Ministry Of Health and Population
Minister Office Sector
General Directorate Of Quality
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DRAFT Standards for Healthcare Organizations

PR. Ethics, Patient Rights and Responsibilities

Organization Ethics

1. The organization informs patients and families about its services and how to access those services.
2. Policy defines the organization's responsibilities for patient's possessions including at least the following:
    1. When responsibility for these possessions begin
    2. How possessions will be protected
3. Information about the organization's responsibility is given to the patient or family.

Individual Rights

General

4. Policy and procedures define at least the following rights:
    1. Rights as defined by laws and regulations
    2. Right to reasonable access to care
    3. Right to know the name of the treating, supervising and/or responsible physician
    4. Right to care that respects the patient's personal values and beliefs

5. Right to be informed and participate in decisions relating to their care
6. Right to refuse care and discontinue treatment
7. Right to security, personal privacy, and confidentiality
8. Right to have pain treated
9. Right to make a complaint or suggestion without fear of retribution
10. Right to know the price of services and procedures

5. Patients are informed of their rights in a manner they can understand.
6. Patients' rights are made visible to patients and staff.
7. Leaders work collaboratively to protect and promote patient and family rights.
8. Policy and procedure defines informing patients and families about their rights and responsibilities related to refusing or discontinuing treatment.
9. Patients are informed about the consequences of refusing or discontinuing treatment.
10. Patients and families are informed about there responsibilities related to refusing or discontinuing treatment.
11. Patients are informed about available care and treatment alternatives.
12. Policy and procedure define the process for patients to make oral or anonymous written complaints or suggestions.

Consent

13. PR3 The organization has a list of procedures or treatments for which informed consent is required, including the following:
    1. Surgery and invasive procedures
    2. Anesthesia/moderate or deep sedation
    3. Use of blood
    4. High-risk procedures or treatments (including but not limited to Electro Convulsive Treatment, radiation therapy, chemotherapy)
    5. Research
14. PR4Informed consent is obtained and documented for all relevant care.
15. PR4Informed consent includes information about the risks, benefits, and alternatives to the proposed treatment plan.
16. PR2, Consent given by someone other than the patient complies with laws and regulation and is PR2.1documented in the patient's medical record.
17. PR3Consent forms are available in all applicable locations.
    1. Cancelled locations PR3 1- PR3-6

PR$ Cancelled informed consent (including research) before & documented before

Patient Responsibilities

18. NewPolicy and procedure define patient responsibilities including at least the following:
    1. Follow the policy and procedures of the organization
    2. Financial obligation according to law and regulation and organization policy
    3. Show respect to other patients and healthcare workers.
    4. Follow the recommended treatment plan.
19. Patients are informed of their responsibilities.

Research

20. PR.5The Ethics or other appropriate committee has reviewed and approved all research protocols that involve human subjects as required by law.and regulation.
21. Specific written criteria define eligibility for enrollment in research projects or protocols. AC1.7
22. PR12.1A signed patient consent (or verbal) form for participation in research is placed in the research file and medical file.
23. 12 signed patient consent form for participation in research in file

Patient Access, Treatment and Continuity of Care

Access to Care

Admission

1. AC1Policy and procedure ensure coordination and continuity of care to include at least the following:
    1. AC1.1Process to screen patients to determine that the organization can meet their health care needs
    2. AC1.2Admission of patients, including those from emergency services
    3. AC1.5 A screening process after admission to determine the priority of the patient's medical and nursing care needs
    4. AC1.3Information to be given to the patient at the time of admission
    5. AC1.4 triage (removed)
2. Patients are screened and admitted according to policy.

Continuity of Care and Consultations

3. All diagnoses are recorded and updated according to the results of investigations and reassessments.

4. All patient care between multiple disciplines (including nurses and physicians) is collaborative and coordinated.
5. All patient care between different clinical settings is coordinated.
6. Policy and procedure define the criteria for when and how to get consultation for patients.
7. Consultations are obtained when criteria are met.
8. Consultations are documented timely in the medical record with sufficient details to enable care of the patient.

Transfer, Discharge, Referral

9. Policy and procedure define the transfer, referral and discharge of patients.
10. Planning for referral and discharge begins early in the care process and when appropriate includes the family.
11. The transfer, referral and discharge are based on the patient's needs for continuing care.
12. Established criteria determine the appropriateness of transfers within the organization.
13. Patients are appropriately transferred, referred and discharged.
14. The reason for the transfer and referral is explained to the patient.
15. The reason for the transfer or referral is documented in the medical record.
16. The complete and up to date patient medical record is transferred with the patient to another clinical unit in the organization.

17. A copy of the medical record is sent with patients transferred to another facility.

Assessment of Patients

Initial Assessments and Reassessment

1. The organization has defined who may screen and assess patients.
2. Policy and procedure define
    1. scope and content of assessment by each discipline
    2. time-frame for completion.
    3. frequency of reassessment.
3. Policy and procedures define the screening and assessment of all patients for the following:
    1. Nutritional risk and needs.
    2. Functional/rehabilitation risk and needs.
    3. Social services and discharge needs.
    4. Educational needs (including family).
4. Qualified individuals develop criteria to identify patients who require further nutritional assessment.
5. Qualified individuals develop criteria to identify patients who require further functional assessment.
6. All screens are completed and documented within 24 hours of admission.
7. Patient's health care needs are evaluated according to the defined screening and assessment processes.
8. Patients are referred for further assessment by the specific service if indicated by the screen.

9. Patients are screened for abuse and referred to the appropriate service (s) for follow up.
10. The findings of assessment performed outside the organization are verified at admission.

Medical Staff Assessments and Documentation

11. Policy and procedure define the minimum scope of the comprehensive history and physical examination for inpatient admission. At least the following elements must be included:
    1. Main complaint
    2. Details of the present illness
    3. Previous admissions and surgery
    4. Allergies
    5. Adverse drug reactions
    6. Medications the patient has been taking
    7. Psychosocial history, including emotional, behavior, and social status
    8. Family history
    9. The required elements of the comprehensive physical examination
    10. Conclusion or impressions drawn from the admission history and physical examination
    11. Initial treatment plan, including investigations
12. A complete history and physical examination is recorded in the patient's medical record within 24 hours of admission.

13. A history and physical examination completed prior to admission may be used provided it is no more than 30 days old.
14. On admission, the physician documents in the medical record subsequent changes to the initial history and physical, based on reassessment of the patient.
15. Physician's progress notes are made at least once per day.
16. Policy and procedure define the minimum scope of assessment (history and physical exam) for short-stay (less than 24 hours) patients.
17. Policy and procedure define the minimum acceptable scope of the history and physical examination for outpatient surgery and invasive procedures.
18. Policy and procedure defines the minimum content of outpatient medical records for new and returning patients for medical assessment.
19. Policy and procedures for short stay, day surgery and clinic outpatients are implemented.

