Kingdom Of Saudi Arabia
Health Services Council

المملكة العـــربية السعودية
مجلس الخـــدمات الصحية

المجلس المركزي لاعتماد المنشآت الصحية
Central Board of Accreditation
for Healthcare Institutions

Hospital Accreditation Guide
2010

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Introduction

The survey guide was developed to serve as a reference for hospitals during the preparation for consultation, mock and accreditation surveys.

The CBAHI- Hospital Accreditation guide is designed to help you learn about the national hospital standards and survey process.

This overview will provide important information about CBAHI, the hospital standards manual, eligibility for accreditation, how to request for accreditation survey, survey preparation, the on-site survey, and the accreditation decision rules.

To fulfill our mission as a driver for continuous improvement, the development of CBAHI accreditation system is a dynamic process. Further modifications will be communicated to the hospital through later editions and amendments.

Our appreciation and gratitude goes to the CBAHI team that contributed to the development, compilation, design, review, revision, and production of this guide. We extended our appreciation to the hospitals and healthcare professionals who where generous with their feedback and suggestions to ensure the fulfillment of our values towards a continuous improvement process.

Thank you,

Dr. Mohammed H.B. Khoshim

CBAHI Chairman

What is Accreditation?

"Accreditation is a self-assessment and external peer review process used by healthcare organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve the healthcare system"

ISQua definition: Federation Operating Rules 1998

According to the World Health Organization (WHO), Accreditation can be the single most important approach for improving the quality of health care structures. Accreditation is not an end in itself, but rather a means to improve quality. The accreditation movement is gaining prominence due to globalization and especially the global expansion of trade in health services. It will eventually become a tool for international categorization and recognition of hospitals.

What are the objectives of Accreditation?

"To ensure the quality of health care through the application of quality concepts"
"To foster a culture of patient safety and minimize the risk of medical errors"
"To achieve optimum organizational results with available resources"
"To increase accountability to patients and identified stakeholders"

The CBAHI Accreditation Standards

The CBAHI Accreditation Standards were developed by a consensus process of health care experts representing (**MOH, national guards hospitals, KFSH&RC , University hospitals, Private hospitals, Security Forces hospital, Saudi Council for Health Specialties, MRQP team**), the standard have been approved by DR. HAMMED ALMANE (Minster of health) – National Standards Preparation committee on 21-24 May 2006.

Central Board of Accreditation for Healthcare Institutions - CBAHI

The CBAHI was formed based on the recommendation and approval of Council of Health Services on 1/3/1426 & 5/5/1426, meeting chaired by the Minister of Health, as Chairman of Council Of Health Services , according to the Authority delegated to him and reference to the Article NO.17 issued with a Royal Deed No.M/11 on 23/3/1423, and Article No.17L

CBAHI was established based on the success of the Makkah Region Quality Program (MRQP) under the leadership of the late governor HRH Prince Abdulmajeed Bin Abdul Aziz Al-Saud. The current CBAHI standards were developed by teams of experts from the various healthcare sectors in the kingdom: ministry of health, National Guard healthcare services, armed forces healthcare services, Saudi ARAMCO, the private sector, King Faisal Specialist Hospital and Research Center, Saudi Commission for Health Specialties, Security Forces healthcare services and Civil Defense. CBAHI standard manual was approved by his Excellency the Minister of Health in 2006.

The CBAHI report to Council Of Health Services to establish and pursue the applying of the Quality Standards in all health sectors all over the regions of the Kingdom to improve the health service provided to meet the international patient safety goals.

CBAHI- Board Chairman:

Dr. Mohamed Hamza Khoshaim nominated by the Minister of Health, as Chairman to head / preside all the Boards meeting and he will approve the Board's recommendations.

Board members:

1. Quality Assurance General Director representing the Ministry Of Health
2. Executive Leader representing the Armed Forces Medical Services Sector,
3. Executive Leader representing the National Guards Medical Services Sector,
4. Executive Leader representing the Ministry of Interior Medical Services
5. Executive Leader representing the University Hospitals,
6. Executive Leader representing the Private Hospitals Sector
7. A Delegate from the Health Insurance Council Corporation
8. A Delegate from the General Association of King Faisal Specialized Hospital
9. A Delegate from Saudi Council for Healthcare specialties
10. A delegate from Saudi ARAMCO healthcare Services

Mission, Vision, Values

Mission

Improvement of healthcare quality standards in the Kingdom by supporting healthcare institutions to implement and accredit the medical quality standards and patient safety by national origin working systems, universal implementation, and distinguished efficiency.

Vision

Prestigious Global Commission in Healthcare quality development field.

Values

1. Commitment to excellence
2. Belief in team work
3. Application of quality standards
4. Holistic approach
5. Integrity

National Hospital Standards – Chapters

The National Hospital Standards have been developed for the key services and functions and organized in the following chapters

Chapter #	***Chapter specialty***	***Applicability***
Chapter I	***Leadership (LD)*** *This chapter addresses the roles and responsibilities of the hospital leadership group in planning and designing services and structures, human resources management and development, and the hospital commitments towards providing safe, efficient, and quality services to its customers and community. The standards, in this chapter, state requirements related to multidisciplinary approach towards care, utilization of resources and information and overall over-site on the implementation of quality standards.*	***All hospitals***
Chapter II	***Medical Staff and Provision of Care (MS)*** *The Medical staff and provision of care chapter requires that medical staff leadership (medical director, medical/clinical heads of department) addresses all care issues starting from patient access and receiving care, transfers and discharge from the facility. This chapter ensures that care provided to the patients is in a coordinated and multidisciplinary approach.*	***All hospitals***
Chapter III	***Nursing (NR)*** *The Nursing leadership together with medical director, quality leader and heads of departments are expected to work collaboratively in ensuring adherence to the nursing standards within the hospital's efforts in providing safe, effective, efficient and quality services.*	***All hospitals***
Chapter IV	***Quality Management and Patient Safety (QM)*** *This chapter addresses the senior leaders and everyone's responsibility towards implementing the quality program. The senior leaders are expected to lead, support, and participate in the implementation of the CBAHI standards. Everyone in the hospitals participates in the teams, projects and activities that implement the monitoring of patient safety goals, and improvement of services.*	***All hospitals***
Chapter V	***Patient & Family Education & Rights (PFE/PFR)*** ***1. Patient Family Education (PFE)*** ***2. Patient Family Rights (PFR)***	***All hospitals***

