATIENT AND FAMILY RIGHTS AND RESPONSIBILITIES INCLUDING INFORMATION

Overview

All citizens within the Emirate of Abu Dhabi have the right to treatment and care. The rights of all patients regardless of age, disability, ethnicity, religion and gender are recognised, respected and complied with by all staff involved in their care or treatment and these rights are documented and implemented.

B4.1 Patient and Family Rights and Responsibilities

(M) B4.1.1 The healthcare facility protects and promotes patient and family rights and informs patients about their responsibilities during care.[1]

Guidance

Consideration is given to the roles and responsibilities of both staff and patients with regard to confidentiality, stated and implied needs, privacy, dignity, respect, safeguarding and involvement in care. Staff are aware of and

[1] **References for B4.1.1:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- Ministerial Resolution No. (14) of 2021 on the Patient's Rights & Responsibilities Charter

respond to the individual and special needs of patients, including the elderly; “people of determination” i.e., those with physical disabilities and/or sensory impairments, those with underlying mental health problems, or who are confused; those with learning disabilities; children and young people. Functional adaptations may be required to assist patients with mobility and/or sensory impairments and these might include, for example, widened doorways, reception desks lowered for wheelchair users, ramps, automatic doors, hearing aid loops, elevators with Braille or announcements, special seating and space for wheelchair users in waiting areas. Staff maintain patient dignity by paying consideration to them by the arrangement of screens and curtains, toilet facilities, washing facilities changing cubicles and staff checking that the patient’s clothing is in place after treatment and care procedures.

Consideration is given to patients of different ethnicities, religions or cultures and how the facility responds to individual requests. This might include, for example, separate facilities for young adults, women; provision of prayer rooms of different denominations and may require staff training to ensure that the needs are understood.

The healthcare facility has processes which guide staff on the ethical consequences and dilemmas in situations when, for example, a patient, or their family, refuses treatment; demands treatment when treatment is not in the best interest of the individual; access to a service is denied; confidentiality issues; denying access to the health record of a family member. The resolution of any raised ethical dilemmas is in accordance with any national legislation that may exist. The process includes the timeframes for responding to any raised ethical dilemmas to ensure that these are managed as quickly as possible, this is especially important if the patient is at risk and escalated within the healthcare facility if required. It is important that staff receive training on the complexities of treating and caring for the diverse population and people of determination.

Patients and their families are required to respect staff, the facility, comply with treatment recommendations, attend appointments and communicate when not able to attend. Any patient who leaves the healthcare facility against medical advice shall absolve the healthcare facility of any consequences from this.

Measurable elements

B4.1.1.1 There is a documented Patients’ Rights and Responsibilities Charter.

B4.1.1.2 The Patient Rights and Responsibilities Charter is made public, either through posters or leaflets or on the facility’s website.

B4.1.1.3 The healthcare facility charter requires staff to behave at all times with courtesy, respect, dignity, confidentiality and discretion in their dealings with patients and families.

B4.1.1.4 The healthcare facility train staff to recognize and respond to the particular emotional and physical needs of patients with special needs including people of determination.

B4.1.1.5 There are processes in place so that staff can ensure the personal dignity of patients is always respected and responded to.

B4.1.1.6 The healthcare facility implements processes to reduce physical, cultural, and other barriers to access and delivery of services. See guidance for further examples.

B4.1.1.7 The healthcare facility has interpreters (including access to sign language interpreters) or systems in place to facilitate translation to overcome language barriers.

B4.1.1.8 The healthcare facility implements a process that recognizes the cultural, religious and spiritual needs of patients. See guidance for further examples.

B4.1.1.9 The healthcare facility has a process to meet any raised ethical consequences and dilemmas (see guidance for further information).

B4.1.1.10 There is a process for the review and conclusion of any raised ethical dilemmas includes the timeframe to investigate and for resolution.

B4.1.1.11 There is evidence that staff receive training on the Patient Rights and their responsibilities in adhering to these.

B4.1.1.12 There is a procedure for the management of patients who wish to ‘leave against medical advice’ which includes how this is documented and the requirements for patients to absolve the healthcare facility from any consequences.

(C) B4.1.2 Patient and family are provided with information prior to or on admission about the proposed care, the expected outcomes of that care, and any expected cost to the patient for the care.[1]

Guidance

The information is based on the best available evidence of effective and appropriate interventions. The materials are written in concise, non-technical language that is easy for people who are not health care professionals to understand. Where appropriate, patients are sent information about treatment options in advance of their appointment, for non-emergency conditions, to enable them to discuss these treatment options. If information cannot be sent in advance, enough time is allowed in the consultation appointment for a full explanation and discussion of the material. The information materials are then available for the patient to take home. Information is available in a variety of accessible formats such as braille, large print, or electronic formats and languages. Staff are given training such as the "teach-back method" to check the patients understanding of the education given. The teach-back method asks patients to state in their own words what they need to know or do about their health and helps confirm that the teaching has been given in a manner patients understand. The related show-me method allows staff to confirm that patients are able to follow specific instructions (for example, how to use an inhaler correctly by asking them to demonstrate how to use it).

Measurable elements

B4.1.2.1 The healthcare facility provides a wide range of evidence-based, up-to-date educational resources in a range of formats to assist patients in their choice of treatment options.

B4.1.2.2 The healthcare facility provides a range of health promotion support initiatives, for example, smoking cessation, weight management.

B4.1.2.3 The healthcare facility provides a range of educational resources that addresses the different cultural beliefs and values to meet the needs of the diverse population it serves.

B4.1.2.4 There is current information for patients informing them of the right to be given a clear explanation of their condition and any treatment, investigation or procedure proposed, including risks and alternatives, before agreeing on the course of action to be taken.

B4.1.2.5 There is information informing the patient and family about their rights and responsibilities related to refusing or discontinuing treatment.

(D) B4.1.2.6 Staff are trained to use the techniques to check that the education and information given to patients about their healthcare has been understood.

B4.1.2.7 Patients are given information on the cost of proposed treatment regimes.

(M) B4.1.3 Sick leave reports are issued in accordance with clinical evidence, professional and ethical practices. It is documented and reported as per DOH regulation.[2]

Guidance

A patient may be required by their employer to provide a doctor's certificate if they cannot attend work.

Measurable elements

B4.1.3.1 A sick leave report is issued after a physical examination of the patient carried out in person or through the telemedicine service.

B4.1.3.2 The physician only provides a sick leave report for patient conditions that fall within their specialty, scope of practice and privileges.

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[1] **References for B4.1.2:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- DOH Standard for Centres of Excellence in the Emirate of Abu Dhabi, 2019

[2] **References for B4.1.3:**

- Department of Health: Standard for the Issuance and Attestation of Sick Leave reports in the Emirate of Abu Dhabi CCR/STD/IASLP/1.0
- https://u.ae/en/information-and-services/jobs/types-of-leaves-and-entitlements-in-the-private-sector/sick-leave"

B4.1.3.3 Sick leave reports are not issued before the date of actual consultation, retrospectively or backdated.
B4.1.3.4 Sick leave reports issued to patients are reported to the DOH using the electronic sick leave system.
B4.1.3.5 All sick leave reports are documented in the patients' files.

B4.2 Patient consent processes

(M) B4.2.1 Patient informed consent is obtained through a process defined by the healthcare facility and carried out by trained staff.[1]

Guidance

Consent before treatment is a legal requirement and is an important part of the discussion and decision-making during the provision of health care services. All healthcare professionals work in partnership with their patients and discuss with them their condition and treatment options in a way that can be understood by the patient. Health care professionals always respect the patient's right to make decisions about their care.

Eligibility for giving consent is in accordance with local and national laws (see References). The healthcare facility identifies the circumstances for which consent is obtained and includes clinical and non-clinical interventions, for example, photographic and audio-visual recording. The person obtaining consent, where possible, is the person performing the procedure or investigation and give a clear explanation to the patient or their consent giver and be confident that they have understood the explanation and are aware that consent can be withdrawn. The policy includes the procedures for which consent is required and who may and may not give consent, these are generally invasive procedures or those of high risk, such as anesthesia, chemotherapy, radiation therapy, IVF, etc. The policy includes the actions to take when the patient does not have the capacity to consent for themselves, for example, if they are unconscious. Consideration is also given to those circumstances where an intervention needs to be undertaken on a patient who does not have the competency to give consent and the treatment is considered essential and in the best interests of the patient, for further information see HAAD Guidelines for Patient Consent, 2016.

Measurable elements

B4.2.1.1 There is a documented policy and procedure for obtaining valid informed consent from patients undergoing investigations and procedures (see guidance).
B4.2.1.2 The procedure includes the processes for gaining consent for patients, who may give consent and under what circumstances, for example, consent for children.
B4.2.1.3 The procedure includes the processes for gaining consent for patients who lack capacity and or competency.
B4.2.1.4 Staff receive training in the implementation of the consent policy and procedures.
B4.2.1.5 Patients and their family are informed about potential benefits, likelihood of successful results and disadvantages of the proposed treatment(s) and about possible results of non-treatment, prior to signing consent.
B4.2.1.6 Standardized format for consent forms are used throughout the healthcare facility.
B4.2.1.7 Signed consent forms are kept in the patient's medical record.

Documentary evidence required:

B4.1.1.1 Patients' Rights and Responsibilities agreement.

[1] **References for B4.2.1:**

- HAAD Guidelines for Patient Consent, 2016
- Abu Dhabi Department of Health, Healthcare Providers Manual, 2017
- DOH Standard for Centers of Excellence in the Emirate of Abu Dhabi, 2019
- Abu Dhabi Department of Health, Standard on Tele-Medicine, September 2020

B4.1.1.12 The procedure for the management of patients who wish to 'leave against medical advice'.
B4.1.3.1 Policy and procedure for obtaining valid informed consent.
B4.1.3.6 Standardized consent form.

Suggested personnel to work with the standards:
Medical director
Nursing director
Unit doctors
Unit nurse

SECTION B5 PATIENT MEDICATION

Overview
This section deals with the medication process and includes prescribing and administration of medication only. The governance of the management of medication and the Pharmacy is in Section D1.

B5.1 Administration of medication

(M) B5.1.1 Medication administration is performed safely.[1]

Guidance
Errors are common as medications are procured, prescribed, dispensed, administered, and monitored but, they occur most frequently during the prescribing and administering actions. The healthcare facility shall put in place processes to mitigate medication errors and promote the ethic of the right medication administered to the right person in the right dose and by the right route. The processes include who may prescribe medications, the agreed use of drug names and guidance on how to use trade and generic drug names, how units of measure are to be used and specification of agreed use of symbols and acronyms. Particular care shall be taken when using high risk drugs and concentrated electrolyte solutions.
Medicines Reconciliation is a process designed to ensure that all medication a patient is currently taking is accurately documented and any further prescribed on admission and at each transfer of care. Medicines Reconciliation on admission is the act of ensuring that "medicines prescribed on admission correspond to those that the patient was taking before admission." The policy/procedure on medicines reconciliation specifies the responsibilities for the process, timescales and strategies for obtaining medication information from patients with communication difficulties. The procedure details the information regarding medication history that has to be taken at admission including allergies.
Where patients are allowed to self-medicate there is a policy that sets out how the facility determines who may self-administer and how they assess patient's competence, what drugs may be self-administered, who supplies the drugs, where the drugs are kept.

Measurable elements
B5.1.1.1 There is a documented procedure for prescribing medication which includes:

a) Who may prescribe medications,
b) The agreed use of drug names and guidance on how to use trade and generic drug names,
c) How units of measure are to be used, and

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[1] **References for B5.1.1:**

- World Health Organization: Patient Safety Solutions numbers 1.5.8.
- Department of Health: Standard on Reporting Medication Errors, 2019
- HAAD Standard for Managing the Supply and Safe Use of Medications in Licensed Healthcare Facilities, 2016
- Department of Health: Standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization,2021

d) Specification of agreed use of symbols and acronyms.

B5.1.1.2 Prescribers have access to the most current and relevant drug information sources.

B5.1.1.3 All staff who prepare and administer medication are trained and receive regular update training. Attendance at training is recorded.

B5.1.1.4 There are documented procedures for the administration of medicines, which includes, but is not limited to the five rights of medicine administration (points a – e):

a) Checking the patient identification,
b) Checking the right drug,
c) Checking the right route,
d) Checking the correct dose,
e) Checking the right time,
f) The use of pre-prepared syringes, if used,
g) Who may administer medications,
h) The person who prepares the medication labels it and this is independently double-checked prior to administration,
i) Second person checks.

B5.1.1.5 There is a documented list of drugs and routes that require a second person check. This includes all the high alert drugs, controlled drugs, look-alike sound-alike drugs, cytotoxic drugs, and intravenous and epidural routes (see also D1.1).

B5.1.1.6 There is a documented policy and procedure for medicines reconciliation of all patients at initial appointment, on admission and transfer to alternative level of care.

B5.1.1.7 There is a policy and procedures to improve the safety of high-alert medications, for example, concentrated electrolytes and cytotoxic drugs. The policy and procedure include labelling, storage and witnessing the administration (see also D1. Pharmacy and Medication).

B5.1.1.8 Medication effects on patients are monitored and adverse effects, including anaphylaxis, managed as soon as possible. Adverse effects are recorded in the patient's medical record.

B5.1.1.9 There are processes in place to reduce incidents of medication omissions, that is prescribed drugs not being administered.

B5.1.1.10 There are systems in place for the secure storage of drugs in all services and units.

B5.1.1.11 There is a policy and procedure for patients who self-administer medication.

B5.1.1.12 Information is given to patients about the use, benefits and potential harm of medicines prescribed.

B5.1.1.13 The labels for take home use contain accurate information about the patient, dose frequency, expiry dates and any precautions.

Documentary evidence required:

B5.1.1.1 Procedure for prescribing medication.

B5.1.1.4 Procedures for the administration of medicine.

B5.1.1.5 Policy and procedures to improve the safety of high-alert medications.

Suggested personnel to work with the standards:

Medical director
Nursing director
Unit doctors
Unit nurse
Pharmacist

SECTION B6 PROCESSES FOR THE MANAGEMENT OF BLOOD AND BLOOD PRODUCTS

Overview

This sub-section deals with the collection of blood (phlebotomy) for diagnostic tests and sampling prior to blood transfusion processes. The transfusion of blood is carried out in accordance with good practice and the requirements of the Health Authority of Abu Dhabi (HAAD) Clinical Laboratory Standards.

B6.1 Safe collection of blood

(C) B6.1.1 The healthcare facility has processes to perform blood sample collection (phlebotomy) which is safe for patients and healthcare workers.[1]

Guidance

Phlebotomy is performed to provide diagnostic or therapeutic monitoring information, including the provision of compatible samples for blood transfusion. It is essential that samples obtained are accurate and representative of the patient's true condition and free from artefacts. Correctly matching patient details to the blood sample(s) is vital. Only licensed and trained staff undertake phlebotomy and work within the documented. policies and procedures.

Staff undertaking phlebotomy monitor the patient carefully to monitor for any adverse event such as fainting, nausea and have equipment at close hand to deal with such an event.

Measurable elements

B6.1.1.1 There are documented procedures for the collection of blood for testing which includes but is not limited to:

a) Checking patient identification with a minimum of two unique identifiers,
b) Consent,
c) Performance of the venipuncture,
d) Insertion of a vascular access device e.g., cannula,
e) Maintaining asepsis,
f) After care of the patient,
g) Providing education and information.

B6.1.1.2 There is a process for checking that the correct collection tubes are used for the tests requested.

B6.1.1.3 There is a system for labelling and transporting the blood tubes from the patient to the laboratory.

B6.1.1.4 A spillage kit is available wherever venipuncture is undertaken.

B6.1.1.5 There are procedures for the management of the patient suffering an adverse event during phlebotomy.

B6.1.1.6 There is a documented procedure for the collection of blood from patients with a communicable disease.

B6.2 Safe transfusion of blood and blood products

(M) B6.2.1 The healthcare facility has systems to provide the safe transfusion of blood and blood products.[2]

Guidance

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[1] **References for B6.1.1:**

- World Health Organization: Guidelines on Drawing Blood, 2010
- Health Authority of Abu Dhabi: Guidelines for Patient Consent, 2016
- Ministry of Health & Prevention: Clinical Laboratory Regulation, 2016

[2] **References for B6.2.1:**

- Ministry of Health & Prevention: Clinical Laboratory Regulation, 2016
- Health Authority of Abu Dhabi (HAAD) Clinical Laboratory Standards, 2011
- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee

Errors in any stage of the blood transfusion process can lead to significant risk for patients. It has been shown that the transfusion of the incorrect blood component incidents is mainly due to human error[1] and can lead to life-threatening hemolytic transfusion reactions and other significant morbidities. This element aims to ensure that the service Is provided by qualified/experienced staff within an environment where the risk to patients is minimal**.** The Department of Health has developed a set of standards for clinical laboratories which includes the transfusion process. The healthcare facility is required to audit its transfusion process against these standards.

This standard statement is assessed with the Laboratories sub section of the Clinical Support services section D4.

Measurable elements

B6.2.1.1 The healthcare facility has audited the transfusion process against the Department of Health Clinical Laboratory Standards (HAAD Clinical Laboratory Standards) (see also D.4).

B6.2.1.2 There is an action and improvement plan arising from the audit of the clinical laboratory standard.

B6.2.1.3 There is a documented procedure for transfusing blood and blood products to patients who cannot confirm their own identity, for example unconscious patients or those with communication difficulties.

B6.2.1.4 There are systems in place to make staff aware of those patients who do not wish to be transfused for religious, cultural or personal reasons, see also B4.1.1.9.

B6.2.1.5 There is evidence that patients are fully informed of the risks and benefits prior to signing consent for a blood transfusion.

B6.2.1.6 There is a system for the recall of any suspect blood products or reagents following an adverse reaction in cases which may be attributed to the donation process.

B6.2.1.7 There is a documented procedure for the management of any adverse events or reactions during and after the transfusion process. It includes the monitoring of patients and how any untoward events (including suspected adverse reactions) are immediately clinically managed and promptly recorded and reported.

(D) B6.2.1.8 The healthcare facility is working towards or has implemented international standards, for example AABB standards for Blood Bank and Transfusion services, CAP transfusion medicine checklist.

Documentary evidence required:

B6.1.1.1 Procedures for the collection of blood for testing

B6.1.1.5 Procedure for the collection of blood from patients with a communicable disease

Suggested personnel to work with the standards:

Medical director
Nursing director
Unit doctors
Unit nurse
Blood bank manager or equivalent

[1] Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee

CHAPTER C. SAFETY

Overview

The Government of Abu Dhabi is committed to protecting and promoting human health and safety for all inhabitants of the Emirate. Employers are obliged to provide a safe and appropriate work environment for their employees[1] through the implementation of an occupational safety and health system and ensuring that the premises and equipment within it are fit for purpose.

Patient safety is a key component of any healthcare facility and a patient safety framework of organized activities that creates cultures, processes, procedures, behaviors, technologies and environments that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur[2].

This section deals with the requirements to provide a safe environment for staff, patients, visitors and contractors to the healthcare facility and that treatment and care is delivered in a safe environment with well-managed and maintained equipment.

This section should be assessed in conjunction with sub-section A3. Risk Management

SECTION C1 OCCUPATIONAL SAFETY AND HEALTH SYSTEM

Overview

This section deals with the occupational safety and health system in compliance with the existing OSHAD-SF requirements. It does not duplicate the requirements but looks at outcomes and ongoing compliance with the national requirements.

C1.1 Implementation of the Occupational Safety and Health Management System (OSHMS)

(M) C1.1.1 The healthcare facility has an established and implemented Occupational Safety and Health Management System (OSHMS) which meets Department of Health standards, the Abu Dhabi Occupational Safety and Health System Framework (OSHAD – SF), and federal & local law.[3]

Guidance

An OSHMS is a framework that allows an organization to consistently identify and control its health and safety risks, reduce the potential for incidents, help achieve compliance with health and safety legislation and continually improve its performance.

There are documented policies and procedures which support the OSH system. The policy should include how the elements of the OSHAD-SF are addressed. The operational procedures will cover facility wide processes and specific departmental processes and include control measures to manage any risks.

[1] Clause 13 of Article 13 of Federal Decree Law No. 33 of 2021 on the Regulation of Labor Relations in the Private Sector

[2] Patient Safety Fact Sheet, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/patient-safety

[3] **References for C1.1.1:**

- Clause 13 of Article 13 of Federal Decree Law No. 33 of 2021 on the Regulation of Labor Relations in the Private Sector (the UAE Labor Law)
- Patient Safety Fact Sheet, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/patient-safety
- Administrative Decision no. (28) of 2022 concerning occupational health & safety & labor accommodations.
- Decree No (42) for 2009 on the Environment, Health and Safety Management System (EHSMS) of the Emirate of Abu Dhabi
- OSHAD – SF, 2017, Element 1: Roles and Responsibilities
- OSHAD – SF, 2017, Element 9: Compliance and Management Review

Measurable elements

C1.1.1.1 There is evidence that the Senior Individuals support the OSH system through the provision of financial, professional, organizational and training resources.

C1.1.1.2 A designated member of the Senior Individuals has responsibility for the management of OSH system in the healthcare facility.

C1.1.1.3 There is an OSH officer responsible for the day-to-day management of the OSH system in the healthcare facility.

C1.1.1.4 The healthcare facility has a documented OSH policy, dated and signed by the designated Senior Individual, which establishes the key management commitments, relevant laws and national requirements and the arrangements and responsibilities for the OSH system.

C1.1.1.5 There are documented operational procedures both facility wide and specific to departments and areas to support the implementation of the OSH policy.

C1.1.1.6 The OSH policy is reviewed annually, and when there are significant changes to the OSHAD -SF and laws.

C1.1.1.7 The OSH policy is available and communicated to all employees and stakeholders.

C1.1.1.8 There is evidence that the management of the OSH system is an agenda item at Senior Individuals management meetings.

(D) C1.1.1.9 There is evidence that OSH is an agenda item at departmental meetings.

(C) C1.1.2 The healthcare facility has initiatives in place to protect staff from occupational harm.[1]

Guidance

Employers have a duty of care for their employees and must assess the risk of occupational harm to their staff and put in place initiatives to control and reduce that harm. This includes undertaking risk assessments of the working environment, in addition to the OSH audits and inspections. The healthcare facility must provide personal protective equipment (PPE) suitable for the environment and specific duties. This includes, for example, the provision of medical grade face masks where patients with infectious diseases are treated, vinyl gloves and eye masks.

Measurable elements

C1.1.2.1 Specific risk assessments are undertaken where there may be an increased occupational risk to staff, for example, when a staff member becomes pregnant or where staff with sensory impairments work.

C1.1.2.2 Staff are provided with the personal protective equipment (PPE) that is suited for their role.

C1.1.2.3 There are initiatives in place to reduce musculo-skeletal injuries among staff.

C1.1.2.4 All staff receive mandatory manual handling training.

(M) C1.1.3 The healthcare facility monitors factors that contribute to the occupational health and safety and wellbeing of the personnel in the facility.[2]

Guidance

The healthcare facility monitors those factors that form part of the Environmental Health and Safety management system including the water and air quality, noise light, the storage and use of hazardous substances, ergonomic workplace practices and occupational illnesses, including, for example, needlestick injuries, musculo-skeletal problems and healthcare facility acquired infectious diseases.

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[1] **References for C1.1.2:**

- Clause 13 of Article 13 of Federal Decree Law No. 33 of 2021 on the Regulation of Labor Relations in the Private Sector (the UAE Labor Law)

[2] **References for C1.1.3:**

- OSHAD – SF Element 07 – Monitoring, Investigation and Reporting

A multidisciplinary walk around the facility assists in the review of the estate including signage, lighting, environment, security, access and considerations for people of determination, fire escapes and systems, state of the structure and décor, (see also A4.1.).

Measurable elements

C1.1.3.1 There is evidence of monitoring of the environmental health and safety factors.

C1.1.3.2 There is evidence that nonconformities of any environmental health and safety factors are investigated and corrected.

C1.1.3.3 The facility monitors the incidence of healthcare acquired illness due to failures of the environmental systems.

C1.1.3.4 The facility monitors incidence of occupational acquired illness and healthcare issues.

C1.1.3.5 There is a plan and processes in place to address the health and safety of staff through assessment and reduction of occupational health and safety risks.

(D) C1.1.3.6 There are regular documented environmental walk arounds describing findings and actions taken.

(M) C1.1.4 The healthcare facility has an annual OSH audit and inspection schedule.[1]

Guidance

Ideally the audits are based on the plan-do-check-act methodology and objectively determine compliance with audit criteria. A risk-based audit examines the inherent risks the healthcare facility faces and then seeks to correct and reframe the controls according to what risks are the most urgent and have the most potential for loss or harm. This is different to auditing compliance with existing controls.

Inspections refer to the critical examination of work tasks, facilities and equipment to determine conformance against policies and legal requirements.

Audit and inspection procedures include the scope, the criteria and objectives, frequency, responsibility, conformance and corrective actions, and reporting mechanisms.

External auditors conducting the third-party annual audits must be approved by OSHAD.

Measurable elements

C1.1.4.1 The healthcare facility has developed and implemented OSH risk-based audit procedures.

C1.1.4.2 The internal OSH audits include compliance to OSHAD-SF requirements, legal requirements, and requirements of the healthcare facility.

C1.1.4.3. There is evidence that the third-party auditors and internal auditors are qualified to conduct audits.

C1.1.4.4 There is evidence of an annual third party full, facility wide audit of the facility's OSH management system.

(D) C1.1.4.5 Audit, inspection reports are made available and circulated to all the stakeholders, once completed.

(M) C1.1.5 The healthcare facility has a systematic process for managing non-conformities against the OSHAD-SF.[2]

Guidance

A non-conformity may arise as a result of audit and inspections, complaints or incidents. There should be procedures for the actions to take when a non-conformity is raised which includes the investigations to do, the

[1] **References for C1.1.4:**

- OSHAD – SF, 2017, Element 08 – Audit and Inspection
- OSHAD – SF, 2017, Mechanism 6.0 – OSH Performance Monitoring & Reporting

[2] **References for C1.1.5:**

- OSHAD – SF, 2017, Element 08 – Audit and Inspection
- https://www.iso9001help.co.uk/index.html

corrective actions that need to be put in place, monitoring the corrective actions and responsibilities. See also A5.1: Quality Management.

Measurable elements

C1.1.5.1 The healthcare facility has a documented, systematic non-conformance and corrective actions process which includes:

a) Investigation and investigative methods,
b) Recording the non-conformity,
c) Evaluating, communicating and implementing corrective actions,
d) Reviewing the effectiveness of corrective action,
e) Closure of the non-conformity.

C1.1.5.2 A central register is maintained to record all non-conformities raised, the corrective actions, monitoring, timescales, closure and responsibilities.

(M) C1.1.6 The healthcare facility maintains a register of all legal requirements relevant to the OSHMS.[1]

Guidance

Compliance with legal requirements is a fundamental obligation of the OSHMS and it is therefore necessary to ensure that these are known, particularly changes and new legal requirements.

Measurable elements

C1.1.6.1 The healthcare facility maintains an up-to-date register of applicable and implemented OHS laws and includes as a minimum:

a) The full title of the OSH law/regulation,
b) Applicable clause(s), article(s) or reference(s),
c) Applicable process / activity impacted by the legal requirement,
d) Internal OSH MS procedure(s) / document(s) reference(s) to ensure compliance,
e) Compliance monitoring requirements.

C1.1.6.2 The list is used to monitor the adherence.

C1.1.6.3 There is evidence that the register has been reviewed annually.

(M) C1.1.7 The healthcare facility conducts at least one planned full OSHMS management review meeting every year.[2]

Guidance

The Senior Individuals shall periodically review the management system to ensure its continuing suitability, adequacy, and effectiveness. The frequency or intervals of the management's formal review shall be defined.

The management review addresses the possible need for changes to policy, objectives, targets, resources and other elements of the management system.

Management review meetings provide useful insight into the operation of the OSH management system and its processes to enable the Senior Individuals to respond to issues and to recommend improvements.

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[1] **References for C1.1.6:**

- OSHAD – SF, 2017, Element 09 Compliance and Management Review

[2] **References for C1.1.7:**

- OSHAD – SF, 2017, Element 09 Compliance and Management Review
- https://www.iso9001help.co.uk/ISO-9001-management-review-procedure.html

Measurable elements

C1.1.7.1 The Senior Individuals have defined the frequency at which a review meeting is to be held.

C1.1.7.2 The management review meeting includes representation from the Senior Individuals.

C1.1.7.3 The Senior Individuals have identified key staff to attend the review meetings.

C1.1.7.4 The agenda for the management review includes:

a) Review of OSHMS by OSH staff,
b) Progress on actions from previous review,
c) Results of internal and external audits,
d) OSH performance against targets and objectives,
e) Changes to legal and other requirements,
f) Relevant communications and complaints,
g) OSH incidents, investigations, non-conformances and corrective actions,
h) The adequacy of resources for maintaining an effective OSHMS,
i) Other changes that impact the organization,
j) Recommendations for continual improvement.

C1.1.7.5 Minutes of the management review meetings are kept. The minutes include actions to be taken, timeframes and responsibilities.

(M) C1.1.8 The healthcare facility shall prepare an annual OSH performance report.[1]

Guidance

The performance report is to inform stakeholders how well the healthcare facility is managing its safety and health objectives. The report needs to include statistical data on, for example, incidents, complaints and non-conformities; performance against meeting targets and objectives; audit and inspection results; areas requiring improvement and also areas that have shown good or improved practice. If the report is made available to external stakeholders, the OSHAD-SF recommends third party verification of the contents.

Measurable elements

C1.1.8.1 The annual performance report includes as a minimum:

a) Incidents,
b) Complaints,
c) Non-conformities,
d) Performance against meeting targets and objectives,
e) Training and competency,
f) Contractors and contract performance,
g) Audit and inspection results,
h) Areas requiring improvement,
i) Areas that have shown good or improved practice.

C1.1.8.2 The annual report is approved and signed by the Senior Individuals.

(D) C1.1.8.3 The annual report is communicated internally.

Documentary evidence required:

C1.1.1.4 Occupational Safety and Health policy

C1.1.1.5 Operational procedures to support the OSH policy.

C1.1.5.1 Process for non-conformance and corrective actions.

C1.1.7.4 Agenda for OSH management review.

C1.1.7.5 Minutes of the OSH management review meeting.

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[1] **References for C1.1.8:**

- OSHAD-SF 2017, Element 04 Communication and Consultation

C1.1.8.1 Annual OSH performance report

Suggested personnel to work with the sub-section:
Senior manager for OSH
OSH manager
Nursing staff
Quality manager

SECTION C2 PATIENT SAFETY

Overview
Patient Safety is a health care discipline that emerged with the evolving complexity in health care systems and the resulting rise of patient harm in health care facilities. It aims to prevent and reduce risks, errors and harm that occur to patients during provision of health care. A cornerstone of this discipline is continuous improvement based on learning from errors and adverse events.
Patient safety is fundamental to delivering quality essential health services. Indeed, there is a clear consensus that quality health services across the world should be effective, safe and people-centered. In addition, to realize the benefits of quality health care, health services must be timely, equitable, integrated and efficient.[1]
The World Health Organization terminology in the 'Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care' have been used in this chapter.

This section addresses healthcare wide patient safety aspects and is assessed in conjunction with Chapter D, section D2 Infection Prevention and Control.

C2.1 Patient Safety Framework

(M) C2.1.1 The healthcare facility has a collaborative approach to Patient Safety.[2]

Guidance
A strategy defines the goals and objectives for patient safety. The implementation policy describes how the objectives will be achieved, responsibilities and accountabilities and performance indicators. Good practice would be to include the 7 strategic objectives of the World Health Organization's Global Patient Safety Action Plan.
Some patients are at higher risk than others, for example, pregnant women, young children, the elderly, those with weakened immune systems and those with three or more chronic diseases with functional limitations that impact their self-care and routine activities of daily living. It is useful to define these categories so that staff are aware of them and how to care for the individuals and manage any associated risks.