Special Patient Populations

20. Policy and procedures define the organization's vulnerable patients, and the specific assessment required for each.
21. Vulnerable children, disabled individuals, the elderly, behavioral health, and others identified by the organization are protected.
22. Policy and procedures for the care of the vulnerable patients are implemented.

Baby-Friendly Care and Pediatrics

23. In organizations with mother-baby units, care is provided according to UNICEF and the World Health Organization (WHO) clinical guidelines.
24. For pediatric patients, the history and physical assessment must include the immunization status.
25. For pediatric patients, the history and physical assessment must include the growth and development chart for ages established by department policy.

Pain

26. Policy and procedures define and guide assessment, reassessment and management of pain.
27. Pain is assessed for all applicable patients.
28. Pain is managed and treated when applicable.
29. Pain is reassessed to determine the effectiveness of treatment.
30. Pain assessment, treatments and reassessments are documented.

Providing Care, Treatment and Services

General

1. Care delivery is uniform when similar care is provided in more than one setting.
2. The care plan is documented and includes all disciplines providing care.
3. Clinical practice guidelines are used when required by law and regulation and national professional organizations.
4. Medical Staff implement clinical practice guidelines based on current professional literature for:
    1. the most common diagnoses
    2. high-risk diagnoses and high-risk procedures
5. Clinical practice guidelines are reviewed at least every two years.
6. Clinical practice guidelines are revised when needed based on current professional literature.
7. Services and treatment are available with defined timeframes for availability.

Laboratory and Pathology

1. Laboratory and pathology services are provided and operated according to applicable laws and regulations.

2. There is 24 hour supervision of laboratory functions by a qualified person.
3. Policy and procedures for laboratory services include at least the following:
    1. Procedure manuals or guidelines for all tests and equipment
    2. Quality control processes to be followed
    3. Inspection, maintenance, calibration, and testing of all equipment.
    4. Management of reagents, including availability, storage, labeling and testing for accuracy
    5. Procedures for collecting, identifying, processing, and disposing of specimens
    6. Laboratory safety program
4. There is a current list of essential reagents and supplies.
5. All reagents and solutions are completely and accurately labeled.
6. Twenty-four hour laboratory coverage is provided to meet routine and emergency needs of patients.
7. There is a written list of laboratory tests that are performed in the organization.
8. Referral laboratory services are available through formal contracts for tests not available in the organization.
9. The referral laboratory is licensed by MoHP.
10. All laboratory test results and reports have reference (normal) ranges, specific for age and sex if applicable
11. Reference ranges are reviewed and updated as needed.
12. Report times for routine and stat results by type of test are defined.

13. Tests are reported within the defined timeframe.
14. Tests requiring professional interpretation are signed by the laboratory physician.
15. All laboratory results are available in the laboratory and reviewed by a laboratory supervisor daily.
16. Cytology services are performed according to written procedure, and are supervised by a pathologist or other qualified physician.
17. Final pathology reports contain gross and microscopic description and diagnosis as relevant to the specimen.

Point of Care Labs

18. Policy and procedure specify:
    1. which tests can be performed in the organization outside of the laboratory
    2. which individuals may perform the test
    3. the training/competence required
    4. Monitoring for calibration of equipment and controls
19. Point of care laboratory work is performed as specified.

Blood Bank and Transfusion Services

20. Blood bank and transfusion services are provided and operated according to applicable laws and regulations.
21. Policy and procedures for the organization's blood bank and transfusion services describe the following:

1. Selection of blood donors in accordance with the national selection criteria.
2. Procedures to be followed for all blood bank tests including screening of specified communicable diseases, blood type and Rh.
3. Safe collection and handling of blood and blood components.

22. Storage of all blood and components in the blood bank meet the national requirements.
23. Blood is stored outside the blood bank prior to administration according to law and regulation.
24. All blood products entering/in the organization are labeled with at least the identification number, name of the product, required storage condition, production date, expiration date, and name of the blood bank.
25. A record is kept to ensure complete tracing of a unit of blood from drawing until final disposition.
26. Policy and procedure define the administration and monitoring of blood transfusions.
27. Administration and monitoring of blood transfusions is performed according to the policy and procedures.

Radiology

1. Radiology services are provided and operated according to applicable laws and regulation.
2. Policy and procedures guiding Radiology include at least the

following:

1. Procedure guidelines for all tests and equipment
2. Quality control program covering the inspection, maintenance, and calibration of all equipment
3. A radiation safety program

3. Radiology services are available 24 hours.
4. Special techniques or procedures that must be performed under physician supervision are listed.
5. All films and diagnostic tests are interpreted by a radiologist or trained, qualified physician.
6. Timeframes for availability of reports for interpretation of radiology tests and procedures, including both emergency (stat) and routine reports by types of tests are defined.
7. Radiology reports are available by the defined reporting times.
8. All radiology results are available in the department.
9. There is a mechanism in which all tests and procedures are documented including the number of films taken.
10. Radiation safety program findings are reported to Environmental Safety.

Emergency Care

1. Emergency services are provided and operated according to applicable laws and regulations.
2. Adequate qualified staff are available 24 hours a day.

3. Criteria are developed and used in the triage process to determine priority of care in emergency services.
4. The emergency department uses clinical guidelines/protocols on emergency care that include at least the following:
    1. Emergency stabilization and treatment of chest pain
    2. Emergency stabilization and treatment of shock
    3. Emergency stabilization and treatment of poly-trauma.
    4. Management of altered level of consciousness
5. Emergency care is provided and documented according to policy, guidelines and protocols.

Intensive Care

1. There is a designated Medical Director for the Intensive Care Unit with defined responsibilities.
2. There are established admit and discharge criteria for the intensive care and specialized units.
3. Appropriate individuals are involved in development of the criteria.
4. Patients admitted to intensive and specialized units meet the criteria.
5. Patients who no longer meet the criteria are discharged from the unit.

Surgical and Invasive Procedures

1. Policy and procedure define safe practices before, during and after surgery and invasive procedures.
2. Surgical procedures are performed only after appropriate history,

physical examination, and indicated diagnostic tests have been completed and documented in the patient's medical record.