Chapter #	*Chapter specialty*	*Applicability*
	These chapters state the basic requirements to ensure provision of care while maintaining patient rights to be informed and involved in his/her care plan and treatment as well as continuously educating patients and their families regarding their options and recommended treatments. *It is also important to note that patient education is now considered as one of the pillars in the treatment plan and it has been shown from evidence based medicine that it makes a difference in the patient's outcome.* *Everyone, each in his own area, is responsible to care for patient and family education and patient and family rights.*	
Chapter VI	***Anesthesia (AN)*** *This chapter addresses the safe use of anesthesia throughout the hospital and ensuring staff competencies in handling the anesthetic agents. Patient safety and appropriateness of care are among the basic requirements listed in this chapter.*	***All hospitals***
Chapter VII	***Intensive Care Unit (ICU)*** ***1. Adult, Pediatric (ICU/PICU)*** ***2. Coronary Care Unit (CCU)*** ***3. Neonate (NICU)*** *The chapters of intensive care focus on the hospital's fulfillment of the manpower, environment and equipment requirements when establishing and providing critical care for the patient populations served in the hospital: adult, pediatrics and neonate.*	***ICU All hospitals*** ***Pediatric ICU based on scope of services*** ***CCU applies for hospitals providing invasive cardiac procedures*** ***NICU for hospitals providing obstetric care***
Chapter VIII	***Operating Room (OR)*** *The operating room chapter focuses on the hospital's fulfillment of the manpower, environment and equipment requirements when establishing and providing services of invasive procedures. This chapter addresses pre-operative and post-operative care as well as patient safety in the operating room.*	***All hospitals***

Chapter #	*Chapter specialty*	*Applicability*
Chapter IX	***Labor & Delivery (L&D)*** *Obstetric care is addressed in the Labor and Delivery chapter. The chapter focuses on the fulfillment of the manpower, environmental and equipment requirements for obstetric care.*	***For hospitals providing obstetric care***
Chapter X	***Haemodialysis (HM)*** *For hospitals providing renal dialysis services, this chapter provides the basic requirements related to staffing, infection prevention and control, environmental and equipment for patients receiving renal dialysis as well as staff safety.*	***For hospitals providing renal dialysis***
Chapter XI	***Emergency Room (ER)*** *The emergency room service in many situations is the gate where patients access care in the hospital. This chapter lists minimal requirements in facilitating patient access and priority to care, staffing competencies, equipments, and space requirements to be set-up in the emergency room.*	***All hospitals***
Chapter XII	*Radiology (RD)* *The Radiology chapter states the requirements for manpower needs and competencies, protocols and approved processes as well as equipment and staff privileges hospitals should adhere to in order to ensure safe, efficient and continuous care for its patients .*	***All hospitals***
Chapter XIII	*Burn Care (BC)* *This chapter lists the basic requirements for establishing Burn Units while maintaining safe equipment and space set-up, staffing and provision of care.*	***Based on Scope of Services***
Chapter XIV	*Medical & Radiation Oncology (MRO)* *For hospitals providing medical and radiation oncology services, this chapter provides the basic requirements related to staffing, infection prevention and control, environmental and equipment for patients receiving renal dialysis as well as staff safety.*	***Based on Scope of Services***
Chapter XV	*Psychiatry (PS)* *The chapter of Psychiatry provides the essential requirements for professional, safe and guide for In-patient Psychiatric facilities. The standards address staff competencies and documentation needed when caring for psychiatry patients*	***For hospitals providing in-patient psychiatry***

