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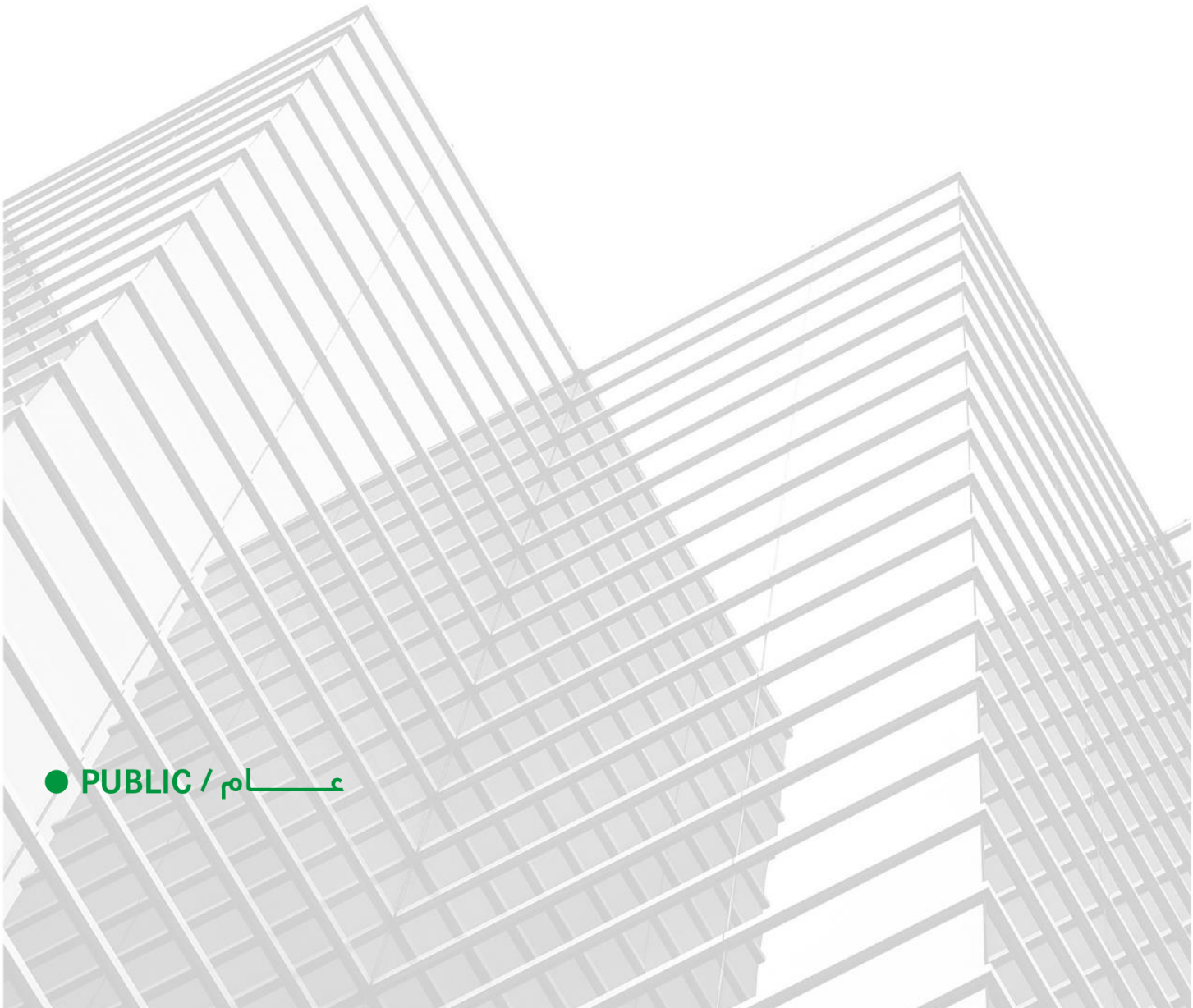
DEPARTMENT OF HEALTH

Standard for Emergency Departments, Urgent Care Centers, and Select Primary Healthcare Centers in Abu Dhabi



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1.Standard Scope

This Standard applies to all healthcare providers, public and private, licensed by DoH in the Emirate of Abu Dhabi that provide planned care and emergency medical care and operate emergency departments, urgent care center services, and select primary health centers.

2. Definitions and Abbreviations

No.	Term / Abbreviation	Definition
2.1	**Abu Dhabi Civil Defense Authority (ADCDA)**	A government entity in the Emirate of Abu Dhabi that provides emergency services including (Rescue, Firefighting, Public Ambulance services and other supporting specialties such as search and rescue and CBRNE).
2.2	**Advanced Cardiac Life Support (ACLS)**	A set of clinical guidelines used by healthcare providers to treat life-threatening cardiovascular conditions, based on a series of procedures and algorithms designed to stabilize patients in critical situations, and taught in standardized certification courses
2.3	**Advanced Life Support (ALS)**	A higher level of medical care, including basic life support functions plus administration of additional medications, advanced patient assessment, use of specific adjunctive medical devices, and other techniques and procedures as authorized by the Medical Director and within DoH EMS Clinical Protocols.
2.4	**Advanced Trauma Life Support (ATLS)**	A training program for medical providers in the management of acute trauma cases, developed by the American College of Surgeons Committee on Trauma.
2.5	**ATMIST**	A mnemonic acronym used by emergency medical services to communicate the important details of a patient Or equivalent standardized mechanism such as CASMEET, is an acronym designed to enhance casualty handover by providing key points within a structure. The individual letters stand for: **A**ge of the patient. **T**ime of the incident or onset of symptoms **M**echanism of injury or the mode of illness. **I**njuries seen or suspected **S**igns including vital signs and indication of improvement or deterioration. **T**reatment —Treatment given
2.6	**Basic Life Support (BLS)**	Noninvasive pre-hospital medical care requiring basic medical assessment and treatment as authorized by the Medical Director and within Clinical Practice Guidelines /Protocols.
2.7	**CASMEET**	A mnemonic acronym used by emergency medical services to communicate the important details of a patient communicated over to an emergency control center, receiving hospital, or other definitive care provider.