3. In life-threatening emergencies, minimally the preoperative diagnosis and plan for surgery has been recorded in the medical record prior to surgery.
4. Informed consent must be documented in the patient's medical record prior to surgery except in life-threatening emergencies.
5. The nursing care of patients undergoing surgery must be planned.
6. The care plan is documented in the medical record.
7. Pain assessment prior and reassessment after surgical and invasive procedures is documented.
8. Operative reports are written in the patient's record immediately after surgery.
9. The operative report includes the post-operative diagnosis.
10. The operative report includes the name of surgeon (s) and assistants.
11. The operative report includes the procedure performed.
12. The operative report includes the findings during surgery.
13. The operative report includes the specimens removed.
14. The operative report is signed by the surgeon.
15. A post operative note is entered in the medical record immediately after surgery or invasive procedures if an operative report is not immediately available.
16. Surgically removed tissue is sent for pathologic examination unless on a list of exempt tissues approved by the Medical Staff.

Anesthesia and Moderate Sedation

Assessment prior

1. Prior to administration of any pre-anesthesia/sedation medication, an informed consent for the use of anesthesia/sedation must be obtained and documented in the medical record.
2. Anesthesia care, which includes moderate and deep sedation, is planned and documented in the patient's record by a qualified physician.
3. A pre anesthesia/sedation assessment is completed and documented by a qualified physician.
4. The pre assessment determines that the patient is a safe candidate for anesthesia or moderate or deep sedation.
5. The patient is reassessed immediately prior to induction of anesthesia and sedation by a qualified physician.
6. The plan includes the anesthesia/sedation to be used and the method of administration.

Monitoring During

7. The patient's physiologic status is continuously monitored during anesthesia or sedation administration and the results of the monitoring are documented in the patient's medical record.
8. The monitoring includes pulse rate and rhythm, blood pressure, respiratory rate and oxygen saturation.
9. The anesthesia/sedation record includes medications administered.

10. The anesthesia/sedation record includes fluids administered.
11. The anesthesia/sedation record includes blood or blood products administered.
12. The anesthesia/sedation record includes actual anesthesia/sedation used.
13. The anesthesia/sedation record includes any unusual events or complications of anesthesia/sedation.
14. The anesthesia/sedation record includes the condition of the patient at the conclusion of anesthesia.
15. The anesthesia/sedation record includes the time of start and finish of anesthesia.
16. The anesthesia record includes the name and signature of the anesthesiologist.

Recovery Phase

17. The patient is monitored during the post-anesthesia/sedation recovery period.
18. The results of monitoring during recovery are documented in the patient's medical record.
19. The time of arrival and discharge from the recovery area are recorded.
20. Patients are recovered from anesthesia/sedation in an area that has equipment required by law and regulation.
21. Qualified nurses are present at all times during the recovery phase.
22. A qualified physician makes the decision to discharge the patient from post-anesthesia care based on documented results of monitoring during anesthesia recovery.

23. The discharge order is signed by a qualified physician.

Nutritional Care

1. Each patient has a complete order for food or other nutrients based on nutritional status or need.
2. A list of all special diets is available and accommodated.
3. Food is appropriate to the patient's clinical condition and needs.
4. There is a schedule for meals and a process to ensure their timely distribution.
5. Patients assessed at nutritional risk receive nutritional therapy.
6. Food and nutrition products are stored under proper sanitation, temperature and ventilation.
7. Food and nutrition products are prepared under proper sanitation, temperature and ventilation.
8. Policy and procedures describe how to deal with food brought in by family members.

Restraint and Seclusion

1. Policy and procedure define the appropriate and safe use of restraints and include the following:
    1. Protection of patient's rights, dignity and well being during use
    2. The least restrictive methods to be used first
    3. Safe and effective application and removal by qualified staff
    4. Monitoring and reassessment during use

2. The application of restraints is according to defined criteria.
3. There is an initial physician order for the use of restraints.
4. The restraint order is renewed at least every 24 hours based on continuing need.
5. Patients in restraints are monitored as per policy and documented.
6. The termination of restraints is according to defined criteria.

Resuscitation

1. Policy and procedure define the response to medical emergencies in the organization for both adult and pediatric patients.
2. Resuscitation is performed as per policy and procedures.
3. Emergency equipment and supplies as required by law and regulation and organization policy are available and age appropriate.
4. Equipment and supplies are replaced immediately after use.

End of Life

1. Policy and procedure guide the management of end-of-life care and include at least:
    1. Management of symptoms, including pain.
    2. Provision of support for psychosocial and spiritual needs and support to the family.
2. Management of end of life care issues are documented in the medical record.

Medication Management

General

1. Pharmacy and medication use practices comply with law and regulation.
2. A licensed pharmacist is available at all times and is responsible for supervising all pharmaceutical services.
3. There is an interdisciplinary drug and therapeutic committee with established terms of reference.
4. The drug and therapeutic committee meetings are at least quarterly and documented.

Patient Specific

5. Patient specific information is available for physicians, pharmacists and nurses, and includes age, gender, diagnoses, allergies, weight, current medications and relevant laboratory values and other relevant information as required by policy.

Selection and Procurement

6. Policy and procedure define the selection and procurement of medications, including when the pharmacy is closed.
7. The Essential Drug List (EDL) or organization developed medication list (formulary) is approved and listed by generic name.
8. The medication list includes all needed therapeutic groups of drugs.
9. The medication list is available for all care givers in all clinical areas
10. The medication list is current and updated at least annually.
11. There is a list of the high risk medications used in the organization.
12. Medications are selected and secured according to law and regulation and policy and procedures.

Storage

13. Policy and procedure define the appropriate storage of medications.
14. There are defined processes to prevent errors with high risk, concentrated, look alike and sound alike medications.
15. Temperature control for all medications and contrast agents meet requirements by law and regulation and manufacturer.
16. Medication refrigerator temperatures are monitored and documented according to policy.
17. Policy and procedure define the distribution and control of narcotics in compliance with law and regulation.
18. Narcotics are accurately accounted for at all time.

19. Medications must be secure at all times.
20. Emergency medications must be readily available and secure at all times.
21. Emergency medications and supplies are replaced immediately after use.
22. Expired medications are removed from the clinical units and pharmacy.
23. All medication areas are checked by pharmacy periodically, at a minimum quarterly.

Ordering

24. The organization identifies those qualified individuals permitted to prescribe or order medications.
25. Policy and procedure define safe prescribing/ordering and include at least the following:
    1. Where medication orders are uniformly written in the medical record
    2. A complete order
    3. Legibility requirement
    4. PRN – as needed orders
    5. Other types of acceptable orders (range, sliding scale, etc)
    6. Actions to take if orders are incomplete, illegible, unclear
    7. Requirement for prescriber's signature
26. Policy and procedure define the use of verbal orders including:

1. When verbal and telephone orders may be used
2. The process to receive and document the order
3. Who can take a verbal/telephone order

27. Policy and procedure define the use of weight based calculations for pediatrics and chemotherapy.
28. Policy and procedure define the use, review and updating of preprinted order sets.
29. Medication orders are complete, legible and follow policy requirements.