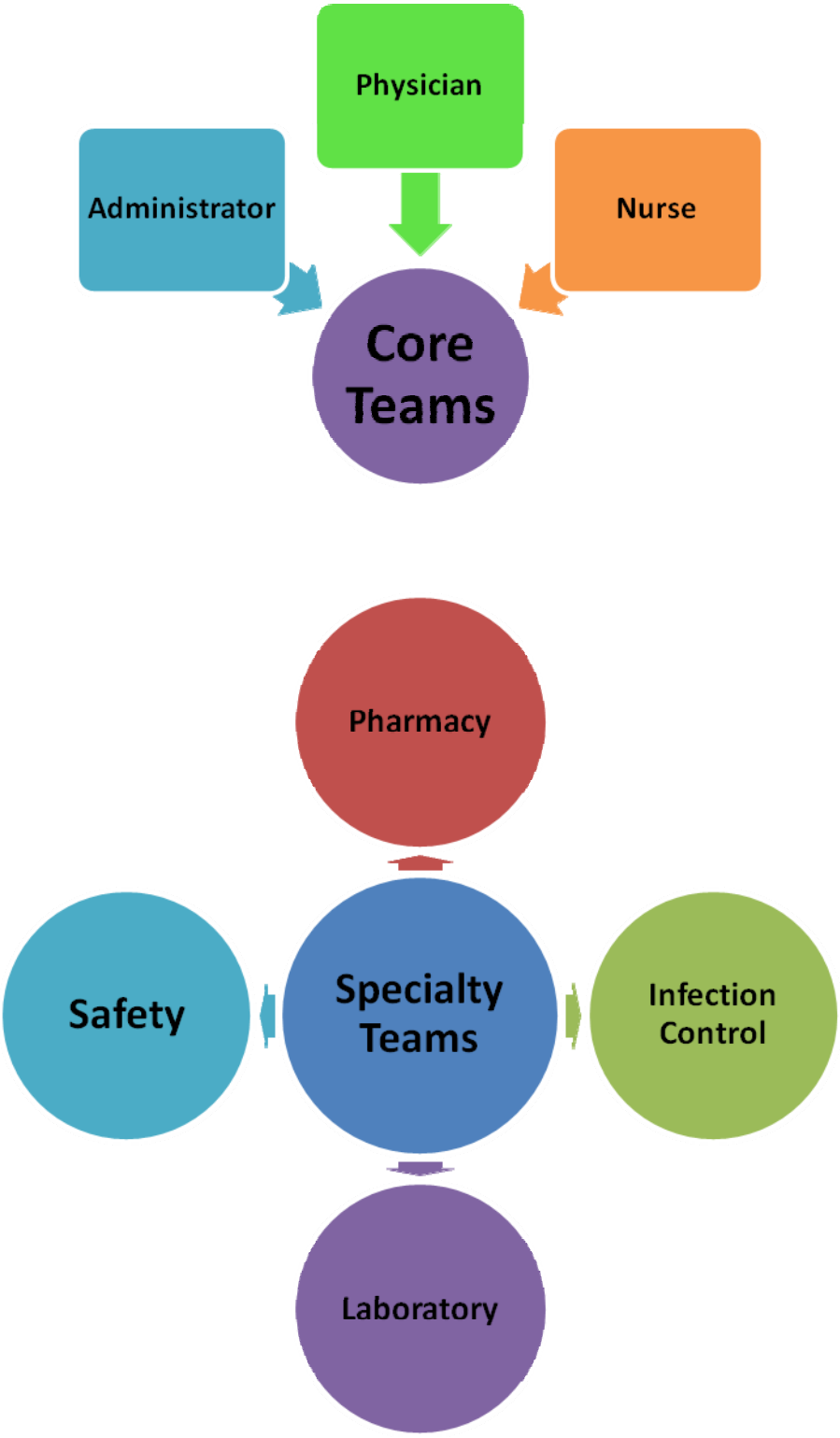
Chapter #	Chapter specialty	Applicability
	in the inpatient setting.	***services***
Chapter XVI	*Specialized Areas (SA)* *1. Respiratory Services (RS)* *The respiratory services chapter addresses the minimum requirement to ensure availability of this care for patients who need it, especially in critical care areas. The chapter lists manpower and equipment needs for safe and efficient care for patients receiving respiratory therapy.* *2. Dietary Service (DT)* *This chapter relates to medical staff role in the nutritional therapy of patients as well as states the requirements for clinical dietary services as vital part of the care provided in the hospitals* *3. Social Workers (SC)* *Social services; screening, referrals and role in the care process are addressed in this chapter as part of the holistic care patients should receive in medical care facilities* *4. Rehabilitation (RH)* *Physical/physiotherapy services as part of the care processes have several requirements listed in this chapter.*	***All hospitals*** Applicable if there is physiotherapy department
Chapter XVII	*Ambulatory Care (AC)* *1. Ambulatory Care (AM)* *The chapter of Ambulatory care addresses requirements for outpatient settings. Required documentation, staffing and high risk procedures done in the outpatient department are clearly stated for hospitals to ensure safety of the care provided in the various settings.* *2. Dental Services (DN)* *This chapter applies for hospitals that provide dental care. These hospitals need to ensure their staff privileges, the clinic settings and adherence to the patient rights and safety requirements when caring for them.*	***All hospitals*** ***Based on Scope***
Chapter XVIII	*Management of Information and Medical Records*	***All hospitals***

Chapter #	Chapter specialty	Applicability
	Information flow and management as source and base for more scientific and significant decisions made in hospitals are among the main requirements of this chapter. Information planning, handling definitions, flow and reporting requirements to ensure security, integrity and usefulness of data elements and information are addressed as well as the manpower and policies needed to management patient medical data/records and administrative documents.	
Chapter XIX	*Infection Control (IC)* *This chapter states the basic requirements to ensure prevention and control of infection among the patients and staff. Monitoring of many activities and functions are addressed such as surveillance of hospital acquired infections, housekeeping services, laundry and other hospital operational and care functions.*	***All hospitals***
Chapter XX	*Pharmacy (PH)* *Pharmacy chapter addresses the medication management structure and processes in hospitals. It establishes the main requirements for safe medication use through space, personnel competencies, hospital policies and storage and handling requirements as well as the monitoring of all medication related functions. This chapter addresses the leadership monitoring systems (committees, data collection, quality control and reporting of events) and the provision of optimal and safe medication management system.*	***All hospitals***
Chapter XXI	*Laboratory (LB)* *The laboratory services: physical setup, equipment maintenance, manpower skills, monitoring of processes, safe use of blood and the management of the various hazards in the laboratory are addressed in this chapter. Quality control process and data and results reporting and reporting are reflected as part of these chapter requirements as well as in relation to medical staff functions.*	***All hospitals***
Chapter XXII	*Facility Management and Safety (FMS)* *Hospital and facility structures, safety measures for staff, patients and resources as well as the management plans and programs are addressed in this chapter. Staff orientation and involvement is safety planning, orientation and drills are specified. Leadership support and commitment is highlighted as one of the key elements in the implementation of the FMS chapter.*	***All hospitals***

Survey Team Composition:

The survey team is a multidisciplinary team of professionals and composed of:

- Core team: Administrator, Nurse, Physician
- Specialty Team: Pharmacy, Infection Control, Laboratory, and Facility Management and Safety.



Chapters Allocation by Specialty

Each member of the survey team is responsible about a set of chapters and occasionally with few standards from other surveyors' chapters in relation to his/her specialty. In general, the chapters handled by the core team are distributed as follow:

SPECIALTY	CHAPTER NAME
Administrator	Leadership (LD)
	Management of Information (MOI)
	Medical Records (MR)
	Quality Management and Patient Safety (QM)
	Social Workers (SC)
	Patient and Family Rights (PFR)
Medical	Medical Staff and Provision of Care (MS)
	Radiology (RD)
	Rehabilitation Services (RH)
	Respiratory Services (RS)
Medical and Nursing	Ambulatory Care (AM)
	Anesthesia (AN)
	Burn Care (BC)
	Dental Services (DN)
	Emergency Room (ER)
	Haemodialysis (HM)
	ICU – NICU – CCU
	Labor and Delivery (L&D)
	Operating Room (OR)
	Medical and Radiation Oncology (MRO)
	Psychiatry (PS)
Nursing	Dietary Services (DT)
	Nursing (NR)
	Patient and Family Education (PFE)

Survey Eligibility:

All hospitals are required to apply for CBAHI accreditation survey.