		Call — sign of the vehicle/unit responding. **A**ge — patient's age. **S**ex — whether the patient is male or female. **M**echanism/Mode — the mechanism of injury or the mode of illness. **E**xamination — the clinical findings from the initial assessment of the patient. **E**TA — estimated time of arrival. **T**reatment — any treatment that has already been provided.
2.8	**Department of Health (DoH)**	The regulative body of the Healthcare Sector in the Emirate of Abu Dhabi, Established based on law No. (10) of 2018.
2.9	**Emergency Condition**	An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." (3) Note that a final diagnosis is validated by history, physical examination, and diagnostic testing and treatment.
2.10	**Emergency Department**	Facilities in a hospital are devoted to providing emergency medical care for all.
2.11	**Emergency Medical Care**	Patients care for a medical or surgical emergency condition.
2.12	**Emergency Medicine**	As per the American College of Emergency Physicians definition used in this Standard, “Emergency medicine is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury. It encompasses a unique body of knowledge. The practice of emergency medicine includes the initial evaluation, diagnosis, treatment, coordination of care among multiple providers, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care”. (4)
2.13	**Emergency Severity Index (ESI)**	A five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs, as recommended by the Agency for Healthcare Research and Quality.
2.14	**Health Emergency Management (HEM)**	An Ecosystem used by the Abu Dhabi Department of Health to capture networks of hospitals treating time-critical healthcare emergencies such as trauma burn, STEMI, Stroke, and ECMO.
2.15	**International Trauma Life Support (ITLS)**	An alternative to ATLS for trauma training for prehospital emergency healthcare professionals
2.16	**Maternity/ Obstetric Emergency Department**	Facilities in a hospital dedicated to providing emergency maternity care.

2.17	**Medical or Surgical Emergency**	An injury or illness that occurs suddenly or unexpectedly and could reasonably be expected to pose an immediate risk /threat to a person's life, limb, body function or long-term health.
2.18	**Medical Screening Examination**	The medical screening examination aims to determine if the patient's condition needs urgent attention, or patient is stable and safe to seek treatment in another facility of their choice where they are covered and is to be performed by licensed medical practitioner or equivalent. Medical screening examination may include some testing to reach the conclusion of medical stability. (5).
2.19	**Most Responsible Physician (MRP)**	The physician, or other regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time.
2.20	**National Emergency, Crises and Disasters Management Authority (NCEMA)**	United Arab Emirate government entity ensuring coordination and compliance of related entities for security, resilience, quality of life, and readiness at the national level for emergencies, crises, and disaster management.
2.21	**Neonatal Resuscitation Program (NRP)**	An evidence-based educational program that introduces neonatal resuscitation concepts and basic skills to the adult learner that is used at all facilities where planned births occur.
2.22	**Pediatric Advanced Life Support (PALS)**	Training offered by the American Heart Association (AHA) for healthcare providers who take care of children and infants in critical condition
2.23	**Pediatric Emergency Department**	Facilities situated in a hospital are devoted to providing pediatric emergency medical care by licensed specialized pediatricians in emergency medicine or competent experienced specialized physicians for children up to the age of 16.
2.24	**Planned Care**	Care that is scheduled in advance.
2.25	**Primary Healthcare Center (PHC), see also Select PHC**	Centers that provide limited, primary, outpatient healthcare services as defined in the "Standard for Primary Healthcare Services in Emirate of Abu Dhabi". These may be standalone or co-located with hospitals.
2.26	**Remote Emergency Department**	An Emergency Department that is more than 100 km away from a city with a population of more than 15,000 and an emergency department with annual visits of more than 10,000 patients.
2.27	**Select Primary Healthcare Center**	**Primary Healthcare Centers** that have additional capabilities to provide additional, services for diagnosing, stabilizing, treating, and transferring more urgent patient conditions. They may also have extended hours of operation.
2.28	**Special Program Pathways (SPP) Task Force (TF)**	Time-critical healthcare emergencies in the HEM that require 24/7 availability of specialized care, equipment, and staff organized in an integrated treatment pathway, often with a formal accreditation process, specific registries, dedicated program management, and performance improvement patient safety programs. SPPs are managed through formal Task Forces comprised of relevant internal and external stakeholders.

2.29	**Stabilization**	With respect to the care provided to patients without regard for their ability to pay, stabilization refers to the management of injury or illness to the point of providing definitive procedures that reverse, remove, or mitigate the cause such that it is no longer life-threatening. All potential diagnoses should be considered. If an emergency condition is possible based on history or physical exam, the patient should be provided with treatment.
2.30	**Stop the Bleed (STB)**	A training program for medical providers in the management of exsanguinating hemorrhage developed by the American College of Surgeons Committee on Trauma
2.31	**Third Party Administrators (TPA)**	An entity that provides operational services such as claims processing and employee benefits management under contract to another company.
2.32	**Triage Categories for emergency patients, T1-T5**	Triage categories are based on 5 level Triage system where T1 is critically ill and needs immediate attention by healthcare providers and T5 is non-acutely ill and can wait to be seen when health care providers are available.
2.33	**Unified Medical Operations Command Center (UMOC)**	DoH operations center run by CEPAR that monitors, facilitates, and optimizes healthcare emergencies in Abu Dhabi.
2.34	**Urgent Care Centers (UCC)**	Facilities in a hospital that provide initial evaluation, stabilization, diagnostic capabilities to treat the urgent injuries and illnesses and provide initial management of select time critical emergencies and transfer to a higher level of care if needed.