Preparing and Dispensing

30. There is a list of qualified individuals permitted to prepare and dispense medications.
31. Policy and procedures define the safe preparation and dispensing of medications.
32. There is a uniform medication and dispensing system to ensure the medication is dispensed:
    1. Right drug
    2. Right dose
    3. Right route of administration
    4. Right time
    5. Right patient
33. There is a mechanism to review each order/prescription before dispensing.
34. Policy and procedure define who can prepare medications

(compounding and admixing) and the equipment and conditions required.

35. All medication dispensed from the pharmacy is labeled with at least the following:
    1. The patient's name
    2. The name of the drug and its concentration/strength
    3. The expiration date
    4. Written instructions for use/administration
36. Preparation and dispensing of medications follow policy and procedures.
37. Pharmacy provides information to nursing, medical staff and if applicable to outpatients on the medication's use, administration, and side effects, including potential adverse reactions.
38. The organization has a medication recall system.
39. Policy and procedure govern the preparation, handling, storage and distribution of parenteral and enteral tube nutrition therapy.

Administration

40. The organization identifies those qualified individuals permitted to administer medications with or without supervision.
41. Policy and procedure define safe and accurate administration of medications including:
    1. The five rights
    2. Patient education regarding side effects
    3. Self administration of medications

4. Pediatric emergency medication dosing

42. Administration of medications follows policy and procedures.
43. Each medication dose administered is documented.

Monitoring

44. Pharmacists are actively involved in the development, implementation and monitoring of all aspects of the medication management system.
45. Policy and procedure define the monitoring of the response to medications including the first dose of a new medication and all high risk medications.
46. Monitoring of medication is performed as required by policy and procedures.
47. Antibiotics are monitored for appropriate use.
48. Medication error is defined.
49. There is a system for reporting medication errors.
50. Medication errors are reported in a timely manner using the established process.

Evaluation

51. Aggregate data about medication errors are analyzed to identify ways to reduce the most common type of errors.
52. The organization uses medication error reporting information to improve medication use processes.

Patient and Family Education

1. Physicians, nurses and other disciplines as applicable, participate in on-going patient and family education and in the discharge process.
2. Policy and procedure guide patient and family education on:
    1. diagnosis and condition
    2. diagnostic tests and treatments
    3. medication and potential side effects
    4. nutrition
    5. food and drug interactions
    6. physical rehabilitation and use of medical equipment
    7. information on risk reduction: diet, exercise, smoking cessation, and other health-related practices
    8. community resources available to the patient
    9. availability of special education classes
3. There is documented evidence that when relevant, patients and family were educated.
4. Patient's understanding of discharge instructions and follow up steps are documented.

Patient Safety, Infection Control and Environmental Safety

Patient Safety Standards

1. At least two (2) ways to identify a patient when giving medicines, blood, or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures are used.
2. A process for taking verbal or telephone orders and for the reporting of critical test results, that requires a verification "read-back" of the complete order or test result by the person receiving the information is implemented.
3. There is a list of the tests that have critical values and the critical values are defined for each test.
4. A standardized approach to hand over communications, including an opportunity to ask and respond to questions is implemented.
5. Concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) are removed from patient care units.
6. The concentrated medications not removed are segregated from other medications with additional warnings to remind staff to dilute before use.

7. All medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in peri-operative and other procedural settings are labeled.
8. A process or checklist is developed and used to verify that all documents and equipment needed for surgery or invasive procedures are on hand, correct and functioning properly before beginning.
9. There is a documented process just before starting a surgical or invasive procedure, to ensure the correct patient, procedure, and body part.
10. The precise site where the surgery or invasive procedure will be performed is clearly marked with the involvement of the patient.
11. Current published and generally accepted hand hygiene guidelines, laws and regulations are complied with.
12. Each patient's risk for falling, including the potential risk associated with the patient's medication regimen is assessed and periodically reassessed.
13. Action is taken to decrease or eliminate any identified risks for falling.
14. Preventive maintenance and testing of critical alarm systems is implemented and documented.
15. Alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.
16. A process is implemented to obtain and document a complete list of the patient's current medications upon admission to the organization and with the involvement of the patient.
17. A complete list of the patient's medications to be taken after discharge is provided on discharge to the patient

18. The discharge medication list is communicated to the next provider of service when the patient is referred or transferred outside the organization.

Infection Control, Surveillance and Prevention

Program Plan and Management

1. A qualified physician oversees the infection control activities.
2. A qualified nurse is involved in infection control activities.
3. There is an active program to reduce the risks of organization acquired infections.
4. The infection control program includes patients, staff, and visitors.
5. The infection control program is based on current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.
6. All areas of the organization are included in the infection control program
7. The infection control program describes the scope, objectives, expectations, and surveillance methods.
8. The infection control program is evaluated, updated and reported to the governing board annually.
9. Infection control policy and procedure are reviewed and updated regularly by the infection control committee at least every two years.
10. There is an established functioning infection control committee.
11. All relevant disciplines are represented on the infection control committee.

12. The infection control committee meets at least monthly.
13. There are clear terms of reference for the infection control committee that include the following:
    1. Coordination of infection control activities
    2. Development, implementation and monitoring of the infection control program
    3. Approval of all relevant infection control polices and procedures.
    4. Approval of the qualifications of the infection control nurse and physician
    5. Approval of the surveillance activities
    6. Reviewing, aggregating, and analyzing infection control data
    7. Taking or recommending action (including education) when infection control issues are identified
    8. Reviewing the effectiveness of the actions taken
14. The policy and procedures are consistent with current professional literature, law and regulations.
15. The organization has identified those procedures and processes associated with increased risk of infection.
16. Policy and procedure describe infection control practices and include at least the following:
    1. Selection and uses of antiseptics and disinfectants
    2. Hand washing techniques
    3. All cleaning activities
    4. Types of isolation with standard precautions (contact and airborne)

5. Immune-compromised patients
6. Disposal of sharps and hazardous materials
7. Identification and management of organization-acquired infections.
8. Infection control surveillance and data collection
9. Reporting of patients with suspected communicable diseases as required by law and regulation
10. Management of outbreaks of infections

17. Policy identifies those situations for which gloves, gowns and/or masks are required.
18. Gloves, gowns, masks, soap, disinfectants and washing detergents are available and used correctly when required.
19. Policy identifies those areas where hand washing and disinfecting procedures are required.
20. Hand washing and disinfecting procedures are used correctly in the identified areas.
21. National guidelines for the care of infectious patients are followed when there is no isolation room available.
22. Infection control policies and procedures are reviewed and updated by the infection control committee at least every two years.
23. Approved policies and procedures are disseminated to all departments.
24. Infection control policies and procedures are implemented.
25. There is a process in place for monitoring the air flow in negative pressure rooms and reporting to the infection control committee at least quarterly.