Accreditation Cycle

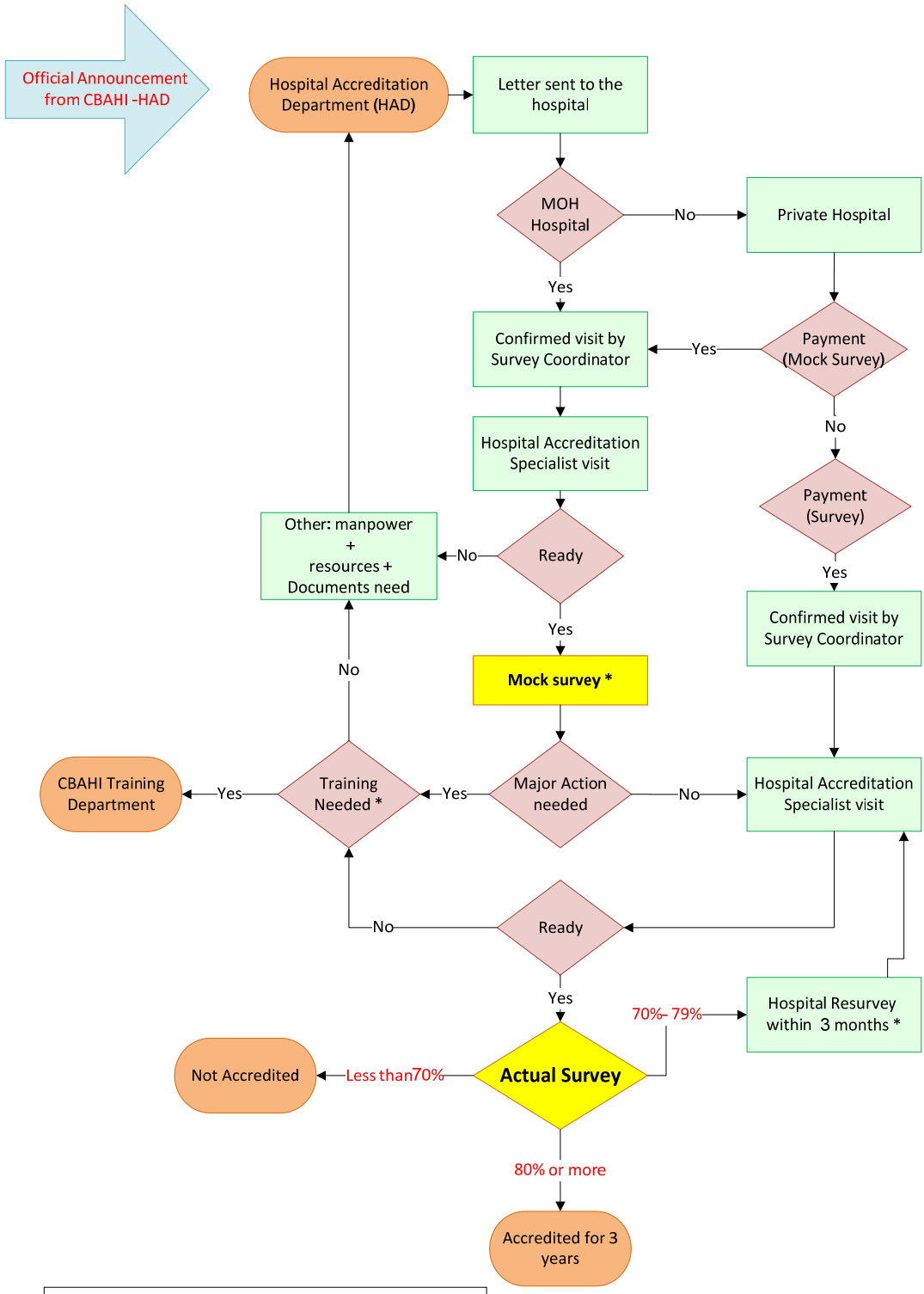
All Ministry of Health hospitals will undergo Mock Survey.

The private hospitals will have the option to undergo a Mock Survey process as hospital readiness assessment and/or consultative services prior to the accreditation survey

Hospital Accreditation Specialist (HAS) visits to hospitals will include both private and **Ministry of Health hospitals**

The following flowchart illustrates the cycle hospitals will go through in order to obtain and maintain their accreditation.

CBAHI Accreditation Cycle



* paid services for private hospitals

Survey Schedules

The hospital Accreditation Department (HAD) at CBAHI handles all scheduling arrangements for hospital surveys. Coordination of MOH hospitals to be surveyed is done through directives by the ministry. Hospitals are notified of the assigned dates. Hospitals may request for rescheduling if the dates assigned are conflicting with major events in the hospital.

Major events are defined as events that will hinder the flow of the survey process such as changes in the management team/leadership of the hospital, natural or other disasters, relocation of the organization to another building.

For the private sector, scheduling of the hospital survey is done upon the completion of the application process by the hospital.

Focused Survey Schedule

In cases were hospital accreditation status is focused survey and they require resurvey to be accredited, the HAD will notify the hospital with most suitable date for the survey. Hospitals should confirm their acceptance of the date within one week of receiving the schedule.

Rescheduling and Postponements of Surveys

Hospitals surveys are scheduled so a team of seven surveyors conduct the survey together to ensure comprehensiveness of the process. Changes in the schedule may cause some difficulties in fulfilling this objective. Therefore, hospitals are encouraged to adhere to the proposed date by the HAD.

However, if rescheduling or postponement is needed, hospitals need to submit in writing their request indicating their justification for the request.

The Scoring Process

The hospital must meet all the applicable standards elements at a satisfactory level to become accredited. Each standard element is scored on a four-point scale:

Initial Survey

- "3" = Fully Met when ≥ 75 % compliance with the standards elements.
- "2" = Partially Met when ≥ 50 to < 75 % compliance with the standards elements.
- "1" = Minimally Met when ≥ 25 to < 50 % compliance with the standards elements.
- "0" = Not Met when < 25 % compliance with the standards elements.

Accreditation Decision Rules

General Principles

- All CBAHI chapters have equal weight regardless of the standard contents. Additionally, all standards within a chapter weigh equally.
- Each standard is assigned ONE point. The ONE point is divided equally among the elements when more than one required element exists. The score of each standard represents the mean score of the included elements.
- Each chapter score is calculated as the mean of standards scores. The overall hospital score is calculated as the mean of the scores of all chapters. All scores are presented as percentage.