3.Standard Requirements and Specifications

3.1 DoH Classification of Emergency Care Provision shall be as follows:

3.1.1 Emergency Department (See **Appendix 1** for full licensing requirements).

3.1.2 Pediatric Emergency Department (See **Appendix 2** for full licensing requirements).

3.1.3 Maternity/Obstetrics Emergency Department (See **Appendix 3** for full licensing requirements).

3.1.4 Remote Emergency Department (See **Appendix 4** for full licensing requirements).

3.1.5 Urgent Care Centers (See **Appendix 4: Licensing Requirements and Minimum Service Specifications for Remote Emergency Departments**

	Remote Emergency Departments
1. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services: • Mandatory services and infrastructures on site: ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation. ➢ Basic Blood Bank services (ability to transfuse blood (packed Red Blood Cells and Fresh Frozen Plasma) for unstable patients), started within 15 minutes. ➢ Clinical Pathology services (either as conventional testing or point of care testing). ➢ Designated area for the assessment and management of pediatric patients ➢ Psychiatric assessment area. ➢ Decontamination facilities (if designated by DoH). ➢ Transfer agreements for surgical services not provided onsite. • Services that can be provided remotely via tele-consultation (patient to physician): ➢ Internal Medicine ➢ General Surgery • Services that can be provided through tele-counseling (physician to physician) to assist in the emergency management of complex patients and those requiring stabilization and transfer to a higher level of care: ➢ Internal Medicine ➢ General Surgery and Surgical Specialties ➢ Anesthesiology ➢ Critical Care Critical Care. • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care.

	• If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department, the HLS shall conform to Civil Aviation Authority standards.
2. Structure	• There is at least one room designated as the "Resuscitation" room. • If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department the HLS shall conform to Civil Aviation Authority standards. Dedicated infrastructure • To receive patients as walk-ins • To send and receive patients via ambulance Dedicated floor space • Waiting room/section • Examination room/section • Procedural room/section Observation room/section
3. Assessment, Stabilization & Care	• Capability to resuscitate patients with life-threatening illness or injury. • Capability to assess and provide early treatment of patients with sudden serious illnesses or injury. • Use of 5 Level Triage ESI or comparable system. • Capability to manage patients requires a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions. • Stabilize and transfer patients with an immediate risk /threat to life, limb, body function or long-term health to an Emergency Department by interfacility ambulance with the appropriate level of care provided (e.g., BLS, ALS, critical care).
4. Clinical Staffing	• The ED shall be led by an Emergency Medicine Consultant. All the staff working in the ED inclusive of physicians, nursing and non-clinical support staff shall report to the ED lead. • At least one Consultant/Specialist in Emergency Medicine per shift.

	• All physicians working in the Remote ED need to maintain active certification in adult, pediatric and trauma resuscitation (ACLS, PALS, NRP, ATLS/ ITLS, BLS). Physicians with Emergency Medicine License working in Remote area only and not covering shifts in tertiary or secondary hospitals are included. • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care. Support staff may consider training in Stop The Bleed (STB). • Pediatric Emergency area can be staffed by trained pediatrics emergency physician (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians with experience in emergency medicine of no less than 5 years.
5. Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET or ATMIST format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover.
6. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization. • Undertake regular clinical audits and review
7. Reporting	• Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting.

8. Patient Referral, Retrieval & Transfer	The facility shall have in place a patient referral and transfer process including memorandums of understanding that include auto-acceptance criteria of patients from the urgent care to a regularly licensed emergency department without delay, and it shall have ALS ambulances licensed for interfacility transfer that can be utilized to initiate transport of the patient requiring higher-level services within 30 minutes from the decision to transfer.
9. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

3.1.6 **Appendix** for full licensing requirements).

3.1.7 Select Primary Healthcare Centers (See Appendix 6 for full licensing requirements).

3.2 Emergency Departments, Urgent Care Centers, and Select Primary Healthcare Center Service Specifications and Requirements

Healthcare Providers that wish to operate Emergency Departments, Urgent Care Centers, and Select Primary Healthcare Centers services shall:

3.2.1 Comply, with designated service requirements found in **Error! Reference source not found.**-6 .

3.2.2 Comply with the specific duties, responsibilities, and regulations referenced in Sections 5-7 of this Standard and requirements of the latest DoH published regulations https://www.DoH.gov.ae.

3.2.3 Follow the list of antidotes that is available in Standard for Antidote Stocking in Healthcare Facilities and submit the monthly report of their antidote stocking levels on the first week of each month via the DoH E-notification Antidote Reporting System: https://bpmweb.DoH.gov.ae/UserManagement/MainPage.html

3.2.4 Use a 5 level triage system consistent with DoH pre-hospital and hospital patient emergency severity index (ESI) or comparable tiering process.

3.3 General Duties for Healthcare Providers/ Payers/ Third Party Administrators (TPAs)

All Emergency Departments shall:

3.3.1 Liaise with DoH Abu Dhabi UMOC on mandated monitoring, reporting, and emergency capacity.

3.3.2 Register, clinically triage, and treat all patients with a potential 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. See Figure 1 below for the insurance management diagram. This includes:

3.3.2.1 Provide medical screening examination and/or stabilizing treatment to all T1 and T2 patients without delay in order to inquire about payment status and ensure that assessment is documented on the patient's medical records.

3.3.2.2 Provide T3, T4 and T5 patients' medical screening examination beyond initial triage. Triage is not equivalent to a Medical Screening Examination.

3.3.2.3 Triage merely determines the "order" in which patients will be seen, not the presence or absence of an emergency medical condition. The medical screening examination shall be performed by a licensed medical practitioner to determine if the patient condition needs urgent attention or patient is stable and safe to seek treatment in another facility of their choice where their health insurance is accepted, and which is more appropriate to the acuity of their medical condition. Medical screening examination may include some testing to reach the conclusion of medical stability. Testing required to determine stability shall not be delayed for processes related to assurance of payment.