Patient safety incidents should always be reported in accordance with the Risk Management Policy (see Sub section A3). Near misses should also be reported as these provide good learning opportunities to proactively stop incidents occurring. A near miss is an unplanned event that has the potential to cause, but does not actually result in human injury, environmental or equipment damage, or an interruption to normal operation.

[1] World Health Organization, September 2019 https://www.who.int/news-room/fact-sheets/detail/patient-safety

[2] **References for C2.1.1:**
- Abu Dhabi Department of Health, Healthcare Regulator Manual November 17
- NHS, Never Events policy and framework Revised January 2018
- WHO: Global Patient Safety Action Plan, 2021
- York Teaching Hospital, NHS Foundation Trust, Patient Safety Strategy 2019 – 2024

Some incidents should never occur. These may be known as "never events". Never Events are defined as "Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers". Never events might include for example, wrong site surgery, retained foreign object post procedure, administration of medication by the wrong route.[1]

The Joint Commission defines a sentinel event as a "Patient Safety Event that reaches a patient and results in any of the following: Death, permanent harm, severe temporary harm and intervention required to sustain life" and requires immediate investigation.

Measurable elements

C2.1.1.1 There is a current documented and implemented patient safety strategy and implementation policy.

C2.1.1.2 The patient safety strategy and implementation policy include the initiatives in place to reduce harm to patients and staff (see C2.1.3).

C2.1.1.3 The patient safety policy includes as a minimum:

a) Defined goals and priorities
b) Categories of high-risk patients
c) Definitions of harm and sentinel events
d) Responsibilities
e) Training requirements
f) Reporting mechanisms
g) Lists of associated patient safety procedures
h) Communication
i) Performance indicators
j) The requirement to report all patient safety incidents and near misses in accordance with a3.3.

C2.1.1.4 The healthcare facility has a defined list of sentinel events.

C2.1.1.5 There is a system for receiving and implementing patient safety alerts from a national central source or product manufacturers.

(C) C2.1.2 There is evidence that the healthcare facility promotes a patient safety culture.[2]

Guidance

Generally, a safety culture is viewed as an organization's shared perceptions, beliefs, values, and attitudes that combine to create a commitment to safety and an effort to minimize harm (Promoting a Culture of Safety as a Patient Safety Strategy: A Systematic Review, Weaver et al.). In the simplest of terms, a safety culture is the combination of attitudes and behaviors toward patient safety that are conveyed when walking into a health facility.

A patient safety culture is multi-faceted and may be demonstrated by management involvement and commitment, staff commitment to patient safety, communication between leaders and all levels of staff, listening and acting on staff and patients' suggestions and acting on and learning from incidents and sharing good practice. Senior managers need to identify ways to gain information and suggestions from patients and staff about safety.

Measurable elements

[1] NHS, Never Events policy and framework Revised January 2018

[2] **References for C2.1.2:**

- Promoting a Culture of Safety as a Patient Safety Strategy: A Systematic Review: Annals of Internal Medicine: Vol 158, No 5_Part_2 March 2013, (acpjournals.org)
- National Patient Safety Agency (NHS), Manchester Patient Safety Framework (MaPSaF) (Acute), 2006
- https://www.hse.gov.uk/humanfactors/topics/common4.pdf
- Health Authority Abu Dhabi, Policy for Quality and Patient Safety, 2017

C2.1.2.1 Senior managers undertake patient safety walk arounds the facility.
(D) C2.1.2.2 There is evidence that senior managers receive and act on patients' suggestions for safety.
C2.1.2.3 There is evidence that senior managers receive and act on staff suggestions for safety.
C2.1.2.4 There is evidence of training for all staff on patient safety as part of induction and regular mandatory update training (see A4.3).

(M) C2.1.3 There are initiatives in place to reduce harm to patients.[1]

Guidance
The initiatives may be based on trends in incident reporting, clinical indicators, staff suggestions, recognised good practice. Examples might include, for example, an early warning system to recognise deterioration in patients, reducing patient falls by having non-slip flooring and grab rails, alarm pulls in bathrooms and toilets, etc.
Staffing levels to maintain patient safety is essential and consideration should be given to the number and competencies of staff required for each shift in each area. Consideration of the competencies should take into account the number and condition of patients; specialist equipment and what steps need to be taken if staffing levels cannot be attained. When harm has been caused to a patient it is important that the healthcare facility communicates this to the patient and their family. The policy should include the training requirements for imparting information, who is responsible for informing patients and carers, how the news is imparted and when, and what support can be provided to patients, carers and staff, reporting mechanisms to the DOH and associated regulatory authorities and how the learning from the risk is shared with other professionals. The documents should also specify what records are required to be kept about the incident and the information given to patients and carers.

Measurable elements
C2.1.3.1 There is evidence that the initiatives in the patient strategy to reduce harm to patients and staff that are being, or have been, implemented.
C2.1.3.2 Patient safety devices are installed throughout the healthcare facility.
(D) C2.1.3.3 Patients and families are involved in the development of patient safety initiatives.
C2.1.3.4 There is a documented policy for defining the number and competencies of staff required to maintain a safe service on each shift in the healthcare facility. The policy includes how this is monitored.
C2.1.3.5 There are mitigation measures in place when safe staffing levels cannot be attained.
C2.1.3.6 There is evidence that there are staff with Basic Life Support certification available on every shift in all clinical areas.
C2.1.3.7 There is evidence that there is at least one member of staff with Advanced Life Support certification on every shift in all clinical areas and on Pediatric units there is a staff member with Pediatric Advanced Life Support certification.
C2.1.3.8 There is a policy and procedure on communicating with patients and their families and carers when a patient has suffered harm as a result of healthcare treatment.
C2.1.3.9 Support and/or counselling is offered to patients, their families and carers who have suffered harm.
(D) C2.1.3.10 Support and/or counselling is offered to staff who have been directly involved in incidents of when a patient has been harmed.

(M) C2.1.4 The Healthcare Facility has developed an approach to improve the accuracy of patient identification.

[1] **References for C2.1.3:**
- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17
- The Shelford Group, Safer Nursing Care Tool, Implementation Resource Pack

Guidance

Throughout the health-care industry, the failure to correctly identify patients and patients' specimens and test results, continues to result in medication errors, transfusion errors, testing errors, wrong person procedures, and the discharge of infants to the wrong families[1].

Measurable elements

C2.1.4.1 There is a documented procedure to check the identification of patients, which includes:

a) The requirement for the use of two patient identifiers, not including the use of the patient's room number or location,
b) Those circumstances when a patient's identification is checked, for example, when administering medication, before an interventional procedure,
c) The actions to take if a misidentification occurs,
d) Specifies the actions to take to identify patients who lack capacity or are unconscious or sedated,
e) The requirement to include the two patient identifiers on all test specimens and imaging media.

C2.1.4.2 There is a documented procedure for the use of identification bands which includes:

a) The information on the identification band,
b) Who must wear an identification band,
c) Who may prepare and fit an identification band,
d) The use of alert stickers or color-coded bands,
e) Removal of the band.

C2.1.4.3 All misidentifications are reported as an incident or as a near miss incident, depending on the circumstances.

(M) C2.1.5 The healthcare facility has a developed approach to reduce the risk of patient harm resulting from falls.[2]

Guidance

Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall[1].

Healthcare facilities need to develop multidisciplinary policies and procedures to address the risk of patient falls. Policies should include preventative measures, multifactorial risk assessments and interventions that may include, for example, strength building, medication review and home assessments. The safety manager (or equivalent) is involved in the development of the policies and procedures.

[1] World Health Organization, Patient Safety Solution 2: Patient identification, 2007

[2] **References for C2.1.5:**

- National Institute for health and Care Excellence (NICE), 2022
- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018
- National Institute for health and Care Excellence (NICE), Falls in older people: assessing risk and prevention, 2022
- https://stem.doh.gov.ae/HealthFacilityGuidelines/

Measurable elements

C2.1.5.1 There is a multidisciplinary policy and associated procedures for the assessment and management of the risk of patient falls.

C2.1.5.2 The initial assessment of patients includes a multifactorial assessment of their risk of falls and includes:

a) History of falls,
b) Assessment of gait and muscle weakness,
c) Visual and cognitive impairment,
d) Assessment of urinary continence,
e) Medication review.

C2.1.5.3 The assessment of the patient's risk is reviewed when circumstances change, for example, medication changes, change in condition, or after a fall.

C2.1.5.4 There are initiatives in place to reduce the risk of falls. These might include, for example, non-slip flooring, correctly fitting footwear.

C2.1.5.5 Patients at risk of falls are offered interventions to reduce the risk.

(D) C2.1.5.6 The family and carers of patients at risk of falls are involved in the development of interventions to prevent falls.

C2.1.5.7 All patient falls are reported as an incident.

(C) C2.1.6 There are procedures to follow in the case of a missing patient.

Guidance

There are many circumstances why a patient may not be where they are expected to be, and the risk depends on the individual patient and their condition. Vulnerable individuals such as people of determination, the young, the elderly and those with mental health, sensory or physical health problems are required to be safeguarded against harm, abuse and neglect and may be at high risk if they are missing.

Measurable elements

C2.1.6.1 The procedure to follow in the case of a missing patient includes:

a) Immediate actions to take when staff first notice a patient is not where they are expected to be,
b) A risk assessment of the patient who is missing, including their level of independence, mobility and mental health status, including any capacity or safeguarding issues,
c) Those who need to be notified, including the police and family or carers.

C2.1.6.2 All cases of a missing patient are reported as an incident and investigated.

(M) C2.1.7 The healthcare facility has a developed approach to improve the effectiveness of communication among caregivers.[1]

Guidance

Verbal orders may be necessary in certain situations such as emergencies and during sterile procedures. However, there are risks to patients associated with verbal orders being misunderstood, misheard, or transcribed incorrectly. Reducing such errors is particularly important when medication is being ordered or changed, but there may also be consequences if tests are being requested or results are being received. The healthcare facility should provide rules on the circumstances by which verbal orders may be given and the necessary actions of those taking the order to ensure accuracy. Verbal orders may be given face-to-face or over the telephone.

[1] **References for C2.1.7:**

- https://www.ismp.org/sites/default/files/attachments/2018-03/NurseAdviseERR201706.pdf

Measurable elements

C2.1.7.1 There is a policy and procedure that sets out how staff are expected to ensure the accuracy of verbal and telephone communications.

C2.1.7.2 The policy specifies the circumstances under which verbal orders may be given.

C2.1.7.3 The policy defines the circumstances under which verbal orders may never be given.

C2.1.7.4 All verbal and telephone orders or test requests or test results are written down by the receiver.

C2.1.7.5 The complete verbal and telephone order or test result is read back by the receiver of the order or test result.

C2.1.7.6 The order or test result that is read back is confirmed by the individual who gave the order or test result.

C2.1.7.7 All errors that occur as a result of a verbal order or test result being placed are reported in accordance with the healthcare facility's risk management system.

(D) C2.1.7.8 The healthcare facility undertakes an audit of the implementation of the policy.

Documentary evidence required:

C2.1.1.1 Patient safety strategy and implementation policy.

C2.1.3.4 Policy for defining the number and competencies of staff required to maintain a safe service.

C2.1.3.8 Policy and procedure for communicating with patients their families and carers when a patient has suffered harm as a result of healthcare treatment.

C2.1.4.1 Procedure for checking patient identification.

C2.1.4.2 Procedure for the use of identification bands.

C2.1.5.1 Policy and procedures for assessment and management of patient falls.

C2.1.6.1 Procedure for missing patient.

C2.1.7.1 Policy and procedure for verbal and telephone communications.

Suggested personnel to work with the standards:

OSH staff

Senior nurses

Facilities manager

Human resources representative

SECTION C3 PREMISES MANAGEMENT

Overview

The healthcare facility's premises, estate (grounds) and facilities are maintained to provide a safe, fit for purpose and clean environment for patients, staff, visitors and contractors. A safe, functional and effective environment for all patients, staff and other individuals is crucial to prevent or minimize risks. The facility is required to comply with the UAE Federal Law No. 13 of 2020 to meet the requirements of people with determination to ensure that the environment meets their needs, this includes the design of spaces where people of determination attend, for example, space to accommodate wheelchairs, elevators with announcements, Braille, hearing loops, signage using colors for the visually impaired and so on, Further information is included on the needs of people of determination in B4.1.1. The Senior Individuals provide support and resources to enable a safe environment in accordance with regulatory requirements.

C3.1 Management

(C) C3.1.1 There are systems in place for the management and maintenance of the facility's premises and plant.[1]

Guidance

There may be a manager who has responsibility for the maintenance and management of the premises. The strategy defines the management of the environment, functional suitability, space utilization, investment, maintenance, disposal of surplus property and performance targets. The plan outlines the work for the year including building work, maintenance, refurbishment, gardening, surveys and audit plans.

Measurable elements

C3.1.1.1 There is a manager with responsibility for the operational day-to-day running of the premises with reporting requirements to the Senior Individuals.
C3.1.1.2 There is a strategy and operational plan written in accordance with the healthcare facility's overall strategic aims for the management of the premises, estate and facilities.
C3.1.1.3 There is a system to access and implement new, and changes to, legislation and guidance pertaining to facilities, buildings, equipment and the environment.
C3.1.1.4 The healthcare facility keeps and maintains up to date site drawings which detail the site layout, floor plans, fire zones and escape routes, infrastructure services, for example, water, gas electricity and drainage.
C3.1.1.5 There is a documented procedure for reporting defects both in and out of normal office hours which includes how tasks are to be prioritized and how status of the task is fed back to the person reporting the defect.
(D) C3.1.1.6 Response times from receipt of a reported defect to implementation of corrective action are monitored.
C3.1.1.7 Where the maintenance of the premises is outsourced, the performance of the contractors is monitored and reviewed (see also A2.5).
C3.1.1.8 There are procedures for maintaining and testing contingency arrangements for major plant failure, which are in accordance with the Major Incident policy (see A1.4).

(M) C3.1.2 The healthcare facility has an established and documented safe system of work (SSoW).[2]

Guidance

As part of the healthcare facility's commitment to providing a safe environment, there should be a formal written system used to control certain types of work, which are potentially hazardous, and risk assessed. As part of this, the healthcare facility needs to implement a Permit to Work system, which aims to ensure that proper consideration is given to the risks of specific work and who the work effects. This will ensure that the risks are dealt with prior to work commencing. The documented formal system identifies the responsibilities of the healthcare facility and contractors, including designated personnel who may issue Permits to Work; types of permits that may be issued, for example, hot work, cold work, electrical; the use of lockout/tagout devices to control hazardous energy when working on electrical equipment; the systems in place for restricting access to areas where work is being carried out, which may just be signage.

[1] **References for C3.1.1:**

- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018
- OSHAD – SF, 2017, Element 3: Management of contractors
- UAE Federal Law No. 13 of 2020

[2] **References for C3.1.2:**

- OSHAD – SF, 2017, Element 3: Management of Contractors

Measurable elements

C3.1.2.1 There is a policy and procedures defining the safe systems of work, including responsibilities.

C3.1.2.2 There is a documented procedure for issuing a Permit to Work. This may be in the form of a process chart.

C3.1.2.3 There is evidence that a risk assessment has been undertaken prior to Permits to Work being issued.

C3.1.2.4 There is a process for the use of lockout/tagout devices to control hazardous energy when working on electrical equipment.

C3.1.2.5 There is a procedure for checking and authorizing the handover by the contractor of equipment and premises as safe to use after work has been carried out.

C3.1.2.6 There are systems in place for restricting access to areas where work is being carried out, which may just be signage.

(M) C3.1.3 The physical environment of the healthcare facility premises is clean, safe, secure and accessible.[1]

Guidance

The environment is clean, ventilated, spacious and movement of people unimpeded, access to emergency exits is kept clear, access for" people of determination" meets the required standard, including ramps, handrails, wide corridors, lifts where patients are required to go above the ground floor, doorways wide enough to take wheelchairs, adapted toilets and bathrooms, in line with the physical requirements of the patient profile.

Measurable elements

C3.1.3.1 There is evidence that the healthcare facility meets the requirements for space and dimensions as specified by the DOH Health Facility Guidelines. This might be a third-party inspection report.

C3.1.3.2 Corridors are kept clear of obstructions to free movement of people and portable equipment.

C3.1.3.3 There is access to the facility for people of determination which might include, for example, specific parking bays close to the entrance, non-slip ramps, handrails, waiting areas with different seating heights and spaces for wheelchairs, see guidance for further information.

C3.1.3.4 The healthcare facility adheres to illuminance levels associated to clinical units as recommended in DOH Health Facility Guidelines 2019 Part-E – Engineering.

(M) C3.1.4 The electrical supply, distribution and maintenance meets the requirement of the differing clinical risk levels A – E.[2]

Guidance

The healthcare facility needs to consider the risk of loss of supply in two main elements: clinical risk (subdivided into patient and non-patient areas); and non-clinical business continuity risks (subdivided into medical services and engineering services). The consequence of a power failure is assessed and graded against a broad range of patient groups from ambulant to critical, grade A being life support and complex surgery needs; grade B areas where treatment and patient safety may be compromised; Grade C areas where treatment and patient safety may not be immediately compromised; Grade D where there would be no direct compromise to treatment and safety, and Grade E being support services and circulation with no immediate effect on treatment and safety.

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[1] **References for C3.1.3:**

- https://stem.doh.gov.ae/HealthFacilityGuidelines/
- Building Regulation & Facilities for The Disabled United Arab Emirates Code requirements
- DOH Health Facility Guidelines 2019 Part-E – Engineering.
- UAE Federal Law No. 13 of 2020

[2] **References for C3.1.4:**

- Abu Dhabi Department of Health, Health Facility Guidelines 2019 Part-E – Engineering: Electrical Service
- UK Department of Health, Health Technical Memorandum 06-01: Electrical services supply and distribution, 2017 edition

Consideration should also be given to business services that may be affected by an electrical supply loss and may be graded from IV, which may include stores, workshops to risk grade I, which may include laboratories, and medical records. For further information on the clinical risk grades, see table: E.3.1 Clinical Risk Grading in the Abu Dhabi Department of Health, Health Facility Guidelines 2019 Part-E – Engineering: Electrical Service.
Tertiary and secondary back up power supplies are available, and these are tested on a regularly scheduled basis with minimal disruption to users.

Measurable elements
C3.1.4.1 The healthcare facility has undertaken a risk assessment on the arrangement of power back-up requirements associated with clinical and business continuity risk mapping, using clinical risk grades A-E and business continuity grades I – IV.
C3.1.4.2 An electrical power distribution strategy has been developed based on the risk assessment and clinical mapping and defines the backup power supplies required to reduce risk to agreed manageable levels.
(D) C3.1.4.3 The strategy is reviewed annually to monitor effectiveness.
C3.1.4.4 There is a published schedule of backup power supply testing.
C3.1.4.5 There is monthly planned maintenance of the Secondary and Tertiary Power Supply units or as recommended by the manufacturer whichever is for shorter period. All maintenance and inspection records are maintained.

(M) C3.1.5 The healthcare facility maintains a hygienic supply of water for clinical use.[1]

Guidance
Healthcare premises are dependent upon water to maintain hygiene and a comfortable environment for patients and staff, and for treatment and diagnostic purposes. Interruptions in water supply can disrupt healthcare activities.
Water to the healthcare facility may be supplied by different sources and include potable water and water systems. One of the biggest risks to the supply of good quality water comes from waterborne pathogens and healthcare facilities shall put in place strategies to monitor and address pathogen contamination quickly. Whilst Legionella control is, in the main, associated with poor engineering configuration and maintenance, Pseudomonas Aeruginosa may be transferred to and from outlets and from one person to another through contaminated hands, equipment, or surfaces. Suspected Pseudomonas Aeruginosa water born infections require additional investigations to determine the source and interventions from infection control specialists and microbiologists. A policy and procedures are required to specify responsibilities, risk assessments, water sampling, type of testing, frequency of testing and measures to reduce water borne infections. The policy should also consider strategies to reduce the amount of water used and wasted.

Measurable elements
C3.1.5.1 There is a documented and implemented policy and procedures for the maintenance of a hygienic water supply.
C3.1.5.2 There is a planned schedule of testing of the water quality and records of the testing are maintained.
C3.1.5.3 There is evidence that preventative measures are taken against the growth of Legionella Pneumophila and other cultures in the water and air conditioning systems that may cause harm.

(M) C3.1.6 The Heating, Ventilation and Cooling (HVAC) systems are controlled and monitored to inhibit and prevent cross contamination or microbial growth.[2]

[1] **References for C3.1.5:**
- Abu Dhabi Department of Health, Health Facility Guidelines 2019 Part-E – Engineering: Water Systems design
- Department of Health Standard, Water Quality DOH/HCQ/ST/0006/HS_EHSMS
- https://www.cdc.gov/hai/organisms/pseudomonas.html

[2] **References for C3.1.6:**

Guidance

With the emergence of airborne pandemics and the use of good ventilation as a mitigating factor it has become critical to ensure that ventilation systems are well-maintained. A policy and procedures for the maintenance of heating, ventilation, and air conditioning (HVAC) systems should be developed to define responsibilities, risk assessments, control measures, ventilation rates and sampling procedures. The policy should also include an inventory of the ventilation systems installed and the different categories of ventilation, which might be local exhaust (LEV), critical healthcare ventilation systems (CHV), general ventilation supply (GVS) and extraction systems.

Measurable elements

C3.1.6.1 There is an implemented policy and associated procedures for the management of the HVAC systems.
C3.1.6.2 There is an inventory of all ventilation systems installed and in use or capable of being used.
C3.1.6.3 There is a schedule of planned preventative maintenance of the HVAC systems and records of maintenance are retained.
C3.1.6.4 There is evidence of air quality sampling.
C3.1.6.5 There is evidence that pressure differentials are continuously monitored.

(M) C3.1.7 There are policies and procedures for the management of medical gases.[1]

Guidance

The effective management of medical gases is crucial to ensuring that the supply and type of gases required in the healthcare facility are available at all times. Policies and procedures include responsibilities, maintenance, and the management of the medical gases in emergency situations. The policy should specify the type of medical gases that fall within its scope including portable gases.

Measurable elements

C3.1.7.1 There is a policy and procedures for the management of medical gases used within the healthcare facility.
C3.1.7.2 The healthcare facility has scheduled inspections and testing of the medical gas piping system and auxiliary components according to the manufacturer recommendation or at least annually.
C3.1.7.3 There is a documented procedure for managing any interruptions of the medical gas pipeline and its authorized reinstatement.
C3.1.7.4 There is a procedure for managing medical gases in emergency situations, which might include supply shortage and fire.
C3.1.7.5 There is a procedure for the management of portable gas cylinders which includes:

a) How portable gas cylinders are delivered and handled,
b) The storage of portable gas cylinders, both full and empty,
c) Protection of the storage areas for portable gas cylinders],
d) Smoke and fire detection for the storage areas responsibility for the portable gas cylinders.

C3.1.7.6 There are strategies in place to prevent the risk of confusion between oxygen and medical compressed air. These may include having different connectors.

- Department of Health Standard, Ambient Air Emissions, Indoor and Occupational Air Quality Management DOH/HCQ/ST/0005/HS_EHSMS
- Abu Dhabi Department of Health, Health Facility Guidelines 2019 Part-E – Engineering

[1] **References for C3.1.7:**

- https://stem.doh.gov.ae/HealthFacilityGuidelines/Guidelines/Index/Engineering
- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018
- Association of Anaesthetists and the Intensive Care Society, Fire safety and emergency evacuation guidelines, 2021

Documentary evidence required:
C3.1.1.2 Estate management strategy and operational plan.
C3.1.1.5 Procedure for reporting defects.
C3.1.1.8 Procedures for maintaining and testing contingency arrangements for major plant failure.
C3.1.2.1 Policy and procedures defining the safe systems of work.
C3.1.2.2 Procedure for issuing a Permit to Work.
C3.1.2.4 Procedure for authorizing the handover by the contractor of equipment and premises as safe to use.
C3.1.4.4 Schedule of back-up power supply testing.
C3.1.5.1 Policy and procedures for the maintenance of a hygienic water supply.
C3.1.6.1 Policy and associated procedures for the management of the HVAC systems.
C3.1.6.3 Schedule of planned preventative maintenance of the HVAC systems.
C3.1.7.1 Policy and procedures for management of medical gases.
C3.1.7.3 Procedure for managing interruptions of the medical gas pipeline.
C3.1.7.4 Procedure for managing medical gases in emergency situations.
C3.1.7.5 The procedure for the management of portable gas cylinders.

Suggested personnel to work with the standards:
Senior manager with responsibility for the estate
Premises manager
OSH staff
Nursing staff
Departmental staff

SECTION C4 EQUIPMENT MANAGEMENT (INCLUDING MEDICAL DEVICES)

Overview
The healthcare facility has systems and processes in place for effective use and to minimize incidents of harm from all equipment including medical devices. These systems and processes include the effective management of equipment, the use of medical devices, replacement programs and efficient purchasing, monitoring, control and maintenance. This section addresses the roles and responsibilities of those that are responsible for the governance processes required.

C4.1 Equipment management

(M) C4.1.1 The healthcare facility has an equipment management system in place.

Guidance
The equipment management system includes the procurement of equipment, installation, maintenance and lifespan, including safe methods of disposal. An inventory should be kept of all medical equipment which includes a unique identification number of each medical device including type, manufacturer, mode and serial numbers, manuals, training requirements, life cycle, location and destruction history.

Measurable elements
C4.1.1.1 There is a documented policy that defines the equipment management system and includes responsibilities, procurement, installation, commissioning, preventative and corrective maintenance, potential lifespan and disposal.
C4.1.1.2 There are key performance indicators to monitor the effectiveness of the equipment management system, which might include, for example, incident reports, frequency of breakdowns.

C4.1.1.3 The healthcare facility holds an inventory of medical devices, including devices it owns or has been loaned (see guidance).
C4.1.1.4 There are procedures for accepting new equipment and medical devices, including checking it meets purchasing specification, recording in the inventory, all parts and accessories checked to be undamaged and functioning, calibrated if required, decontamination certificate valid if appropriate, training and responsibility for accepting equipment.
C4.1.1.5 There is a planned replacement program for all equipment, which considers the projected lifetime of equipment and new technologies.

(M) C4.1.2 There is a schedule of planned preventative maintenance of all equipment and medical devices.

Guidance
Each department may have its own schedule for planned preventative maintenance or these may be collated into one major schedule. There are contracts in place where specialist maintenance is required to be outsourced, for example, radiology equipment.
Tools required for undertaking preventative maintenance or quality control are also subject to calibration and maintenance to ensure they are measuring accurately. These might include for example, voltmeters, ionization chambers.

Measurable elements
C4.1.2.1 There is evidence that the maintenance of equipment is performed only by qualified personnel and according to manufacturers' recommendation (whether in-house or contracted).
C4.1.2.2 There is a list of all equipment and medical devices that require outsourced specialists for preventative and corrective maintenance and/or repair, with supporting evidence of contracts.
C4.1.2.3 Records of all work done on equipment and medical devices are maintained. These include inspections, maintenance work/re-work, calibration, test records, works performed after equipment breakdown, equipment transfer/lease or decommissioning of equipment or any other activities performed on equipment.
C4.1.2.4 Service manuals are available for all equipment and medical devices.
C4.1.2.5 There is an inventory of test tools required for carrying out preventive and corrective maintenance of equipment. The inventory includes calibration records.
C4.1.2.6 All testing equipment is calibrated in accordance with manufacturer's recommendations.

(M) C4.1.3 There is a system to identify and remove potentially defective equipment throughout the facility.

Guidance
Staff have a duty of care not to use defective equipment and should report any suspected defect as soon as possible and not use the equipment until it has been handed back as being approved for use. If the equipment cannot be repaired, then it is labelled as not to be used and must be removed and disposed of according to manufacturers' requirements or by specialist waste removal. Some items of equipment are critical for patient safety and alternative arrangements must be considered to maintain that level of safety.

Measurable elements
C4.1.3.1 There are processes and records in place for the removal of defective and obsolete equipment including labelling, segregation and disposal of defective and obsolete equipment.
C4.1.3.2 There is a process for receiving and acting upon recall and hazard notices. These may be from manufacturers or as a result of a recorded incident.
C4.1.3.3 There is evidence of alternative or back-up system of critical equipment being made available in the event of it being unfit for use.

(M) C4.1.4 Staff are trained and competent to use equipment and medical devices they will use within their scope of practice.

Guidance

Each department/service shall ensure that staff are competent to use the equipment and medical devices that are used within the service. Competency frameworks are developed and used to assess required training, particularly when new equipment is installed, or staff move to different sections or departments in the facility. Staff Rotas are used to plan that trained and competent staff are on duty when equipment and medical devices are in use.

Measurable elements

C4.1.4.1 End-user training programs are prepared for the use of equipment, which includes knowledge of equipment safety features and user-level diagnostic maintenance of equipment.
C4.1.4.2 Staff competency regarding equipment and medical devices is assessed prior to them being allowed to operate it. Competency is recorded.
C4.1.4.3 Update training and competency is held, at least annually, to maintain knowledge and skills.
C4.1.4.4 Staff Rotas are in place to ensure that only trained and competent staff are on duty to operate specialist equipment.

Documentary evidence required:

C4.1.1.1 Policy that defines the equipment management system.
C4.1.1.4 Procedures for accepting new equipment and medical device.

Suggested personnel to work with the standards:

Premises manager
Procurement
Nurses

SECTION C5 FIRE SAFETY

Overview

The healthcare facility has a duty of care to protect patients, staff, visitors and contractors from fire and smoke. Fire safety includes preventative measures, being prepared for emergency situations and ensuring staff are trained and know what to do in the event of a fire.

C5.1 Fire safety management

(M) C5.1.1 The healthcare facility has measures in place to protect patients, staff, visitors and contractors from fire and smoke.

Guidance

The healthcare facility should have access to a qualified and experienced fire safety manager. This may be the Safety manager or advice provided by the local civil defense. The policies and procedures define the measures required to prevent fires, train staff and how to manage an emergency situation. Staff fire training should include how to evacuate staff, patients, visitors and contractors in accordance with the fire policy, legislation and advice of the fire safety manager or equivalent.

Measurable elements

C5.1.1.1 There is, or there is access to a qualified and experienced fire safety manager.

C5.1.1.2 There is a policy and procedures for fire and smoke safety which includes:

a) Preventative measures,
b) Risk assessments,
c) Mechanisms for detecting fire, smoke and carbon monoxide, including testing of the mechanisms,
d) Explosions,
e) Managing flammable material or potentially explosive atmospheres
f) Training,
g) Drills and awareness,
h) Patient and staff evacuation, with specific reference to those with special needs and those with restricted mobility,
i) Investigation,
j) Reporting mechanisms.

C5.1.1.3 Staff are trained in how to respond to potential and actual fires.

C5.1.1.4 Each employee attends at least one fire drill annually and attendance is recorded.

C5.1.1.5 There is evidence that the fire drills and the evacuation plan are reviewed and continuously improved and updated.

C5.1.1.6 There is evidence that the healthcare facility complies with the recommendations and regulations arising from inspections by the civil defense.

(D) C5.1.1.7 There are fire marshals assigned to geographical areas around the healthcare facility, who are empowered to lead on fire and smoke safety in the areas to which they are assigned.

(M) C5.1.2 Firefighting system and resources are available and regularly inspected as per Civil Defense and UAE fire and life safety code requirements.[1]

Guidance

Firefighting equipment includes, for example: fire extinguishers, hydrants, hose reels and fire blankets. Equipment should be appropriate to the type of fire most likely to occur in the area in which it is located and marked with the type of appliance with instructions for use.

Attention should be given to hazardous areas such as engineering plant rooms/boiler rooms, fuel and gas storage compounds, clinical record storage areas, kitchens, laundry storage areas and linen rooms, refuse collection areas, refuse storage areas, rooms or spaces used for permanent or temporary storage of combustible supplies and equipment, and treatment rooms and patient bed areas where oxygen and other potentially hazardous gases are used.