Survey Outcome

Accreditation Decision:

- Accredited – The hospital is awarded accreditation if:
  - the overall compliance score equals to or more than 80 % and
  - no more than 2 chapters score less than 50%
- Accreditation Denied – The hospital will be denied accreditation if:
  - the overall score is less 70 % or
  - more than 2 chapters score less than 50 %
- Hospitals scoring from 70 to 79% is required to be resurveyed within 90 days of the result for chapters that score less than 50%

Validity of accreditation: every 3 years

Truthfulness and Ethics Clause

The hospital is expected to provide accurate information to CBAHI surveyors and not withhold any information or falsify any information. This includes not divulging to CBAHI accurate information regarding CBAHI surveyors that have been employed and paid for their services by the hospital.

Prior to the survey, the CBAHI will send a list of the surveyors. If the hospital knows that anyone of the surveyors has been gainfully employed by them, then the hospital is expected to notify CBAHI immediately and another surveyor will be assigned.

If CBAHI discovers, at any time, that the hospital has not been truthful with them; CBAHI will make a determination and the hospital may lose its accreditation status.

Appeal Process

1. The appeal to the Central Board must be in writing no later than one (1) month after receiving the accreditation results.
2. The Central Board will review the appeal and inform the hospital of the following decision(s):
    2.1. Accreditation decision upheld and re-survey DENIED.
    2.2. Accreditation decision to be reviewed within 90 days to perform a focus survey, and then make the decision for accreditation.

SURVEY APPLICATION

The form contains several information regarding the hospital, its facilities, manpower and resource to enable establishment of a hospital profile.
The form is divided to 2 sections. The encoded data may be saved in stages and updated as needed. The form sections contain the instructions and guidelines to clarify the information required in every section respectively.

1- APPLICANT INFORMATION

1. Hospital Information				
Hospital Name				
Address:				
Street:				
District				
City				
Mailing address				
Telephone:				
Fax				
Ownership	☐ MOH	☐ Private	☐ Military	☐ National Guard
	☐ University Hospital	☐ Other (specify):		
If the hospital is Private:				
*Saudi Arab Commercial Registration no				
*Ministry of Health License no				
*Management responsibility	☐ Company	☐ Self managed	☐ ……	
The hospital is	☐ Branch	☐ Single standing hospital		
Level of care:	☐ Primary	☐ Secondary	☐Tertiary	☐ Other (specify):
Specialty	☐ General	☐ Children/ Pediatrics	☐ Maternity	☐ Other (specify)
Size /Bed capacity				
Total no. of beds				
No. of staffed beds				
Average daily census:				

2. Leadership Contact:					
List individuals representing the following:					
	Name	**Phone**	**Mobile**	**Fax**	**Email**
Hospital Director					
Medical Director					
Nursing Director					
TQM Director/QI Designee					
Survey Coordinator					

3. Survey Counterpart:					
Please list the names, positions and contact information for the following areas (in relation to CBAHI standards implementation):					
Area of responsibility	***Name***	***Position***	***Hand phone no.***	***Email***	***Fax***
Leadership and quality	1.				
	2.				
Medical staff	1.				
	2.				
Nursing	1.				
	2.				
Pharmacy	1.				
	2.				
Laboratory	1.				
	2.				
Facility Management and Safety	1.				
	2.				
Infection Control	1.				
	2.				

2- ORGANIZATIONAL DESCRIPTION

1. In-Patient Unit:			
List Inpatient Care Units (excluding specialty areas), the number of beds and the type of care given on each unit (per following table):			
	Inpatient Unit / ward	***Number of beds***	*Comments*

2. Specialty Unit:		
Please indicate the number of beds in the following specialty wards:		
	Specialty	***Number of Beds***
	Burn units	
	CCU	
	Day care unit	
	Emergency unit	
	Intensive Care	
	Isolations rooms	
	Labor and Delivery	
	NICU	
	Nursery	
	Operating Room	
	Recovery Rooms	
	Renal Dialysis	

	3. Out-patient Services:	
Please indicate the average of Outpatient visits/Quarter		
	Specialty	***Number of visits/ Quarter***
	Cardiac Surgery	
	Cardiology	
	Dentistry	
	Dermatology	
	ENT	
	General Surgery	
	Internal Medicine	
	Neurology	
	Neurosurgery	
	OB/GYN	
	Ophthalmology	
	Orthopedics	
	Pediatrics	
	Pre-operative clinic	
	Urology	
	Other (specify)	
	Other (specify)	

	4. List the Top Five Patient Discharge Diagnoses and the Top Five Surgical Procedures Performed:	
	Top Five Diagnoses	Top Five Surgical Procedures
1		
2		
3		
4		
5		

5. Site Demographics.				
List the buildings /locations in which care is provided to patients. **List sites separately wherever there is a distinct street address. Buildings with the same address or connected site should be considered as one site.**				
Building Name	**Building Number**	**Location**	**Main or Additional Site**	**How many kilometers from main site?**

6. Sedation Location:				
Please indicate the areas where anesthesia (general/ local/ sedation) is performed in the following table:				
	Area	***Yes***	***No***	*Not applicable*
	Operating Room	☐ **Yes**	☐ **No**	
	Endoscopy	☐ **Yes**	☐ **No**	
	Cardiac Cath unit	☐ **Yes**	☐ **No**	
	Dental Clinic	☐ **Yes**	☐ **No**	
	Labor and Delivery Room	☐ **Yes**	☐ **No**	
	Emergency Room	☐ **Yes**	☐ **No**	
	Surgical wards	☐ **Yes**	☐ **No**	
	Day procedure unit	☐ **Yes**	☐ **No**	
	Neurology clinic	☐ **Yes**	☐ **No**	
	Radiology	☐ **Yes**	☐ **No**	
	ICU	☐ **Yes**	☐ **No**	
	Pediatrics wards	☐ **Yes**	☐ **No**	

1. Sub-Contract Services:					
If you have any sub-contracted services, please complete the following section:					
Area / function	***Company***	***No. of employees***	***Hospital supervisor assigned***		***Comments***
			Yes	***No***	
Maintenance			☐ **Yes**	☐ **No**	
Medical waste			☐ **Yes**	☐ **No**	
Bio-Medical Engineering/ Maintenance			☐ **Yes**	☐ **No**	
House keeping			☐ **Yes**	☐ **No**	
Housing			☐ **Yes**	☐ **No**	
Food Services			☐ **Yes**	☐ **No**	
Communication (operators)			☐ **Yes**	☐ **No**	
Security			☐ **Yes**	☐ **No**	
Safety			☐ **Yes**	☐ **No**	
Laundry			☐ **Yes**	☐ **No**	
Landscape			☐ **Yes**	☐ **No**	
Transportation			☐ **Yes**	☐ **No**	
Other (specify)			☐ Yes	☐ No	

Authorized Signatory

I the undersigned verify that the information above is accurate and I have been given the authority to make this application on behalf of:

Name of Applicant Organization:……..