Sterilization

26. The organization has a central sterilization supply department (CSSD) or defined unit.
27. The functions of cleaning, processing, and sterile storage and distribution are physically separated.
28. In all areas where instruments are cleaned there must be airflow that prevents cross-contamination and prevents contaminated material from exiting the area.
29. There are means of preventing cross-contamination in the cleaning area.
30. There is at least one functioning sterilizer.
31. There is documented evidence that complete sterilization has been accomplished.
32. Policy and procedure guide each sterilization technique or device used, and includes the manufacturer's recommendations.
33. Policy and procedure have been developed and used for all processes, including the following;
    1. Receiving and cleaning of used items and disinfection.
    2. Preparation and processing of sterile packs
    3. Storage of sterile supplies
    4. Inventory levels have been established
    5. Emergency flash sterilization
    6. Expiration dates for sterilized items
34. Reprocessing follows laws and regulations.
35. Quality control processes are implemented using indicators as recommended by the manufacturer.

36. Results of sterilizer quality of control tests are reported to the infection control committee at least quarterly.
37. Policy and procedures are uniformly applied and implemented.

Laundry and Linen

38. Policy and procedure define laundry and linen services and are approved by the infection control committee. At least the following are included:
    1. Collection and storage of contaminated linen
    2. Cleaning of contaminated linen
    3. Storage and distribution of clean linen
    4. Quality control program, including water temperatures
39. Laundry and linen policy and procedures are implemented.
40. Contaminated linen is separated from clean linen at all times.
41. There is at least one functioning fully automatic washing machine.

Surveillance and Monitoring

42. The organization has established an Infection Control surveillance program which includes all areas of the organization.
43. The Infection Control surveillance program has been implemented.
44. The surveillance data of organization acquired infections and the effectiveness of the program, are regularly aggregated and analyzed by the infection control committee.

45. Results of the surveillance program are reported at a minimum quarterly to the Infection Control Committee and to the Leadership.
46. The results are disseminated to departments or units and, when relevant, are utilized by them for improving the quality of care.
47. Results of the surveillance are compared with internal and external benchmarks.
48. All communicable diseases are reported to the appropriate agencies as required by law and regulations.
49. Organization acquired infection resulting in an adverse outcome of a patient or employee, is thoroughly investigated utilizing a process of intense analysis.

Facility and Environmental Safety

Planning and Implementation Activities

1. The organization follows laws, regulations, and facility inspection requirements that relate to management of the physical environment.
2. There is a designated individual with oversight of the facility maintenance and environmental safety.
3. There is an Environment of Care committee that meets at least quarterly.
4. The organization has a documented, current, and accurate inspection of the physical facilities.
5. Hazardous surveillance rounds are conducted in patient care areas no less than twice a year and in non clinical areas no less than annually.
6. Clinical and diagnostic services have adequate space according to the requirements by law and regulation and scope of services provided.
7. The physical location of the emergency room must support at least the following:
    1. Designated access (s) for ambulance, car, and walk-in patient
    2. Signage both within and outside the organization that provide clear directions
    3. A designated check in area
    4. A designated triage area

Safety and Security

8. There is a plan to manage general safety and security.
9. There are measures to protect against infant abduction and to protect patients, visitors, and staff from harm, including assault.
10. All organization staff can be identified at all times.
11. Individuals without identification are investigated
12. Remote or isolated areas of the facility are monitored.
13. Action is taken to correct identified deficiencies in safety and security.
14. The safety and security plan is reviewed annually and updated as needed.
15. The safety and security plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement.
16. Results of the monitoring and analysis of the safety and security plan are submitted to Leadership at least every 12 months.

Emergency Preparedness

17. There is an emergency preparedness plan to respond to likely internal emergencies.
18. The plan for response to internal emergencies includes a personnel recall system; alternate care sites, if needed; and alternate sources of medical supplies, utilities, and communication.
19. The organization has tested the internal emergency plan at least annually.
20. There is an emergency preparedness plan to respond to likely

community emergencies.

21. The plan for response to external emergencies is developed according to government guidelines relating to the responsibility of the organization in the event of an external emergency.
22. The organization has tested its external emergency plan at least annually.
23. The emergency preparedness plan is reviewed annually and updated as needed.
24. The emergency preparedness plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement.
25. Results of the monitoring and analysis of the emergency preparedness plan is submitted to Leadership at least every 12 months.

Hazardous Materials and Waste

26. There is a hazardous materials and waste management plan for the use, handling, storage, and disposal of hazardous materials and waste that addresses at least the following:
    1. Safety and security requirements for the handling and storage
    2. Requirements for personal protective equipment
    3. Procedures following spills and accidental contact due to spills or exposures
    4. Disposal in accordance with applicable laws and regulation
    5. Labeling of hazardous materials and waste
    6. Monitoring data on incidents to allow corrective action
27. There is an up to date inventory of the types and locations of

hazardous materials and waste. (MSDS)

28. The hazardous materials and waste management plan is implemented.
29. The hazardous materials and waste management plan is reviewed annually and updated as needed.
30. The hazardous materials and waste management plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement.
31. Results of the monitoring and analysis of the hazardous materials and waste management plan are submitted to Leadership at least every 12 months.

Fire Safety

32. There is a fire and smoke safety plan that addresses prevention, early detection, response, and safe exit when required by fire or other emergencies. The plan addresses at least the following:
    1. Frequency of inspecting fire detection and suppression systems
    2. Maintenance and testing of fire protection and abatement systems, including kitchen
    3. Documentation requirements for staff training in fire response and evacuation
    4. The assessment of fire risks when construction is present in or adjacent to the facility.
33. Fire drills are conducted at least once a year in each clinical area.
34. The facility evacuation plan is tested annually
35. The fire and smoke safety plan is implemented with documentation of

all inspections, maintenance, testing, and training.

36. The law prohibiting smoking in the organization is enforced.
37. The fire and smoke safety plan is reviewed annually and updated as needed.
38. The fire and smoke safety plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement.
39. Results of the monitoring and analysis of the fire and smoke safety plan are submitted to Leadership at least every 12 months.