3.3.2.4 If a patient's insurance does not cover ongoing treatment at the treatment hospital, but the patient requires further urgent medical or surgical intervention *and is stable and safe to transfer to another hospital*, the treating hospital should coordinate with the patient and the patient's insurance company to identify a preferred transfer location (see Figure 1). This shall not impede the care necessary to stabilize the condition of the patient or the work of the transferring hospital. Health insurance companies should have 30 minutes to provide guidance. If services cannot be rendered at the initial hospital, the patient is entitled to transfer to a hospital capable of meeting the medical needs of the patient. If a capable hospital that accepts the patient's insurance is not found within 30 minutes, the patient should be transferred without regard to insurance status. If the services are available at the initial hospital, but the patient prefers transfer to another hospital due to insurance coverage, the patient may be transferred. If another hospital that takes the patient's insurance is found and can provide the needed medical services, but the

patient prefers to be treated at the non-covered hospital, the patient should agree to the cost.

3.3.2.5 For those patients determined not to have a medical emergency or to be at risk of a medical emergency in the following 72 hours, in line with the definition of an emergency condition, the Emergency Department may, following medical screening exam and where clinically documented as safe to do so, discharge the patient and advise the patient where they might get the appropriate, non-emergency medical treatment.

3.3.2.6 For patients who do not have health insurance, the hospital should recover the medical expenses directly from the patient, his sponsor, or include it under activity-based mandates as per the rules and regulations without jeopardizing the delivery of appropriate care as defined above.

3.3.2.7 For patients who refuse medical screening and decide to leave the facility:

3.3.2.7.1 They must have medical capacity to make critical health decisions, as deemed by the most responsible physician.

3.3.2.7.2 They shall be provided with an explanation of the risk of their actions.

3.3.2.7.3 If they insist on leaving, they must sign a "Leaving against medical advice" form. Reasons for leaving should be documented if known, preferably in the patient's own words. In case of refusal, the healthcare provider shall document the refusal clearly.

3.3.3 When a healthcare facility is unable to provide treatment sufficient to fully stabilize the patient's condition, or when not designated by DoH regulation to treat, the healthcare facility shall provide an appropriate transfer of the patient to another, appropriate medical facility, after obtaining the consent of the receiving hospital to accept the transfer, and stabilizing the patient to the best of the ability of the referring healthcare facility within the guidelines of DoH regulations and in coordination with UMOC.

3.3.3.1 This shall be done in accordance with the hub and spoke model of the DoH Health Emergency Management (HEM) Special Program Pathway (SPP) hospital networks as developed through regional, city, and population distributions.

3.3.3.2 All Interfacility Transfers shall be documented in real-time using the designated transfer process in the DoH UMOC, and support requested from the healthcare organization's hospital liaison officer when needed.

3.4 Upskilling of treatment centers:

3.4.1.1 DoH requires facilities in remote regions with limited access to critical care to ensure the continued provision of advanced critical services. Where case volumes are too low to maintain licensing competencies, facilities shall implement measures such as ongoing staff upskilling, telemedicine support, and robust interfacility transfer capability to mitigate the risk and meet licensing requirements. Designated Select Primary Healthcare Centers shall be staffed and equipped to provide a higher level of acute care support as per Appendix 6: Licensing Requirements and Minimum Service Specifications for upskilled, Select Primary Healthcare Centers, below.

3.5 All insurers and TPAs must:

3.5.1 Reimburse the emergency treatment provided regardless of whether the hospital is in its insurance network.

4.Key stakeholder Roles and Responsibilities

4.1 SPP TF roles and responsibilities are outlined in separate Terms of Reference for each SPP.

Stakeholder name	Stakeholder Key Role
DoH Center of Emergency Preparedness and Response (CEPAR)	Coordinator for DoH Sectors and SPP Task Forces, Manager of UMOC, ensures policies and standards are maintained and updated, coordinates with other DoH Sectors in their regulatory authorities
DoH Sectors	Regulations, coordination, monitoring, and ensure integration, alignment and continuous quality and performance improvement
Abu Dhabi Public Health Center (ADPHC)	Key stakeholder for prevention and community awareness programs, data abstraction, and community health
Abu Dhabi Civil Defense Authority	Provision of EMS Services including public safety 999 call taking and dispatch
Health Insurers	Compliance, support, commitment, timely reimbursement
Healthcare Providers	Compliance, support, commitment, accreditation / certification where applicable, reporting and data-sharing as required
Healthcare Professionals	Provision of the standard of care, compliance with QA/ QI/ Performance Improvement Programs

5.Monitoring and Evaluation

The indicators are reviewed and developed annually by the DoH Quality Division with support from local and international emergency care expertise.

All DoH waiting time guidance can be accessed on this link (JAWDA Quarterly Waiting Time Guidelines for Specialized and General Hospitals):
https://www.DoH.gov.ae/resources/jawda-abu-dhabi-healthcare-quality-index

DoH may revise and update these metrics taking into consideration service needs, performance and population health challenges. Department of Health sectors maintain relevant authorities for regulatory oversight. CEPAR shall coordinate the development and functioning of Special Program Pathway Task Forces to ensure ongoing coordination across all internal and external stakeholders in the development, maintenance, and updating of these documents.

5.1 Most mission objectives are measured against international standards and best practices that have well-established key and quality performance indicators. While these can be added to and tracked in Jawda, it is anticipated that CEPAR will be able to discover and establish novel KPIs and QPIs. Additionally, for time-critical healthcare emergencies, Abu Dhabi healthcare providers will seek to meet international accreditation, certification, or validation for the following SPPs:

5.1.1 Trauma Center—American College of Surgeons Committee on Trauma (ACS COT) for Levels I, II, III/IIIN

5.1.2 Burn Centers-American Burn Association (ABA)

5.1.3 STEMI Centers—American Heart Association (AHA) for Comprehensive Chest Pain, Primary Chest Pain, and Chest Pain Ready levels

5.1.4 Stoke Centers—AHA for Comprehensive, Primary, and Stroke Ready levels.

5.1.5 ECMO Services—Extracorporeal Lifesaving ELSO for Pediatrics and Adult ECMO

5.1.6 Hospitals—International Society for Quality in Healthcare (ISQua)

5.1.7 Hospitals and EMS Accreditation—Joint Commission International (JCI)

5.1.8 Rehabilitation Medicine Facilities—Commission on Accreditation of Rehabilitation Facilities (CARF)

6.Enforcement and Sanctions

6.1 DoH may impose sanctions in relation to any breach of requirements under this standard in accordance with the disciplinary regulation of the healthcare sector.