Measurable elements

C5.1.2.1 There is evidence of the availability of firefighting equipment in all areas of the healthcare facility (see guidance).

C5.1.2.2 There are smoke detectors throughout the facility.

C5.1.2.3 There is evidence that the firefighting equipment is inspected and maintained.

C5.1.2.4 Evacuation maps and fire safety posters (RACE & PASS) * are placed throughout the healthcare facility.

C5.1.2.5 Fire exits, and escape routes are clearly displayed and illuminated and constantly kept free of obstruction, accessible and wide enough for non-ambulatory people.

C5.1.2.6 In areas where doors must be locked there are written and pictorial instructions detailing alternative means of escape.

[1] **References for C5.1.2:**

- Association of Anesthetists and the Intensive Care Society, Fire safety and emergency evacuation guidelines, 2021

C5.1.2.7 The intensive care units and operating theatres have individualized evacuation policies and evacuation route plans. Evacuation policies include the evacuation equipment required to maintain the safety of each patient.
C5.1.2.8 There are fire safe areas where patients, staff, visitors and contractors assemble.

*RACE & PASS is a fire safety acronym and protocol: Rescue, Alarm, Contain and Extinguish when you first encounter a fire, and Pull, Aim, Squeeze and Sweep when using a fire extinguisher.

(C) C5.1.3 The healthcare facility has a collaborative approach to prevent the risk of fires.

Guidance
The healthcare facility should undertake fire risk assessments and consider methods to reduce the risk of fires occurring. This includes using fire resistant furnishing, maintaining the electrical safety of equipment, particularly equipment brought in by patients, and the storage of flammable substances.

Measurable elements
C5.1.3.1 The healthcare facility can demonstrate that the furniture and furnishings within the healthcare facility are made from fire resistant material.
C5.1.3.2 Locations in which flammable and hazardous materials are stored are clearly labelled and where possible, stored in a fireproof container.
C5.1.3.3 There is a schedule for portable appliance testing (PAT) of all electrical equipment held within the healthcare facility.

Documentary evidence required:
C5.1.1.2 Policy and procedures for fire and smoke safety
C5.1.3.3 Schedule for portable appliance testing

Suggested personnel to work with the standards:
Fire safety manager
Senior manager
Staff representatives

SECTION C6 SECURITY

Overview

The healthcare facility has appropriate security measures in place to ensure a safe and secure environment for patients, staff, visitors and contractors and their individual property, together with the facility's property and equipment.

C6.1 Security Management

(C) C6.1.1 The healthcare facility has a defined approach to maintaining the security of its patients, staff, visitors and contractors.

Guidance

The approach includes a strategy which includes the scope, for example, the security measures for data; finances (see also A6.2); crime prevention; access to buildings; security systems and equipment; reporting of security incidents; staff training on security and conflict resolution measures; night-time security measures; monitoring via closed circuit television. The strategy should specify the ongoing review of security issues and how the review is reported to the Senior Individuals.

Procedures for security should include the actions to take when there has been a breach of the security arrangements, which may include reporting to the regulatory authorities.

Measurable elements

C6.1.1.1 There is, or there is access to a trained security manager.

C6.1.1.2 There is a current implemented security strategy (see guidance).

C6.1.1.3 There are documented procedures for:

a) Safe keeping of patients' property,
b) Controlling access to buildings and departments,
c) Management of any Closed-Circuit TV Systems (CCTV),
d) Management of cash collected in the facility.

C6.1.1.4 There are procedures for the security of high risk and hazardous materials including but not limited to:

a) Controlled drugs,
b) Prescription forms,
c) Radioactive sources,
d) Pathogens and toxins.

(D) C6.1.1.5 There is a policy for managing assaults and aggressive behavior against staff. The policy includes physical and non-physical assault.

C6.1.1.6 There is evidence that security measures are in place to protect vulnerable patients. These include children, the elderly and areas where patients with special needs are cared for.

C6.1.1.7 All staff, including permanent and temporary, wear an identification badge which includes a photograph.

Documentary evidence required:

C6.1.1.4 Procedures for security of high risk and hazardous materials

C6.1.1.5 policy for managing assaults and aggressive behavior against staff.

Suggested personnel to work with the standards:

Security manager

Staff representatives

CHAPTER D. CLINICAL SUPPORT SERVICES

The clinical support services for the purpose of these standards, are the diagnostic services that are necessary to support the clinical care of patients and those services essential to maintain the safety of patients and staff.

These services are considered as core to any healthcare facility and therefore subject to external evaluation.

SECTION D1 MANAGEMENT OF MEDICINES INCLUDING PHARMACY

Overview
The healthcare facility has systems in place to ensure that medicines are purchased, stored, prescribed, dispensed, administered and reviewed safely and securely at every point, in accordance with regulatory requirements and professional best practice.
The healthcare facility has strategies to address demand and capacity issues, costs, optimizing the pharmacy service, management of medication risks and improved outcomes.
Where there is an in-house pharmacy service it is appropriately equipped and staffed by trained people to ensure the safe preparation and administration of medicines.

This sub section must be assessed together with the Patient's Medication sub section of B5 Person Centered Care.

D1.1 Medicines management

Overview
Medication management is the process of overseeing that medications prescribed for a patient are administered properly to achieve the planned outcome. The processes include the strategies in place to address safety and adherence concerns, reduce adverse drug events, educate patients, and engage patients and their caregivers. The safe management of medicines is the responsibility of all staff who handle medication.

(C) D1.1.1 There is delegated responsibility for the management of medicines.[1]

Guidance
The objectives included in the management of medication strategy meet with the overall objectives of the healthcare facility and objectives set by the regulators to standardize practice.
There are policies and procedures for all steps in the management of medicines and responsibility for the development and implementation of these policies may be delegated to a committee that has representation from management, medical staff, pharmacists and nurses.
The management of medicines policy includes roles and responsibilities, the relevant legislation, procurement, prescribing and administration, high alert drugs, supply and procurement, storage, disposal, risk management and training requirements.

Measurable Elements
D1.1.1.1 There is a multidisciplinary drugs and therapeutics committee with documented terms of reference that meets no less than quarterly.
D1.1.1.2 There is a strategy and policy for the management of medicines which identifies the objectives for managing medicine across the healthcare facility and how those objectives are to be met.

[1] **References for D1.1.1:**
- Department of Health, Healthcare Regulator Manual, 2017
- Department of Health: Standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization, 2021

D1.1.1.3 Available medications, material and equipment comply with the healthcare facility's license and scope of services offered as well as any professional's scope of practice.
D1.1.1.4 The healthcare facility has developed and implemented a medications and materials management policy and procedures, which includes who is authorized to order medicines, the sources of supply, and stock control.
D1.1.1.5 No medication/materials are to be sold at the healthcare facility unless authorized to do so.

(M) D1.1.2 There are strategies in place to support the safe management of medication across the healthcare facility.[1]

Guidance

Strategies to reduce harm from medication errors include a program of risk assessments, audit, error and adverse event reporting mechanisms, secure storage, safe disposal of drugs and staff training.

Measurable Elements

(D) D1.1.2.1 The medication process is tracked from start to finish to identify potential risks and errors with mitigation measures being implemented for any identified risks.
D1.1.2.2 There is a documented policy for the recognition and reporting of medication errors which includes the definition of a medication error, and the reporting mechanisms to be used.
D1.1.2.3 The healthcare facility uses medication errors reporting information to improve medication use processes.
D1.1.2.4 The healthcare facility has a developed approach to improve the safety of high-alert medications, for example, concentrated electrolytes and cytotoxic drug and includes labelling and storage.
D1.1.2.5 There is a procedure for the management and administration of look-alike, sound-alike medicines.
D1.1.2.6 There is a procedure for the safe disposal of medicines which specifies the type of waste, whether it is hazardous or not, the waste containers to be used and the disposal method and where and under what conditions medicines for disposal are kept until their removal from the site.
D1.1.2.7 Spillage kits are available where cytotoxic drugs are reconstituted, stored and administered.
D1.1.2.8 Only those permitted by the healthcare facility and by relevant licensure, laws, and regulations may administer medications.
D1.1.2.9 There is a competency program for staff on medications and materials usage and practices.
D1.1.2.10. Staff with designated responsibilities track the expiry of supplies, medications and materials.
D1.1.2.11 All ambulatory syringe drivers in use across the healthcare facility have safety mechanisms installed.
D1.1.2.12 There is a system in place to recall pharmaceuticals.
D1.1.2.13 There is a procedure for managing damaged products that includes how they are destroyed.

[1] **References for D1.1.2:**

- Department of Health: standard on Reporting Medication Errors, March 2019
- Department of Health: Standard on Delivery of Pharmacy Medications, February 2020 Department of Health: Healthcare Reguator Manual, November 17
- World Health Organization: Patient Safety Solution number 1: Look-alike, sound-alike medication names, 2007
- World Health Organization: Patient Safety Solutions number 5: Control of concentrated electrolyte solutions, 2007
- World Health Organization: Patient Safety Solutions number 6: Assuring medication accuracy at transitions in care, 2007
- Abu Dhabi Health Authority: Policy for Recall of Drugs and Healthcare Products, 2012

D1.2 Pharmacy Management

(M) D1.2.1 The pharmacy service is led and staffed by qualified and competent staff with documented governance and management arrangements.[1]

Guidance

The healthcare facility is responsible for ensuring that the pharmacy is staffed by competent and experience personnel, is licensed to undertake the services it offers and has documentation to guide the governance and management arrangements including responsibilities for reporting to the Senior Individuals and regulatory authorities.

Measurable Elements

D1.2.1.1 The pharmacy displays all the required licenses for the pharmaceutical products it compounds and uses in the Healthcare Facility.

D1.2.1.2 The pharmacy service is led by a qualified and licensed pharmacist or clinical pharmacist.

D1.2.1.3 The in-patient pharmacy service is led by a qualified and licensed clinical pharmacist.

D1.2.1.4 The pharmacy has an operational policy which defines the scope of the service offered, management and governance arrangements, equipment, the standards the service shall work within, monitoring and audits, operating hours; the number of staff and skill mix required and reporting responsibilities.

D1.2.1.5 The pharmacy holds a current list of authorized prescribers and signatures or identification for electronic prescribing.

D1.3 Dispensing

(M) D1.3.1 Controls and checks are in place to maintain the safe provision of medication.[2]

Guidance

The dispensary fulfils a double-checking role of prescriptions as errors may occur if the expertise of the prescriber is limited. The pharmacy has to ensure the 5Rs of drug administration which are that the right patient gets the right drug, in the right quantity, in the right dose and strength and by the right route every time a drug is dispensed. Standing operating procedures are based on national guidance and regulations and include checking procedures and quality control. Checklists may help to ensure that the operating procedures are adhered to. Some medications need to be dispensed in sterile conditions and there are facilities in the pharmacy to allow this.

Measurable elements

D1.3.1.1 There are standing operating procedures covering all processes of pharmacy activities including, but not limited to:

a) Compounding,
b) Dispensing,
c) Repackaging,
d) Quality control,

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[1] **References for D1.2.1:**

- DOH standard on Delivery of Pharmacy Medications February 2020
- UAE Unified Healthcare Professional Qualification Requirements, 2022

[2] **References for D1.3.1:**

- Abu Dhabi Department of Health: Standard on Delivery of Pharmacy Medications, February 2020
- World Health Organization: Patient Safety Solution number 8: Single use of injection devices, 2007

e) Labelling.

D1.3.1.2 There is a process to check that prescriptions are clinically suitable for patients before they are dispensed.

D1.3.1.3 There is a system, checklist or similar, to check that all prescriptions and medicines are accurate prior to leaving the pharmacy.

D1.3.1.4 Labels are attached to all dispensed drugs and are in Arabic or English and contains the patient and drug identification including dosage, route of administration and expiry date.

D1.3.1.5 There is a policy and procedure for the use of multi-dose vials which outlines:

a) How the pharmacy ensures stability of the medication,
b) If multi-dose vials may be used for multiple or single patient use,
c) Checking that vials are marked with the date and time of reconstitution or first use and the initials of the person who reconstituted or first used the vial.

D1.3.1.6 A sterile needle is used every time a dose is withdrawn from a multi-dose vial and needles are not left in the vial for multiple withdrawals.

D1.3.1.7 Sterile products, parenteral nutrition and intravenous additives, cytotoxic drugs and radiopharmaceuticals are prepared in a specially designed and designated area which has air filtration to maintain asepsis.

D1.4 Specialist Medication

(M) D1.4.1 There are safe and secure systems of work to ensure that specialist medications are purchased, stored, prescribed, dispensed, administered and reviewed, in accordance with regulatory requirements and professional best practice.[1]

Guidance

Specialist medications include narcotics, psychotropic, cytotoxic and radioactive drugs. Narcotic and psychotropic drugs in particular are addictive and harmful and are subject to regulation. Cytotoxic drugs for cancer chemotherapy and radioactive pharmaceuticals raise safety issues as they are potentially harmful if not handled correctly.

The healthcare facility therefore has policies and procedures for the secure and safe access to these drugs, safe storage and transportation facilities and procedures for receiving, administration, disposal, destruction, and record keeping of these drugs.

Measurable elements

D1.4.1.1 There is a named person in the healthcare facility who has overall responsibility for controlled drugs who has an overview of the purchase, issue, storage, monitoring, safe handling and disposal of controlled drugs.

D1.4.1.2 There is a register of controlled drugs.

D1.4.1.3 There is a documented policy and procedure relating to the healthcare facility's use of controlled and narcotic drugs, which includes secure and safe access, storage requirements in the pharmacy and units, transportation, receiving, administration, disposal and destruction, and the required records to be kept.

D1.4.1.4 There is a named individual in each area where controlled drugs are stored who has responsibility for the safe custody of controlled drugs.

D1.4.1.5 A monthly audit is undertaken of the controlled drugs daily stock checks carried out and a Narcotic and Controlled Drugs consumption report sent through to the Department of Health.

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[1] **References for D1.4.1:**

- Department of Health: Standard for the Management of Narcotics, Psychotropic and Semi-Controlled Medicinal Products, June 2021
- Federal Authority for Nuclear Regulation (FANR): Basic Safety Standards for Facilities and Activities involving Ionizing Radiation other than in Nuclear Facilities (FANR-REG-24), Version 1

D1.4.1.6 Healthcare facilities that administer cytotoxic chemotherapy have standard operating procedures for all aspects of cytotoxic chemotherapy related work, which includes:

a) The assessment of staff competence,
b) Prescribing,
c) Storage requirements in the pharmacy and areas where chemotherapy is administered, transportation,
d) Receiving,
e) Administration,
f) Disposal and destruction,
g) The required records to be kept.

D1.4.1.7 In healthcare facilities that undertake intrathecal cytotoxic chemotherapy there are standard operating procedures for the labelling, transportation, storage and administration of these drugs.

D1.4.1.8 In healthcare facilities that undertake tests and treatments using radiopharmaceuticals, there are standard operating procedures for all aspects of using radiopharmaceuticals including:

a) Preparation,
b) Storage,
c) Transportation,
d) Prescribing,
e) Receiving and administration,
f) Disposal,
g) Required records to be kept and the
h) Assessment of staff competence in the preparation and administration of radiopharmaceuticals.

D1.5 Storage and Environment

(C) D1.5.1 The pharmacy is designed and maintained in good condition that is conducive to a safe working environment with access only for designated staff.[1]

Guidance

The pharmacy has enough space to work efficiently, air conditioning for the area size, good lighting, shelves and storage tanks to preserve medicines, refrigeration and secure storage for controlled medicines. Any sterile rooms used for drug preparation have air-filtration to maintain an asepsis environment. Dispensing areas support safe and efficient working practices to minimize fatigue and distractions and have good lighting, space and air-conditioning with noise kept to a minimum.

Measurable elements

D1.5.1.1 There is evidence that the pharmacy meets all the environmental requirements for licensing.

D1.5.1.2 There are processes in place to maintain a safe and comfortable working environment including, controlled temperature and lighting, firefighting equipment and first aid kits as a minimum.

D1.5.1.3 There is restricted access to the pharmacy.

D1.5.1.4 The dispensing areas are designed to minimize errors and maximize safety.

D1.5.1.5 Areas used for sterile drug preparation have air-filtration systems to ensure an aseptic environment.

D1.5.1.6 Pharmaceuticals and related substances are kept under conditions which conform to statutory and manufacturers' requirements, which may include deep freeze, refrigerator or cold room.

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[1] **References for D1.5.1:**

- DOH standard on Delivery of Pharmacy Medications February 2020
- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018

D1.5.1.7 Refrigerator, freezer and cold room temperatures are monitored to maintain the cold chain.
D1.5.1.8 Temperature data loggers are installed to constantly monitor the temperatures of equipment used for cold storage of drugs.
D1.5.1.9 The refrigerators, freezers and cold rooms have warning systems if the temperature falls outside the normal range allowed.
D1.5.1.10 Flammable and combustible materials are stored away from pharmaceuticals, in labelled fireproof containment.
D1.5.1.11 There is a designated storage area in the pharmacy for materials under quarantine, for example, materials that are deemed not fit for purpose, for example, drug recalls, out of date drugs, damaged vials.
D1.5.1.12 There are documented procedures for the receipt, storage and stock control of all medicines used in and supplied from the healthcare facility.

Documentary evidence required:
D1.1.1.2 Management of medicines strategy.
D1.1.2.2 Policy for the recognition and reporting of medication errors.
D1.1.2.5 Procedure for the management and administration of look-alike, sound-alike medicines.
D1.1.2.6 Procedure for the safe disposal of medicines.
D1.2.1.4 Operational policy for the pharmacy.
D1.3.1.1 Standing operating procedures covering all processes of pharmacy activities.
D1.3.1.5 Policy and procedure for the use of multi-dose vials.
D1.4.1.3 Procedures for the use of controlled and narcotic drugs.
D1.4.1.6 Standard operating procedures for all aspects of cytotoxic chemotherapy.
D1.4.1.7 Standard operating procedures for intrathecal cytotoxic chemotherapy.
D1.4.1.8 Standard operating procedures for radiopharmaceuticals.
D1.5.1.12 Procedures for the receipt, storage and stock control of medicines.

Suggested personnel to work with the standards:
Head of pharmacy
Pharmacy staff
Medical director
Nursing director
Medical physicist (if radiopharmaceuticals prepared)

SECTION D2 INFECTION PREVENTION AND CONTROL

Overview

Infection Prevention and Control (IPC) is a practical, evidence-based approach that prevents patients and healthcare workers from being harmed by avoidable and preventable infections[1]. The COVID-19 pandemic demonstrated not only the importance of protecting health workers and patients through IPC, but also the central role of healthcare facilities in the control of emerging infectious diseases.[2]
An evidence-based approach to IPC is aimed at the protection of patients, healthcare workers, visitors and contractors to healthcare facilities by preventing avoidable infections, including those caused by antimicrobial-resistant pathogens, acquired during the provision of healthcare services. It is the responsibility of all staff who work in healthcare to understand and follow all the IPC policies.

[1] World Health Organization, Core Competencies for Infection Prevention and Control Professionals, 2020

[2] World Health Organization, Global report on infection prevention and control, 2022

This sub section addresses the management of IPC and includes the Sterile Services, Waste Management and Housekeeping, including the laundry and kitchen.

D2.1 Management of IPC

(M) D2.1.1 There are systems and processes in place to prevent and control infections.[1]

Guidance

Although infection control is the individual responsibility of all staff they need to be trained and guided in good practice and the healthcare facility needs to identify healthcare professionals who have experience and qualifications to take responsibility for infection control. A multidisciplinary infection control committee, the members of which have experience and competencies in infection control, provides an overview on several issues, for example, the annual infection control surveillance, outbreaks, infection control audits and procurement matters. Ideally this committee will be chaired by a microbiologist but maybe any healthcare professional with qualifications, training and experience in infection control and has access to a specialist microbiologist. A skilled and competent multidisciplinary infection control team has day to day operational responsibility for infection control and undertaking surveillance and audits.

The infection control policy details the arrangement, responsibilities, and accountabilities for infection control. It includes all infection control activities to be undertaken, for example, risk assessments, annual surveillance, strategies to prevent cross infection, dress codes, reporting mechanisms and also defines a communication plan for informing staff of infection control requirements. The implementation plan identifies key objectives, priorities, and actions in place to meet the requirements of the policy.

Surveillance is an essential component for the prevention and control of infection; it involves the systematic collection of data on infections that occur naturally in populations and as a direct result of healthcare interventions, its analysis and dissemination to facilitate appropriate action. High quality information on healthcare associated infection (HCAI) is essential to tracking progress, investigating underlying causes and instituting prevention and control measures. A surveillance program will include post-operative infection rates; healthcare acquired infections; incidence of Methicillin-resistant Staphylococcus aureus (MRSA); urinary tract infections; environmental audits and occupational health data including needle stick injuries.

Training for infection control may be held in-house or, for specific infection control procedures staff may be required to attend specialist training courses. All staff attend mandatory training in infection control at induction at annual refresh courses and records of attendance are maintained (see also sub section A4). In addition, the healthcare facility provides education to patients and their families on preventing and controlling infection in their own circumstances. This may be specific to patients or through general educational media outlets. Staff are vaccinated against COVID and hepatitis.

Measurable Elements

D2.1.1.1 There is an infection control policy describing the responsibilities and accountabilities for the prevention and control of infection.

D2.1.1.2 There is a multidisciplinary infection control committee with documented terms of reference.

D2.1.1.3 There is an infection control team responsible for the day-to-day operational management of infection prevention and control.

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[1] **References for D2.1.1:**

- Abu Dhabi Department of Health, JAWDA Quarterly Guidelines for (Specialized and General Hospitals), 2022
- World Health Organization, Global report on infection prevention and control, 2022
- https://www.ips.uk.net/ips-competencies-framework
- Health Authority Abu Dhabi, Policy for Quality and Patient Safety, 2017
- Royal College of Nursing (UK), The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework, 2021 ©

(D) D2.1.1.4 Each unit, service or department has an identified infection control link person who works with the infection control team.

D2.1.1.5 There is an infection control implementation plan written in accordance with national regulations and priorities.

D2.1.1.6 The healthcare facility can demonstrate that it has implemented a systematic and proactive ongoing program for the assessment of risk of infection.

D2.1.1.7 There is a policy and implementation plan for undertaking a regular infection surveillance program and include the JAWDA requirements as a minimum.

D2.1.1.8 The surveillance program includes microbiologic sampling.

D2.1.1.9 The healthcare facility has on-going training and education programs on infection prevention and control for all staff. Training records are kept.

D2.1.1.10 There is a competency framework for the infection control team that includes clinical practice, quality improvement, education, and management.

D2.1.1.11 There are competency frameworks for staff working in specific areas and include competency for:

a) Urinary catheter insertion and care,
b) Central venous line insertion and care,
c) Ventilator care,
d) Surgical site care,
e) Hand hygiene,
f) Decontamination and sterilization,
g) Safe injection practice.

D2.1.1.12 There is evidence that personal protective equipment (PPE) is available and used correctly.

D2.1.1.13 There is evidence that the infection control committee reviews and investigates infection control incidents and adverse events.

(D) D2.1.1.14 There is evidence that the healthcare facility provides infection prevention and control education to patients and family members.

D2.1.1.15 There is a process to identify and monitor contacts, including staff and patients, of personnel who are found to have a potentially transmissible condition.

D2.1.1.16 There is evidence that all staff employed by the healthcare facility including contractors and temporary staff have been vaccinated in accordance with local mandatory requirements.

D2.2 Policies and procedures

Overview

Over the last decade, major outbreaks such as those due to the Ebola virus disease and the Middle East respiratory syndrome coronavirus (MERS-CoV), and the coronavirus disease 2019 (COVID-19) pandemic, have demonstrated how epidemic-prone pathogens can spread rapidly through health care settings.[1]

Standard infection control procedures underpin safe practice, reducing the risk to staff and patients from healthcare related infections.

(M) D2.2.1 There are documented policies and procedures for infection prevention and control.[2]

Guidance

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[1] World Health Organization, Global report on infection prevention and control, 2022

[2] **References for D2.2.1:**

- World Health Organization, Global report on infection prevention and control, 2022
- https://www.nipcm.scot.nhs.uk/about-the-manual/
- NHS England, National infection prevention and control manual for England,2022
- Gulf Cooperation Council-Center for Infection Control, Infection Prevention and Control Manual, 3rd edition, 2018

For standard precautions to be effective, high levels of compliance are required to be achieved by all healthcare staff involved in patient care. Policies and procedures are developed to address the main conditions found in the community the healthcare facility serves. Staff need to be able to access these, be trained on their use, and be monitored and audited. With the continuing threat of major outbreaks of disease, it becomes critical to update policies and procedures and to ensure that staff are aware of them and are implementing them. It is also important to check staff wellbeing and have processes for them to follow if they become unwell and also in case they are a potential source of infection.

Measurable elements

D2.2.1.1 There is evidence that the infection control committee reviews the infection control policies and procedures at least annually or whenever a need arises, such as new technology or new research evidence and updates them if noted.

D2.2.1.2 There is evidence that members of the infection control team are included in the development and review of clinical guidelines and care plans.

D2.2.1.3 The infection control and prevention policies and procedures are available in all areas of the healthcare facility.

D2.2.1.4 The policies and procedures are contained within an infection control manual and include but are not limited to:

a) Standard infection control precautions including aseptic techniques and handling, potentially infectious material and instruments,
b) Hand hygiene,
c) Safe handling and disposal of sharps,
d) Managing patients in isolation and protective environments,
e) Barrier and reverse barrier nursing,
f) The use of personal protective equipment,
g) Respiratory and cough hygiene to prevent spread of air borne infections,
h) Management of outbreaks of communicable diseases including gastrointestinal infections/viral gastroenteritis, MRSA, clostridium difficile, pseudomonas aeruginosa including how these are reported to authorities,
i) Management of blood borne viruses,
j) Prevention of infections from urinary catheters,
k) Prevention of ventilator associated infections,
l) Management of central line associated bloodstream infections (CLABSI),
m) Management of surgical sites (SSI).

D2.2.1.5 There is a planned schedule for the audit of practice against the documented policies and procedures.

D2.2.1.6 There is evidence that the findings and action plans developed as a result of audit are presented to the infection control committee.

D2.2.1.7 There is evidence that good infection control procedures are followed when medications and creams are used for more than one patient.

D2.2.1.8 There is a process for staff to follow if they feel unwell.

D2.3 Healthcare acquired infections (HAI)

Overview

Every year, large numbers of patients are harmed or die because of unsafe health care, creating a high burden of death and disability worldwide, especially in low- and middle-income countries. On average, an estimated one in 10 patients is subject to an adverse event while receiving hospital care in high-income countries. Available evidence suggests that 134 million adverse events due to unsafe care occur in hospitals in low- and middle-

income countries, contributing to around 2.6 million deaths every year. According to recent estimates, the social cost of patient harm can be valued at US$ 1 trillion to 2 trillion a year.[1]

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile). HCAIs pose a serious risk to patients, staff, visitors and contractors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.[2]

(M) D2.3.1 There are initiatives in place to reduce healthcare associated infections.[3]

Guidance

Screening patients with potentially transmissible infections at point of entry is key to reducing cross infection. The healthcare facility needs to identify those patients who may present a particular cross-infection risk. These might include, for, example, patients presenting with symptoms such as loose stools or diarrhea, vomiting, fever or respiratory symptoms; known or suspected to have been previously positive with a Multi-drug Resistant Organism (MDRO) e.g., MRSA, CPE (Carbapenemase producing Enterobacteriaceae). Patients with a known or potential transmissible infection need to be carefully placed to avoid cross-infection to other patients. This may mean isolation and the healthcare facility needs to have an approved policy for where patients can be placed.

Restrictions on the use of antibiotics and antimicrobials will assist in reducing the incidence of Anti-Microbial Resistance (AMR). A multi-disciplinary policy on the use of anti-biotics and anti-microbials is developed by infection control and pharmacy staff. Good antibiotic stewardship helps to reduce the need for antimicrobials.

Communication of infection status is vital to reducing HAI and when a patient with a transmissible infection has to visit a department for tests or treatment that department needs to be made aware of this and take the necessary precautions.

Needlestick injuries are potentially serious and the procedure for managing these includes immediate care and assessment, managing potential significant exposure and post exposure prophylaxis and reporting requirements.

Measurable elements

D2.3.1.1 There is a system in place to assess the risk of patients having a potentially infectious condition at the point of entry to the healthcare facility, including transfers from other healthcare facilities.

(D) D2.3.1.2 Travel and occupational history is included in the assessment of patients attending the healthcare facility.

D2.3.1.3 There is a procedure for screening patients for Multi Drug Resistant Organisms (MDRO).

D2.3.1.4 There is a policy and procedure for the placement of patients with a transmissible infection.

D2.3.1.5 There are negative pressure isolation rooms with attached wash and ante rooms available for patients with infections spread by the airborne route.

D2.3.1.6 There are positive pressure isolation rooms for patients who are severely immunocompromised (e.g., patients after hematopoietic stem cell transplant) requiring protective isolation requiring protective isolation.

D2.3.1.7 There are clinical guidelines for the management of patients with MDRO.

D2.3.1.8 There is a policy on antibiotic and antimicrobial prescribing which is checked for implementation.

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[1] World Health Organization, Global report on infection prevention and control, 2022

[2] NHS England, NHS England » Healthcare associated infections

[3] **References for D2.3.1:**

- Abu Dhabi Department of Health, Guidelines for Antimicrobial Stewardship Programs, 2017 (DOH/ASP/GL/1.0)
- Abu Dhabi Department of Health, Policy for Infection Control in the Health Care Facilities (May 2007)
- https://www.hps.scot.nhs.uk/a-to-z-of-topics/multi-drug-resistant-organism-mdro-admission-sreening/
- 1World Health Organization, Global report on infection prevention and control, 2022
- NHS England, National infection prevention and control manual for England,2022
- NHS England, NHS England » Healthcare associated infections

D2.3.1.9 There is evidence that the healthcare facility has systems in place for inter-facility communication of infectious status.
D2.3.1.10 There is evidence that the infection status of patients is communicated to those facilities to which a patient may be transferred from the healthcare facility.
D2.3.1.11 The infection control committee monitors the JAWDA quarterly submission rate of Healthcare-Associated MDRO Bloodstream Infections and investigates, risk assesses and develops actions as required.
D2.3.1.12 There is a documented procedure for the management of individuals who have experienced a needlestick injury.
D2.3.1.13 There is evidence that needlestick injuries are reported as an incident.
D2.3.1.14 Healthcare workers at risk of exposure to blood or body fluids can show evidence of immunity to the Hepatitis B virus.
D2.3.1.15 All new healthcare workers are screened for communicable diseases and vaccinated as per the Policy for Infection Control in the Health Care Facilities (May 2007).

Documentary evidence required:
D2.1.1.1 The framework showing the responsibilities and accountabilities for the prevention and control of infection.
D2.1.1.5 Infection control policy and infection control implementation plan.
D2.1.1.7 Policy and implementation plan for infection surveillance program.
D2.2.1.4 Infection prevention and control manual.
D2.3.1.3 Procedure for screening patients for Multi Drug Resistant Organisms.
D2.3.1.4 Policy and procedure for the placement of patients with a transmissible infection.
D2.3.1.5 Clinical guidelines for the management of patients with MDRO.
D2.3.1.6 Policy on antibiotic and antimicrobial prescribing.

Personnel to work with the sub section:
Infection control team
Director of Nursing
Director of medicine
OSH staff
Pharmacist

D2.4 Sterile Services

Overview
A major part of preventing cross infection is achievable by removing pathogenic microorganisms from potential sources of infection. One of the sources of infection is found on equipment and reducing the risk from this source can be accomplished by the decontamination of materials, equipment and surfaces. Equipment and medical devices are either single use or reusable. Devices designated for 'single use' are not to be reused under any circumstances. All reusable equipment is appropriately decontaminated before use and between each patient's use.
Healthcare facilities that out-source a sterile service have written contracts for the service provision which cites the specification for supply and monitoring arrangements (see A2.4).