Medical Equipment

40. There is a plan for inspecting, maintaining, and testing medical equipment that addresses at least the following:
    1. Inventory of all medical equipment
    2. Schedule for inspection and preventive maintenance according to manufacturer's recommendations
    3. Testing of all new equipment before use and repeat testing when required
    4. Qualified individuals who can provide these services.
    5. Data monitoring for frequency of repair or equipment failure
41. There is a current list of all equipment in the organization.
42. All diagnostic equipment is calibrated, and maintenance records are maintained.
43. Temperature control for all refrigerators and freezers meet requirements by law and regulation or manufacturer for appropriate storage.

44. Policy and procedures define the monitoring of refrigerators and freezers.
45. There is documented evidence of appropriate temperature storage for all refrigerators and freezers but no less than every 12 hours.
46. Alarm system(s) are tested minimally at the frequency recommended by the manufacturer.
47. The medical equipment plan is reviewed annually and updated as needed.
48. The medical equipment plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement.
49. Results of the monitoring and analysis of the medical equipment plan are submitted to Leadership at least every 12 months.

Utility Systems

50. There is a plan for regular inspection, maintenance, and repair of essential utilities that addresses at least the following:
    1. Electricity, including stand-by generators
    2. Water
    3. Heating, ventilation, and air conditioning
    4. Medical gases
    5. Communications
    6. Waste disposal
    7. Regular inspections
    8. Regular testing
    9. Regularly scheduled maintenance

10. Correction of deficiencies identified

51. The utilities plan is implemented.
52. Water used in chronic renal dialysis is tested regularly.
53. The utility plan is reviewed annually and updated as needed.
54. The utility plan is monitored with collection, aggregation, and analysis of data to identify areas for improvement.
55. Results of the monitoring and analysis of the utility plan is submitted to Leadership at least every 12 months.

Information Management

Confidentiality and Security

1. Policy and procedures define the confidentiality and security of data and information and protection from loss or damage that addresses at least the following:
    1. Who may have access to the patient's record to ensure confidentiality of patient information
    2. The circumstances under which access is granted
    3. Determination of who can access what type of data and information for decision making.
2. Medical records and information are protected from loss, destruction, tampering, and unauthorized access or use.

Information Processes

3. The organization has a plan to meet information needs based on at least the following:
    1. The identified information needs of clinical and managerial leaders of the organization
    2. The size and the types of services provided by the organization
    3. Clinical and managerial staff participates in selecting, integrating, and using information management technology.

4. The organization has a policy on the retention time of records, data, and information.
5. The organization contributes to external databases in accordance with laws or regulations.
6. Standardized diagnosis and procedure codes are used.

Patient-Specific Information – Medical Record

7. Policy and procedures define a uniform/consistent structure of the medical record including:
    1. The order of filing of the notes and reports
    2. Where all orders, including those for medications, must uniformly be written.
8. The organization has defined who is authorized to make entries in the medical record.
9. Nurses document directly in the patient's medical record.
10. The author of all entries in the medical record can be clearly identified by name and title.
11. All entries in the medical record are dated.
12. All entries in the medical record are legible.
13. Policy and procedures define the types of verbal/telephone orders that can be received, the type of individuals who can receive these orders, and the time frame to be authenticated.
14. Verbal/telephone orders are signed within the time frame required by law and regulation and policy.
15. All diagnostic and therapeutic orders are signed by the ordering practitioner.

16. Results of diagnostic tests are documented in the patient's medical record within an established timeframe.
17. All treatments, including medications administered, are documented and signed by the person providing the treatment.
18. There is a medical record for each patient evaluated and treated.
19. Each medical record contains sufficient information to:
    1. Identify the patient, including name, address, and date of birth
    2. Promote continuity of care
    3. Support the diagnosis
    4. Justify the treatment
    5. Document the course and results of treatment
20. The medical record of every patient receiving emergency care includes at least the following:
    1. Time of arrival and discharge
    2. Conclusions at termination of treatment
    3. Patient's condition at discharge
    4. Patient's disposition at discharge
    5. Follow-up care instructions
21. Medical records of discharged patients are completed no later than 15 days from date of discharge.
22. The patient's medical record must be available when needed to care providers and contain up-to-date information.
23. In patient medical records must contain a discharge summary.
24. The discharge summary must include the following:
    1. The reason for admission
    2. Any diagnosis made

3. Investigations
4. Significant findings
5. Procedures performed
6. Medications and/or other treatments
7. Patient's condition at discharge
8. Discharge instructions, including diet, medications and follow-up instructions
9. The name of the physician who discharged the patient.

25. The referral/transfer sheet is sent with the patient when referred to another facility.
26. The referral/transfer sheet contains at least the following:
    1. Reason for referral/transfer
    2. Transportation means and required monitoring
    3. Condition on transfer/transfer
27. A copy of the referral sheet is retained in the patient's medical record.
28. The organization has a process for review of medical records that includes the following:
    1. Review of a representative sample of all services
    2. Involvement of representatives of all disciplines who make entries in the medical record
    3. Review of the completeness and legibility of entries

Performance Improvement

Process and Design

1. The governing body, organization director, and heads of departments actively participate in the planning and monitoring of the performance improvement and patient safety plan.
2. The performance improvement and patient safety plan is implemented organization wide.
3. There is a performance improvement and patient safety plan that defines at least the following:
    1. The membership of the performance improvement and patient safety committee
    2. Authority of the committee
    3. Criteria for establishing priorities
    4. A description of the methodology to be used
    5. Information flow and reporting frequency
4. There is a committee assigned to improving the quality and outcomes of care.
5. The committee has a designated chairperson.
6. The membership is multidisciplinary and includes members of the medical and nursing staff, other department representatives, and the performance improvement coordinator.
7. There are terms of reference for the committee, which include the

following:

1. Ensuring that all departments participate
2. Establishing organization wide priorities for improvement
3. Ensuring that all required measurements are done including the frequency of data collection
4. Reviewing the analysis of aggregate data
5. Taking action in response to identified performance improvement or patient safety issues
6. Reporting information both to leaders and to staff members

8. The committee meets at least monthly
9. There is an assigned, qualified performance improvement coordinator.
10. The performance improvement coordinator is a member of all relevant committees.
11. There is a written job description for the performance improvement coordinator.
12. All medical staff participates in performance improvement activities as needed.
13. Definitions describe required and all other indicators, including frequency of data collection and analysis.