7. Relevant Reference Documents			
No.	**Reference Date**	**Reference Name**	**Relation Explanation / Coding / Publication Links**
1	**Accessed July 2025**	List of cities in UAE	http://www.dubaifaqs.com/list-of-cities-uae.php
2	**June 2024**	Policy for Health Emergency Management (HEM)	https://www.DoH.gov.ae/-/media/3FAA333EC7BA41429AC8987979B08500.ashx
3	**January 2024**	Medical Direction System Standards	https://www.DoH.gov.ae/-/media/DBDCA02AE4AB443685BBEB941175C9D8.ashx
4	**May 2024**	DOH Standard for Special Program Pathways in Abu Dhabi	https://www.DoH.gov.ae/-/media/830FA18BF12749FC9203D92A8DBCCFCF.ashx
5	**December 2023**	Abu Dhabi Ambulance and EMS Standard	https://www.DoH.gov.ae/-/media/F8647B708EDE4AFD87FEB6A024F2E907.ashx
6	**September 2024**	Critical Care Transport Service (CCTS) Standard	https://www.DoH.gov.ae/-/media/D5436743B0E648678504E479346B95AD.ashx
7	**December 2019**	Australian College of Rural and Remote Medicine. Recommended Minimum Standards for small rural hospital emergency departments [Internet].	https://www.acrrm.org.au/docs/default-source/all-files/college-standards-for-small-rural-hospital-emergency-departments.pdf?sfvrsn=7b50f7b_6
8	**Accessed July 2025**	EMTALA Fact Sheet [Internet].	https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/

9	**Accessed July 2025**	Definition of Emergency Medicine [Internet].	https://www.acep.org/patient-care/policy-statements/definition-of-emergency-medicine/
10	**Accessed July 2025**	Best Practices – Medical Screening Exam	**EMTALA and Prudent Layperson Standard FAQ | ACEP**
11	**Accessed July 2025**	DoH Web Page for Emergency Departments in Abu Dhabi	**Emergency Departments in Abu Dhabi - Featured - Department of Health**
12	**December 2024**	Standard for Antidote Stocking in Healthcare Facilities	https://www.doh.gov.ae/-/media/Feature/Resources/Standards/doh-standard-for-antidote-stock.ashx
13	**Accessed July 2025**	DoH E-notification Antidote Reporting System:	https://bpmweb.DoH.gov.ae/UserManagement/MainPage.html

9. Appendices

Appendix 1: Licensing Requirements and Minimum Service Specifications for Emergency Departments

	Emergency Departments
1. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services. • Mandatory services and infrastructures: ➢ Emergency Medicine ➢ Internal Medicine ➢ General Surgery ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation ➢ Blood Bank ➢ Clinical Pathology services ➢ Anesthesiology ➢ Operating Theatres ➢ Critical Care ➢ Psychiatric assessment area ➢ Decontamination facilities (if designated by DoH) ➢ Designated area for the assessment and management of pediatric patients • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care. • If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department the HLS shall conform to Civil Aviation Authority standards.

	Emergency Departments
2.Assessment, Stabilization & Care	• Capability to resuscitate patients with life-threatening condition or injury. • Capability to assess and early treatment of patients with acute condition or severe/ life threatening injuries. • Use of 5 Level Triage ESI or comparable system. • Capability to manage patients requiring a short period of programmed investigations and observation to ensure safe and appropriate disposition of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions. Dedicated infrastructure • To receive patients as walk-ins • To send patients via ambulance Dedicated floor space • Dedicated resuscitation room • Waiting room/section • Examination room/section • Procedural room/section Observation room/section
3. Clinical Staffing	• The ED shall be led by an Emergency Medicine Consultant. All the staff working in the ED inclusive of physicians, nursing and non-clinical support staff shall report to the ED lead. • Hospitals that are major trauma centers (level 1,2), Comprehensive/ Primary Stroke Centers, ECMO Centers must have at least one Consultant in Emergency Medicine per shift. All other EDs may be staffed by an ED specialist provided a consultant is immediately available on call at all times. • All physicians working in the ED need to maintain current certification in adult, pediatric and trauma resuscitation (ACLS, PALS, ATLS/ ITLS). • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care. • Pediatric Emergency area can be staffed by trained pediatrics emergency physician (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians with experience in emergency medicine of no less than 5 years.

	Emergency Departments
4.Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET or ATMIST format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover.
5. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization. • Undertake regular clinical audits and review
6.Reporting	• Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting.
7. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process
8. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

Appendix 2: Licensing Requirements and Minimum Service Specifications for Pediatric Emergency Departments

	Pediatric Emergency Departments
1. Access	Open 24 hours a day, seven days a week with access to comprehensive pediatric emergency services. • Mandatory services and infrastructures: ➢ General Pediatrician (consultant and/or specialist) ➢ Pediatric Intensive Care Unit ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation ➢ Clinical pathology services ➢ Blood bank ➢ Anesthesiology ➢ Pediatric Surgery Service ➢ Operating Theater ➢ Psychiatric assessment area ➢ Decontamination area (if designated by DoH) • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports pediatric patients, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care. • If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department the HLS shall conform to Civil Aviation Authority standards.
2. Assessment, Stabilization & Care	• Capability to resuscitate pediatric patients with life-threatening illness or injury. • Capability to assess and early treatment of pediatric patients with sudden serious illness or injury. • Use of 5 Level Triage ESI or comparable system. • Capability to manage pediatric patients requiring a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions. Dedicated infrastructure • To receive patients as walk-ins • To send patients via ambulance Dedicated floor space • Dedicated resuscitation room