(M) D2.4.1 The healthcare facility has processes to reduce the risk of infection from equipment and medical devices.[1]

[1] **References for D2.4.1:**
- Abu Dhabi Health Authority, Standard for Endoscopy Services, 2014
- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018

Guidance

The decontamination policy details the structures, responsibilities and accountabilities for decontamination, including contractors. It outlines the different methods of decontamination for different materials in different areas, such as endoscopy and dental departments; tracking and traceability; single use items; handling equipment undergoing decontamination; monitoring effectiveness and training requirements.

Human prion agents are unusually resistant to disinfection and sterilization by most of the physical and chemical methods in common use for decontamination of infectious pathogens. Consideration may have to be given to destroying the instruments or placing them in quarantine.

The sterile services department has designated areas for receiving contaminated items, disassembly, cleaning areas, inspection areas, packaging areas, storage areas including separate areas for cleaning materials and raw materials and areas for damaged devices. The whole area is arranged so that contaminated devices are not moved through areas containing decontaminated devices.

Containers for transporting equipment are leak-proof; easy to clean; rigid, to contain instruments, preventing them becoming a sharps hazard to anyone handling the goods and to protect them against accidental damage; capable of being closed securely; lockable, where appropriate, to prevent tampering; clearly labelled to identify the user and the contents; robust enough to prevent instruments being damaged in transit.

Measurable elements

D2.4.1.1 There is a decontamination policy (see guidance).

D2.4.1.2 There are procedures which define and control all stages of the decontamination processes and includes, but is not limited to:

a) Receipt into the sterile services department,
b) Decontamination,
c) Packaging,
d) Storage,
e) Transportation,
f) Tracking and traceability,
g) Product recall,
h) Record keeping.

D2.4.1.3 There are documented procedures for the operation and testing of all washers/disinfectors and autoclaves which include the actions to take if they do not meet stated requirements.

D2.4.1.4 Records are kept of the performance of all equipment used for decontamination.

D2.4.1.5 There is a documented procedure for gas sterilization.

D2.4.1.6 There are procedures for the decontamination of instruments used on patients with a known or suspected human prion disease.

D2.4.1.7 The healthcare facility uses single use instruments as a preference to reusable devices where possible.

D2.4.1.8 The design and layout of the sterile services department is arranged to manage the segregation of clean and contaminated items.

D2.4.1.9 Instruments are transported to and from the sterile service department in purpose-built containers (see guidance).

D2.4.1.10 The area for decontamination and the area for assembly and packing are served by monitored negative and positive ventilation systems respectively.

D2.4.1.11 There are documented procedures for unpacking and checking re-usable instruments for damage or loss and includes the degree of inspection e.g., using magnification devices and the steps to take if any instrument, device or piece of equipment is found to be damaged and no longer fit for purpose or missing.

- Medicines and Healthcare Products Regulatory Agency (UK), Managing Medical Devices, Guidance for health and social care organizations. January 2021 ©
- Gulf Cooperation Council-Center for Infection Control, Infection Prevention and Control Manual, 3rd edition, 2018

D2.4.1.12 There is evidence that staff receive training relevant to the work of the sterile services department and the equipment used. Attendance records are kept.
D2.4.1.13 The sterile service implements a quality assurance system with measures which include but are not limited to:

a) Use of chemical indicators being used in every package,
b) Biological indicators, or spore tests, being used at least weekly,
c) Mechanical monitoring is done for every sterilizer load,
d) Corrective actions developed for any results out of tolerance including product recall,
e) Bowie dick tests.

D2.4.1.14 Quality assurance results are submitted to the infection control committee with action plans for any identified issues.
D2.4.1.15 The quality assurance results include a report on water quality used for sterilization purposes.
D2.4.1.16 Access to sterile equipment is available at all times.

Documentary evidence required:
D2.4.1.1 Decontamination policy.
D2.4.1.2 Procedures for the stages of decontamination.
D2.4.1.3 Procedures for the operation and testing of all washers/disinfectors.
D2.4.1.5 Procedure for gas sterilization.
D2.4.1.6 Procedures for the decontamination of instruments used on patients with a known or suspected human prion disease.
D2.4.1.11 Procedures for unpacking and checking re-usable instruments.

Personnel to work with the sub section:
Sterile service manager or equivalent
Infection control team representative
Operating theatre representative

D2.5 Waste Management

Overview

The secure management of healthcare waste is an essential part of ensuring that healthcare activities do not pose a risk or potential risk of infection. Good waste management also identifies opportunities to improve waste minimization and reduce the associated environmental and carbon impacts of managing waste, which is a stated goal for the Emirate of Abu Dhabi.

(M) D2.5.1 The healthcare facility reduces the risk of infection through the safe disposal of waste.[1]

Guidance
The waste management policy includes the designation of a responsible officer, waste segregation and coding, classification of waste, waste minimization (including targets for reducing waste), re-use of equipment and re-cycling, options for cost-effective disposal, the role of the infection control team, and staff training. The policy also references the current legislative obligations to be met.

[1] **References for D2.5.1:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17
- Ministry of Health & Prevention, Hospital Regulations, 2018
- World Health Organization, Safe management of wastes from health-care activities, 2nd edition, 2014

The “waste hierarchy” ranks waste management options according to what is best for the environment. Most commonly a waste hierarchy is ‘Prevention, Re-use, Recycling, Recovery, Disposal’ and is often presented as a framework or inverted pyramid. Priority is given to preventing waste then passes through stages of re-use, recycling, other recovery methods to final disposal, including determining the best disposal routes, which for hazardous waste will involve specialist waste disposal contractors. The healthcare facility assures itself that the contractor has all the correct permits and licenses to perform the tasks which are contained within the contract. The contract specifies how periodic monitoring will be undertaken and penalty clauses if specifications are not met. The contract also includes contingency arrangements in the event of service failure.

Staff who use needles and other sharp instruments, such as scalpels, need to use particular care in their use to avoid needlestick injuries. A policy for the use and disposal of sharps specifies that sharps are disposed of in special containers which may be of different colors to identify particular hazards, for example, if used for cytotoxic drugs. The containers are labelled and dated to identify where sited; they are sealed and removed when three-quarters full. The full containers are stored securely until disposed of by the waste disposal contractor.

Waste includes general waste which generally falls into the category of ‘disposal’ unless it can be recycled, such as glass, plastics and paper. Care needs to be taken to ensure that any patient identifiable information or any other deemed as confidential (financial, staff records, minutes of meetings etc.) is either shredded or disposed of in a way that ensures that it is kept confidential.

Measurable Elements

(D) D2.5.1.1 There is a designated manager with training and experience in healthcare waste management.

D2.5.1.2 The healthcare facility has a Medical Waste Certificate and medical waste disposal contract between the facility and an approved company from the Centre of Waste Management – Abu Dhabi (TADWEER).

D2.5.1.3 There is a waste management policy (see guidance).

D2.5.1.4 The waste policy specifies how the healthcare facility will address the waste hierarchy in accordance with national legislation.

D2.5.1.5 The waste management policy and associated procedures are developed in conjunction with the infection control team.

D2.5.1.6 The healthcare facility has a dated contract with a licensed contractor for the removal and disposal of waste from the facility.

D2.5.1.7 There are procedures for the segregation and disposal of all waste produced within the healthcare facility, which include but are not limited to, the disposal of:

a) Clinical waste including body parts and pathology samples,
b) Non-clinical waste,
c) Hazardous waste, including drugs,
d) Cytotoxic and cytostatic waste,
e) Radioactive waste,
f) Liquid waste,
g) Kitchen waste,
h) Confidential waste,
i) Large items, such as furniture, beds, chairs etc.

D2.5.1.8 There is a policy and procedures for the safe use and disposal of sharp objects.

D2.5.1.9 The healthcare facility can demonstrate that it provides approved containers suitable for the type of waste generated and in accordance with the requirements of the waste disposal contractor.

D2.5.1.10 Segregated waste is kept secure in a dedicated and locked waste storage room.

D2.5.1.11 All staff who deal with clinical waste undertake a training program in clinical waste handling and management. Records of attendance are kept.

Documentary evidence required:

D2.5.1.3 Waste management policy.

D2.5.1.6 Contract with waste disposal contractor.
D2.5.1.7 Waste management procedures as listed.
D2.5.1.8 Policy and procedure for use and disposal of sharps.

Personnel to work with the sub section:
Waste manager
Infection control team representative
OSH staff
Duty nurses
Facilities manager
Medical Physicist (if the facility produces radioactive waste)

D2.6 Housekeeping

Overview
To maintain infection prevention and control, it is vital that the healthcare facility is maintained in a clean and hygienic condition by staff trained in infection control measures. The processes for housekeeping are developed with infection control staff advice, equipment and resources are provided to ensure effectiveness and minimize risk to patients, staff, visitors and contractors. This element addresses the roles, responsibilities, processes and activities.

(M) D2.6.1 There are processes and systems for keeping the healthcare facility clean and hygienic.[1]

Guidance
There is a dedicated housekeeping manager whose role includes liaison with nursing staff and the infection control team to ensure cleanliness throughout the healthcare facility. If the cleaning services are undertaken by an external contractor, then the contract specifies the cleaning responsibilities, schedules and expected standards of cleanliness. The infection control team is involved in the contracting process.
The housekeeping policy outlines, responsibilities, schedules, contingency planning, cleaning methodologies, including a list of approved and up to date disinfectants and detergents, monitoring and reporting mechanisms, measure for protection of cleaning staff, and how cleaning equipment itself is cleaned. The policy is in accordance with national recommendations/regulations.
A color-coding system defines which cloths and mop heads are used for patient areas, catering areas, sanitary areas and general areas so helps prevent cross infection.
Measurable elements
D2.6.1.1 There are roles and responsibilities for the management of cleaning services within the healthcare facility.
D2.6.1.2 There is a policy for the domestic services/housekeeping.
D2.6.1.3 There are schedules for daily and weekly cleaning and for periodic cleaning tasks such as window cleaning and deep cleaning.
D2.6.1.4 Cleaning processes have been risk assessed to check the procedures used for each task and area provide a high level of cleanliness.
D2.6.1.5 There is a procedure for the management of spillage of body fluids.
D2.6.1.6 There are procedures for managing and reporting the presence of vermin and pests.
D2.6.1.7 There are procedures on the use, cleaning, storage and care of cleaning equipment.
D2.6.1.8 Housekeeping equipment is not stored with waste.

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[1] **References for D2.6.1:**
- Gulf Cooperation Council-Center for Infection Control, Infection Prevention and Control Manual, 3rd edition, 2018

D2.6.1.9 There is a color-coding or labelling system for cleaning equipment and materials.
D2.6.1.10 There are procedures for measurement, labelling, storage and correct use of the approved cleaning products, including stock control and stock rotation.
D2.6.1.11 Housekeeping staff receive in-service training on infection control. Attendance is recorded.
D2.6.1.12 Housekeeping staff have received specific training when working in the area of critically ill patients (see also E2.3.4).

Documentary evidence required:
D2.6.1.2 The policy for the domestic services/housekeeping.
D2.6.1.5 The procedure for the management of spillage of body fluids.
D2.6.1.6 The procedures for managing and reporting the presence of vermin and pests.
D2.6.1.7 The procedures on the use, cleaning, storage and care of cleaning equipment.
D2.6.1.10 The procedures for measurement, labelling, storage and correct use of the approved cleaning products, including stock control and stock rotation.

Personnel to work with the sub section:
Housekeeping manager
Infection control team representative
OSH staff
Director of Nursing
Duty nurses

D2.7 Laundry and linen

Overview
The provision of an adequate laundry service is a fundamental requirement of direct patient care. Although soiled linen may be contaminated with microorganisms the risk of disease transmission is negligible if it is handled, transported and laundered in a manner that avoids dispersal (Damani 2003).
Laundry and linens used by patients are designed to preserve the patient's dignity, promote the patient's care, and be appropriate to the patient group, gender, clinical status, religion and beliefs. For the purposes of this sub section, linen includes bed linen, curtains, hoist slings, patient clothing (gowns, nightdresses and shirts, pajama tops and bottoms) and staff clothing.
Healthcare facilities that outsource their laundry service have processes to assure themselves that linens are handled safely and effectively through close monitoring of the contracted service.

(C) D2.7.1 Laundry practices are managed to minimize any risk from harm of cross infection from linen used in the healthcare facility.[1]

Guidance
There needs to be responsibilities and accountability for the management of linen that is used in the facility. This may be the housekeeping manager, but the role includes liaison with nursing staff and the infection control team to ensure the supply of clean linen and the safe removal of soiled linen throughout the healthcare facility. If the laundry services are undertaken by an external contractor, then the contract specifies the cleaning responsibilities, schedules and expected standards of cleanliness as well as key performance indicators. The infection control team is involved in the contracting process.

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[1] **References for D2.7.1:**
- Manual of infection control procedures, N.N. Damani (Ed.), Greenwich Medical Media Ltd., 2003
- https://www.nipcm.hps.scot.nhs.uk/chapter-1-standard-infection-control-precautions-sicps
- Gulf Cooperation Council-Center for Infection Control, Infection Prevention and Control Manual, 3rd edition, 2018

The linen and laundry policy includes the categories of linens for infection control, for example, clean, used, infectious, and how each category is to be handled, including the use of color coded and dissolvable bags. The associated procedures specify the frequency of laundering for each item, bed linen, curtains, uniforms and how they are laundered i.e., cleaning methods and temperatures used for the types of linen in use and the infection control category. The storage areas used for clean and dirty linens rooms are not used for the storage of anything else.

Measurable Elements

D2.7.1.1 There are arrangements and accountabilities for the management of the laundry and linen services within the healthcare facility.

D2.7.1.2 There is a current documented policy for the management of linen and the laundry (see guidance).

D2.7.1.3 There are documented procedures for the handling and laundering of linen.

D2.7.1.4 There is functional separation of clean and used linen during storage and transport.

D2.7.1.5 There is evidence that only linen is stored in the clean and dirty linen storage areas.

D2.7.1.6 Containers for transporting soiled linen bags and storage areas are cleaned on a systematic basis.

D2.7.1.7 Contracted out linen and laundry services are monitored against this standard.

(C) D2.7.2 The in-house laundry is managed to protect staff and patients.[1]

(Note: where there is no in-house laundry this criterion may be assessed with staff from the company providing the service.)

Guidance

The in-house laundry is required to have safe practices to protect staff and to ensure the equipment is maintained to be effective. The healthcare facility also needs to ensure that clean linen is stored and handled carefully to protect it from moisture and dirt.

If staff receive an injury from sharps left in the laundry, there is traceability to where the linens were used and bagged to enable tracking the source and assessing the risk of infection to the injured staff member and their treatment and ongoing care reflects this.

Measurable Elements

D2.7.2.1 The laundry is situated within a designated room that is temperature controlled and is used for laundry purposes only.

D2.7.2.2 The on-site laundry has:

a) Separate washing machines and dryers (for commercial use),
b) Segregated area for dirty linen and linen skips,
c) Segregated area for temporary clean linen storage,
d) A separate ironing area away from used linen,
e) Hand wash basin with liquid soap and paper towel dispenser,
f) Disposable gloves and aprons,
g) Waterproof dressings available to cover any cuts and sores on the hands.

D2.7.2.3 The laundry facility has separate areas for dirty and clean linen that allows for a flow of items from the dirty to clean area only.

[1] **References for D2.7.2:**

- National Guidance for Safe Management of Linen in NHS Scotland Health and Care Environments, 2020
- https://www.nipcm.hps.scot.nhs.uk/chapter-1-standard-infection-control-precautions-sicps
- UK Department of Health, Health Technical Memorandum 01-04: Decontamination of linen for health and social care, management and provision, 2016

D2.7.2.4 There is evidence that the washing machines and dryers are subject to a planned program of service and maintenance.
D2.7.2.5 Clean and unused linen clean linen is stored off the floor in an allocated clean cupboard away from used/soiled linen, to prevent undue re-absorption of moisture, airborne depositions and pests.
D2.7.2.6 Laundry staff are provided with personal protective equipment.
D2.7.2.7 There is evidence that laundry staff are monitored for allergic reactions, contact dermatitis and respiratory conditions as a result of working with detergents and linens.
D2.7.2.8 Any injuries sustained by laundry staff due to sharp objects being left in soiled linen is reported as an incident and the staff treated accordingly.
D2.7.2.9 Laundry staff receive in-service training on infection control. Attendance is recorded.
D2.7.2.10 There is evidence that the infection control team undertakes infection surveillance in the laundry.

Documentary evidence required:
D2.7.1.2 Policy for the management of linen and the laundry.
D2.7.1.3 Procedures for the handling and laundering of linen.

Personnel to work with the sub section:
Laundry/ Housekeeping manager
Infection control team representative
OSH staff
Director of Nursing
Duty nurses

D2.8 Catering Service

Overview
Catering services for patients and staff provide nutritious well-balanced meals that are produced in hygienic kitchens by appropriately trained staff.
(Note: where there is no catering service run by the healthcare facility this element may be assessed with staff from the company providing the service.)

(M) D2.8.1 The catering service has processes for the provision of safe foods.[1]

Guidance

The person with overall responsibility for the catering service has training and experience in catering, nutrition, therapeutic diets and food hygiene, in order to understand the needs of patients and staff.

The operational policy takes into account all provisions of Public Health Laws. It outlines the specification and scope of the catering services provided. It defines the service's objectives to provide food, which is safe, balanced, and nutritious and meets patient's clinical, religious and dietary needs including notification of patient allergies. The policy states how the service works with dieticians and nutritionists to plan menus and special meals. The policy includes the catering arrangements for staff and visitors and makes explicit arrangements for staff working night shifts. For contracted services the contract contains key performance indicators for delivery such as food kept at the correct temperature.

Measurable Elements

D2.8.1.1 There is a qualified and experienced senior manager or equivalent responsible for the catering service and facilities**.**

D2.8.1.2 There is evidence that where healthcare facilities provide food the catering facilities meet Public Health Law for food hygiene requirements**.**

D2.8.1.3 There is an operational policy for the catering service, including contracted catering services.

D2.8.1.4 The catering service works with nutritionists and dieticians in preparing menus and special diets.

D2.8.1.5 There are documented procedures on the hygienic preparation, cooking and cooling of foods, including (but not limited to):

a) Washing of raw foods,
b) Thawing frozen foods,
c) Cooking temperatures,
d) Serving temperatures.

D2.8.1.6 There is a documented procedure for managing food waste which is in accordance with the healthcare facility's waste management policy (D2.5.1.3).

D2.8.1.7 There is a process of stock control ensuring stock is rotated on a first-in-first-out basis and that there are no out of date items in stock.

D2.8.1.8 There are documented procedures for the storage of different food types.

(D) D2.8.1.9 There is a system to ensure that food kept in vending machines is fit for consumption and has not exceeded safe use by dates and is replenished when stocks run low

(M) D2.8.2 The kitchens and equipment are maintained and supports infection prevention.[2]

Guidance

The kitchen equipment needs to be maintained to ensure food safety and this includes temperature and calibration checks of refrigerators, freezers, gas and pressure equipment, deep fat fryers and ovens. Particular attention is given to safety systems or alarms on walk-in refrigerators and freezers and heated food trolleys. Food preparation areas are segregated to allow for the safe preparation of food for those with known allergies such as nuts, shellfish, lactose, eggs etc.

Measurable Elements

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[1] **References for D2.8.1:**

- Abu Dhabi Food Control Authority, A Guide to the Preparation of a HACCP-Based Food Safety Management System for Schools & Hospitals, 2012

[2] **References for D2.8.2:**

- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018

D2.8.2.1 There is a system to restrict unauthorized entry to the food preparation and storage areas.
D2.8.2.2 The layout of the kitchen is designed for efficient and hygienic flow of food preparation and there are separate areas for:

a) Food preparation, including areas for special diets such as gluten free, infant feeds and for those with allergies,
b) Cooking and reheating,
c) Holding areas for prepared food at correct temperatures for the type of food,
d) Food storage for dry goods, fresh fruit and vegetables,
e) Food waste,
f) Equipment storage areas,
g) Cleaning equipment,
h) Designated sinks for hand washing.

D2.8.2.3 There is evidence that equipment complies with relevant safety standards and is maintained in accordance with manufacturers' instructions.
D2.8.2.4 The temperature, ventilation and humidity levels of the kitchen are controlled to maintain a comfortable working environment.
D2.8.2.5 There are documented procedures on washing and cleaning of catering equipment which include what detergents and cleaning materials may be used on what equipment.
D2.8.2.6 There are separate areas for the storage of cleaning equipment and materials.
D2.8.2.7 Kitchen wall coverings are made of waterproof, non-absorbent and non-toxic material.
D2.8.2 8 Firefighting equipment is available within the kitchen.
D2.8.2 9 There are devices and regular inspections to deal with pests, vermin and insects within the catering service.

(C) D2.8.3 Catering Staff are trained and supervised in infection control.[1]

Guidance

Catering staff receive induction and training to the same degree as clinical staff as their role in maintaining infection prevention and control is vital. The policy for the health of catering staff includes requirements for health screening, immunizations, personal cleanliness standards expected and the use of protective clothing, covering of cuts and wounds and the actions to take if a food handler reports a condition which may or may not be potentially infectious.

Measurable elements

D2.8.3.1 There is a training program in place for catering supervisors and food handlers which includes:

a) Food handling and hygiene practices,
b) Infection control practices,
c) Health and safety in the kitchen including the use of protective equipment and clothing,
d) Risk assessments.

D2.8.3.2 Records of catering staff training are kept, including attendance at mandatory training (see sub-section A4.3)
D2.8.3.3 There is a policy and procedures on the health and personal hygiene requirements for catering staff and food handlers.

Documentary evidence required:

D2.8.1.3 Operational policy for the catering service.

[1] **References for D2.8.3:**

- Abu Dhabi Food Control Authority, A Guide to the Preparation of a HACCP-Based Food Safety Management System for Schools & Hospitals, 2012

D2.8.1.5 Procedures on the hygienic preparation, cooking and cooling of foods.
D2.8.1.6 Procedure for managing food waste.
D2.8.1.8 Procedures for the storage of different food types.
D2.8.2.6 Procedures on washing and cleaning of catering equipment.
D2.8.3.3 Policy and procedures on the health and personal hygiene of catering staff.

Personnel to work with the sub section:
Catering manager
Infection control team representative
Duty nurses

SECTION D3 DIAGNOSTIC IMAGING

Overview
The assessment/reassessment of patients to determine the proper diagnosis, the course of treatment, and evaluation of treatment plan for future decisions may require diagnostic imaging services. There is a range of diagnostic imaging that the healthcare facility may offer. This sub section addresses the roles and responsibilities of those who manage the imaging services, and how the safety and wellbeing of the patient and staff are maintained.
Whilst all healthcare facilities are subject to the Federal Authority for Nuclear Regulation (FANR) 24[1] (and possibly FANR 007[2]) these standards are not intended to replace these inspections but are intended to help meet the regulations. The FANR-24 article is referenced where appropriate.

D3.1 General Radiology

(M) D3.1.1 The imaging department has management plans in place to provide a safe and effective service.

Guidance
The operational policy details the management structure for the service; governance arrangements, equipment available, the standards the service shall work within, multidisciplinary teams and the lead clinicians for the teams, monitoring and audits, normal operating hours and the out of hours provision; the number of staff and skill mix required to cover all the services provided; reporting responsibilities; routine maintenance and how service breakdowns are managed; liaisons with other departments.
The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.

Measurable Elements
D3.1.1.1 The imaging service has a current operational policy which outlines the core services provided by the service.
(D) D3.1.1.2 The imaging service has a current documented service plan.

(M) D3.1.2 The healthcare facility complies with the general radiology requirements of FANR-24.[1]

Guidance

The imaging department may not have had any recent inspections in respect of the FANR-24 (and FAN-007) requirements, it is therefore important that the service monitors its own compliance and has an action plan to address any non-conformities found. The healthcare facility has responsibility to monitor the amount and activity of radioactive material held in accordance with the FANR-007 and FANR-24 and take action accordingly.

Measurable Elements

D3.1.2.1 There is evidence that the imaging service has met the requirements of FANR-24 and monitors ongoing compliance.
D3.1.2.2 There is evidence that the imaging service has an action plan to meet those requirements of FANR-24 that were not met at the most recent inspection.
D3.1.2.3 The imaging department has the required license to use ionizing radiation generators and radioactive materials.

(M) D3.1.3 The imaging service has procedures and competent staff to provide imaging services.[2]

Guidance

Competency frameworks are developed for each imaging type, for example, general radiology, MRI, CT scanning. Staff are supervised until they have attained the competency level set.
A Medical Physics Expert is involved as appropriate for consultation on optimization, including patient dosimetry and quality assurance, and to give advice on matters relating to radiation protection concerning medical exposure, as required, in all other radiological practice. They have responsibility for leading the requirement to meet the FANRs.
The procedures for recording include how and by whom images are interpreted, reported, verified, time limits, situations when results may be given verbally and what information is required. The procedures detail the actions to take in the event of an unexpected significant finding including the recommendation for further tests. Ultrasound examinations might be undertaken by obstetricians and midwives if they have the training specified by the Ministry of Health. There is a list of clinicians who may undertake and report the findings of sonography examinations.

Measurable Elements

D3.1.3.1 There are competency frameworks in place for all staff working in the imaging service, including radiation technologists, medical experts, radiation protection officers.
D3.1.3.2 There is an approved list of non-medical staff and physicians who are licensed and competent to report on images. This may include orthopedic and thoracic surgeons, specialist radiation technologists, midwives.
D3.1.3.3 The healthcare facility employs, or can access, a qualified and licensed medical physics expert (MPE).
D3.1.3.4 There are documented procedures for the recording and reporting of results.
D3.1.3.5 Ultrasound examinations are undertaken by clinicians with training and experience in the specific area of sonography.

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[1] **References for D3.1.2:**

- Federal Authority for Nuclear Regulation, Basic Safety Standards for Facilities and Activities involving Ionizing Radiation other than in Nuclear Facilities, (FANR-REG-24) Version 1

[2] **References for D3.1.3:**

- UAE Unified Healthcare Professional Qualification Requirements, 2022
- Federal Authority for Nuclear Regulation, Basic Safety Standards for Facilities and Activities involving Ionizing Radiation other than in Nuclear Facilities, (FANR-REG-24) Version 1

(M) D3.1.4 The practices of the imaging service are managed to protect staff, patients, visitors and contractors from harm arising from the use of ionizing radiation in accordance with the requirements of FANR-24.[1]

Guidance

The role of the medical exposures committee (or equivalent) is to review compliance with national regulations on radiation exposure. It has responsibility to consider issues including protocols for medical exposure; medico-legal exposures; diagnostic reference levels and any doses exceeding reference levels; initial and continuing training of practitioners and operators; and clinical audit. The committee membership is comprised of a member of the Senior Individuals, a radiologist, radiology manager and qualified radiation expert, the OSH staff. The minutes of all meetings are kept.

Controlled and supervised areas are areas which are likely to receive a certain amount of radiation; this may be from radiation producing equipment or areas using radioactive sources. Both controlled and supervised areas are clearly signposted. Although the magnetic resonance scanner does not produce ionizing radiation it is also be located in a controlled area. The local rules are written in accordance with article 22 of the FANR-24 and are to ensure that work is carried out in accordance with the regulations. There is a defined set of rules covering each area where ionizing radiation is produced or used.

Room safety checks may be undertaken at the same time as regular quality checks of the equipment. The equipment includes all physical control measures, for example, shielding, enclosure, ventilation, safety features and warning devices to ensure that their condition does not deteriorate so that they no longer provide the required level of protection. Records are maintained of all inspections and calibrations. The safety checks include the integrity of personal protective equipment such as lead aprons and screens. The procedure to check accuracy of instrumentation for the measurement of radiation includes maintenance checks and the frequency of calibration of the ionization chambers against a secondary standard. Calibration certificates are kept.

Audits of patient dose levels are used to compare doses received against the national dose reference levels. Where these are consistently exceeded, corrective measures are taken, and the audits repeated.

Radiation imaging undertaken in areas other than the imaging department include the use of mobile radiography, operating theatres. The procedures define how these areas are designated and the steps taken to maintain radiation safety.

The procedures for imaging pregnant women, and women who are breast feeding state what measures are to be taken to identify such women, the relevant clinical risks involved and the responsibility for making the decision to proceed or not. It includes the steps to be taken to reduce the radiation dose to the minimum, having regard for the latest recommendation on doses to fetuses. The procedure includes imaging by non-ionizing modalities, for example magnetic resonance imaging (MRI).

A request for imaging contains sufficient clinical information for a clinician or practitioner to agree the most appropriate procedure for the clinical presentation and for it to be a justifiable examination. This may be done with a set of authorization guidelines which may be locally or nationally approved. The request is also from an approved referrer.

Quality assurance essentially consists of an organized set of activities and processes that ensure x-ray equipment is functioning properly and providing satisfactory diagnostic information in a timely manner with minimum radiation dose to patients. The quality assurance program includes routine equipment tests carried out by department staff and annual/biennial tests by medical physicists. The program includes an assessment of radiation doses received by patients from different types of examination.

Measurable Elements

[1] **References for D3.1.4:**

- Federal Authority for Nuclear Regulation, Basic Safety Standards for Facilities and Activities involving Ionizing Radiation other than in Nuclear Facilities, (FANR-REG-24) Version 1
- Federal Authority for Nuclear Regulation, Radiation Safety (FANR-RG-007), Version 1
- United Arab Emirates Ministry of Health and Prevention, Hospital Regulations, 2018
- UAE Unified Healthcare Professional Qualification Requirements, 2022

D3.1.4.1 There is a medical exposures committee (or equivalent) with documented terms of reference.
D3.1.4.2 There are designated controlled and supervised areas where ionizing radiation is produced (article 21).
D3.1.4.3 There are local rules for each controlled area (article 22).
D3.1.4.4 There is a quality assurance program for all equipment (article 12).
D3.1.4.5 There is a schedule for all rooms and equipment to be assessed for quality and safety by a qualified radiation expert (article 38).
D3.1.4.6 There is a documented procedure to check the accuracy of instrumentation used for the measurement of radiation and radioactive sources (article 35).
D3.1.4.7 There is evidence that the service audits patient radiation doses received during a range of procedures (articles 36, 37).
D3.1.4.8 Staff working with radiological equipment or radiation sources wear radiation monitoring devices that are assessed (articles 8- 10).
D3.1.4.9 There are documented procedures for imaging examinations undertaken in areas other than the imaging department.
D3.1.4.10 There is a documented procedure on imaging pregnant women and imaging the abdomen of women of childbearing age (articles 33, 39).
D3.1.4.11 There are prominently displayed posters warning pregnant women on the dangers of radiation to the fetus. The posters are in Arabic and the dominant language of the community.
D3.1.4.12 There is a documented procedure for the assessment of requests for imaging (article 33).

(M) D3.1.5 The imaging service's equipment and information technology are maintained.[1]

Guidance

Preventative maintenance includes all physical control measures for example, shielding, enclosure, ventilation, safety features and warning devices to ensure that their condition does not deteriorate so that they no longer provide the required level of protection. Records are maintained of all inspections and calibrations.
Replacement programs consider the projected lifetime of equipment and consideration given to new technologies particularly those allowing dose reduction and features to measure radiation doses delivered, principally when using fluoroscopy.

Measurable Elements

D3.1.5.1 There is a planned preventative maintenance program for all equipment (article 14).
D3.1.5.2 There is a planned replacement program for all equipment.
D3.1.5.3 There is a policy for the use of the imaging service's information technology systems in accordance with the healthcare facility's information technology governance and risk management (see section A6).
D3.1.5.4 There is a documented procedure for the retention and destruction of radiological images, both digital and hard copies and in accordance with the healthcare facility's policy (see section A6).
D3.1.5.5 There are secure storage areas in the service for records, hard copy images, calibration equipment.