Collecting and Measuring Activities

14. Policy and procedure define an incident-reporting system that includes at least the following:
    1. List of reportable incidents
    2. Persons responsible for initiating reports

3. How, when, and by whom incidents are investigated
4. Corrective action plan and assigned responsibilities

Clinical Care Monitoring includes at least the following:

15. Patient assessment is monitored
16. Surgical and invasive procedures are monitored
17. Use of anesthesia and moderate and deep sedation is monitored
18. Use of medications is monitored
19. Medication errors and adverse outcomes are monitored
20. Use of blood and blood products is monitored
21. Use of restraints and seclusion is monitored
22. Medical records, including availability and content are monitored
23. Infection control, surveillance and reporting is monitored

Managerial monitoring includes at least the following:

24. Reports as required by law and regulation is monitored
25. Risk management is monitored
26. Utilization management is monitored
27. Patient and family expectations and satisfaction is monitored
28. Patient complaints are monitored
29. Staff expectations and satisfaction is monitored
30. Patient demographics, diagnoses and procedures are monitored
31. Procurement of routinely required supplies and medications essential to meet patient needs is monitored
32. Financial management is monitored

Analyzing Data

33. Individuals with appropriate experience, knowledge, and skills systematically aggregate and analyze data in the organization.
34. Data review is timely and appropriate.
35. All data is aggregated, trended over time and analyzed.
36. Data are transformed into useful information.

Comparative Activities, Benchmarking

37. The organization uses internal and external reference databases for comparative purposes.

Improving Activities

38. Action to correct problems is timely.
39. The organization documents the improvements.
40. Data are available to demonstrate that the improvement was sustained.

Adverse Significant Events

41. Policy and procedure define the criteria and process for intensive analysis when significant unexpected events and undesirable trends and variation occur.

Significant events to be analyzed include:

42. Unexpected morbidity and mortality including those due to organization acquired infections are analyzed.
43. Confirmed transfusion reactions are analyzed.
44. Significant adverse drug reactions that cause harm to a patient are analyzed.
45. Significant medication errors that cause harm to a patient are analyzed.
46. Significant anesthesia events that caused harm to a patient are analyzed.
47. Significant differences between pre- and post-operative diagnoses, including surgical pathology findings are analyzed.

Organization Management

Governance – Governing Body

1. The organization's governance structure is defined.
2. The organizational structure indicates clear lines of authority.
3. Governance responsibilities and accountabilities are defined.
4. Those responsible for governing and managing are identified by title and name.
5. The organization has a mission statement developed and approved by the governing body.
6. The mission statement is visible in a public (s) area.
7. The governing body supports and promotes quality improvement and patient safety efforts.
8. Processes provide communication and cooperation between governance and management.
9. The organization's budget is approved by the governing body.
10. The governing body allocates the resources required to meet the organization's mission.

Leadership

1. A full-time director appointed by the governing body is assigned to manage the organization in accordance with applicable laws and regulations.

2. The organization director has appropriate training and/or experience in health management as defined in the job description.
3. The director has a clear written job description that defines at least the following responsibilities:
    1. Ensuring that the organization complies with all laws and regulations
    2. Providing oversight of day-to-day operations
    3. Ensuring that policy and procedures are developed and approved by the governing body
    4. Providing oversight of human, financial, and physical resources
    5. Ensuring that there is a functional, organization wide program for quality improvement and patient safety, with appropriate resources
    6. Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation
    7. Ensuring oversight of all contracted services
4. There is a clear process for coordination and communication between the director and the staff.
5. The nurse director is a member of the leadership team of the organization.
6. The nurse director attends the leadership staff meetings.
7. The nurse director and other nursing leaders participate with the leaders of the governing body, management, and medical staff in the development, ongoing review, and implementation of all relevant organization programs, policies and plans.

8. Nurses participate in all relevant committees, including, but not limited to, the following:
    1. Infection control
    2. Performance improvement and patient safety
    3. Drug utilization
9. Leaders plan and budget to meet applicable laws, regulations, and other requirements.
10. Leaders plan and budget for the upgrading or replacing of systems, buildings, or components needed for the continued operation of a safe and effective facility.
11. Leaders has ensures the organization meets the conditions of facility inspection reports or citations.
12. Leaders design and implement processes that support continuity and coordination of care.
13. Leaders create a "blame-free" process for reporting.
14. The organization data are reviewed and analyzed and used by management for decision making.
15. Leaders ensure all required policies, procedures and plans have been developed and implemented.
16. Support diagnostic services are available according to laws and regulation.
17. Organizations either have an ambulance (s) or a formal arrangement for ambulance services.
18. The organization owned ambulance service meets all laws and regulations.
19. Services performed through an outside contract, must be approved by

leaders and show documentation of oversight.

20. The contractor meets required quality issues and all accreditation requirements.

Direction of Departments and Services

21. A designated head is assigned to each department and service.
22. The responsibilities of department and service heads are defined in writing and include at least the following:
    1. Providing a written description of the services provided by the department (scope of service)
    2. Ensuring coordination and integration of these services with other departments when relevant
    3. Recommending space, staffing, and other resources needed to fulfill the department's responsibility
    4. Defining the education, skills, and education needed by each category of employee in the department
    5. Ensuring that there is a department specific orientation and continuing education program for the department's employees.
    6. Ensuring the department is involved in the performance improvement and patient safety program.
23. Each department has a written staffing plan that defines the following:
    1. The number of staff needed to fulfill the department's responsibilities
    2. The types of staff needed
    3. The required license, education, skills, knowledge, and experience required for each position

Human Resources

Planning

1. The staffing plan is periodically reviewed and updated as required, but at least annually.
2. Nursing assignments are made on the basis of the job description and the evaluation of the individual nurse's competence.
3. There are licensed pharmacists and support personnel to meet the needs of the organization.
4. Each employee has a current job description.
5. The job description includes the required education, skills, knowledge, and experience and a description of the responsibilities of the individual.
6. There is documentation in each employee's file that the job description has been discussed with and signed by the employee.
7. There is a recruitment process that is uniformly applied.
8. Appropriate leaders participate in the recruitment process.
9. There is a process for evaluating the qualifications of new staff that is uniformly applied.
10. There is a process for appointing new staff members that is uniformly applied.
11. A personnel file is maintained for each employee.
12. Each personnel file must contain, when applicable to that employee, the following elements:
    1. Copies of verified diplomas, licenses, certifications

2. Work history
3. Current job description
4. Evidence of orientation to the organization, the assigned department, and the specific job
5. Evidence of initial evaluation of the employee's competence to perform the assigned job
6. In-service education received
7. Copies of annual evaluations
8. Other documents as required by law and regulation

Orientation

13. There is a formal orientation program for all employees.
14. Orientation to the organization is provided by the leaders.
15. Orientation includes review of the organization structure, policies, including environment of care, infection control, and performance improvement and patient safety.
16. Orientation to the assigned department includes the review of relevant policies and procedures.
17. Orientation to the specific job within the department is provided.
18. There is documented evidence that each employee was oriented to the organization, department and specific job.