	Pediatric Emergency Departments
	• Waiting room/section • Examination room/section • Procedural room/section Observation room/section
3. Clinical Staffing	• The Pediatric ED shall be led by: ➢ A Pediatric Emergency Medicine Consultant; or ➢ Emergency Medicine Consultant, or ➢ A Pediatric consultant with 5 years Emergency experience if no Pediatric Emergency Medicine consultant can be found. All the staff working in the ED inclusive of physicians, nursing, and non-clinical support staff shall coordinate through the ED Head of Department; • Pediatric Emergency Departments shall be staffed by trained pediatric emergency physicians (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians or general practitioners with experience in emergency medicine of no less than 5 years. • At least one Consultant as identified above per shift. • All physicians working in the ED need to maintain current certification in pediatric and trauma resuscitation (PALS, ATLS/ ITLS). All physicians must have taken the neonatal resuscitation program (NRP) course but are not required to maintain certification. • Availability of appropriate mix of multidisciplinary pediatric emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to pediatric patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe pediatric emergency care.
4. Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET or ATMIST format; and providing medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover.
5. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization. • Undertake regular clinical audits and review
6. Reporting	Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting.

	Pediatric Emergency Departments
7. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process
8. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

Appendix 3: Licensing Requirements and Minimum Service Specifications for Maternity Emergency Departments

	Maternity/ Obstetrics Emergency Department
1. Access	Open 24 hours a day, seven days a week with access to comprehensive emergency services. • Mandatory services and infrastructures: ➢ Obstetrics: emergency obstetric care, early pregnancy complications and postnatal emergency care ➢ Neonatal intensive care for level 3 and above ➢ Internal Medicine ➢ Radiology/ Diagnostic imaging including plain radiography, ultrasound, access to CT and timely access to radiologist consultation and image interpretation ➢ Blood Bank ➢ Clinical Pathology services ➢ Anesthesiology ➢ Operating Theatres ➢ Psychiatric assessment area ➢ Decontamination area (if designated by DoH) • Critical Care or agreement to transfer patient who need ICU to another facility with critical care facility: If the facility has no onsite ICU (critical care level 3), the facility must have onsite critical care level 2 as a minimum (this is also known as High Dependency Unit (HDU) care) as well as access to another facility with ICU provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all maternity and neonatal patients, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care. • If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department, the HLS shall conform to Civil Aviation Authority standards.
2. Assessment, Stabilization & Care	• Capability to resuscitate maternity and neonatal patients with life-threatening illness or injury. • Capability to assess conditions and provide early treatment of maternity patients with sudden serious illness or injury. • Use of 5 Level Triage ESI or comparable system. • Capability to manage patients requires a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions. Dedicated infrastructure • To receive patients as walk-ins • To send and receive patients via ambulance Dedicated floor space • Dedicated resuscitation room

	• Waiting room/section • Examination room/section • Procedural room/section • Observation room/section
3. Clinical Staffing	• The Maternity Emergency Department shall be led by an Obstetrics Consultant. All the staff working in the geographically distinct Maternity Emergency Departments inclusive of physicians, nursing and non-clinical support staff, shall report to the Maternity Emergency Department lead. • At least one Consultant in Obstetrics per shift. • All obstetricians and neonatologists need to maintain active certification in adult and neonatal resuscitation (ACLS, NRP, and PRactical Obstetric Multi-Professional Training (PROMPT)). • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care.
4. Admission & Handover	• The maternity Emergency Department must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET or ATMIST format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover
5. Quality & Safety	Maternity/ Obstetrics Emergency Department quality and safety committee to monitor, assess and improve performance and report on adverse events. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization. • Undertake regular clinical audits and review.
6. Reporting	• Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting.
7. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process
8. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

Appendix 4: Licensing Requirements and Minimum Service Specifications for Remote Emergency Departments

	Remote Emergency Departments
10. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services: • Mandatory services and infrastructures on site: ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation. ➢ Basic Blood Bank services (ability to transfuse blood (packed Red Blood Cells and Fresh Frozen Plasma) for unstable patients), started within 15 minutes. ➢ Clinical Pathology services (either as conventional testing or point of care testing). ➢ Designated area for the assessment and management of pediatric patients ➢ Psychiatric assessment area. ➢ Decontamination facilities (if designated by DoH). ➢ Transfer agreements for surgical services not provided onsite. • Services that can be provided remotely via tele-consultation (patient to physician): ➢ Internal Medicine ➢ General Surgery • Services that can be provided through tele-counseling (physician to physician) to assist in the emergency management of complex patients and those requiring stabilization and transfer to a higher level of care: ➢ Internal Medicine ➢ General Surgery and Surgical Specialties ➢ Anesthesiology ➢ Critical Care Critical Care. • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care. • If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department, the HLS shall conform to Civil Aviation Authority standards.