Name:……

Title:……

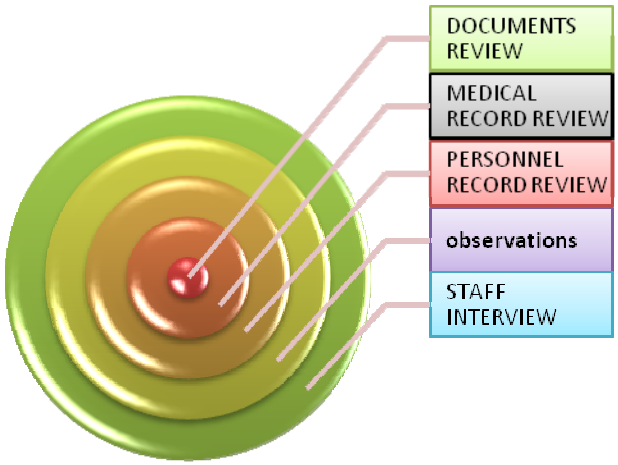
Signature:……

Date:……

Survey Process

The On-Site Survey

The purpose of the accreditation process is to improve the services of the Kingdom healthcare sector, to ensure the safety of our patients and to assist the hospital establish the baseline infrastructure.
Hospitals undergoing their first survey need to demonstrate a track record of four months of compliance with the standards.
Hospitals being resurveyed need to demonstrate twelve months of compliance with the standards.
Understanding the organization and assessing compliance is accomplished through a number of methods including the following:



The on-site evaluation consists of the following steps:

- Survey planning meeting
- Opening conference and orientation to the organization
- Documents Review/ Medical Records/ Personnel File
- Interviews
- Facilities tour(s) & Units Visits
- Surveyors Debriefing
- Exit conference

Survey Agenda

The agenda of the visit duration reflects the activities to take place during the survey, CBAHI personnel and hospital staff will participate in those activities. Information received from the hospital through the completion of the survey application will guide the flow of the unit visit activity as well as the duration of the survey (three or four days).

The agenda has been developed for the Core/Main team (Administrator, Physician and Nurse) to reflect a 3-day survey, which is most of the surveys carried out by CBAHI. A 4-day survey agenda has been designed and will be made available for hospitals with wider scope of services and larger bed capacity (such as tertiary care hospitals and physically large facilities with multiple buildings and locations).

The agenda for the specialty (Pharmacy, Infection Control, Laboratory, and Facility Management and Safety) has been designed. Specialty surveyors will complete their surveys within two days.

For more details on the hospital representative and agenda items requirements please refer to each activity detailed in this guide.

Kindly note that the prayer time difference in the various regions may affect the survey agenda for the business lunch time.

HOSPITAL SURVEYOR AGENDA (Main Team) - 3 Days

DAY 1

Time	Activity	Area , department	surveyors	Hospital staff
08:00 am – 09:00 am	Surveyor planning session	Room for all surveyors, room to be designated by hospital	All	---
09:00 am – 09:10 am	OPENING CONFERENCE	Meeting Room	All	Hospital Administrator Medical Director Nursing Director Quality Management Director
09:10 am – 09:30 am	Hospital Director presentation	Auditorium		
09:30 am – 01:00 pm	Documents Review	Room for 5 surveyors, room to be designated by hospital	Nurse Administrator Physician	Nurse, Administrator, Physician counterparts
01:00 pm – 02:00pm	BUSINESS LUNCH FOR SURVEYORS			
02:00 pm – 04:30 pm	Documents Review	Room for 5 surveyors, room to be designated by hospital	Nurse Administrator Physician	Nurse, Administrator, Physician counterparts
04:30 pm – 05:00 pm	**SURVEYORS MEETING**			

DAY 2

Time	Activity	Area , department	Surveyors	Hospital staff
08:00 am – 08:30 am	Surveyor planning session	Room for all surveyors, room to be designated by hospital	All	---
08:30 am – 09:00 am	SURVEYORS DEBRIEFING			Hospital counterparts
09:00 am – 10:00 am	Leadership Interview	Room for 3 surveyors + 13 hospital staff , room to be designated by hospital	Nurse Administrator Physician	Hospital Administrator Medical Director Nursing Director Quality Management Director
10:00 am – 01:00 pm	Documents Review/ Medical Records/ Personnel File	Conference room	Administrator Nurse Physician	Quality Management counterparts Medical, Nursing counterparts
01:00 pm – 02:00 pm	**BUSINESS LUNCH FOR SURVEYORS**			
02:00 pm – 03:45 pm	FACILITY TOUR	Units Visit	Nurse Physician	Anesthetist, Medical Chair of OR committee, Head Nurse Medical, Nursing counterparts
	Unit Visit	Social Services, Human Resources	Administrator	Quality Management director
03:45 pm – 04:30 pm	Data entry for Core Team			
04:30 pm – 05:00 pm	**SURVEYORS MEETING**			

DAY 3

Time	Activity	Area , department	surveyors	Hospital staff
08:00 am – 08:30 am	Surveyor planning session	Room for 3 surveyors, room to be designated by hospital	Nurse Administrator Physician	---
08:30 am – 09:00 am	**SURVEYORS DEBRIEFING**			Hospital counterparts
09:00 am – 11:00 am	Staff Interview	Room for 2 surveyors + 15 hospital staff , room to be designated by hospital	Nurse Physician	15 sampled staff: physician, ward clerk, dentist, nurse aide, nurses, dietitian, housekeepers, kitchen staff & medical records.
	Unit Visits	Medical Records Sample units and departments	Administrator	Medical record head QM director
11:00 am – 1:00 pm	Unit Visits	QM Department MOI Department	Administrator	Quality Management director & Staff from areas
		Unit Visits	Nurse Physician	Medical, Nursing counterparts Staff from areas
01:00 pm – 02:00 pm	**BUSINESS LUNCH FOR SURVEYORS**			
02:00 pm – 3:30 pm	Preparation for Closing Conference Remarks (Team Leader)Data entry for Core Team			
03:30 pm – 05:00 pm	**CLOSING CONFERENCE**			