[1] **References for D3.1.5:**

- Federal law No. 2, on the Use of The Information and Communication Technology (ICT) In Health Fields, 06/02/2019
- Abu Dhabi Department of Health, Standard on Patient Healthcare Data Privacy, 2020
- Abu Dhabi Department of Health Policy on the Abu Dhabi Health Information Exchange, April 2020

(C) D3.1.6 Patients attending the imaging service are treated with dignity and respect.[1]

This criterion must be assessed as part of Section B: Person Centered Care.

Guidance

Patients and their family accompanying persons are given information about the specific examination being undertaken and are informed about the benefits, possible side effects and risks of the procedure and the risks of not having the procedure, as well as stating that they can change their minds if they do not wish to proceed.

The contrast media policy includes who has permission to administer contrast media and what types of agents are used and under what conditions. The procedures state what contrast agent is to be used for each type of examination, the steps taken to prevent allergic reactions and the actions taken if these occur, reference is also be made to aseptic techniques. Records are kept of all contrast media administered, including patient's name, contrast media batch number, quantity and concentration, method of administration and person administering the agent.

Conscious sedation is a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be conducted, but during which verbal contact with the patient is maintained throughout the period of sedation. There may be several imaging examinations that require conscious sedation. The policy and procedure for their use identifies the examinations and circumstances under which conscious sedation may be required. The drugs and techniques used to provide conscious sedation carry a margin of safety wide enough to render loss of consciousness unlikely. The policy specifies who may introduce sedation or anesthesia, the age of patients that it may be used for, the drugs (including nitrous oxide) and route used, the facilities and equipment that is available, staff competency, patient assessment, pre and post sedation instructions. If services are being offered for children and young people under the age of 16 years, there are staff with specialized pediatric anesthetic and resuscitation skills available. The procedures include aftercare instructions.

The information materials offered are available in both Arabic and English and the language of the dominant migrant population. They include, for example, instructions such as fasting needs, water consumption before the examination, and the likely length of time the examination will take.

Where children and young adults are examined, there is also a range of age-appropriate material.

Measurable Elements

D3.1.6.1 The imaging service provides facilities for patients to wait comfortably with:

a) A range of seating to allow patients with mobility problems to sit and rise with ease,
b) Space for wheelchairs,
c) Cubicles for trolleys to allow privacy,
d) Good access to toilets,
e) Areas allowing privacy for patients to change into gowns.

D3.1.6.2 Imaging service staff treat patients attending the service with dignity and respect considering the special needs of people of determination, the elderly, children whilst maintaining awareness of cultural beliefs.

D3.1.6.3 There is a process in place for giving patients a clear explanation of the procedure they are to have prior to a radiation exposure.

D3.1.6.4 There is a list of examinations and circumstances that require signed consent.

D3.1.6.5 There is evidence that informed consent to radiological and ultrasound examinations is obtained where required in accordance with the healthcare facility's policy on informed consent (see sub section B4.3).

D3.1.6.6 There is evidence that imaging service staff check the identity of the patient prior to starting examination in accordance with the healthcare facility's procedure (C2.4).

D3.1.6.7 There is a policy and procedures on the use of contrast media (see guidance).

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[1] **References for D3.1.6:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17

D3.1.6.8 There is a policy and procedure for the use of conscious sedation and anesthesia (see guidance).
D3.1.6 9 There is a range of information available for patients to inform them about the examination and the preparations that may be needed.

Documentary evidence required:
D3.1.1.1 Current operational policy which outlines the core services provided by the service.
D3.1.1.2 Current documented service plan.
D3.1.3.4 Procedures for the recording and reporting of results.
D3.1.4.1 Terms of reference of the medical exposures committee.
D3.1.4.6 Procedure to check the accuracy of instrumentation used for the measurement of radiation and radioactive sources.
D3.1.4.9 Procedures for imaging examinations undertaken in areas other than the imaging department.
D3.1.4.10 Procedure on imaging pregnant women and imaging the abdomen of women of childbearing age.
D3.1.4.12 Procedure for the assessment of requests for imaging.
D3.1.5.3 Policy for the use of the imaging service's information technology systems.
D3.1.5.4 Procedure for the retention and destruction of radiological images.
D3.1.6.7 Policy and procedures on the use of contrast media.
D3.1.6.8 Policy and procedure for the use of conscious sedation and anesthesia.

Suggested personnel to work with the sub section:
Radiologist
Radiographers
Ultrasonographer
Reception staff
IT staff
Nursing staff

D3.2 Interventional Imaging

(M) D3.2.1 There are procedures for undertaking safe interventional imaging.[1]

Overview
Interventional imaging is a technique whereby medical imaging is used to guide minimally invasive surgical procedures that diagnose, treat, and cure several conditions. Imaging modalities used include fluoroscopy, MRI, CT, and ultrasound.

Guidance
A holistic assessment of the patient is undertaken to obtain a thorough medical history of the current condition and general medical/surgical status including current medical treatments. A physical examination is performed to evaluate the patient's status, level and origin of symptomatology and to adapt the treatment strategy accordingly. Special attention is given to the risk factors for allergic predispositions for contrast media, local anesthetics and antibiotics.
The World Health Organization's surgical checklist may be adapted to suit local requirements.

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[1] **References for D3.2.1:**

- World Health Organization, Implementation Manual, Surgical Safety Checklist 2009
- https://www.cirse.org/education/standards-of-practice/ir-patient-safety-checklist/
- Cardiovascular and Interventional Radiological Society of Europe, Clinical Practice Manual, Andreas H. Mahnken, Esther Boullosa Seoane, Allesandro Cannavale, Michiel W. de Haan Rok Dezman Roman Kloeckner Gerard O'Sullivan, Anthony Ryan, Georgia Tsoumakidou, 2021

Measurable Elements

D3.2.1.1 Interventional imaging is performed in a room that is equipped with cardiac monitoring and resuscitation equipment and undergoes deep cleaning after use.

D3.2.1.2 The imaging service can evidence that interventional procedures are only undertaken or supervised by senior licensed radiology specialist physician with specific training in the procedure.

D3.2.1.3 There is a documented procedure for the evaluation of patients who may benefit from interventional imaging in preference to a more invasive procedure.

D3.2.1.4 There is a documented procedure for the preparation of patients who are to have an interventional imaging procedure.

D3.2.1.5 The imaging service applies the WHO Surgical Safety Checklist when undertaking interventional procedures.

D3.2.1.6 There is a documented procedure for handling biological specimens taken during an interventional procedure.

D3.2.1.7 Post procedure care instructions are given to the patient in accordance with the healthcare facility's policy (see B3.1).

Documentary evidence required:

D3.2.1.3 Procedure for the evaluation of patients who may benefit from interventional imaging.

D3.2.1.4 Procedure for the preparation of patients who are to have an interventional imaging procedure.

D3.2.1.6 Procedure for handling biological specimens taken during an interventional procedure.

Suggested personnel to work with the sub section:

Specialist Radiologist

Specialist radiographers

Nursing staff

D3.3 Magnetic Resonance Imaging (MRI)

Overview:

Magnetic resonance imaging (MRI) is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. An MRI scan can be used to examine almost any part of the body including the brain and spinal cord, bones and joints, breasts, heart and blood vessels, internal organs, such as the liver, womb or prostate gland. The results of an MRI scan can be used to help diagnose conditions, plan treatments and assess how effective previous treatment has been. There are different types and strengths of scanners. Whilst they do not carry the same risks as ionizing radiation, not all scanners are appropriate for all patients, particularly if the patients are claustrophobic or very obese.

(M) D3.3.1 There are procedures for undertaking safe magnetic resonance imaging.[1]

Guidance

Referring physicians consider the ability of their patients to undergo an MRI scan and assess if they are claustrophobic and able to fit into a standard scanner if this is the only type available. This assessment is mentioned on the request. The request is required to specify if the patient has any implantable device. These may include cardiac pacemakers, defibrillators, neuro-stimulators, cochlear implants and drug infusion pumps. There are MR conditional pacemakers available, but this needs to be verified for each patient.

Non-active implantable medical devices may include hip/knee joint replacements, heart valves, aneurysm clips, intravascular stents, filters and coils, ocular implants. Some transdermal patches contain metal in the backing so if in doubt the patch is removed.

There may be several controlled zones around the scanner. The 0.5 and 3mT fringe fields are displayed and access restricted accordingly. These fringe fields are measured independently of the manufacturer's plots. There are clear warning signs at each entrance to the designated control area from which staff are able to see the entrance to the scanner room and the corridors around the entrance to ensure limited access. This may be by close circuit television system if necessary.

There is a potential risk of oxygen displacement in the scanner room due to cryogenic boil off and the healthcare facility assesses this risk. The vent pipes are designed so that ingress by rain or detritus is not possible. The pipes may not be checked by the manufacturers during routine maintenance, so the healthcare facility takes responsibility. There is an alarm system in place to alert staff to falling oxygen levels.

Ancillary equipment is labelled using color coded labels to describe the equipment as MR safe; MR conditional; MR unsafe this includes oxygen cylinders and fire extinguishers. If more than one MRI system is used with different field strengths, then the maximum magnetic field is labelled as well. All staff in the unit are aware of the labelling and understand its implications. The MRI service keeps an updated list of all compatible equipment.

Gadolinium based contrast agents are not used in patients with renal impairment or pregnant and breast-feeding women. The procedure states who may take the decision to use a gadolinium-based contrast agent. New warnings from the FDA, added in 2018, say gadolinium can stay in the body for months to years after receiving these drugs during an MRI scan. It can build up in bone, brain and kidney tissue.

Measurable Elements

D3.3.1.1 There is a process for assessing the ability of patients to undertake an examination in an MRI scanner.

D3.3.1.2 There is a documented procedure for the identification of patients with active and non-active implantable medical devices.

D3.3.1.3 The magnetic resonance scanner is in a controlled area.

D3.3.1.4 The MRI scanner room has 'low oxygen' warning alarms.

D3.3.1.5 External vent pipes from the scanner are regularly inspected and maintained.

D3.3.1.6 Ancillary equipment kept in the MRI unit is clearly labelled as safe to use in the area.

D3.3.1.7 There is a documented procedure for the use of gadolinium-based contrast media.

Documentary evidence required:

D3.3.1.2 Procedure for the identification of patients with active and non-active implantable medical devices.

D3.3.1.7 Procedure for the use of gadolinium-based contrast media.

Suggested personnel to work with the sub section:

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[1] **References for D3.3.1:**

- Ministry of Health & Prevention, Hospital Regulations, 2018
- https://www.drugwatch.com/gadolinium/side-effect
- Medicines and Healthcare products Regulatory Agency (UK): Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use, 2021 ©

Specialist Radiologist
Specialist radiographers
Nursing staff

SECTION D4 LABORATORIES

Overview

The assessment/reassessment of patients to determine the proper diagnosis, the course of treatment, and evaluation of treatment plan for future decisions may require laboratory services. There may be a number of different specialist laboratories, each of which will have a specialist lead.

D4.1 General

(M) D4.1.1 The laboratories are managed to provide safe and effective services.[1]

Guidance

There may be one operational policy covering all the different laboratory specialties and sections. The policy/policies detail the range and scope of services offered, roles and responsibilities, communication processes, hours of operation, quality objectives, compliance with relevant regulations and legislation, staffing and skill mix and a statement of purpose of the quality management system.

There may be one service plan for all the sections of the laboratory or separate ones. The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.

All Laboratories in healthcare facilities in the Emirate of Abu Dhabi are required to have ISO 15189 certification as per Circular (58) issued on 16/10/2019. The Department of Health has developed a comprehensive set of standards (HAAD Clinical Laboratory Standards) for clinical laboratories which the healthcare facility is audited against to identify areas for improvement. This sub-section does not repeat the requirements but checks compliance and actions required for improvement.

Some healthcare facilities may not have the full range of laboratory specialties and will outsource the service through a formal contract process. The contract process ensures that the outsourced work is carried out by a laboratory with current ISO15189 certification from an approved agency.

Measurable Elements

D4.1.1.1 The laboratory services have an operational policy describing the services offered and the management and governance framework.

(D) D4.1.1.2 The laboratory services have a current documented service plan.

D4.1.1.3 The healthcare facility has current licenses to undertake the scope of laboratory services offered.

D4.1.1.4 There is evidence that the design of the laboratories has been assessed against the Ministry of Health & Prevention Clinical laboratory Regulation (2016).

D4.1.1.5 There is evidence that the laboratory service has fulfilled the requirements of ISO 15189 and is certificated by an approved agency.

D4.1.1.6 The healthcare facility has evidence of the ISO15189 certificate for outsourced laboratory services.

D4.1.1.7 The laboratory can demonstrate that it has been audited against the Department of Health (HAAD) Clinical Laboratory Standards.

[1] **References for D4.1.1:**

- Ministry of Health & Prevention: Clinical Laboratory Regulation, 2016
- Health Authority of Abu Dhabi (HAAD) Clinical Laboratory Standards, 2011
- ISO 15189: Medical laboratories — Requirements for quality and competence

D4.1.1.8 There is an action and improvement plan arising from the audits against the Department of Health (HAAD) Clinical Laboratory Standards and ISO 15189.
D4.1.1.9 There is a set of current standard operating procedures in accordance with Ministry of Health & Prevention: Clinical Laboratory Regulations.
D4.1.1.10 There is a process for the review and update of all the standard operating procedures.
D4.1.1.11 There are competency frameworks in place for all staff working in the laboratories.

Documentary evidence required:
D4.1.1.1 Operational policy
D4.1.1.2 Service plan
D4.1.1.5 ISO 15189 certificate
D4.1.1.8 Action and improvement plan

Suggested personnel to work with the standard:
Laboratory staff
Unit staff using the laboratory services

SECTION D5 ENDOSCOPY SERVICE

Overview
There are several types of endoscopy, most involve having a tube with a tiny camera on the end passed through a natural opening in the body depending on which part of the body is being examined. Endoscopy is used as a diagnostic tool and allows for direct viewing and for biopsies to be taken but it can also be used to treat and relieve symptoms. Most endoscopic procedures are undertaken on a day care basis.

D5.1 General

(M) D5.1.1 The endoscopy service is managed to provide a safe and effective service.[1]

Guidance
The operational policy details the management structure for the service; governance arrangements, equipment available, the standards the service shall work within, multidisciplinary teams and the lead clinicians for the teams, monitoring and audits, normal operating hours and the out of hours provision; the number of staff and skill mix required to cover all the services provided; reporting responsibilities; routine maintenance and how service breakdowns are managed; liaisons with other departments.
The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.
The Department of Health has developed a comprehensive set of standards for endoscopy services which the healthcare facility audits itself against and compiles an action plan to meet those areas requiring improvement. This sub-section does not repeat the requirements but checks compliance and actions required for improvement.
Measurable Elements
D5.1.1.1 The endoscopy service has a current operational policy which outlines the core services provided by the service (see guidance).
D5.1.1.2 The scope of endoscopic procedures offered is made publicly available.

[1] **References for D5.1.1:**
- Abu Dhabi Health Authority, Standard for Endoscopy Services, 2014

D5.1.1.3 The scope of services offered does not exceed the license which has been granted.
(D) D5.1.1.4 The endoscopy service has a current documented service plan.
D5.1.1.5 There are competency frameworks in place for all staff working in the endoscopy service, including staff working in decontamination.
D5.1.1.6 There is evidence that the endoscopy service meets the requirements of the Department of Health HAAD Standard for Endoscopy Services.
D5.1.1.7 There is an action and improvement plan arising from audits against the Department of Health HAAD Standard for Endoscopy Services.
D5.1.1.8 Arrangements are in place to manage demand during the downtime when the endoscopy unit is undergoing maintenance and deep cleaning

(C) D5.1.2 Patients attending the endoscopy service are treated with dignity and respect.[1]

This criterion must be assessed as part of Section B: Person Centered Care.

Guidance

Patients and their family accompanying persons are given information about the specific examination being undertaken and are informed about the benefits, possible side effects and risks of the procedure and the risks of not having the procedure, as well as stating that they can change their minds if they do not wish to proceed. Patients are assessed before the procedure to assess whether they are suitable to undergo the procedure and to be given preparation information and medication, if required. This may take place at a pre-assessment clinic, where other tests may be performed or ordered.
The information materials offered are available in both Arabic and English and the language of the dominant migrant population. They include, for example, instructions such as fasting needs, water consumption before the examination, the likely length of time the examination will take and if an escort home is required for those being sedated. Where children and young adults are examined, there is a range of age-appropriate material.
Conscious sedation is a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be conducted, but during which verbal contact with the patient is maintained throughout the period of sedation. There may be several endoscopy procedures that require conscious sedation. The policy and procedure for their use identifies the examinations and circumstances under which conscious sedation may be required.
The drugs and techniques used to provide conscious sedation carry a margin of safety wide enough to render loss of consciousness unlikely. The policy specifies who may introduce sedation or anesthesia, the age of patients that it may be used for, the drugs (including nitrous oxide) and route used, the facilities and equipment that are available, staff competency, patient assessment, pre and post sedation instructions. If services are being offered for children and young people under the age of 16 years, there are staff with specialized pediatric anesthetic and resuscitation skills available. The procedures include the aftercare of patients who have been sedated and their safe discharge.

[1] **References for D5.1.2:**

- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17
- Joint Advisory Group on GI Endoscopy, Pre-assessment and Patient Preparation, 2017
- Joint Advisory Group on GI Endoscopy, Global rating scale (GRS) for UK services, 2021

Measurable Elements

D5.1.2.1 The endoscopy service provides facilities for patients to wait comfortably with:

a) A range of seating to allow patients with mobility problems to sit and rise with ease,
b) Space for wheelchairs,
c) Cubicles for trolleys to allow privacy,
d) Good access to toilets,
e) Areas allowing privacy for patients to change into gowns.

D5.1.2.2 There is evidence that staff of the endoscopy service treat patients attending the service with dignity and respect and considering the special needs of people of determination, the elderly, children whilst maintaining awareness of cultural beliefs.

(D) D5.1.2.3 There is a process for patients to have a pre-assessment consultation prior to an endoscopic procedure.

D5.1.2.4 There is a process in place for giving patients a clear explanation of the procedure they are to have prior to an endoscopic procedure.

D5.1.2.5 There is a range of information available for patients to inform them about the examination and the preparations that may be needed.

D5.1.2.6 There is evidence that informed consent to an endoscopic procedure is obtained in accordance with the healthcare facility's policy on informed consent (see sub section B4.3).

D5.1.2.7 There is evidence that staff of the endoscopy service check the identity of the patient prior to starting examination in accordance with the healthcare facility's procedure (C2.4).

D5.1.2.8 There is evidence that the patients are fully assessed on their suitability for the procedure.

D5.1.2.9 There is evidence that patients are assessed to check that they have followed the preparation instructions and are suitably prepared for the endoscopy procedure.

D5.1.2.10 There is a policy and procedure for the use of conscious sedation and anesthesia (see guidance).

D5.1.2.11 There are procedure-specific aftercare patient information leaflets and discharge instructions for all procedures performed.

D5.1.2.12 There is evidence that patients are given follow-up instructions.

(D) D5.1.2.13 There is a 24-hour helpline for patients or carers who have questions or experience problems.

D5.1.2.14 There is a process for reporting critical findings to the referring physician without delay.

Documentary evidence required:

D5.1.1.1 Operational policy
D5.1.1.4 Service plan
D5.1.1.7 Action and improvement plan
D5.1.2.10 Policy and procedure for the use of conscious sedation and anesthesia

Suggested personnel to work with the standard:

Endoscopy specialist
Endoscopy nurses
Reception staff

SECTION D6 RESUSCITATION

The healthcare facility has a duty of care to provide a safe, early and high-quality resuscitation service, for individuals who present or develop a medical emergency requiring cardiopulmonary resuscitation. Cardiopulmonary resuscitation may be required by any individual in the facility including patients, visitors, contractors and staff. Consideration is given to the availability and type of resuscitation equipment in non-clinical areas to ensure that any medical emergency can be dealt with as quickly as possible.

D6.1 Management of resuscitation

(M) D6.1.1 The healthcare facility provides safe and early management of all individuals who require cardiopulmonary resuscitation.[1]

Guidance

The resuscitation team (or equivalent) is led by a consultant physician with advanced life support training and experience. The role of the resuscitation team is to attend to individuals and to give resuscitation. It also has a wider role to ensure staff adhere to the healthcare facility's policies and procedures for resuscitation, to audit and review outcomes, planning for training, procurement decisions, and developing new procedures in line with latest guidance.

The resuscitation policy details membership of the resuscitation team or teams, the healthcare facility's systems for calling the resuscitation team i.e. the call codes which may be categorized into different colors depending on the patient profile, how to manage this and the responsibilities of staff to this, requirements for healthcare professionals to be competent to perform basic life support and the training in place to support this, post resuscitation care, audit and monitoring arrangements and equipment status. The policy includes the location of crash carts, responsibilities for checking these and frequency.

All procedures for administering resuscitation include post resuscitation care and emergency transfer if required. Special circumstances include cases of massive hemorrhage and neck breathers i.e., those with a tracheostomy.

Records of the resuscitation attempt are kept in the patient's clinical record or record for transfer to a specialist facility.

The process to summon assistance in the event of a suspected cardiac alert is taught at induction, and awareness is raised through ongoing communication, such as information posted in all clinical areas as reminders.

Privacy and dignity of individuals are preserved by moving other people away from the area where possible and the use of screens.

Measurable Elements

D6.1.1.1 There is a multidisciplinary resuscitation team (or equivalent).

D6.1.1.2 All members of the resuscitation team have advanced cardio-vascular life support (ACLS) certification.

D61.1.3 For healthcare facilities that treat children, members of the resuscitation team also have Pediatric and neonatal advanced life support (or Neonatal Resuscitation Programme) certification (PALS and NALS/NRP).

D6.1.1.4 There is a resuscitation policy written in accordance with evidenced-based guidelines (see guidance).

D6.1.1.5 There are documented procedures on adult resuscitation and, where children are treated, pediatric and neonatal resuscitation.

D6.1.1.6 There are documented procedures for managing special circumstances where resuscitation is required.

D6.1.1.7 Detailed records of each resuscitation attempts are kept and includes:

a) The actions taken,
b) Drugs given,
c) Vital signs,
d) Timings,
e) Staff involved,
f) Outcomes.

D6.1.1.8 There is a publicized process for staff to summon assistance in the event of a cardiopulmonary arrest.

D6.1.1.9 There is evidence that the resuscitation team practice resuscitation drills and an evaluation of the drill carried out and reported to the clinical governance committee (see A2.2).

D6.1.1.10 The dignity and privacy of the patient is maintained during the cardiopulmonary resuscitation process.

[1] **References for D6.1.1:**

- https://www.resus.org.uk/library/2021-resuscitation-guidelines
- Royal College of Pediatric and Child Health, Induction to newborn resuscitation Standards of Practice, 2022

D6.2 Equipment

Resuscitation equipment is readily available in different areas of the healthcare facility including access in non-clinical areas such as the kitchen and laundry. All resuscitation equipment is maintained, and crash carts stocked in accordance with the resuscitation policy.

(M) D6.2.1 Working resuscitation equipment and in-date medication are available or accessible in all areas.[1]

Guidance

The procedure for checking resuscitation equipment includes responsibilities for carrying out the checks on each crash cart and acting on any discrepancies. The procedure includes checking that all equipment is in working order, drugs are current, kept at the correct temperature and humidity and that the cart is always suitable for use, e.g., locked, suction working. Checks are recorded with the checker's signature.

Where children are treated, the Broselow™ system, which is a color-coded system for assessing medication doses in pediatric resuscitation, may be used. The system uses a color-coded tape to measure the length of the child. The system, if available, then allows immediate access to pre-sized emergency equipment, based on the color coding.

Measurable Elements

D6.2.1.1 Resuscitation equipment is available in all acute inpatient areas and includes:

a) A charged defibrillator and ECG monitor,
b) Oxygen with appropriate valves and masks,
c) First line in-date resuscitation drugs,
d) Equipment for maintaining and securing the airway of a patient including suction equipment.

D6.2.1.2 In healthcare facilities where children are treated, each crash cart has a pediatric intubation tray and equipment to insert and maintain intravenous infusions and Broselow bags are available in designated areas.

D6.2.1.3 In non-acute treatment areas and non-clinical areas there is ready access to a defibrillator and airway management equipment if not carried by the resuscitation team. There are clear details displayed of where the nearest crash cart is located.

D6.2.1.4 There is a procedure to ensure that resuscitation equipment is checked using a standardized checklist on each shift (unless otherwise recommended by the manufacturer's instructions).

D6.2.1.5 There is evidence that resuscitation equipment is cleaned and decontaminated after each usage, including practice use.

D6.2.1.6 Resuscitation equipment is subject to Infection Control surveillance procedures.

Documentary evidence required:

D6.1.1.5 Resuscitation policy

D6.1.1.6 Procedures for managing special circumstances where resuscitation is required.

D6.2.1.4 Procedure to ensure that that resuscitation equipment is checked.

Suggested personnel to work with the sub section:

Cardiologist

Members of the resuscitation team

Unit staff

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[1] **References for D6.2.1:**

- Resuscitation Council UK, Quality Standards: Acute Care Equipment and Drug Lists, 2020

CHAPTER E. CLINICAL SERVICES

Overview

The services included here are those that present higher risk and that meet the current disease prevalence within the Emirate of Abu Dhabi.

SECTION E1 MATERNITY AND NEONATAL CARE

Introduction

There may be different facilities available for pregnant women depending on the scope of practice for which the healthcare facility is licensed and therefore the type of maternity service delivered. Whatever the type of healthcare facility, the service provided for women and their children are designed and managed to enable rapid, safe and continuous care which is individualized to meet the patients' needs and always with dignity and respect.

E1.1 Management

(M) E1.1.1 The maternity services are managed, led and staffed by qualified and experienced teams.[1]

Guidance

The maternity service may consist of a number of different services, for example, ante-natal care, labor and delivery units, post-natal care, fetal medicine and this requires planning and for staff to work collaboratively to provide effective and safe care to pregnant women, mothers and babies.

The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements. The service plan also includes an impact assessment by considering other service plans and activities within and planned for the healthcare facility.

Measurable elements

E1.1.1.1 There is a policy defining the management, scope, values and delivery of care of the maternity service which outlines:

a) What types of services are offered,
b) Whether midwife or physician led,
c) How the maternity services are planned and delivered in line with national guidance,
d) The governance arrangements and the standards of care provided (see references),
e) The roles and responsibilities of midwives, maternity nurses, obstetricians and care assistants (if available),
f) A commitment to the "baby friendly initiative" supported by UNICEF.

E1.1.1.2 There is evidence that staff numbers and skill mix requirements are based on a systematic process with consideration to historical demand, risk, criticality and acuity of patients, models of care and staffing availability.

E1.1.1.3 There are competency frameworks for licensed midwives, nurses and physicians which includes general skills and knowledge, specific skills and knowledge around ante-natal, labor and birth and ongoing care of women and neonates.

(D) E1.1.4 The Maternity Service has a current documented service plan.

[1] **References for E1.1.1:**

- Health Authority – Abu Dhabi: Policy for the Health Care Facilities, Providing Maternity Services (Labor and delivery), 2012
- UNICEF: Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative, 2018

E1.2 Ante-Natal and Pre-Partum Care

(M) E1.2.1 Ante-natal care is provided to prepare pregnant women for the birth.[1]

Guidance

Antenatal care is a key component of a healthy pregnancy. Regular antenatal care helps to identify and treat complications and to promote healthy behaviors. Ante-natal care services may also provide counselling and education.

A multidisciplinary care plan which contains the assessment, history and any risks, monitoring, screening tests, scan dates and outcomes is created for every pregnant woman. In addition, the pregnant woman is encouraged to create their own care and birth plan to include the type of birth and care they wish to have, but it depends on the medical history of the woman and personal circumstances as well as what is available in the maternity service.

In addition to the dating ultrasound scan, a mid-pregnancy scan (also known as a fetal anomaly scan) may also be offered at between 18 and 21 weeks. If a fetal abnormality is discovered the pregnant woman is referred to a specialist service, if available.

The procedure for women who have suffered a miscarriage includes the provision of information and a choice of management options. It specifies that these women are cared for away from women about to go into labor or with newborns.

Emergency maternity care is provided either within the maternity service or within the Emergency Department.

Measurable elements

E1.2.1.1 At first attendance to the ante natal clinic, pregnant women are given comprehensive information, for example, the pregnancy care pathway, nutrition and diet, exercises including pelvic floor exercises, screening tests, antenatal classes and other related workshops.

E1.2.1.2 A care plan is in place for all pregnant women which is available at all attendances to the maternity service.

(D) E1.2.1.3 Pregnant women are encouraged to create a care and birth plan.

E1.2.1.4 A risk and needs assessment is undertaken to identify concomitant health, physical, psychosocial, emotional and social issues. The assessment is documented in the care plan.

E1.2.1.5 The risk assessment includes any history of consanguinity or congenital anomalies.

E1.2.1.6 A dating ultrasound is offered at between 10 -14 weeks to determine gestational age and to detect multiple pregnancies.

E1.2.1.7 Ante-natal screening tests are undertaken and include:

a) Gestational diabetes,
b) Blood group and rhesus status,
c) Iron deficiency,
d) Testing for pre-eclampsia,
e) infectious diseases including (but not limited to) HIV, Varicella, syphilis, VDRL.

E1.2.1.8 There is an evidence-based guideline for the use of Anti-D to be used to prevent or minimize the risk of rhesus iso-immunization for all rhesus negative pregnant women.

E1.2.1.9 Emergency maternity care is provided.

E1.2.1.10 There Is access to at least one Consultant/Specialist in Obstetrics per shift to manage maternity emergencies.

E1.2.1.11 There is a system in place for referring women experiencing problems in early pregnancy to an early pregnancy unit /fetal medicine unit (or equivalent).

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[1] **References for E1.2.1:**

- Health Authority Abu Dhabi: for Routine Antenatal Screening and Care, 2012
- Abu Dhabi Department of Health: Standard for Emergency Departments and Urgent Care Centers, 2021

(M) E1.2.2 Women with complex pregnancies or whose fetus (or fetuses) has a confirmed or suspected disorder are provided a patient focused high quality evidence-based care.[1]

Guidance

There are a number of reasons and conditions why a woman's pregnancy may be considered complex and a "high risk". These may include problems experienced during previous pregnancies or the existence of a long-term condition such as cancer, diabetes, heart disease.

Fetal abnormalities may be identified in both high and low risk pregnancies, and the needs of the fetus and the parents need to be addressed. Ideally, such cases are referred to a specialist Fetal Medicine unit, but if the healthcare facility does not provide such a service, then arrangements are in place to refer women to facilities that offer such a service. Literature and specialist support is available to help women and their husbands understand the options available when a fetal abnormality is confirmed.

Measurable elements

E1.2.2.1 There is an evidence-based ante-natal pathway for women with high-risk pregnancies.

E1.2.2.2 There are documented evidence-based protocols for the management of high-risk conditions which include but are not limited to:

a) Severe pre-eclampsia,
b) Multiple pregnancy and birth,
c) Venous thromboembolism,
d) Pre-existing long-term conditions such as diabetes, cancer, heart disease,
e) Hypoxic-ischemic encephalopathy (HIE).

E1.2.2.3 There are evidence-based protocols for the management of early, late and term intrauterine fetal deaths.

(D) E1.2.2.4 Where possible, the woman is given a choice of induction of labor or expectant management.

D) E1.2.2.5 There is a quiet area for worried and distressed mothers and fathers and access to counselling after a miscarriage.

E1.2.2.6 There are documented procedures for early referral and initial information to be given to parents when a fetal abnormality is detected in pregnancy.

E1.2.2.7 There are evidence-based protocols for the management of women with a confirmed or suspected fetal abnormality.

E1.2.2.8 There is a range of support available when a fetal abnormality is suspected and confirmed.