	Remote Emergency Departments
11. Structure	• There is at least one room designated as the "Resuscitation" room. • If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department the HLS shall conform to Civil Aviation Authority standards. Dedicated infrastructure • To receive patients as walk-ins • To send and receive patients via ambulance Dedicated floor space • Waiting room/section • Examination room/section • Procedural room/section Observation room/section
12. Assessment, Stabilization & Care	• Capability to resuscitate patients with life-threatening illness or injury. • Capability to assess and provide early treatment of patients with sudden serious illnesses or injury. • Use of 5 Level Triage ESI or comparable system. • Capability to manage patients requires a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions. • Stabilize and transfer patients with an immediate risk /threat to life, limb, body function or long-term health to an Emergency Department by interfacility ambulance with the appropriate level of care provided (e.g., BLS, ALS, critical care).
13. Clinical Staffing	• The ED shall be led by an Emergency Medicine Consultant. All the staff working in the ED inclusive of physicians, nursing and non-clinical support staff shall report to the ED lead. • At least one Consultant/Specialist in Emergency Medicine per shift. • All physicians working in the Remote ED need to maintain active certification in adult, pediatric and trauma resuscitation (ACLS, PALS, NRP, ATLS/ ITLS, BLS). Physicians with Emergency Medicine License working in Remote area only and not covering shifts in tertiary or secondary hospitals are included. • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care. Support staff may consider training in Stop The Bleed (STB).

	Remote Emergency Departments
	• Pediatric Emergency area can be staffed by trained pediatrics emergency physician (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians with experience in emergency medicine of no less than 5 years.
14. Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET or ATMIST format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover.
15. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization. • Undertake regular clinical audits and review
16. Reporting	• Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting.
17. Patient Referral, Retrieval & Transfer	The facility shall have in place a patient referral and transfer process including memorandums of understanding that include auto-acceptance criteria of patients from the urgent care to a regularly licensed emergency department without delay, and it shall have ALS ambulances licensed for interfacility transfer that can be utilized to initiate transport of the patient requiring higher-level services within 30 minutes from the decision to transfer.
18. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

Appendix 5: Licensing Requirements and Minimum Service Specifications for Urgent Care Centers

	Urgent Care Centers

1. Access	Open 24 hours a day, seven days a week with access to care for minor, urgent medical conditions.
	
	• Mandatory services and infrastructures:
	  ➢ Radiology/ Diagnostic imaging including plain radiography,
	  ➢ Clinical Pathology services
	
	• Provision of urgent care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access.
	
	• Availability of hospital wide escalation policy for when an urgent care center is approaching full and the associated risks. Criteria for escalation should be determined locally.
	
	Across all facilities
	
	Protocols for inter-facility transfer
	
	List of adult indications for referral from UCC/ PHC to ED (after initial stabilization) Burns, Stroke, Trauma, STEMI, Cardiac Arrest
	
	List of pediatric indications for referral from UCC to ED (after initial stabilization)
	
	Protocols for documentation of transfers and referrals
	
	• If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department, the HLS shall conform to Civil Aviation Authority standards.

2. Assessment, Stabilization & Care	• Capability to perform initial resuscitation of patients with life-threatening illness or injury. • Capability to assess and provide early treatment of patients with sudden serious illness or injury. • Use of 5 Level Triage or comparable system. • Stabilize and transfer patients with an immediate risk /threat to life, limb, body function or long-term health to an Emergency Department by interfacility ambulance with the appropriate level of care provided (e.g., BLS, ALS, critical care). Dedicated infrastructure • To receive patients as walk-ins • To send patients via ambulance Dedicated floor space • Dedicated resuscitation area

	• Waiting room/section • Examination room/section • Procedural room/section/ area • Observation room/section/ area
3. Clinical Staffing	• The Urgent Care Center shall be Consultant led. All the staff working in the Urgent Care Center inclusive of physicians, nursing and non-clinical support staff shall report along their administrative human resource organizational structure for administrative issues and shall align with the appointed clinical consultant lead regarding clinical healthcare protocols and care. • At least one Consultant/Specialist or GP per shift. • All Urgent Care Center physicians need to maintain current certification in adult and pediatric resuscitation (ACLS, PALS, BLS, ATLS/ ITLS). Ambulance Capabilities • At least one ALS (IFT) Ambulance available full time for interfacility transfer that can be utilized to initiate transport of the patient requiring higher-level services within 30 minutes from the decision to transfer. • Abu Dhabi Civil Defense Authority EMS ambulance as backup • Availability of appropriate mix of multidisciplinary Urgent Care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing Urgent Care to patients and that staff receive appropriate and up to date training to support quality and safe urgent care. Support staff may consider training in STB.
4. Admission & Handover	• Staff scheduling must be designed to ensure safe handover
5. Quality & Safety	• Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting. • Urgent Care Center quality and safety committee to monitor, assess and improve performance and report on adverse incidents. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization. • Undertake regular clinical audits and review
6. Patient Referral, Retrieval & Transfer	The facility shall have in place a patient referral and transfer process including memorandums of understanding that include auto-acceptance criteria of patients from the urgent care to a regularly licensed emergency department without delay, and it shall have ALS ambulances licensed for interfacility transfer that can be utilized to initiate transport of the patient requiring higher-level services within 30 minutes from the decision to transfer.

	• Centers shall develop clear protocols for IFT with appropriate service level agreements for travel time and IFT performance including special program pathways timelines for time-sensitive emergencies. • Centers shall collaborate with AD Civil defense Authority EMS to ensure appropriate cases are diverted to appropriate facilities and to support transfer of critical cases when necessary. • Centers shall have telemedicine capabilities with referral hospitals to secure telemedicine support from consulting services and emergency medicine consultants/specialists.
7. Signage & Patient information	Urgent Care Department Signage Patient information is appropriate to the facilities scope of services. All Urgent Care Centers are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

Appendix 6: Licensing Requirements and Minimum Service Specifications for Select Primary Healthcare Centers.