HOSPITAL SURVEYOR AGENDA (Specialty Team) – 2 Days				
Day 1				
Time	**Activity**	**Area, department**	**Surveyors**	**Hospital Staff**
08:00 am – 09:00 am	Surveyor planning session	Room for all surveyors, room to be designated by hospital	All	**---**
09:00 am – 09:10 am	Opening Conference	Meeting Room	Pharmacy Infection Control Laboratory Facility Management & Safety With core team	Infection Control Director Laboratory Director Pharmacy Director Quality Management Director
09:10 am – 09:30 am	Hospital Director presentation	Auditorium		
09:30 am – 01:00 pm	Documents Review	Pharmacy, Infection Control " with core team in same room" Laboratory (in Lab) FMS (in 2nd room)	Pharmacy Infection Control Laboratory Facility Management & Safety	Pharmacy QI Designee Infection Control Practitioner Laboratory Director/ Laboratory QI Designee Safety Officer
01:00 pm – 02:00 pm	**BUSINESS LUNCH FOR SURVEYORS**			
02:00 pm – 04:30 pm	Medical Records /Personnel File (required records & files to be provided by 09:00 am)	Pharmacy, Infection Control " with core team in same room" Laboratory (in Lab) FMS (in 2nd room)	Pharmacy Infection Control Laboratory (in Lab) Facility Management & Safety (in 2nd room)	Pharmacy QI Designee Infection Control Practitioner Laboratory Director/ Laboratory QI Designee Safety Officer
04:30 pm – 05:00 pm	**SURVEYORS MEETING**			

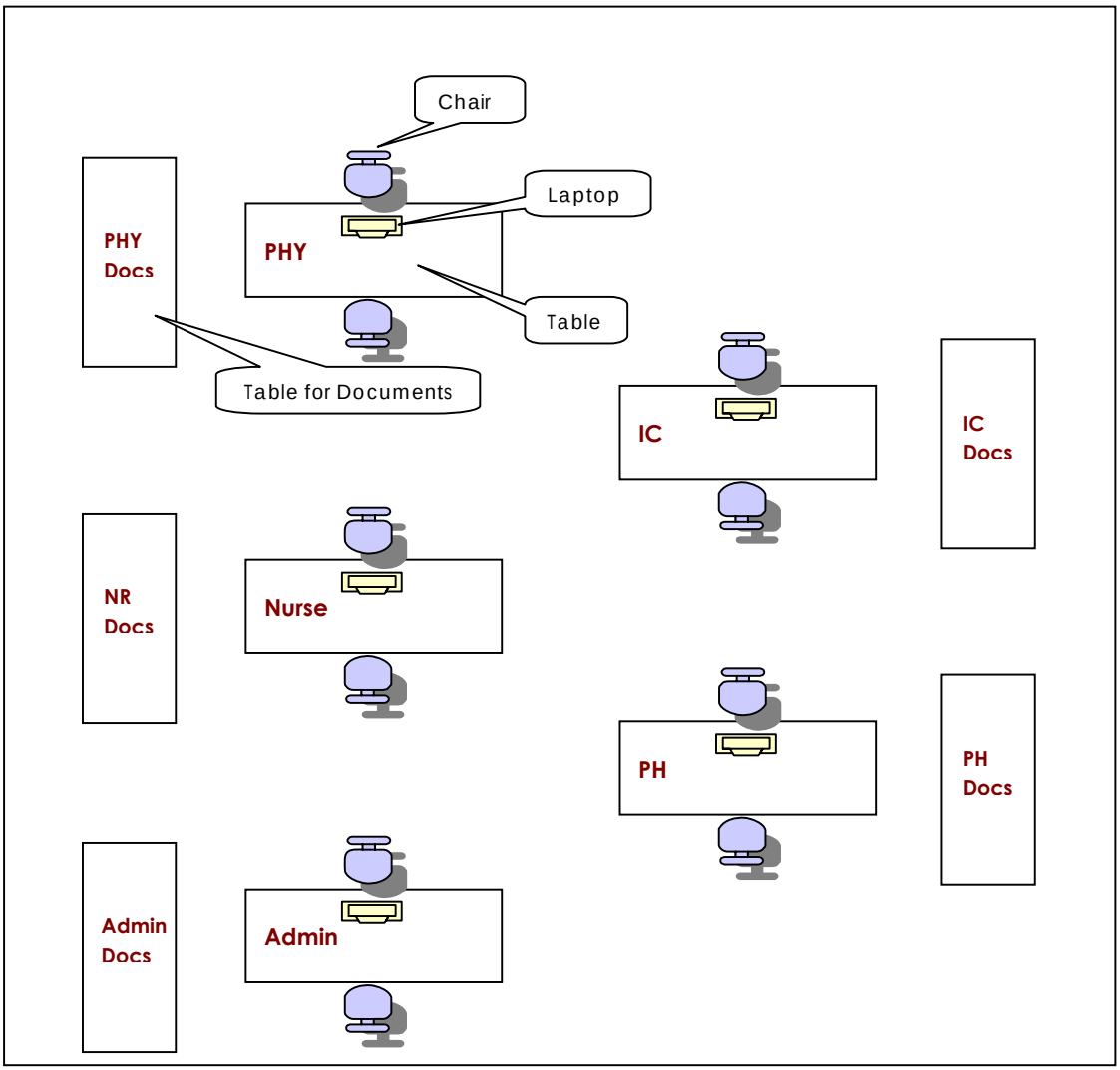
HOSPITAL SURVEYOR AGENDA (Specialty Team) – 2 Days				
Day 2				
Time	**Activity**	**Area , department**	**Surveyors**	**Hospital Staff**
08:00 am – 08:30 am	Surveyor planning session	(room for all surveyors, room to be designated by hospital)	All	---
08:30 am – 09:00 am	Surveyors Debriefing			Hospital counterparts
09:00 am – 10:00 am	Specialty Interviews	Pharmacy department	Pharmacy	P&T Committee Other staff as needed
		Infection Control department	Infection Control	Infection Control Chairperson Infection Control Nurse Other staff as needed
		Laboratory department	Laboratory	Lab Director Lab Safety Officer/Lab quality designee Other staff as needed
		FMS department	FMS	Safety Committee Chairperson Safety Officer Other staff as needed
10:00 am – 01:00 pm	Facility Tour	Pharmacy department	Pharmacy	Pharmacy QI
		Infection Control department	Infection Control	Infection Control Practitioner
		Laboratory department	Laboratory	Laboratory QI + Safety Officer
		FMS department	FMS	Safety Officer
01:00 pm – 02:00 pm	BUSINESS LUNCH FOR SURVEYORS			
02:00 pm – 04:00 pm	Data entry (Pharmacy- Infection Control- Laboratory- FMS)			
04:00 pm – 04:30 pm	Preparation for Closing Conference Remarks (Team Leader)Data entry for SPECIALTY Team			
04:30 pm – 05:00 pm	**SURVEYORS MEETING**			