Competence Assessment, Training and Education

19. Each employee's competence is assessed at time of hire, and any time there is a change in job and annually.
20. There is a continuing education and training program for all employees.
21. There are programs for ongoing in-service training based on evaluation of the employees' needs.
22. Education and training is provided for infection control policy and procedure as relevant to the position or job.
23. Education and training is provided for environmental safety and all plans.
24. Education and training is provided for occupational health hazards and safety procedures.
25. Education and training is provided for information management, as appropriate to responsibilities or job description.
26. Education and training is provided for pain assessment and treatment.
27. Education and training is provided for restraint use ad seclusion.
28. Education and training is provided to relevant staff for the clinical guidelines used in the organization.
29. Education and training is provided for basic cardiopulmonary resuscitation training at least every two years for all staff that provides direct patient care.
30. Education and training is provided for performance improvement and patient safety.
31. Education and training is provided for patient complaint process.

32. Education and training is provided for patient satisfaction.
33. Education and training is provided for interpersonal communication between patients and other staff.
34. There is an annual training review for all staff in at least infection control, patient and environmental safety.
35. All education and training is documented.
36. There is a library with materials appropriate to the services provided by the organization.
37. The library is accessible 24 hours to all staff.

Performance Review of Staff

38. There is a process for performance review of each category of employee that is uniformly applied.
39. The performance review is based upon the employee's job functions as described in the job description.
40. Performance Reviews are done annually for each employee.

Occupational and Employee Health

41. The employee health program has a designated responsible person to manage the program.
42. The organization has an employee health program that covers all employees.
43. The employee health program conforms to laws and regulations.

44. Policy and procedures define and guide the employee health program.
45. The organization has completed and documented an occupational hazard survey that is used to reduce risk.
46. Action is taken on identified hazards to decrease risk.
47. Policy and procedures define the extent and frequency of the health and physical assessment, testing, actions to be taken including the reporting of occupational hazards for staff.
48. Each new employee has a complete pre-employment evaluation as relevant to the occupational hazards for each department and job, as required by law and regulation or by organization policy.
49. Each employee who may have direct or indirect contact with patients has a medical evaluation as required by law and regulation or by organization policy.
50. When screening results or investigations are positive, action is taken as per policy.
51. There is a process of communication between responsible personnel for Infection Control and Employee Health.

Nursing

1. The nurse director is a registered nurse qualified by education and managerial experience, as required by the job description.
2. The nurse director has responsibilities defined in a job description.
3. The nurse director is responsible for implementing nursing standards of practice and documentation for at least the following:
    1. A nursing assessment
    2. A nursing care plan
    3. Nursing reassessments and treatments
    4. Evaluation of the effectiveness of nursing treatments
4. The nursing department develops and implements written policy and procedure guiding nursing care. Policy and procedure include, but are not limited to, the following:
    1. Basic patient hygiene
    2. Skin care and prevention of pressure sores
5. The nurse director ensures that schedules and assigned tasks to the staff are completed.

Medical Staff

Organized Medical Staff Structure

1. There is an organized medical staff that provides oversight of uniform quality of care, treatment and services.
2. The medical staff reports to the governing body and is accountable to the governing body.
3. There is a structured, functioning medical staff committee with defined, documented duties.
4. Bylaws, rules and regulations and policy and procedure address the following:
    1. The structure of the entire medical staff
    2. The structure and function of the medical staff committee
    3. The appointment process including the process for validating the license, education and certification of all medical staff, other staff and visiting consultants and professors
    4. The privileging process
    5. The reappointment, revision and/or renewal of privileges
    6. The process to identify those members who may provide care without supervision
    7. The process and criteria for suspension
    8. The mechanism for a fair hearing and appeal process
    9. The process for peer review and criteria for external peer review

5. The medical staff bylaws, rules and regulations and policy and procedure are in accordance with law and regulations, and approved by the governing body.
6. The medical staff includes licensed physicians and dentists and may include other licensed individuals permitted by law to provide patient care services independently in the organization.
7. All medical staff members and all others with delineated privileges are subject to medical staff rules, regulations, and policies.
8. Each medical department has a designated head.
9. The head of the department is certified in an appropriate specialty and/or has appropriate documented experience as required by the job description.

Appointment, Reappointment and Privileging

10. There is a file/record for every medical staff member that contains a copy of all documents related to license, education, experience, and certification.
11. Appointment and reappointment of medical staff members is done according to the medical staff bylaws, law and regulation.
12. The license, education and certification of all medical staff, other staff and visiting consultants and professors is verified from the original source when possible.
13. All medical staff appointments and reappointments are approved by the governing body.

14. Medical staff members are reappointed no more than every 3 years.

Privileges

15. All medical staff members have current delineated clinical privileges or job descriptions approved by the governing body.
16. Privileges or job description indicate if the individual can admit, consult and define the scope of patient care services and types of procedures they may provide in the organization.
17. Privileges are determined based on documented competency.
18. Privileges are reviewed and renewed not more than every three years.
19. Physicians and other individuals with privileges do not practice outside the scope of their privileges.
20. There is an effective mechanism that enables appropriate staff to determine that an individual is approved for admit, consult and care and which types of procedures.
21. The mechanism for a fair hearing and appeal process when adverse decisions are made to appointment, reappointment and privileges is implemented.
22. Competency for Initial Assessment, Reassessment and Re-privileging
23. The performance of individual medical staff members is reviewed no less than every 3 years to determine continued competence to provide patient care services.

24. Performance and quality data used to determine competency includes medical record review for completeness and timeliness.
25. Performance and quality data used to determine competency includes utilization practice.
26. Performance and quality data used to determine competency includes complications, mortality and morbidity.
27. Performance and quality data used to determine competency includes blood utilization.
28. Performance and quality data used to determine competency includes medication use.
29. Medical staff performance is reviewed when indicated by the findings of the quality improvement activities.

Peer Review

30. There is an ongoing process of peer review.
31. There are criteria/indicators for when peer review is required.
32. There are criteria for when cases are sent for external peer review.
33. Internal and external peer review is done timely as per criteria.
34. The data and information from peer review is used for competency assessment.

Continuing Education

35. The organization has a functioning continuous medical education program.
36. All medical staff members participate in continuing medical education.

Graduate Medical Education

37. In organizations participating in professional graduate education programs, physicians in training are supervised by a qualified medical staff member in carrying out their patient care responsibilities.
38. Policy and procedure define the scope of student, house officer and resident assessment and treatment of patients.
39. Medical students, house officers and residents practice within their scope/job description.
40. Medical students, house officers and residents are oriented to and comply with all medical staff rules and regulations and policy and procedures of both the medical staff and the organization.
41. There is an effective mechanism for communication between the committee/person with oversight of the training program (s), the medical staff committee and the governing body.