	Select Primary Healthcare Centers

1. Access	Open 24 hours a day, seven days a week with the following:
	• Consultant EM physician on-site or remotely supervising Family Medicine Physician on site
	  ○ BLS, ACLS, PALS, and ATLS/ ITLS requirement for EM, FMs, and GPs managing urgent care
	• Appropriately trained Family Medicine physicians are available on-site. FM physicians shall have completed at least 3 months of supervised emergency room experience in a Tier 1 or 2 ER.
	• Appropriately trained nurses available on-site
	  ○ BLS, ACLS for nurses in urgent care
	Mandatory services and infrastructures:
	• **Radiology/ Diagnostic imaging** including plain radiography, must be accompanied by dedicated sub-specialty physician or medical technician
	• **Clinical Pathology services** must be accompanied by dedicated sub-specialty physician or medical technician
	• **Pharmacy** available in-house
	• Provision of urgent care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access.
	• Availability of healthcare center wide escalation policy for when an urgent care center is approaching full and the associated risks. Criteria for escalation should be determined locally.
	• If there is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department, the HLS shall conform to Civil Aviation Authority standards.

2. Escalation and Transfer	Escalation policy for transfer in case of severity and in case of high utilization Group PHCs: • Designated hospital with ED within network to receive transfers Standalone PHCs • Active signed MoU with nearby hospitals with ED to receive transfers with auto-acceptance criteria. • Active signed MoU with nearby hospitals with ED for their EM physicians to remotely supervise FMs in standalone PHCs, especially during night shift • Active signed MoU with hospitals or consultants in multidisciplinary team (PEDs, OBGY) to remotely supervise FMs in standalone PHCs, especially during night shift Across all facilities • Protocols for inter-facility transfer • List of adult indications for referral from UCC/ PHC to ED (after initial stabilization) Burns, Stroke, Trauma, STEMI, Cardiac Arrest • List of pediatric indications for referral from UCC/ PHC to ED (after initial stabilization)

	• Protocols for documentation of transfers and referrals Ambulance Capabilities • At least one ALS (IFT) Ambulance available full time for interfacility transfer that can be utilized to initiate transport of the patient requiring higher-level services within 30 minutes from the decision to transfer. • Abu Dhabi Civil Defense Authority EMS ambulance as backup
3. Assessment, Stabilization & Care	Capability to resuscitate patients with life-threatening illness or injury. • Capability to assess, stabilize, and initiate early treatment of patients with sudden serious illness or injury. • Stabilize and transfer patients with an immediate risk /threat to life, limb, body function or long-term health to an Emergency Department by interfacility ambulance with the appropriate level of care provided (e.g., BLS, ALS, critical care). Consult with accepting referral hospital consultant • Use of 5 Level Triage or comparable system. Dedicated infrastructure • To receive patients as walk-ins • To send patients via ambulance Dedicated floor space • Dedicated resuscitation room • Waiting room/section • Examination room/section • Procedural room/section • Observation room/section

4. Clinical Staffing	• **Physicians**: Select PHCs shall be Consultant led- ideally an Emergency Medicine Physician
	  ○ Shift requirements
	  ▪ Ideal - EM available 24 hours/ day with FM coverage
	  ▪ Optional - Adequately trained FM that is monitored by EM remotely
	• **ALS (IFT) licensed** ambulance
	• **Multi-disciplinary care team**: On site requirement 24/7
	  ○ FM
	  ○ On site during morning shift and remote supervision during night shift (via telemedicine through hospital with signed and active MoU)
	  ▪ OB/ GYN
	  ▪ Pediatrician
	• All Select PHC physicians need to maintain active certification in adult and pediatric resuscitation (ACLS, PALS, BLS, ACLS). Support staff may consider training in STB.

5. Admission & Handover	• Staff scheduling must be designed to ensure safe handover with clear, timely documentation of care provided.

6. Quality & Safety	• Participating in healthcare data registries as defined by DoH, including related functions of coordination of communication and case management and follow up, and data analysis, monitoring and reporting.
	• PHC quality and safety committee to monitor, assess and improve performance and report on adverse incidents. Mandatory reporting for events as per Incident Reporting and Management Standard and the DoH standard on Reporting Suspected Adverse Drug Reactions and Adverse Events Following Immunization.
	• Facility shall perform regular clinical audits and reviews:
	  • Audit to be conducted at least annually.
	• Mandate reporting of 4 KPIs (outcome, and process related) to measure safety, quality and performance - namely,
	  ○ WT008: Seeing a doctor in emergency department or urgent care center (Door to Doctor Time)
	  ○ WT009: Registration to leaving emergency department or urgent care center (Door to Door Time)
	  ○ WT010: 24 hours -Re attendance rate to emergency department or urgent care center
	  ○ WT011: Left Without Being Seen (LWBS) documented by the most responsible physician

7. Patient Referral, Retrieval & Transfer	• The facility shall have in place a patient referral and transfer process including memorandums of understanding that include auto-acceptance criteria of patients from the urgent care to a regularly licensed emergency department without delay, and it shall have ALS ambulances licensed for interfacility transfer that can be utilized to initiate transport of the patient requiring higher-level services within 30 minutes from the decision to transfer. • Centers shall develop clear protocols for IFT with appropriate service level agreements for travel time and IFT performance including special program pathways timelines for time-sensitive emergencies. • Centers shall collaborate with AD Civil defense Authority EMS to ensure appropriate cases are diverted to appropriate facilities and to support transfer of critical cases when necessary. • Centers shall have telemedicine capabilities with referral hospitals to secure telemedicine support from EM and consulting physicians. This shall include protocols and indications for FMs in PHCs to opt for telemedicine for supervision (e.g., from EM, OBGYN, PAED)
8. Signage & Patient information	Addition of UCC signage at select PHCs All Select PHCs are expected to display the correct signage which is published on DoH website on this link https://www.DoH.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

Appendix 7: Key Performance Indicators for Emergency Departments

The Indicators are reviewed and developed annually by the DoH Quality Division with support from local and international emergency care expertise.

All DoH waiting time guidance can be accessed on this link (JAWDA Quarterly Waiting Time Guidelines for Specialized and General Hospitals):
https://www.DoH.gov.ae/resources/jawda-abu-dhabi-healthcare-quality-index

DoH may revise and update these metrics taking into consideration service needs, performance and population health challenges.

Figure 1. Management schema for insurance/ non-insurance status.