E1.3. Intra-partum Care

(C) E1.3.1 Intra-partum care is provided with dignity and respect for the pregnant woman's choice.[2]

Guidance

Intra-partum care includes the care of women and their babies during labor and immediately after the birth. It includes women who go into labor at term with a low risk of complications during labor and those who go on to

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[1] **References for E1.2.2:**

- North Devon NHS Trust: Care of Pregnancy Complicated by Lethal Fetal Anomaly Guideline, 2019
- https://www.england.nhs.uk/mids-east/maternity/maternity-work-programmes/fetal-medicine/
- https://birthinjurycenter.org/types-of-birth-injuries/intrauterine-fetal-demise/

[2] **References for E1.3.1:**

- UNICEF: Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative, 2018
- World Health Organization: Robson Implementation Manual. 2017
- World Health Organization: Safe Childbirth Checklist Implementation Guide, 2015

develop complications. Pregnant women have a choice in their care and include, for example, mode of delivery, anesthesia type, the use of special equipment, the pain relief and the presence of their husbands at the birth.

Measurable elements

E1.3.1.1 A risk and needs assessment is carried out at the start of labor.

E1.3.1.2 There are documented evidence-based protocols for the induction of labor including the methods of induction, maternal and fetal observations and actions for possible complications.

E1.3.1.3 There are documented procedures for the care and management of women in labor and include as a minimum:

a) Fetal monitoring,
b) Fetal blood sampling and cord pH,
c) The actions to take if there is meconium in the amniotic fluid,
d) Maternal observations,
e) The use of instruments.

E1.3.1.4 A range of pain relief is available to meet the woman's needs and choices.

E1.3.1.5 There are documented evidence-based protocols for the management of caesarean section deliveries.

E1.3.1.6 There is a full-time specialist obstetrician available at all times.

E1.3.1.7 There is access to a consultant obstetrician if required.

(D) E1.3.1.8 There is a procedure for the collection of cord blood.

E1.3.1.9 There are documented evidence-based protocols for the management of high-risk conditions which include but are not limited to:

a) Perineal tears,
b) Shoulder dystocia,
c) Cord prolapse,
d) Postpartum hemorrhage,
e) Hypoxia.

E1.4. Facilities and equipment

(M) E1.4.1 The healthcare facility has equipment and an environment for women with a low to high risk of fetal or maternal complications.[1]

Guidance

Different healthcare facilities will have different facilities depending on their scope of practice and the type of maternity service delivered. Smaller healthcare facilities may only manage uncomplicated births, but larger tertiary centers may require an obstetric theatre and intensive care facilities for mother and/or baby. Whatever the type of care that the woman is receiving, the environment of the birthing/delivery room (not the theatre) has a non-institutional ambience and enables self-management in privacy and as comfortably as possible. In all units, rooms are designed to give women choice and control over their labor and birth, to normalize the process and welcome family participation. Well maintained equipment and supplies of essential drugs are always available.

Measurable elements

E1.4.1.1 There is an operating theatre which is equipped to undertake obstetric procedures and maintained to the same standard as the main theatres.

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[1] **References for E1.4.1:**

- World Health Organization: Safe Childbirth Checklist Implementation Guide, 2015

E1.4.1.2 The obstetric equipped theatre has space for neonatal resuscitation including ventilation equipment and incubators.
E1.4.1.3 Birthing/delivery rooms are designed to be flexible to meet the requirements of a variety of birthing plans.
E1.4.1.4 The basic equipment available in the birthing/delivery room includes:

a) Back up air and oxygen cylinders,
b) Baby resuscitaire plugged into wall medical gas supplies,
c) Disposable gloves,
d) Cord clamp,
e) Scissors,
f) Self-inflating resuscitation bag, such as an Ambu bag,
g) Circuits that can be used on the pressure limiting ventilation device of the resuscitaire,
h) Face masks of at least three different sizes (00, 0 and 1),
i) Suction catheters,
j) Stethoscope,
k) Oropharyngeal (Guedel) airways,
l) Laryngoscopes with straight blades, size 0 and 1,
m) Plastic bags for preterm babies,
n) A cardiotocography unit to monitor the fetal heartbeat and the uterine contractions during pregnancy and labor or equivalent,
o) Cardiac resuscitation equipment.

E1.4.1.5 The birthing/delivery rooms have:

a) Washing and toilet facilities,
b) Storage areas,
c) Dimmable lights,
d) A delivery table that can be turned into the Trendelenburg position.

E1.4.1.6 The maternity service maintains stocks of up-to-date essential medication in accordance with the healthcare facility's formulary and agreed by the Drugs and Therapeutics committee (or equivalent).
E1.4.1.7 There is a planned preventative maintenance program for all equipment in the obstetric theatre, birthing and delivery rooms including any anesthesia machines.

Documentary evidence required: E1.1 – E 1.4)
E1.1.1.1 Policy defining the management, scope, values and delivery of care of the maternity service.
E1.1.1.4 Current documented service plan.
E1.2.1.8 Evidence-based guideline for the use of Anti-D
E1.2.2.1 Evidence-based ante-natal pathway for women with high-risk pregnancies.
E1.2.2.2 Evidence-based protocols for the management of high-risk conditions
E1.2.2.3 Evidence-based procedures for the management of early, late and term intrauterine fetal deaths.
E1.2.2.6 Procedures for early referral and initial information to be given to parents when a fetal abnormality is detected in pregnancy.
E1.2.2.7 Evidence-based protocols for the management of women with a confirmed or suspected fetal abnormality.
E1.3.1.2 Protocols for the induction of labor
E1.3.1.3 Procedures for the care and management of women in labor
E1.3.1.5 Evidence-based protocols for the management of caesarean section deliveries.
E1.3.1.8 Procedure for the collection of cord blood.
E1.3.1.9 Protocols for the management of high-risk conditions

Suggested personnel to work with the standards:
Midwives

E1.5 Post-natal Care

Overview

The majority of babies are born without any problems and can be discharged home if the mother is confident with breastfeeding and in the care of the newborn. However, babies may have some difficulties and require extra care. The level of care depends on the degree of the difficulty and services may provide intensive care for seriously ill babies with complex problems; high dependency care for babies who need continuous monitoring and special care baby units for babies who are premature or stepped down from more complex treatment.

(C) E1.5.1 The mother is supported after the birth and at discharge from the service.[1]

Guidance

The service provides holistic post-natal care with consideration to the mother and baby's medical needs but also to recognize the potential need for psychological and emotional support, as well as of the importance of meeting fundamental needs such as nutrition and pain management.

Measurable elements

E1.5.1.1 The new mother is assessed immediately after giving birth to identify any medical complications and any emotional or psychological problems.

E1.5.1.2 Skin to skin contact between mother and baby is promoted until the first breast feed or until the mother chooses to end it.

E1.5.1.3 There is evidence that the service provides support to new mothers, which includes helping them to breast feed, expressing milk, help and information given on bottle feeding, personal hygiene, post-natal exercises, managing episiotomy and caesarean surgical wounds and care of a new baby.

(D) E1.5.1.4 There is a range of post-natal information available for mothers which includes physical health and well-being and emotional well-being and how to get further support.

E1.5.1.5 Parents are given information about follow-up services including immunization programs.

E1.5.1.6 There is evidence that the healthcare facility provides support and information to families experiencing a maternal death.

E1.6 Immediate Neonatal Care

Overview

The immediate care of the newborn baby is an important first step in allowing term babies to transition safely between intrauterine and newborn life. This section deals with the immediate care of the newborn baby that has made this transition without requiring anything other than basic care.

(M) E1.6.1 The newborn baby is assessed and cared for immediately after birth.[2]

Guidance

[1] **References for E1.5.1:**

- UNICEF: Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative, 2018
- World Health Organization: Safe Childbirth Checklist Implementation Guide, 2015

[2] **References for E1.6.1:**

- https://www.nhs.uk/conditions/baby/newborn-screening/overview/
- Abu Dhabi Newborn Screening Program, Healthcare Professional's Manual, First Edition 2009

The immediate observations that need to be taken include measuring and recording of the Apgar score (Appearance (skin color), Pulse (heart rate), Grimace response (reflexes), Activity (muscle tone) Respiration (breathing rate and effort)), head circumference, weight and length, temperature, physical examinations, screening tests such as a blood spot test and first bowel and urine movement. The procedures must include the timing of when all observations are to be carried out. The procedures also include timings of the first bath for well babies and pre-term or ill babies. The procedures identify the actions to be taken if the observations and measurements reveal any potential complications.
The aim of the physical examination is the early identification of any problems so that treatment can be started as soon as possible. Typically, it will include an examination of the newborn's eyes, hips, heart etc. Screening tests may also be offered include a hearing test, and a blood spot screen (heel prick).
The system for identifying the baby or babies may be preserved by placing a label on one leg and one arm of each baby immediately after birth. The mother verifies with the nurse by checking the labels prior to them being attached. Identity tags are placed on cots and incubators and checked every time babies are put into them. The procedures cover the steps to ensure the correct baby is linked to the correct mother, particularly in the case of multiple births. The tags include the mother's name and the date and time of birth.

Measurable elements
E1.6.1.1 There are procedures for the clinical observations of the newborn.
E1.6.1.2 A clinical risk assessment is carried out on every baby and a care plan developed that reflects the baby's individual needs and is based on the observations and measurements at birth.
E1.6.1.3 There are procedures for the recognition and management of common problems of newborn babies, including jaundice, hypoglycemia, streptococcal infection, and rewarming.
E1.6.1.4 The newborn has a physical examination within 72 hours of birth.
E1.6.1.5 Newborn screening tests are undertaken.
E1.6.1.6 There is a process for the creation of a neonatal care record for every new baby, in which the observations are documented, in accordance with the healthcare facility's new admission policy (Section B).
E1.6.1.7 There is a documented procedure for the identification of newborns while in the care of the healthcare facility.

E1.7 Level I: Neonatal Care

Overview
Neonatal care is provided in a postnatal clinical environment by the mother and supported by appropriately trained healthcare professionals. These babies do not fulfill the criteria for admission to an intensive care unit but might require some support or treatment.

(C) E1.7.1 Newborn babies requiring extra care are nursed on level I neonatal care unit.[1]

Guidance
In the transitional unit the mother remains resident with the baby and receives support from a midwife or healthcare professional. A transfer to a transitional unit may be beneficial for babies born between 32- and 37-weeks' gestation, or babies with mild jaundice or feeding problems, and requiring specific treatments such as antibiotics. The parents are kept informed of their baby's condition and all investigations, procedures and treatments that may be performed on their baby and their rights to decide to consent or not to the care plan.
A policy describes the type of Level I neonatal transitional care available and the criteria for admission. includes all the services available to support parents and newborn babies.

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[1] **References for E1.7.1:**
- https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017
- Abu Dhabi Department of Health Standard for provision of Neonatal Care Services, 2019.

Protocols may include surgical procedures, caring for infectious conditions, nutritional requirements, skin care, continuous monitoring methods and screening tests.
All nursing staff working in any of the neonatal unit receive a comprehensive induction to the environment in which they are going to work and includes basic clinical observations, nutrition and fluids, infection prevention and control, skin integrity, recognition of deterioration, pain management and interacting with families.

Measurable elements
E1.7.1.1 There is a policy defining the management, scope, values and delivery of care of the level I neonatal care service.
E1.7.1.2 There are procedures for the recognition and timely admission of sick babies to a transitional care unit.
E1.7.1.3 A clinical risk assessment is carried out on every baby admitted for transitional care and a care plan developed to reflect the baby's individual needs.
E1.7.1.4 There are evidence-based protocols for the clinical management of babies in transitional care.
E1.7.1.5 The healthcare facility can demonstrate that it meets all the Department of Health requirements for a Level I neonatal service.
E1.7.1.6 There is a documented procedure for the safe transfer of babies from level I care to a higher level of care, which includes the transportation requirements.
E1.7.1.7 There is evidence that parents are supported in providing care for their babies.
E1.7.1.8 There is a documented procedure for safeguarding babies nursed on the unit which includes controlling access to the unit.
E1.7.1.9 Parents are given information about follow-up services including immunization programs.
E1.7.1.10 All new neonatal nurses assigned to the Level I NICU have received induction into the unit which is supervised and signed off by a senior nurse.

E1.8 Level II: Neonatal Special Baby Care Unit (SCBU)

Overview
This service is for babies who do not need intensive care. Often, this will be for babies born at or more than 32 weeks' gestation. Care can include monitoring their breathing or heart rate. Giving more oxygen, treating low body temperature, treating low blood sugar, feeding help, helping babies who become unwell soon after birth.
All nursing staff working in any of the neonatal unit receive comprehensive induction to the environment in which they are going to work and includes basic clinical observations, nutrition and fluids, infection prevention and control, skin integrity, recognition of deterioration, pain management and interacting with families.

(M) E1.8 1Newborn babies requiring some intervention or more specialist care are nursed in a level II special baby care unit.[1]

Guidance
The policy describes the type of Level II special baby care available and the criteria for admission. It includes all the services available to support parents and newborn babies. In level II baby care units, the baby may be nursed in an incubator. The policy describes how babies are admitted into these units, staffing ratios, governance arrangements, contingency plans for when the units are full or when a safe nursing to baby ratio cannot be met. The procedures for admission to the unit cover the responsibilities of all staff groups involved in the admission, the criteria for admission to the unit, including the reporting and learning of lessons from unanticipated admissions to the unit, the transport arrangements for the movement of the sick newborn from all care settings and the procedure for information sharing by healthcare professionals within the unit.

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[1] **References for E1.8.1:**
- https://www.nhs.uk/pregnancy/labour-and-birth/after-the-birth/special-care-ill-or-premature-babies/
- The Abu Dhabi Department of Health Standard for Provision of Neonatal Care Services, 2019

The procedure for transferring patients to a higher level of care includes the transport, equipment and escort requirements, particularly if the higher level of care is at a different facility.
Parents need to be supported whilst their babies are being cared for and this may include allowing them to stay in a room nearby, counselling and their involvement in clinical decisions.

Measurable elements

E1.8.1.1 There are multidisciplinary critical care delivery teams which include pediatricians, nurses, pharmacists and allied healthcare professionals, with specialist experience in neonatal critical care.
E1.8.1.2 There is a policy defining the management, scope, delivery of care and values of the level II (special care) neonatal care service.
E1.8.1.3 There are procedures for the recognition and timely admission of sick babies to a level II special care baby care unit.
E1.8.1.4 A clinical risk assessment is carried out on every baby admitted to the level II baby care unit and a care plan developed to reflect the baby's individual needs.
E1.8.1.5 The care plan is reviewed at agreed timeframes.
E1.8.1.6 There are evidence-based protocols for the clinical management of babies in the level II baby care unit.
E1.8.1.7 Parents are supported to make physical contact with their baby whilst in the level II baby care unit.
E1.8.1.8 There is a facility for the babies in level II special baby care to be fed with their mother's expressed milk.
(D) E1.8.1.9 Parents have the opportunity to discuss their baby's diagnosis, care and treatment with a senior physician.
E1.8.1.10 There is a documented procedure for the safe transfer of babies from Level II care to a higher level of care, which includes the transportation requirements.
E1.8.1.11 There is a documented procedure for safeguarding babies nursed on the unit which includes controlling access to the unit.
E1.8.1.12 The healthcare facility can present its most recent DOH audit report to demonstrate that it meets all the Department of Health requirements for a Level II neonatal service.
E1.8.1.13 Parents are given information about follow-up services including immunization programs.
E1.8.1.14 There is evidence that the healthcare facility assigns a case manager/social worker to parents of babies in level II neonatal special care baby units.
E1.8.1.15 All new neonatal nurses assigned to the Level II NICU have received induction into the unit which is supervised and signed off by a senior nurse.

E1.9 Level III: neonatal intensive care unit (NICU)

Overview

A Levels III neonatal intensive care unit provides care for very small or sick babies who may require, for example, breathing support with a ventilator, weigh less than 1500 gram or were born at less than 32 weeks gestation. NICUs can provide a baby with the entire range of neonatal care, including post-surgical care. Only level IV services can provide highly specialized services, such as neonatal surgery.

(M) E1.9.1 Newborn babies requiring invasive and non-invasive intensive support are nursed in a level III neonatal intensive care unit (NICU).[1]

Guidance

The policy describes the type of Level III intensive neonatal care services available and the criteria for admission. The policy describes how babies are admitted into the units, staffing ratios, governance arrangements, contingency plans for when the units are full or when a safe nursing to baby ratios cannot be met. The policy also includes what procedures may be performed by which staff, including the undertaking of special procedures, under what circumstances and under what degree of supervision.

Parents may not wish to leave the unit whilst their baby is being cared for, so where possible facilities are available for them to stay near to the unit including access to food and drink, comfortable chairs or sofas and access to counselling or psychological support. Staff working in the unit may also require emotional support and help.

All nursing staff working in any of the neonatal unit receive comprehensive induction to the environment in which they are going to work and includes basic clinical observations, nutrition and fluids, infection prevention and control, resuscitation techniques, skin integrity, recognition of deterioration, pain management and interacting with families.

Measurable elements

E1.9.1.1 There are multidisciplinary critical care delivery teams which include (but not limited to) pediatricians, nurses, pharmacists and physiotherapists who are specialists in neonatal critical care.

E1.9.1.2 There is a policy defining the management, scope and values and delivery of care of the level III NICU.

E1.9.1.3 There are procedures for the recognition and timely admission of sick babies to a level III NICU.

E1.9.1.4 A clinical risk assessment is carried out on every baby admitted to the level III/NICU and a care plan developed to reflect the baby's individual needs.

E1.9.1.5 The care plan is regularly reviewed.

E1.9.1.6 There are evidence-based protocols for the clinical management of babies in the level III NICU.

E1.9.1.7 There is a documented procedure for the step down of babies to a level II or I neonatal care unit which includes transfer and transportation requirements.

(D) E1.9.1.8 Parents have the opportunity to discuss their baby's diagnosis, care and treatment with a senior physician.

E1.9.1.9 There is a dedicated quiet room for counselling parents and to provide distressed parents with privacy.

(D) E1.9.1.10 There is evidence that the healthcare facility assigns a case manager/social worker to parents of babies in level III and IV neonatal care units.

E1.9.1.11 There is evidence that the healthcare facility provides support and information to families experiencing a neonatal death.

(D) E1.9.1.12 There is psychosocial support available for staff working in level III/IV NICU.

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[1] **References for E1.9.1:**

- Abu Dhabi Department of Health Standard for provision of Neonatal Care Services, 2019.
- https://www.rcpath.org/discover-pathology/news/new-guidelines-for-the-investigation-of-sudden-unexpected-death-in-infancy-launched.html

E1.9.1.13 There is a documented procedure for safeguarding babies nursed on the unit which includes controlling access to the unit.
E1.9.1.14 The healthcare facility can demonstrate that it meets all the Department of Health requirements for a Level III NICU.
E1.9.1.15 Parents are given information about follow-up services including immunization and high-risk follow up programs and access to neurodevelopmental clinics.
(D) E1.9.1.16 Parents have access to an area where they can wait in comfort and obtain food and drink.
(D) E1.9.1.17 There is evidence that staff working in the unit can access emotional support and help.
E1.9.1.18 All new neonatal nurses assigned to the Level II NICU have received induction into the unit which is supervised and signed off by a senior nurse.

E1.10 Level IV neonatal intensive care

Overview
A level IV neonatal intensive care unit has all the amenities of a level III unit but in addition provides specialist services including for example, surgical repair of complex congenital or acquired condition and advanced ventilation support. Only level IV services can provide highly specialized services, such as neonatal surgery.
All nursing staff working in any of the neonatal unit receive comprehensive induction to the environment in which they are going to work and includes basic clinical observations, nutrition and fluids, infection prevention and control, skin integrity, recognition of deterioration, pain management and interacting with families.

(M) E1.10.1 Newborn babies requiring specialist invasive and non-invasive intensive support are nursed in a level IV neonatal intensive care unit (NICU).

Guidance
The policy describes the type of Level IV intensive neonatal care specialist services available and the criteria for admission. The policy describes how babies are admitted into the units, staffing ratios, governance arrangements, contingency plans for when the units are full or when a safe nursing to baby ratios cannot be met. The policy also includes what procedures may be performed by which staff, including the undertaking of special procedures, under what circumstances and under what degree of supervision.
Parents may not wish to leave the unit whilst their baby is being cared for, so where possible facilities are available for them to stay near to the unit including access to food and drink, comfortable chairs or sofas and access to counselling or psychological support. Staff working in the unit may also require emotional support and help.

Measurable elements
E1.10.1.1 There are multidisciplinary critical care delivery teams which include (but not limited to) pediatricians, nurses, pharmacists and physiotherapists who are specialists in neonatal critical care.
E1.10.1.2 There is access to specialist neonatal healthcare professionals.
E1.10.1.3 There is a policy defining the management, scope and values and delivery of care of the level IV NICU.
E1.10.1.4 There are procedures for the recognition and timely admission of sick babies to a level IV NICU.
E1.10.1.5 A clinical risk assessment is carried out on every baby admitted to the level III/NICU and a care plan developed to reflect the baby's individual needs.
E1.10.1.6 The care plan is regularly reviewed.
E1.10.1.7 There are evidence-based protocols for the clinical management of babies in the level III NICU.
E1.10.1.8 There is a documented procedure for the step down of babies to a level III or II neonatal care unit which includes transfer and transportation requirements.
(D) E1.10.1.9 Parents have the opportunity to discuss their baby's diagnosis, care and treatment with a neonatologist.

E1.10.1.10 There is a dedicated quiet room for counselling parents and to provide distressed parents with privacy.
(D) E1.10.1.11 There is evidence that the healthcare facility assigns a case manager/social worker to parents of babies in level III and IV neonatal care units.
E1.10.1.12 There is evidence that the healthcare facility provides support and information to families experiencing a neonatal death.
(D) E1.10.1.13 There is psychosocial support available for staff working in the level IV NICU.
E1.10.1 14 There is a documented procedure for safeguarding babies nursed on the unit which includes controlling access to the unit.
E1.10.1.15 The healthcare facility can demonstrate that it meets all the Department of Health requirements for a Level IV NICU.
E1.10.1.16 Parents are given information about follow-up services including immunization and neuro-development programs.
(D) E1.10.1.17 Parents have access to an area where they can wait in comfort and obtain food and drink.
(D) E1.10.1.18 There is evidence that staff working in the unit can access emotional support and help.
E1.10.1.19 All new neonatal nurses assigned to the Level II NICU have received induction into the unit which is supervised and signed off by a senior nurse.

Documentary evidence required: (E1.5- E1.10)
E1.6.1.1 Procedures for the clinical observations of the new-born.
E1.6.1.3 Procedures for the recognition and management of common problems of new-born babies
E1.6.1.7 Procedure for identifying neonates while in the care of the healthcare facility.
E1.7.1.1 Policy defining the management, scope, values and delivery of care of the level I neonatal care service.
E1.7.1.2 Procedures for the recognition and timely admission of sick babies to a transitional care unit.
E1.7.1.6 Procedure for the safe transfer of neonates from level I care to a higher level of care.
E1.7.1.8 Procedure for safeguarding babies nursed on the unit.
E1.8.1.2 Policy defining the management, scope, delivery of care and values of the level II (special care) neonatal care service.
E1.8.1.3 Procedures for admission to a level II special care baby care unit.
E1.8.1.10 Procedure for the transfer of neonates from Level II care to a higher level of care.
E1.8.1.11 Procedure for safeguarding babies nursed on the unit.
E1.9.1.2 Policy for the management, scope and values, and delivery of care of the level III neonatal intensive care service.
E1.9.1.3 Procedures for admission to a level III special care baby care unit.
E1.9.1.7 Procedure for the step down of neonates to a level II or I neonatal care unit.
E1.9.1.13 Procedure for safeguarding babies nursed on the unit.
E1.10.1.3 Policy defining the management, scope and values and delivery of care of the level IV NICU.
E1.10.1.4 Procedures for the recognition and timely admission of sick babies to a level IV NICU.
E1.10.1.8 Procedure for the step down of babies to a level III or II neonatal care unit.
E1.10.1 14 Procedure for safeguarding babies nursed on the unit which includes controlling access to the unit.

Suggested personnel to work with the standards:
Neonatal pediatrician
Staff from all NICU levels

SECTION E2 ADULT AND PAEDIATRIC INTENSIVE CARE SERVICES

Overview

There have been many advances in critical care services in response to new technology, surgical and medical techniques and procedures, and also managing an increasing older patient population with complex diagnoses and comorbidities. The advances demand a highly specialized and trained team of doctors, nurses and other healthcare professionals. Staff are required to manage a number of variables which includes infection control, particularly pandemics, the size and geographical layout of the service, the number of beds in a unit, case mix, safety in relation to ventilated patients, mixed sex accommodation needs, and the individual experience of each member of staff. This requires the healthcare facility to plan its resources, particularly its staff resources, to ensure competent, trained staff are always available to care for the demand for critical care beds.

Critical care services are organized for the management of critically ill patients and may be situated in different areas of the healthcare facility including coronary care, pediatric intensive care units and intensive therapy units. For the purpose of this standard, levels of care are defined as[1]:

Level 1: Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute unit with additional advice and support from the critical care team.

Level 2: Patients requiring more detailed observation or intervention, including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.

Level 3: Patients requiring advanced respiratory support alone or basic respiratory support, together with at least two organ systems. This level includes all complex patients requiring support for multi-organ failure and may be defined as Critical Care Unit (CCU).

E2.1 Management

(M) E2.1.1 Critical care services are provided by qualified healthcare professionals.[2]

Guidance

The strategy for managing critical care services defines how the needs of patients requiring critical care at different levels i.e., unit based, high dependency and intensive care, can be managed to provide flexible capacity in caring for the different levels of care.

Measurable elements

E2.1.1.1 Each critical care unit is led by a licensed specialist consultant physician in intensive care or anesthesiology.

E2.1.1.2 There are multidisciplinary critical care delivery teams which include physicians, pediatricians where children are cared for, nurses, pharmacists, and other allied healthcare professionals who have experience in critical care.

E2.1.1.3 There is an implemented strategy for managing the delivery of adult and pediatric critical care across the healthcare facility.

E2.1.1.4 Specialist critical care physicians are available for the critical care areas 24 hours a day.

E2.1.1.5 Nurse to patient ratio is based on patient numbers, criticality and acuity.

E2.1.1.6 There is a competency-based assessment framework for all staff involved in the critical care service.

(D) E2.1.1.7 There is psychosocial support available for staff working in the critical care unit.

E2.2 Clinical Care

[1] NHS Data Model and Dictionary

[2] **References for E2.1.1:**

- Health Authority - Abu Dhabi Health Care Standards for Hospitals, 2008
- https://www.rcpath.org/discover-pathology/news/new-guidelines-for-the-investigation-of-sudden-unexpected-death-in-infancy-launched.html

(M) E2.2.1 Admission to or from units providing intensive or specialized services is determined by established criteria.[1]

Guidance

Critical care may be provided in a number of units, including an intensive care unit, a high dependency unit, specialty units, for example, cardiac and renal care. There are defined pathways of care from admission to transfer or discharge. Evidenced based protocols are used to care for patients in each critical care unit.

Measurable elements

E2.2.1.1 There is a set of parameters for assessing suitability for admission to a critical care unit, which includes the specialty and level of care required.
E2.2.1.2 There are guidelines to assist the decision to admit seriously ill patients presenting with a communicable disease to a critical care unit, including patients with a confirmed or suspected communicable infection.
E2.2.1.3 All admissions to critical care areas are seen by a competent physician with experience in intensive care medicine within a locally agreed time frame.
E2.2.1.4 A clinical risk assessment is carried out on every patient admitted to a critical care unit and a care plan developed to reflect the patients' individual needs.
E2.2.1.5 The care plan is regularly reviewed.
E2.2.1.6 The multidisciplinary critical care team makes daily unit rounds as a minimum and twice a day in level 3 units.
E2.2.1.7 There are evidenced based protocols on care techniques and emergency procedures for critically ill patients, including specific pediatric protocols.
E2.2.1.8 There is a pathway for escalation of care from level 2 to level 3 (i.e., from high dependency to intensive care) if a patient's condition is deteriorating.
E2.2.1.9 There are evidence-based documented procedures for the care of patients requiring ventilation, including manual ventilation and mechanical ventilators, and the use of positive and negative pressure ventilation, including pediatric ventilation.
E2.2.1.10 There is a process for the discharge of patients from critical care levels 2 and 3.
E2.2.1.11 There is a documented policy and procedures for the safe transfer of critically ill patients, which includes indications and contra-indications for transfer (see also B3)
(D) E2.2.1.12 There is evidence that the healthcare facility assigns a case manager/social worker to parents of children in a critical care unit.
E2.2.1.13 There are processes for referring patients to relevant specialists for post-acute care.

E2.3 Environment and Equipment

(C) E2.3.1 The critical care environment is kept safe and secure.

Guidance

Due to the severity of conditions of patients being cared for in critical care units, access is restricted to allow patients to be cared for in a peaceful environment, with enough space to allow for staff to maneuver safely around the bed and the accompanying equipment. All bed spaces are capable of providing visual privacy and reasonable auditory privacy, when required, and have natural daylight with outside views wherever possible. Artificial lighting is dimmable and of sufficient strength to enable surgical interventions and response to life-threatening situations at the bedside.

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[1] **References for E2.2.1:**

- Health Authority - Abu Dhabi Health Care Standards for Hospitals, 2008
- Faculty of Intensive Care Medicine Guidance On: The Transfer of The Critically Ill Adult, 2021

Measurable elements

E2.3.1.1 Access to the high dependency and/or intensive care units are controlled.

E2.3.1.2 Space around each bed can accommodate bulky equipment.

E2.3.1.3 There are facilities in place to prevent and control the risk of infection from patients with communicable diseases being cared for in critical care areas.

E2.3.1.4 The service checks that housekeeping staff have received specific training when working in the area of critically ill patients.

E2.3.1.5 Privacy and patient dignity is maintained.

(D) E2.3.1.6 There is a quiet room available for the families of patients being cared for in a critical care unit.

E2.3.1.7 There are fire resistant doors on all access points to the critical care unit.

Documentary evidence required:

E2.1.1.3 Strategy for managing the delivery of adult and pediatric critical care across the healthcare facility.

E2.2.1.7 Evidenced based protocols on care techniques and emergency procedures for critically ill patients,

E2.2.1.9 Procedures for the care of patients requiring ventilation.

E2.2.1.11 Policy and procedures for the safe transfer of critically ill patients

Suggested personnel to work with the standards:

Lead critical care physician

Critical care nurses

SECTION E3 SURGERY AND ANESTHESIA SERVICES

Surgical procedures are provided in operating theatres or appropriate clinical environments with relevant equipment and staffing arrangements, supported by comprehensive documented procedures. The pre-assessment procedures are undertaken by competent staff in a safe, effective and timely manner and there are appropriate post-operative care arrangements in place which include the early involvement of anesthetists and critical care specialists, supported by comprehensive policies and procedures.

E3.1 Management of the surgery and anesthesia services

(M) E3.1.1 The surgery and anesthesia services are managed to provide safe and efficient care.[1]

Guidance

The organizational chart shows the different sections of the Surgical and Anesthesia Service which might include specialist surgery such as orthopedics, day surgery, obstetric, trauma, etc. The chart shows the current staff posts and lines of responsibility and accountability. All staff have access to the chart.

There may be a managerial lead as well as clinical leads overseeing a number of services as well as leads in each specialism depending on the size of the healthcare facility and the Surgical and Anesthesia Services. Clinical and managerial leads assume professional, consultative and administrative responsibility for their services. This includes, but is not limited to, developing the service, ensuring equipment and facilities are available and fit for purpose, ensuring adequate staff resources, staff appraisals, quality assurance, health and safety of patients and staff.

The operational policy provides a framework to capture key information regarding service delivery and service arrangements. It outlines the context of the service and explains the service philosophy of care. The policy

[1] **References for E3.1.1:**

- https://www.rcoa.ac.uk/safety-standards-quality/guidance-resources/guidelines-provision-anaesthetic-services
- Abu Dhabi Department of Health, Healthcare Providers Manual, November 17

provides staff and other stakeholders with clear guidance and understanding of a team or service's role, function and objectives.
The procedures are based on the most recent evidence-based and best practice that are subject to documentation control. The procedures include the necessary steps to control risks e.g., from body fluids, blood, contamination and infection. The procedures also specify the processes for managing special conditions, e.g., patients with special needs, for example, sensory impairment, learning disabilities, infectious patients.
The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements. The service plan also includes an impact assessment by considering other service plans and activities within and planned for the healthcare facility.

Measurable elements

(D) E3.1.1.1 There is an organizational chart representing the formation of all the Surgery and Anesthesia Services.
E3.1.1.2 The Surgery and Anesthesia Services are led by qualified and licensed medical, nursing and managerial leads.
E3.1.1.3 The Surgery and Anesthesia Service has a current operational policy and procedures for delivering the services (see guidance).
(D) E3.1.1.4 The Surgery and Anesthesia Services has a current documented service plan.
E3.1.1.5 There is a competency framework for all theatre staff including nurses, theatre technicians and support workers.
E3.1.1.6 There is a staff Rota to ensure that there are staff on duty to cover all areas of the healthcare facility where surgery and anesthesia are delivered.
E3.1.1.7 Operating lists are planned and current any changes agreed by all relevant parties and to ensure that the correct equipment is available.
E3.1.1.8 The service checks that surgical procedures are performed by physicians with the correct licenses and privileges to do so.

E3.2 Pre-Procedure Care

Overview

Depending on the type and degree of proposed surgical procedure the patient is to have, they may attend a pre–operative assessment clinic a few days prior to scheduled surgery to check for any medical problems that might need to be treated before the procedure. This is an appointment usually with a nurse, either in person or it may be possible to have a video or telephone consultation. The pre-operative assessment is also an opportunity for the patient to ask any questions about the procedure and receive all the information and advice about the admission.

(C) E3.2.1 Patients are prepared and supported for an invasive procedure.[1]

Guidance

Time is made in the consultation appointment for a full explanation to be given of any proposed treatments. This must include the risks, benefits and alternatives, before agreeing on the course of action to be taken and

[1] **References for E3.2.1:**

- https://www.rcseng.ac.uk/news-and-events/news/archive/elective-surgery-after-covid-consensus-statement/

consent given. The information may be supplemented in the form of information booklets or a website but must be accessible to the patient in their home.
The pre-operative assessment procedures include the type of pre-assessment required for different procedures including suitability for short stay/day procedures; when these are to be undertaken; who will undertake the different types of assessment and their required competencies. The procedures also include investigations required, the documentation used, record keeping, actions to be taken in the case of patients who do not attend, actions to be taken in the case of patients who are deemed unfit for surgery/treatment, and who will make the final decision on fitness, the needs of children, adolescents and the elderly, patients with special needs including bariatric patients and those with allergies and antibiotic resistance. The pre-procedure assessment is documented in the multidisciplinary care plan and includes plans for safe discharge and post discharge care.
For patients with an infectious disease the ideal solution would be to defer the surgery until the patient is no longer an infection risk. However, if this is not possible, then the surgeon must minimize the risk of exposure to the infection by involving a minimal number of healthcare staff and shortening the occupation of the operating theatre. If surgery is critical then infectious patients have their risk of mortality (and complications, where possible) calculated using a validated risk score.

Measurable elements
E3.2.1.1 The service can demonstrate that at their consultation with the surgeon, patients and their carers are given a clear explanation of their condition and the proposed procedure, (see guidance and also B4.2).
E3.2.1.2 The patient has a documented multidisciplinary care plan, based on the assessment of the patient's health care needs and the proposed procedure to be undertaken (see also B2.1).
E3.2.1.3 There is a documented policy and supporting procedures for the pre-assessment of patients accessing services and treatments.
E3.2.1.4 A signed informed consent is given for both the surgery and anesthesia prior to surgery (see also B4.3).
E3.2.1.5 There is a documented policy for the management of patients with infectious diseases who are undergoing invasive procedures.
E3.2.1.6 An anesthetist completes a pre-operative assessment prior to transfer to theatre or area where the intervention will be undertaken (unless it is an emergency) either in a pre-operative clinic or on the patient unit.

E3.3 Post procedure care

Overview
Postoperative care is very important for the successful outcome of the surgical procedure. It commences as soon as the patient leaves the theatre and continues to discharge and beyond.

(C) E3.3.1 Patients are given care and support after an invasive procedure.[1]

Guidance
Patients are observed post procedure or following surgery, in the recovery area by staff trained in recovery procedures and resuscitation/reanimation, until the patient regains full consciousness following anesthesia and surgery. International guidelines suggest that the ratio is 1 nurse to 2 patients. Staff must remain in the recovery area until the anesthetist has approved the discharge of all patients back to the unit.
Postoperative assessments take place immediately after surgery on return to the unit or rest area of the department. This assessment provides a baseline against which the patient's condition may subsequently be assessed and identifies any problems that may have occurred on transfer from the service undertaking the

[1] **References for E3.3.1:**

- https://www.barna.co.uk/
- Aseni P, Orsenigo S, Storti E, Pulici M, Arlati S. Current concepts of perioperative monitoring in high-risk surgical patients: a review. Patient Safety in Surgery. 2019 Oct

intervention. Post operation monitoring procedures include the actions to be taken if the patient shows signs of distress or deterioration.
The discharge policy and procedure includes, for example liaison with and information given to the patient's general practitioner; or referrer, information given to the patient concerning future management of their condition, management of their condition at home and appropriate support in place, and/or any advised changes in lifestyle; the coordination and supply of equipment/aids, issues relating to the supervised discharge of patients, including the support needs when a general anesthetic or sedation has been given. The procedure includes details of who is authorized to discharge patients or allow them to leave a service, including nurses discharging from the day care service.

Measurable elements
E3.3.1.1 There is a procedure for the monitoring and observation of patients immediately post-surgery or post procedure.
E3.3.1.2 Units and departments receiving post-operative/intervention patients have a risk assessment process in place for the management and monitoring of the patient postoperative care.
E3.3.1.3 There is a documented procedure for the on-going monitoring and care of the post-operative patient including but not limited to:

a) Blood pressure and temperature,
b) Oxygen saturation,
c) Pain management,
d) Wound management and infection control,
e) Medication for the prevention of venous thromboembolism (VTE),
f) Airways and respiration,
g) Fluid control.

E3.3.1.4 There is a documented policy and procedure for the discharge of patients from the service post procedure or post anaesthesia, either to another clinical unit or to home.
E3.3.1.5 Patients are given information on their post-operative care which includes a contact number for any concerns.

E3.4 Operating theatres management

The healthcare facility has a duty to ensure the optimal use of operating theatre capacity and resources, maximizing operating theatre performance and avoiding cancelled operations in order to provide high quality health care to patients admitted for surgery. Theatre practices and guidelines are documented and implemented.

(M) E3.4.1 The healthcare facility maintains safe theatre practices for invasive procedures.

Guidance
The policy and procedures for the management of the theaters includes all the theatres within the healthcare facility, including those used for day surgery. The procedures include, but are not limited to, scheduling, theatre utilization, emergency surgery, equipment usage and checks, use of checklists, co-ordination with pathology and radiology and units.
Demand and capacity calculations are useful to understand how theatres can best be utilized and how changing technologies affects the demand, for example, the number of procedures that can be undertaken on a day case basis may create different demands and allow for different utilization of theaters.
The theatre register is completed at the time of the procedure. It includes the identity of staff responsible for the primary and secondary checking of swabs, needles and equipment.

The operation notes documents: the timing of events, details the name and signature of the operating and assisting surgeons; the name of the consultant responsible; a description of the findings; the diagnosis made, and the procedure performed; details of tissue removed, altered or added; details of sutures used; details of blood transfusions; an accurate description of any difficulties encountered and how they were overcome; immediate post-operative instructions.

Measurable elements

E3.4.1.1 There is a documented policy and procedures for the management of the theatres.

E3.4.1.2 There is evidence that the healthcare facility has an understanding of the demand for different types of theatre and can vary the capacity to meet those demands.

E3.4.1.3 There is a process to control access to different areas of the theatres.

E3.4.1.4 There are documented procedures to guide practice in the theatres and include but not limited to:

a) Preparing and cleaning the anesthetic rooms,
b) Surgical site marking,
c) Transfer of patients to the theatre,
d) Identification of patient,
e) Skin preparation,
f) Use of diathermy,
g) Swab, instrument and needle count,
h) Capture of electronic data,
i) Cleaning of the operating theatre,
j) Theatre waste,
k) Infection control,
l) Managing emergencies.

E3.4.1.5 The service retains a register of all operations/procedures performed in each theatre and includes:

a) Date,
b) Name of patient,
c) Identity number of patients,
d) Unit patient has come from and will go to post procedure,
e) Start time of anesthesia,
f) Where the procedure took place,
g) Operation/procedure performed,
h) Start and finish time of the operation/procedure,
i) Principal surgeon or operator,
j) Assistant surgeon,
k) Principal anesthetist,
l) Assistant anesthetist,
m) Theatre nurses/operating department practitioners and scrub nurses.

E3.4.1.6 The service routinely applies the World Health Organization Surgical Safety Checklist or local adaptation.

E3.4.1.7 A record of the invasive procedure (operation note) is maintained and kept within the patient's clinical record.

E3.4.1.8 There is a documented procedure for the safe handling and transfer of specimens from the theatre to the pathology department which includes,

a) Containers and fixtures used,
b) Transportation,
c) Documentation,
d) Traceability,
e) Responsibility.

E3.5 Anesthesia service

Overview

The anesthesia service may have a number of specialist anesthetists and includes pre-assessment, peri-operative and post-operative multidisciplinary teams.

(M) E3.5.1 The anesthesia service has a culture and leadership that prioritizes patient safety, quality of care and improved patient outcomes as well as staff wellbeing.[1]

Guidance

Anesthesia and sedation may be required in areas other than the operating theatres and include radiology and endoscopy. The standards of care must be the same wherever anesthesia is administered. Anesthetists are involved at an early stage of the surgery pathway if the patient has any co-morbidities. Obese patients are a significant anesthetic risk and a policy for their management is required, this may advise weight loss before surgery can be scheduled and the policy will define how this will be managed. There may also be a requirement for an operating table capable of accommodating obese patients.

Guidelines for the management of emergencies must be displayed and readily available in all sites where anesthesia and sedation are provided. Full resuscitation equipment is available including a defibrillator, suction, oxygen, airway devices and a means of providing ventilation.

The checks prior to anesthesia must be done by suitable qualified staff, for example, anesthetists or anesthetic nurses. The procedure states the steps to be taken if the necessary equipment or drugs are not available or if instruments are damaged.

The anesthetist has communication with the surgeon (or whoever is performing the procedure) before commencing anesthesia to confirm that it may commence.

The list of anesthetic drugs is agreed in conjunction with the Drugs and Therapeutics committee (see D1.5) and includes the recommended pediatric and adult doses.

Measurable elements

E3.5.1.1 There are policies and procedures for the provision of anesthesia.

E3.5.1.2 Anesthetists are part of the multidisciplinary teams managing patients when they are scheduled both elective and emergency surgery.

E3.5.1.3 There is a policy for the management of high-risk patients including those with obesity and significant co-morbidities.

E3.5.1.4 There are current and evidence-based guidelines for the management of anesthetic emergencies (including pediatric and obstetric).

E3.5.1.5 There are full facilities for resuscitation available in all sites where anesthesia and sedation are administered.

E3.5.1.6 There is a procedure for checking all the necessary equipment and drugs before commencing anesthesia or invasive procedure.

E3.5.1.7 There are systems in place to check that anesthesia is not commenced before the physician undertaking the procedure is present in the theatre (or in the preparation room where the procedure is being undertaken).

E3.5.1.8 A comprehensive anesthesia record is maintained throughout all procedures in which an anesthetic is administered and kept in the patient's clinical record.

E3.5.1.9 The anesthesia record includes:

a) The procedure planned and performed,
b) Urgency of the case,

[1] **References for E3.5.1:**

- https://www.rcoa.ac.uk/ - Royal College of Anesthetists

c) Pre-operative checks carried out,
d) The pre-operative assessment, including risk factors,
e) Record of checks of apparatus in the anesthetic room and theatre,
f) Drugs and doses given during anesthesia and route of administration,
g) Monitoring data,
h) Fluid loss and intravenous fluid therapy, if given,
i) Use of specialized equipment such as blood warmers or body warmers,
j) The method used to secure and maintain the patient airway and any special difficulties, encountered patient positioning and attachments,
k) Post-anesthetic instructions where appropriate,
l) Records of any untoward events,
m) Any warnings for future care,
n) Name and signature of attending anesthetist(s),
o) Accurate recording of the timing of events.

E3.5.1.10 There is an approved list of anesthesia drugs.
E3.5.1.11 There is a policy and procedures for the storage and handling of anesthetic agents.

E3.6 Equipment and Environment

Overview
The healthcare facility ensures that it meets the requirements for operating theatres as set out in the Ministry of Health & Prevention: Hospital Regulations, 2018.

(M) E3.6.1 The equipment and environment of the operating theatres are maintained and are safe.[1]

Guidance
The cleaning schedule specifies the areas in each room of the theatre that need to be checked and cleaned and the frequency. It includes the cleaning to be done at the end of each day and frequency of deep cleaning procedures.

The preventative maintenance schedule includes for example, any robot systems, anesthesia machines diathermy, all monitoring and anesthesia systems and radiology units.

Measurable elements
E3.6.1.1 There is an environmental theatre cleaning schedule.
E3.6.1.2 There is a process for designating a theatre as a hot spot which has negative pressure to be utilized during high-risk procedures, aerosol generating procedures (AGP) or for high-risk patients.
E3.6.1.3 There are clean and dirty utility areas including a one-way flow for equipment through the theatres.
E3.6.1.4 There is evidence that surgical trolleys are prepared in an area located away from the scrub rooms.
E3.6.1.5 There are only hands-free domestic waste bins in the anesthesia and scrub rooms.
E3.6.1.6 There is a preventative maintenance schedule for all the equipment used in the operating theatres.
E3.6.1.7 Arrangements are in place to manage demand during the downtime when theatres are undergoing maintenance and deep cleaning.

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[1] **References for E3.6.1:**

- NHS England, Health Technical Memorandum 03-01 Specialized ventilation for healthcare premises Part A: The concept, design, specification, installation and acceptance testing of healthcare ventilation systems, 2021
- Managing theatre processes for planned surgery between COVID-19 surges, Tim Cook, Kathleen Ferguson, Helgi Johannsson and William Harrop-Griffiths, 2020

Documentary evidence required:

E3.1.1.1 Organizational chart representing the formation of all the Surgery and Anesthesia Services.

E3.1.1.3 Operational policy and procedures for delivering the services.

E3.1.1.4 Current service plan.

E3.2.1.3 Policy and supporting procedures for the pre-assessment of patients.

E3.2.1.5 Policy for the management of patients with infectious diseases who are undergoing invasive procedures.

E3.3.1.1 Procedure for the monitoring and observation of patients immediately post-surgery or post procedure.

E3.3.1.3 There is a documented procedure for the on-going monitoring and care of the post-operative patient.

E3.3.1.4 Policy and procedure for the discharge of patients from the service post procedure.

E3.4.1 1 Policy and procedures for the management of the theatres.

E3.4.1.4 Procedures to guide practice in the theatres.

E3.4.1.8 Procedure for the handling and transfer of specimens from the theatre.

E3.5.1.1 Policies and procedures for the provision of anesthesia.

E3.5.1.3 Policy for the management of high-risk patients.

E3.5.1.6 Procedure for checking all the necessary equipment and drugs before commencing anesthesia or invasive procedure.

E3.5.1.11 Policy and procedures for the storage and handling of anesthetic agents.

Suggested personnel to work with the standard:

Surgeon

Theatre manager (or equivalent)

Theatre technicians

Anesthetist

SECTION E4 EMERGENCY SERVICES

Healthcare facilities may operate their emergency services along different models of care, but the usual model supports the principle of treatment of the sickest patient first, with 24/7 access to acute medical service/senior clinical decision makers, and 24/7 access to surgical opinion. Emergency services in Abu Dhabi must also provide an Urgent Care service for initial assessment, stabilization, diagnostic and referral services to patients with illnesses and minor injuries on a walk-in basis.

Less sick patients may be signposted to be seen by more junior staff, and patients with minor injuries may be seen in a separate area within the service to free up the resources for those requiring immediate and consultant level care.

The healthcare facility provides emergency services run by qualified and competent staff in facilities that are fit for purpose. The equipment provided is maintained and staff are competent in its use. The patients presenting are triaged, assessed and prioritized in order of criticality. This sub section addresses the roles and responsibilities of the clinical team, the clinical care, and the care environment.

E4.1 Management of the emergency service

(M) E4.1.1 The emergency services are managed to provide care by competent staff on 24 hour/7 days a week basis.[1]

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[1] **References for E4.1.1:**

- UAE Unified Healthcare Professional Qualification Requirements, 2022
- DOH Standard for Emergency Departments and Urgent Care Centers, June 2021
- M Cottey L, Roberts T, Graham B, et al. Need for recovery amongst emergency physicians in the UK and Ireland: a cross sectional survey. BMJ Open 2020;10: e041485. doi:10.1136/ bmjopen-2020-041485

Guidance

The operational policy incorporates, for example, aspects such as communication with other agencies/services, both internal and external, provision of 24-hour services staffing requirements, the level of training required, accessing care guidelines/protocols, the provision of legal reports, security of both the service and staff, including handling physical and verbal abuse. The policy also includes the types and amounts of equipment required to maintain and deliver the service, this may also include access to external sources.

The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.

The policy for managing a major incident is in accordance with the healthcare facility's major incident policy and would include how the Emergency Care Service is involved in both pre-arrival triage and triage on arrival to the service; communication with the emergency services; how stocks of medication, blood, dressings etc. are maintained; what arrangements are in place to admit, discharge and transfer patients to other healthcare providers; and how care is documented. The procedures include those for the initial assessment and management of trauma patients. It also includes how the Emergency Care Service is involved in testing the 'all hazards' incident plan, how feedback is obtained, and the lessons learned from the testing.

Staff competencies will include triage, life support techniques, pain assessment, first aid techniques, infection control, managing vulnerable people, and competencies in the use of equipment. All staff, clinical and non-clinical, have training in basic life support and clinical staff have advanced life support training.

A study from 2019 found that working as an emergency physician is one of the most fatiguing and stress-inducing professions, a result of regularly working shifts longer than 12-hours, struggling to find work-life balance, and burnout. This was recorded prior to the pandemic, during which the pressures on Emergency Medicine staff significantly increased.[1]

Monitoring the numbers and criticality of patients attending the service helps the healthcare facility to understand the demand and reasons why patients are attending for emergency care rather than more appropriate resources, such the Urgent Care Service.

Measurable elements

E4.1.1.1 There is at least one licensed Consultant/Specialist in Emergency Medicine on duty per shift.

E4.1.1.2 There is at least one qualified, licensed nurse with experience in emergency medicine on duty in the emergency service at all times.

E4.1.1.3 There is an operational policy for the Emergency Care Service.

(D) E4.1.1.4 The Emergency Care Service has a current documented service plan.

E4.1.1.5 There is evidence that the emergency care department registers, clinically triages and treats all patients with a medical emergency to avoid loss of life or occurrence of damage to limb, body function or long-term health regardless of insurance and residency status, nationality or ability to pay.

E4.1.1.6 There is a competency framework for all staff working in the Emergency Care Service.

E4.1.1.7 The Emergency Care Service is involved in the development of the healthcare facility's major incident, all-hazards policy and implementation plan (see A1.4).

E4.1.1.8 The Emergency Care Service has a documented policy and associated procedures for managing a major incident.

(D) E4.1.1.9 There are processes for dealing with overcrowding and managing capacity within the Emergency Care Service.

- https://rcem.ac.uk_ The Royal College of Emergency Medicine (UK), Initial Assessment of Emergency Department Patients, February 2017

[1] M Cottey L, Roberts T, Graham B, et al. Need for recovery amongst emergency physicians in the UK and Ireland: a cross sectional survey. BMJ Open 2020;10: e041485. doi:10.1136/ bmjopen-2020-041485

E4.1.1.10 There is evidence that the healthcare facility has initiatives in place to protect and support the frontline Emergency Care Service staff from psychological and exhaustive work practices.
E4.1.1.11 There is evidence that the Emergency Care service monitors the number, and criticality of patients attending the service.

E4.2 Clinical care

Patients attending the emergency service are treated with dignity and respect, and care provided as soon as possible depending on the severity of the complaint.

(M) E4.2.1 Patients are stabilized and assessed by staff of the Emergency Care Service with prompt handover to the most relevant place and clinical team for treatment.[1]

Guidance

The triage procedures include the need to assess children and people presenting with certain conditions, for example, chest pain and acute trauma immediately. The procedure defines who can undertake the triage assessment and the documentation required.
The management pathways might include, for example, the management of patients presenting with suspected acute myocardial infarction, pulmonary embolism, cerebral-vascular attack (stroke), head injuries, major trauma, and neutropenic sepsis. The procedures are developed with staff from the specialist services and account taken of the main presenting conditions of the local population particularly when there is a high incidence of endemic, epidemic or pandemic diseases.
The initial assessment of elderly, frail or immobile patients includes any evidence of skin vulnerability. Patients with vulnerable skin are placed on mattress toppers or air beds to avoid the risk of a pressure injury developing whilst waiting for a consultation or treatment.
Although life-saving care may need to be administered as quickly as possible, it is still important to ensure that privacy and dignity of the patient is maintained, that treatment is not given in full view of a waiting room and that the patient is kept covered to maintain dignity.
The Emergency Care Service specifies those procedures for which signed consent must be obtained in accordance with the healthcare facility's main consent policy (see B4.3). Minor procedures, such as physical examination, small wound repair and an electrocardiogram may be considered as implied consent.

Measurable elements

E4.2.1.1 There is a documented procedure for the triage of patient priorities and their specific needs.
E4.2.1.2 There are documented procedures or pathways for managing patients presenting with specific conditions (see guidance).
E4.2.1.3 There are documented procedures for the transfer of patients to other Emergency Care Services if their needs cannot be met at the healthcare facility (see also B3.2).
E4.2.1.4 There are evidence-based guidelines for the immediate management of patients.
E4.2.1.5 There is a policy and procedures for managing patients with a suspected infectious disease.
E4.2.1.6 There is evidence that the Emergency Care Service can access critical services on a 24-hour basis, including radiology, surgery, the laboratories, blood transfusion service and pharmacy.

[1] **References for E4.2.1:**

- https://rcem.ac.uk_ The Royal College of Emergency Medicine (UK), Initial Assessment of Emergency Department Patients, February 2017
- Royal College of Pediatrics and Child Health Triage in a Pediatric Emergency Department, 2022
- https://www.nice.org.uk/guidance/conditions-and-diseases/injuries--accidents-and-wounds

E4.2.1.7 There is a process for the Emergency Care Service to access specialist surgeons and physicians, including pediatricians, either for advice or to attend.
E4.2.1.8 There is a procedure for dealing with patients who are dead on arrival at the service and who die in the service.
E4.2.1.9 A skin vulnerability assessment is performed on frail and elderly patients.
E4.2.1.10 There is evidence that patients are treated with dignity and respect throughout their time in the Emergency Care service.
E4.2.1.11 The healthcare facility's policy for obtaining consent does not impede emergency care.
E4.2.1.12 There is evidence that the waiting time from arrival to assessment of patients is monitored.

E4.3 Environment

The Emergency Care Service has to attend to patients who vary from being in a life-threatening condition to those who have a relatively minor issue. These patients need to be attended to in different areas of the service with different resources. The design of the Emergency Care Service will depend on the type and criticality of patients that are typically attending the service and their ultimate discharge destination. Depending on the resources available and the demand for services, patients may have to wait to be treated so there needs to be space for wheelchairs and stretchers, and chairs.

(C) E4.3.1 The Emergency Care Service has facilities to care for patients in relevant treatment areas.[1]

Guidance

The areas that may be seen in an Emergency Care Service include a resuscitation area for the immediate care of patients and those suffering a cardiac arrest, airway, breathing and circulation compromise, a "majors" area where the majority of patients will be attended and a minor procedures room. There may also be a short stay admission unit where patients are continuously monitored until the best next step is agreed. In all areas, the patient's dignity and privacy is preserved and this may be through limited access to the resuscitation areas and screened cubicles in the "majors" area. The policy for the use of the areas of the service specifies how patients are directed to each area and who will manage each area, how the areas could change use depending on demand.
A decontamination area may be a structure that can be constructed quickly and on a temporary basis. If there is space, then children are attended to in a completely separate area to where adult patients are received and treated to ensure child protection. The waiting areas here have play facilities for children.

Measurable elements

E4.3.1.1 There is separate access for emergency vehicles and pedestrian patients.
E4.3.1.2 There is a reception area for registering patients.
E4.3.1.3 There are specific areas in the Emergency Care Service equipped for different complexities, criticality and needs (see guidance).
E4.3.1.4 There is a policy for defining how the areas of the Emergency Care Service are used.
E4.3.1.5 There is evidence that privacy and dignity are maintained in all the areas of the Emergency Care Service.
E4.3.1.6 There is an isolation area for patients attending with a known or suspected infectious disease.
E4.3.1.7 There is a decontamination area for patients attending with chemical or radiation contamination.
E4.3.1.8 There is a designated area for the examination and treatment of children.
(D) E4.3.1.9 There is a waiting area with:

[1] **References for E4.3.1:**

- The Ministry of Health & Prevention: Hospital Regulations, 2018
- Department of Health (UK), Health Building Note 15-01: Accident & Emergency Departments-Planning and Design Guidance, 2013
- Royal College of Pediatrics and Child Health, Facing the Future: Standards for children in emergency care settings, 2018

a) A range of chairs to assist patients and families with mobility problems,
b) Access to food and drinks,
c) Access to toilets.

E4.4 Urgent Care Services (Minor Injuries Unit)

Overview

An Urgent Care Service is for patients who do not need to attend an Emergency Care Service but who require an assessment and possible treatment quickly. The sort of conditions that may be seen in an Urgent Care Service include minor injuries, eye or ear inflammation, strains and sprains.

(M) E4.4.1 The healthcare facility provides urgent care by competent staff to patients to access without an appointment.[1]

Guidance

The operational policy specifies the types of patients who can receive treatment, and those that it cannot accept, for example children, non-ambulatory patients. The policy also defines what minor surgery is able to be performed to treat minor injuries and the level of anesthesia required.
The healthcare professionals working in the Urgent Care Service may be competent nurses or junior doctors, but they must have access to an experienced physician who can prescribe or deal with more serious issues.

Monitoring the numbers and criticality of patients attending the service helps the healthcare facility to understand the demand and reasons why patients are attending for urgent care rather than other more appropriate resources.

Measurable elements

E4.4.1.1 There is an operational policy which defines the type and extent of urgent care that may be accepted and treated in the service.
E4.4.1.2 The opening hours have been agreed by the Abu Dhabi Department of Health.
E4.4.1.3 Information on the scope of the service that includes the type of ailments and extent of injuries that may be accepted and treated, and those that cannot, is made publicly available.
E4.4.1.4 There is a competency framework for all healthcare professionals working in the Urgent Care service.
E4.4.1.5 Healthcare professionals in the Urgent Care Service are supervised by a physician.
E4.4.1.6 There is a documented procedure for the management and transfer of patients presenting with conditions that the service cannot deal with.
E4.4.1.7 There are evidence-based procedures for the management of the most common conditions treated in the Urgent Care Service.
E4.4.1.8 Patients are discharged from the service with information on how to self-care post procedure, which may include, for example, inserting eye or ear drops.
E4.4.1.9 A record is maintained for all patients attending which contains a history and the timings of all interventions and discharge details.
E4.4.1.10 There is evidence that staff working in the service have up-to-date Basic Life Support training.
(D) E4.4.1.11 The Urgent Care Service monitors the number, and criticality of patients attending the service for audit purposes.

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[1] **References for E4.4.1:**

- NHS (UK) Transformation of urgent and emergency care: models of care and measurement, 2020
- https://www.nice.org.uk/guidance/conditions-and-diseases/injuries--accidents-and-wounds

Documentary evidence required:
E4.1.1.3 Operational policy for the Emergency Care Service.
E4.1.1.4 Current service plan for the Emergency Care Service.
E4.1.1.8 Policy and associated procedures for managing a major incident.
E4.2.1.1 Procedure for the triage of patient priorities.
E4.2.1.2 Procedures or pathways for managing patients presenting with specific conditions.
E4.2.1.3 Procedures for the transfer of patients to other Emergency Care Services.
E4.2.1.5 Policy and procedures for managing patients with a suspected infectious disease.
E4.2.1.8 Procedure for dealing with patients who are dead on arrival at the service.
E4.3.1.4 Policy for defining use of the areas of the Emergency Care Service.
E4.4.1.1 Operational policy for the Urgent Care Service.
E4.4.1.6 Procedure for the management and transfer of patients.

Suggested personnel to work with the sub section:
Emergency Care doctors
Emergency and Urgent Care nurses
Support staff e.g., radiographers, plaster technicians
Receptionists

SECTION E5 RENAL SERVICES

Overview

A Renal Service provides diagnosis and treatment for a range of kidney diseases. One of the treatment options may be hemodialysis for advanced chronic kidney disease. Recent research has identified that hemodialysis needs to be carried using a patient-centered approach, where the planning and provision of hemodialysis is accompanied with counselling, patient education and choice as well as the provision of resources and well-trained staff.

E5.1 Management

(M) E5.1.1 The renal services are managed, led and staffed by qualified and experienced teams.[1]
Guidance

The operational policy details the management structure for the service; governance arrangements, equipment available, the standards the service must work within, multidisciplinary teams and the leads for the teams, monitoring and audits, normal operating hours and the out of hours provision; the number of staff and skill mix required to cover all the services provided; reporting responsibilities; routine maintenance and how service breakdowns are managed; liaisons with other services. The service plan details the objectives of the service and reflects the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.
The multidisciplinary team(s) includes doctors, nurses, dialysis technicians, counsellors and pharmacists. There may be different teams for different aspects of renal care.

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[1] **References for E5.1.1:**

- Abu Dhabi Health Authority, HAAD Standard for renal dialysis clinical service, 2010
- Association of Nephrology Nurses: National Competency Framework for Registered Nurses in Adult Critical Care Intermittent Hemodialysis (IHD) Specialty Competencies, 2021

Measurable elements

E5.1.1.1 There is an operational policy which outlines the core services provided by the Renal Service.
(D) E5.1.1.2 The Renal Service has a current documented service plan.
E5.1.1.3 There are designated licensed clinical leads with qualifications and experience in renal care.
E5.1.1.4 A multi-disciplinary team with experience in renal care supports the delivery of the Renal Services.
E5.1.1.5 There is a competency-based training and assessment framework and implementation plan for all staff involved in the renal and hemodialysis service and includes:

a) Pre-assessment of the patient,
b) Cannulation skills,
c) Care and management of the vascular access,
d) Preparation of the machine,
e) Monitoring of patients,
f) Monitoring for and acting on machine alarms,
g) Disconnection procedures,
h) Post hemodialysis assessment.

E5.1.1.6 There is 24 hours a day access to a nephrologist.
E5.1.1.7 There is evidence that at least one staff member with Advanced Cardiac Life Support certification is on duty when patients are undergoing dialysis in the service.

E5.2 Care of the Patient

(C) E5.2.1 Patients are assessed and offered an informed choice of evidence-based treatment.[1]

Depending on the degree of renal disease a range of treatment options may be offered if appropriate. Patients must be given full information of the options available for their specific circumstances and time to discuss with their families and come to a decision.

Guidance

The information given to patients contains the benefits and risks of all the treatment options available and does not contain medical jargon. Patients may also be directed to websites.
The patient's general health, co-morbidities, social and cultural aspects are taken into consideration when assessing patients for dialysis or other treatment modalities including possible transplantation. The options for treatment based on their general health are explained to the patient.
Patients with kidney disease are vulnerable to blood and air borne diseases so must be screened and managed if found to have a positive test.
Patients receiving hemodialysis either in the healthcare facility or at home are supported by their family. The renal service supports this by holding training sessions that patients and their carers can attend prior to treatment starting and answering any queries and worries the families and carers have.
For patients requiring a kidney transplant, the care plan includes the discussions held with the patient and their family including the risks and benefits of transplantation and the process for obtaining a kidney from a living

[1] **References for E5.2.1:**

- The Renal Association: Clinical Practice Guideline Hemodialysis, 2019
- https://www.renalandurologynews.com/home/decision-support-in-medicine/nephrology-hypertension/hemodialysis-prescription-and-assessment-of-adequacy/
- https://www.kidney.org/professionals/guidelines

donor. The procedures include the tests and tissue typing that must be completed. The procedures also include the process for placing patients on the national waiting list if there is one.

Measurable elements

E5.2.1.1 Patients referred to the Renal Service have a full assessment including a full range of investigative tests, medical history and co-morbidities, social, cultural and psychological assessment.

E5.2.1.2 Every patient has a care plan based on the assessment of their specific needs and choices.

E5.2.1.3 There is evidence that patients and families are provided with information about treatments available to enable them to make an informed choice of treatment.

E5.2.1.4 There is evidence that the choice of modality for the management of renal disease is based on clinical principles and patient preference.

E5.2.1.5 The care plan of patients choosing dialysis specifies the dialysis prescription and includes:

a) The goals of the therapy,
b) Expected solute clearance needs,
c) Volume removal needs,
d) Residual kidney function,
e) Timing of the therapy and logistical concerns.

E5.2.1.6 The Renal Service obtains the patient's written consent prior to any treatment modality, which is kept in the patient's clinical record.

E5.2.1.7 There are procedures for the on-going monitoring and management of blood and air borne viruses.

E5.2.1.8 Staff of the Renal Service are screened for blood and air borne viruses and vaccinated for immunization against hepatitis, and Covid-19, in accordance with mandatory requirements.

E5.2.1.9 Patients on hemodialysis are assessed by a nephrologist at least fortnightly or if there is a change in their condition and changes to the treatment plan following the assessment are documented in the clinical record.

(D) E5.2.1.10 There is evidence that family and carers are encouraged and supported to be part of the hemodialysis process.

E5.2.1.11 There are documented procedures for the assessment of patients for kidney transplantation.

E5.3 Clinical management of dialysis

(C) E5.3.1 Patients who require renal replacement therapy receive evidence-based care.[1]

Guidance

The procedure for initiating dialysis includes the care required to avoid dialysis disequilibrium syndrome in uremic patients. Catheter insertion is undertaken by a multidisciplinary team with appropriate training and expertise. The procedures specify the timing between the insertion and commencement of treatment. The procedures also include steps to take in the case of complications such as leaks, and these are in accordance with best evidence practice.

The peritoneal membrane characteristics of some patients will change as they spend months and years on therapy, usually leading to a decreased ultra-filtration capacity and an increase in the transport rate for small solutes so it is vital to check the membrane for changes that may impact on efficacy of treatment. The membrane is assessed 6 weeks after commencement of treatment and thereafter annually unless otherwise clinically indicated. A recognized peritoneal equilibration test or equivalent is used.

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[1] **References for E5.3.1:**

- The Renal Association: Clinical Practice Guideline Hemodialysis, 2019
- https://www.renalandurologynews.com/home/decision-support-in-medicine/nephrology-hypertension/hemodialysis-prescription-and-assessment-of-adequacy/
- https://www.kidney.org/professionals/guidelines

Measurable elements

E5.3.1.1 There are evidence-based treatment protocols for dialysis including the dialysis dose.

E5.3.1.2 There are standing operating procedures to define and control all stages of hemodialysis and includes:

a) Clinical tests and assessments to be done prior to starting treatment,
b) Vascular access assessment and monitoring, including ultrasound of vessels,
c) Pre-dialysis cardiac assessment,
d) Monitoring small molecular clearance,
e) Post hemodialysis assessment,
f) Care of patients with arteriovenous fistula (AVF) or graft,
g) Management of anticoagulation,
h) Management of electrolyte imbalance,
i) Care of temporary/permanent catheter,
j) Management of clinical complications.

E5.3.1.3 There is a procedure for initiating dialysis for the first time.

E5.3.1.4 There are documented procedures for the insertion and care of the catheter for peritoneal dialysis.

E5.3.1.5 There are documented procedures for the routine tests to be undertaken to check the adequacy of the dialysis which include:

a) Biological and hematological tests,
b) Frequency of testing, for example monthly
c) Steps to take if results are not as expected.

E5.3.1.6 There are procedures and techniques for the infection prevention and control of patients undergoing renal replacement therapy and includes:

a) Recognition of infectious complications, including peritonitis,
b) Antibiotic prophylaxis,
c) Topical anti-biotic administration,
d) Flush before fill dialysis systems for continuous ambulatory peritoneal dialysis (CAPD),
e) Sharps disposal at each bed or chair,
f) Hand hygiene,
g) Disinfection of equipment,
h) Use of personal protective equipment.

E5.3.1.7 There is close liaison with the microbiology service and infection control team.

E5.3.1.8 There is a process for monitoring the peritoneal membrane function on a regular basis (see guidance).

E5.4 Equipment

(M) E5.4.1 The quality of equipment used in the renal service is maintained to be safe.

Guidance

Planned downtime may be for routine servicing or cleaning/disinfecting. Downtime does not take place between on-going episodes of dialysis and never when treatment is underway. It therefore needs to be carefully planned to minimize disruption to patient treatment.

Measurable elements

E5.4.1.1 There are documented procedures for checking the quality of the water supply and distribution systems used for dialysis which include but not limited to:

a) Hardness and chlorine content,
b) Microbiological tests,
c) Disinfection of the feeding pipelines of reverse osmosis systems,
d) Frequency of endotoxin assays,
e) Actions to be taken in the event of the water supply and quality not being fit for purpose,
f) Emergency actions to be taken to maintain treatment until the water quality and supply is fit for purpose.

E5.4.1.2 There is a schedule for planned downtime for the preventative maintenance of dialysis equipment, including the water treatment and distribution systems.
E5.4.1.3 There is a documented procedure for the actions to take in the case of a system failure.
E5.4.1.4 Arrangements are in place to limit disruption to treatments due to planned down-time for maintenance or repairs.

Documentary evidence required:

E5.1.1.1 Operational policy.
E5.1.1.2 Service plan.
E5.2.1.7 Procedures for the on-going monitoring and management of blood and air borne viruses.
E5.2.1.11 Procedures for the assessment of patients for kidney transplantation.
E5.3.1.3 Procedure for initiating dialysis for the first time.
E5.3.1.4 Procedures for the insertion and care of the catheter for peritoneal dialysis.
E5.3.1.5 Procedures for the routine tests to check the adequacy of the dialysis.
E5.3.1.6 Procedures and techniques for infection control.
E5.4.1.1 Procedures for checking the quality of the water supply.
E5.4.1.3 Procedure for the actions to take in the case of a system failure.

Suggested personnel to work with the sub section:

Nephrologist
Renal nurse
Dialysis technicians

SECTION E6 THERAPIES

The Therapies are a group of specialisms to assess, treat, support, rehabilitate and advise patients with a variety of physical and often chronic, conditions. Different healthcare facilities will have different services to offer.
This sub-section may be completed by the following services:

- Physiotherapy service including rehabilitation
- Occupational Therapy service (OT)

- Speech and language service (SALT)
- Audiology

E6.1 Management

There will be leads for each part of the Therapies service but there is overall management and supervision so that the specialisms work as an integrated group.

(M) E6.1.1 The therapies specialisms are managed to provide efficient services led by qualified and experienced staff.[1]

Guidance

The healthcare professional with responsibility for overall management may be a physician such as a rheumatologist, or a senior physiotherapist.

The operational policy details the management structure for the service; governance arrangements, equipment available, the standards the service must work within, multidisciplinary teams and the lead healthcare professionals for the teams, monitoring and audits, normal operating hours and the out of hours provision; the number of staff and skill mix required to cover all the services provided; reporting responsibilities; routine maintenance and how service breakdowns are managed; liaisons with other departments. It must also state if children are accepted into the service.

The service plan(s) detail the objectives of the service(s) and reflect the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.

The different therapies will have the competencies relevant to their specialty and scope of practice.

All the services may be required to treat children, but the Speech and Language Therapy service is most likely to need to interact with children. The policy considers safeguarding, how children may express their choices and the communication with the families as well as the range and type of information to be given to them.

The preventative maintenance includes all the equipment used for the assessment of patients, treadmills, wheelchairs and other physical aids, calibration of equipment including ultrasound units, electrical stimulator, hydro collator, wax therapy, electromagnetic devices, splinting equipment etc. The schedule also includes all equipment that is on loan to patients.

Measurable elements

E6.1.1.1 There is a qualified and licensed healthcare professional with a background in one of the therapies who has overall management of the Therapies Service.

E6.1.1.2 There are clinical leads for each specialism.

E6.1.1.3 There is evidence that the clinical leads meet with the overall manager at least monthly.

E6.1.1.4 There is an operational policy which details the services offered by the Therapies Services.

(D) E6.1.1.5 There is a current documented service plan.

E6.1.1.6 There is a competency framework for all licensed therapists.

E6.1.1.7 There is a documented policy for treating children in the Therapies Services.

E6.1.1.8 There is a process in place to ensure that only trained and competent staff use specialized equipment unless supervised.

E6.1.1.9 There is a preventative maintenance schedule for all the equipment used in the Therapy Services.

E6.2 Clinical and Patient Care

[1] **References for E6.1.1:**

- UAE Unified Healthcare Professional Qualification Requirements, 2022

(C) E6.2.1 Patients are assessed and offered an informed choice of evidence-based treatment.[1]

Guidance

Referral may be from a physician, nurse with privileges or primary care facility. Different services may have different referral criteria. The referral process is made known to those who refer to the services. Cases are allocated to therapists who have the requisite skills and experience to manage the specific complaint and needs. Patients are prioritized according to clinical need. Speech and Language therapists may be allocated patients according to a language need.

The assessment procedures state who can carry out the first assessment, and when more complex cases need to be overseen by a senior therapist who has the skills and experience to undertake such an assessment. Patients referred for rehabilitation following a trauma have an assessment of their psychiatric, social and educational needs. Assessments may be carried out in the patient's home environment, particularly for Occupational Therapy.

The best practice for developing treatment and care plans is for a multidisciplinary approach and treatment options and goals discussed with the patient and their carers before starting treatment. The options include the risks, benefits and expected outcomes of the treatment with estimated timescales. Care plans are reviewed at defined intervals to assess progress.

When patients need assistance to move, consideration is given to the patient's culture and religion. The patient is allowed to have a chaperone present if required. Pain relief and muscle stimulation techniques may include exercises and the use of ultrasound, transcutaneous electric nerve stimulation (TENS), acupuncture and hydrotherapy.

The hydrotherapy pool water is analyzed for bacteriological count at least once a month. Disinfectant agents used to protect users might include chlorine, and chlorine and ozone or ultraviolet combinations.

Speech and Language therapists treat patients with a range of speech and language including patients who have had a stroke, Parkinson's disease, stammers, swallowing difficulties, cleft palate and voice disorders.

Therapists who provide home treatment may go alone, however, they take precautions by informing a staff member at the healthcare facility where and when they entered the property and when they leave. The home assessment may be in the form of a checklist of areas to assess and might include checking access through the home, for example, in using stairs, getting through doorways with a wheelchair, getting in and out of a bath or shower. The assessment also includes what aids would be available to help the patient.

Measurable elements

E6.2.1.1 There is a process for referral to and accepting patients for all the Therapy Services.

E6.2.1.2 There is a process for the allocation of new referrals to the Physiotherapy, Occupational Therapy, Speech and Language Therapy and Audiology teams.

E6.2.1.3 There are documented procedures for the assessment of patients referred for treatment which include the assessment tools and outcome measures used.

E6.2.1.4 Based on the assessment and patient history, treatment and care plans are developed personalized to the patients' needs and ability.

E6.2.1.5 There are documented procedures for how gender specific privacy and dignity is maintained during any treatment.

E6.2.1.6 There are evidence-based documented procedures for techniques involving manual handling of patients.

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[1] **References for E6.2.1:**

- https://www.nhsinform.scot/tests-and-treatments/counselling-and-therapies/occupational-therapy#introduction
- Chartered Society of Physiotherapy: Quality Standards for physiotherapy service delivery, 2012
- https://www.nhs.uk/conditions/physiotherapy/how-it-works/
- Royal College of Speech and Language Therapists: https://www.rcslt.org/
- https://www.cpft.nhs.uk/speech-and-language-therapy-toolkit/
- European Region of the WCPT: Professional Issues WG (PI WG): Audit tools – for use with the quality assurance standards of physiotherapy practice and delivery, 2018

E6.2.1.7 There are evidence-based documented procedures for treating patients with a range of mobility issues.
E6.2.1.8 There are evidence-based documented procedures for techniques to relieve pain and stimulate muscle repair.
E6.2.1.9 There is a documented policy on the conduct of group therapy classes which includes:

a) The number of patients,
b) The patient/ therapist and assistant ratio per class,
c) Patient criteria,
d) Frequency,
e) Location,
f) Equipment,
g) Single or mixed sex groups,
h) The instructions provided to patients invited to group sessions.

E6.2.1.10 There is an evidence-based documented procedure for the management of patients requiring prostheses and splinting which includes:

a) The assessment,
b) Treatment planning and measurement,
c) Choice of prosthesis,
d) Trail fitting,
e) Patient training,
f) Timeframes for commencing physiotherapy after receipt of the prosthesis,
g) Review of prostheses.

E6.2.1.11 There are evidence-based documented procedures for the management of the residual limb and phantom limb sensation and pain which includes:

a) Management of the residual limb,
b) Phantom limb sensation and pain,
c) Wound and scar care,
d) Information given to patients to maintain self-care and home use.

E6.2.1.12 There is a documented policy for the safe care and management of patients using the hydrotherapy pool which includes:

a) The scheduling of staff,
b) Patient selection,
c) How long staff may work in the pool,
d) The number of patients in the pool at any one time,
e) Monitoring and maintenance of the pool.

E6.2.1.13 There are documented procedures for maintaining the correct conditions of the pool water which include:

a) Temperature,
b) Ph and calcium hardness,
c) Frequency and method for monitoring these criteria,
d) The steps to take if the conditions are out of required specifications.

E6.2.1.14 There is evidence that the hydrotherapy pool water is checked and treated to protect users from pathogens.
E6.2.1.15 There are documented and evidence-based procedures for treating patients with a range of speech and language disorders.
E6.2.1.16 There are documented and evidence-based procedures for treating patients with a range of swallowing and feeding disorders.
E6.2.1.17 There are systems to protect staff who visit patients' homes.
E6.2.1.18 The Occupational Therapy service has a documented procedure for the assessment of the patient’s home.

E6.2.1.19 The Therapies Services provide a range of information of techniques for patients to assist them manage their daily lives.

Documentary evidence required:
E6.1.1.4 Operational policy for the Therapies Service.
E6.1.1.5 Current service plan or plans.
E6.1.1.7 Policy for treating children in the Therapies Services.
E6.2.1.3 Procedures for the assessment of patients referred for treatment.
E6.2.1.5 Procedures for how gender specific privacy and dignity is maintained.
E6.2.1.6 Procedures for techniques involving manual handling of patients.
E6.2.1.8 Procedures for techniques to relieve pain and stimulate muscle repair.
E6.2.1.9 Policy on the conduct of group therapy classes.
E6.2.1.10 Procedure for the management of patients requiring prostheses.
E6.2.1.11 Procedures for the management of the residual limb and phantom limb sensation.
E6.2.1.12 Policy for the safe care and management of the hydrotherapy pool.
E6.2.1.13 Procedures for maintaining the conditions of the hydrotherapy pool water.
E6.2.1.15 Procedures for treating patients with a range of speech and language disorders.
E6.2.1.16 Procedures for treating patients with a range of swallowing and feeding disorders.
E6.2.1.18 Procedure for the assessment of the patient's home.

Suggested personnel to work with the sub section:
Lead for each specialism
All therapists

SECTION E7 DIABETES CLINICS

The Independent Diabetes Foundation reports that in 2011 there were 32,600,000 people with diabetes in the Middle East and North Africa region. In 2021 this had risen to 72,671,900 and it is predicted to further rise to 95,000,000 in 2030.[1]

Note. This sub-section does not include childhood diabetes or gestational diabetes.

E7.1 Management

(M) E7.1.1 The diabetes clinic is managed to provide care and support to patients with confirmed or at risk of a diabetes condition.[2]

Guidance
The operational policy details the management structure for the service; governance arrangements, equipment available, the standards the service must work within, multidisciplinary teams and the lead healthcare professionals for the teams, monitoring and audits, normal operating hours and the out of hours provision; the number of staff and skill mix required to cover all the services provided; reporting responsibilities; routine

[1] Independent Diabetes Foundation, Diabetes Atlas, 10th Edition, 2021

[2] **References for E7.1.1:**

- UAE Unified Healthcare Professional Qualification Requirements, 2022

maintenance and how service breakdowns are managed; liaisons with other departments. It must also state if children are accepted into the service.
The service plan(s) detail the objectives of the service(s) and reflect the strategic objectives of the healthcare facility. It contains an outline of the current work undertaken and includes plans for expanding and developing the service, staff and training needs, budget plans, quality objectives and audit plans, equipment review and replacement requirements.
Staff working in a diabetes service may include an ophthalmologist, a podiatrist, pharmacist, and specialist nurses.

Measurable elements
E7.1.1.1 There is a qualified and licensed physician with responsibility for the management of the diabetes clinic.
E7.1.1.2 There is an operational policy which details the services offered by the Diabetes Clinic.
(D) E7.1.1.3 There is a current documented service plan.
E7.1.1.4 There is a competency framework for all staff working within the clinic including staff providing education programs.
E7.1.1.5 There is a process in place to ensure that only trained and competent staff use specialized equipment unless supervised.
E7.1.1.6 There is a preventative maintenance schedule for all the equipment used in the Diabetes Clinic.

E7.2 Risk assessment of diabetes in adults

Overview
Type II diabetes can come on slowly, usually over the age of 40. The signs may not be obvious, or nonexistent and it might be up to 10 years before signs develop so knowing the diabetes risk factors is important to prevent the disease from developing.
Although the majority of patients will be assessed in primary care, individuals already within the healthcare facility system for the management of some conditions are already at risk and healthcare professionals are alert to this.

(C) E7.2.1 Individuals at risk of developing diabetes are supported and advised to have their risk assessed.[1]

Guidance
Many people will not realize that they are at risk of developing diabetes. This includes people with particular conditions that can increase the risk such as cardiovascular disease, hypertension, obesity and stroke. There are also genetic and age factors that increase the risk. All healthcare professionals are aware of the risk factors of their patients and how to refer them or undertake risk assessment. There are a number of web-based risk assessments for individuals to check for themselves or the healthcare facility may use an evidence-based point system.
Individuals who are at a high risk and whose blood glucose levels are higher than the agreed acceptable limit and therefore considered to be pre-diabetic require information, advice and support to manage this condition and to stop it developing into Type II diabetes. Referral to weight loss clinics and smoking cessation clinics, diet sheets and videos or referral to exercise classes are discussed with the individuals. This may be done in the diabetes clinic or at the specialist clinics if the individual is already receiving treatment within the healthcare facility for other conditions.

[1] **References for E7.2.1:**
- https://www.diabetes.org.uk/
- https://www.who.int/news-room/fact-sheets/detail/diabetes
- National Institute for Health and Care Excellence (NICE),
- https://www.medscape.co.uk/s/viewarticle/type-2-diabetes-prevention-people-high-risk-2022a1001a5p

Measurable elements

E7.2.1.1 There is guidance for all healthcare professionals to recognize individuals who may be at risk of developing diabetes.

E7.2.1.2 There is a process for individuals at risk to have a diabetes risk assessment.

(D) E7.2.1.3 There is information available throughout the healthcare facility to inform patients and visitors of the risk factors and how to undertake a self-risk assessment.

E7.2.1.4 There is a process for referring individuals at high risk of diabetes for a risk assessment and urine and blood tests.

E7.2.1.5 Patients identified as being pre-diabetic are given information about the condition and given advice on how to make healthy lifestyle changes.

E7.2.1.6 There is information and advice available for weight management for pre-diabetic individuals.

E7.2.1.7 There is information and advice available for individuals to be more active.

E7.1.1.8 There is information on accessing smoking cessation clinics.

E7.1.1.9 There is information on accessing professional emotional support and well-being.

E7.3 Managing adult patients with Type II diabetes

Overview

Although diabetes cannot be cured, Type II diabetes can be got into remission in many circumstances by changes in lifestyle. Care is individualised to provide treatment and support to get them into remission.

(C) E7.3.1 Patients with a diagnosis of Type II diabetes are treated and supported on an individualised basis.[1]

Guidance

Treatment and care plans are developed together with the patient so that the first line drugs, if required, can be tailored to their needs and circumstance. A multidisciplinary approach to treatment ensures several aspects of care are addressed.

Structured education programmes are delivered by trained staff and may be provided to groups or individualised. Families are encouraged to attend education sessions.

The type of glucose monitoring devices offered depends on whether the patient is being managed with insulin or by diet alone and what they can manage.

Measurable elements

E7.3.1.1 Patients referred to the Diabetes Clinic with suspected Type II diabetes have a full assessment which includes an assessment of their current lifestyle, social and cultural circumstances, any co-morbidities and their individual preferences and needs.

E7.3.1.2 There are evidence-based guidelines for the treatment of Type II diabetes.

E7.3.1.3 Based on the assessment, a multidisciplinary treatment and care plan are developed, discussed and agreed with the patient.

E7.3.1.4 The care plan includes initial treatment options.

E7.3.1.5 The care plan includes agreed targets for HbA_{1C}, weight, smoking and exercise levels and educational requirements.

E7.3.1.6 The care plan is reviewed and re-assessed every 3- 6 months and includes the monitoring of non-adherence to their medication schedules. All changes are documented in the care plan.

E7.3.1.7 There is evidence that medication choice is based on the individual circumstances and co-morbidities.

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[1] **References for E7.3.1:**

- https://www.diabetes.org.uk/
- National Institute for Health and Care Excellence (NICE), Type 2 diabetes in adults: Management, 2015 (updated 2022)

E7.3.1.8 There is a process to refer patients to a dietitian or nutritionist for a review and guidance on diet.
E7.3.1.9 There is guidance and support available for the patient to increase their activity levels.
E7.3.1.10 The healthcare facility has evidence-based structured education programmes for patients living with Type II diabetes and their families.
E7.3.1.11 There is access to a counsellor, or equivalent, to support the patient's emotional well-being.
E7.3.1.12 There is a procedure for providing glucose monitoring devices.
E7.3.1.13 There is evidence that patients are taught how to check their own blood glucose levels.
E7.3.1.14 Patients are advised to have regular oral health reviews to reduce the risk of periodontitis in accordance with their physician's recommendation.
E7.3.1.15 There is evidence that patients are referred for eye screening.
E7.3.1.16 A foot check is undertaken at least annually.
E7.3.1.17 There are evidence-based procedures for managing complications, including neuropathy, retinopathy, cardiovascular or kidney problems.
E7.3.1.18 There is evidence that families of the patient are encouraged to be involved in the care of patients living with Type II diabetes.

E7.4 Managing patient with Type I diabetes

Overview

Unlike patients with Type II diabetes, patients cannot go into remission by diet and exercise alone, although a healthy lifestyle will help reduce the risks of cardiovascular disease. Treatment is still based on patient choice and circumstances.

(C) E7.4.1 Patients with a diagnosis of Type I diabetes are treated and supported on an individualised basis.[1]

Guidance

Treatment and care plans are developed together with the patient so that insulin prescription can be tailored to their needs and circumstance. A multidisciplinary approach to treatment ensures several aspects of care are addressed.
Structured education programmes are delivered by trained staff and may be provided to groups or individualised. Families are encouraged to attend education sessions.
The type of glucose monitoring devices offered depends on the patients' individual abilities.

Measurable elements

E7.4.1.1 Patients referred to the Diabetes Clinic with suspected Type I diabetes have a full assessment which includes an assessment of their current lifestyle, social and cultural circumstances, any co-morbidities and their individual preferences and needs.
E7.4.1.2 There are evidence-based guidelines for the treatment of Type I diabetes.
E7.4.1.3 Based on the assessment, a multidisciplinary treatment and care plan is developed, discussed and agreed with the patient.
E7.4.1.4 The care plan includes the initial treatment options.
E7.4.1.5 The care plan includes agreed targets for HbA_{1C}, and educational requirements.
E7.4.1.6 The care plan is reviewed and re-assessed every 3- 6 months and includes the monitoring of non-adherence to their medication schedules. All changes are documented in the care plan.
E7.4.1.7 There is evidence that choice of insulin delivery is based on the individual circumstances and co-morbidities.

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[1] **References for E7.4.1:**

- https://www.diabetes.org.uk/
- National Institute for Health and Care Excellence (NICE), Type 1 diabetes in adults: Diagnosis and Management, 2015 (updated 2022)

E7.4.1.8 There is evidence that patients and their family are taught how to administer insulin.
E7.4.1.9 There is evidence that patients and family are taught how to be aware of and manage hyperglycaemia and hypoglycaemia.
E7.4.1.10 There is a procedure for providing glucose monitoring devices.
(D) E7.4.1.11 The healthcare facility has evidence-based structured education programmes for patients living with Type I diabetes and their families.
(D) E7.4.1.12 Education programmes are run by qualified staff with experience in managing diabetes.
E7.4.1.13 There is a process to refer patients to a dietitian or nutritionist for a review and guidance on diet.
E7.4.1.14 A foot check is undertaken at least annually.
E7.4.1.15 There is access to a counsellor, or equivalent, to support the patient's emotional well-being.
E7.4.1.16 Patients are advised to have regular oral health reviews to reduce the risk of periodontitis.
E7.4.1.17 There is evidence that patients are referred for eye screening.
E7.4.1.18 There are evidence-based procedures for managing complications, including neuropathy, retinopathy, cardiovascular or kidney problems.
E7.4.1.19 There is evidence that families of the patient are encouraged to be involved in the care of patients living with Type I diabetes.

Documentary evidence required:
E7.1.1.2 There is an operational policy which details the services offered by the Diabetes Clinic.
E7.1.1.3 There is a current documented service plan.
E7.4.1.2 Evidence-based guidelines for the treatment of Type I diabetes.
E7.3.1.12 and E7.4.1.10 Procedure for providing glucose monitoring devices.
E7.4.1.18 Evidence-based procedures for managing complications.

Suggested personnel to work with the standards:
Endocrinologist
Specialist diabetes nurses
Ophthalmologist
Podiatrist
Pharmacist

4. KEY STAKEHOLDER ROLES AND RESPONSIBILITIES

Stakeholder name	Stakeholder Key Role
Department of Health Abu Dhabi (DOH)	DOH, as a regulator for healthcare in the Emirate of Abu Dhabi, mandates that all Healthcare Facilities (Hospitals) comply with the DOH Hospital Standards. DOH will survey all Healthcare Facilities (Hospital) for the compliance with the standards.
Healthcare Facilities (Hospitals)	Healthcare Facilities (Hospitals) are required to comply with this standard and should regularly review and update their policies and procedures based on the latest scientific evidence, guidelines from DOH, and specific risks and needs of the setting in which it is implemented.

5. MONITORING AND EVALUATION

The standards are assessed by a team of DOH approved peer reviewers (surveyors) using the reporting tool designed for the purpose. The report from evaluation of the facility includes the outcome of the evaluation, this is reviewed by an expert panel who will endorse the accreditation award based on the findings of the peer review team and scoring calculations.

6. ENFORCEMENT AND SANCTIONS

The Department of Health is firmly committed to ensuring the highest standards of quality and safety in healthcare facilities across Abu Dhabi. The Hospital Accreditation Standards are designed to protect the wellbeing and rights of patients by setting clear expectations for compliance. The standards link to DOH Abu Dhabi regulations and publications and also refer to international practice to give guidance on quality improvement.

The standards will be enforced through facility level assessments and evaluations to ensure the compliance of the required criteria. Our aim is not only to ensure compliance but also to provide support and guidance to healthcare facilities, facilitating their journey towards excellence. By promoting a culture of continuous improvement, we strive to create a healthcare environment that instills confidence in patients and upholds the highest levels of care.

7. RELEVANT REFERENCE DOCUMENTS

No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
1.	2012	Abu Dhabi Food Control Authority, A Guide to the Preparation of a HACCP-Based Food Safety Management System for Schools & Hospitals, 2012	https://www.adafsa.gov.ae/English/PolicyAndLegislations/Guidelines/Documents/Schools%20and%20hospitals%2021.pdf
2.	2019	The Renal Association: Clinical Practice Guideline Hemodialysis, 2019	https://ukkidney.org/sites/renal.org/files/FINAL-HD-Guideline.pdf
3.	2021	Resuscitation Council UK, 2021 Resuscitation Guidelines	https://www.resus.org.uk/library/2021-resuscitation-guidelines
4.	2010	Abu Dhabi Health Authority, HAAD Standard for renal dialysis clinical service, 2010	https://www.doh.gov.ae/en/resources/standards
5.	2014	Abu Dhabi Health Authority, Standard for Endoscopy Services	https://www.doh.gov.ae/en/resources/standards
6.	2012	Abu Dhabi Health Authority: Policy for Recall of Drugs and Healthcare Products, 2012	https://www.doh.gov.ae/en/resources/standards
7.	2009	Abu Dhabi Newborn Screening Program, Healthcare Professional's Manual, First Edition 2009	https://www.doh.gov.ae/en/resources/standards
8.	2019	Agency for Healthcare Research and Quality (AHRQ), Rapid Response Systems	https://psnet.ahrq.gov/primer/rapid-response-systems
9.	2019	Aseni P, Orsenigo S, Storti E, Pulici M, Arlati S. Current concepts of perioperative monitoring in high-risk surgical patients: a review. Patient Safety in Surgery. 2019 Oct	https://pubmed.ncbi.nlm.nih.gov/31660064/
10.	2021	Association of Anaesthetists and the Intensive Care Society, Fire safety and emergency evacuation guidelines, 2021.	https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15511
11.	2021	Association of Nephrology Nurses: National Competency Framework for Registered Nurses in Adult Critical Care Intermittent Hemodialysis (IHD) Specialty Competencies, 2021	https://www.cc3n.org.uk/uploads/9/8/4/2/98425184/renal_competencies_working_document_final_jan_21.pdf
12.	2007	Bhabra G, Mackeith S, Monteiro P, Pothier DD. An experimental comparison of handover methods. Ann R Coll Surg Engl. 2007	https://pubmed.ncbi.nlm.nih.gov/17394718
13.	2023	Birth Injury Center, Intrauterine Fetal Demise (Stillbirth)	https://birthinjurycenter.org/types-of-birth-injuries/intrauterine-fetal-demise/
14.	2017	British Association of Perinatal Medicine, Neonatal Transitional Care - A Framework for Practice (2017)	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017

No.	Reference Date	Reference Name	Relation Explanation / Coding / Publication Links
15.	2022	Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Speech and Language Therapy Toolkit	https://www.cpft.nhs.uk/speech-and-language-therapy-toolkit/
16.	2021	Cardiovascular and Interventional Radiological Society of Europe, Clinical Practice Manual, Andreas H. Mahnken, Esther Boullosa Seoane, Allesandro Cannavale, Michiel W. de Haan Rok Dezman Roman Kloeckner Gerard O'Sullivan, Anthony Ryan, Georgia Tsoumakidou, 2021	https://www.cirse.org/publications/standards-of-practice/clinical-practice-manual/
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