Room Schematics

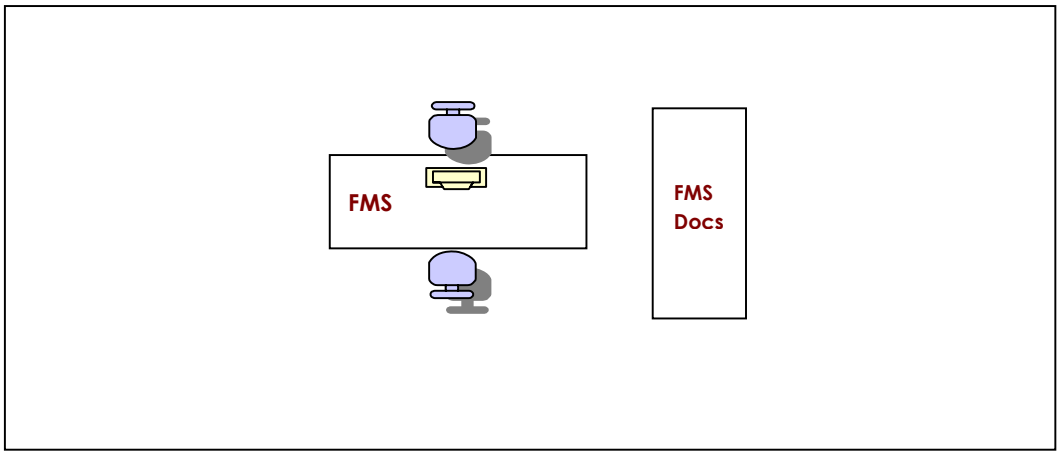
Session(s):

1. Document Review - (Core Team, Specialty)
2. Medical Records Review (Closed) - [Core Team, IC, LB]
3. Personnel Files Review (Core Team, Specialty Team)
4. Data Entry (Core Team, Specialty Team)

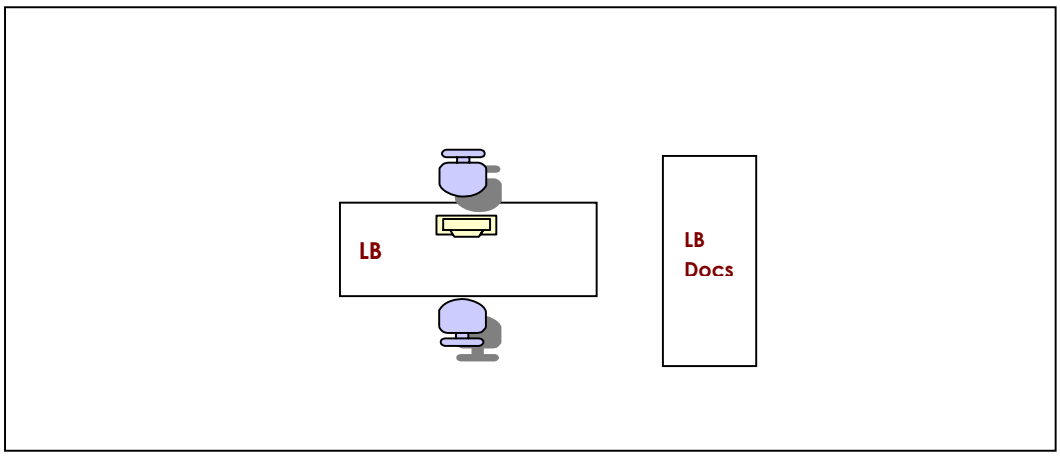
(1 Room)



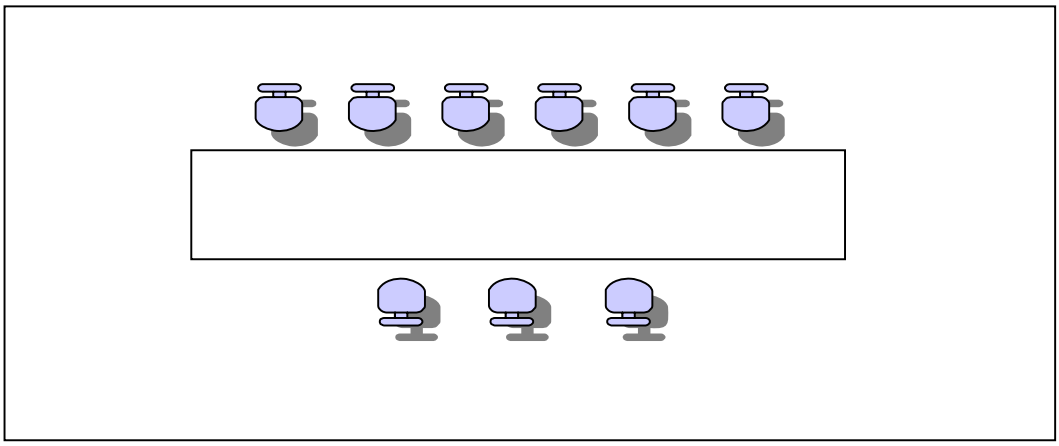
(1 Room - Separate)
Sessions-Document Review, Personnel File & Data Entry



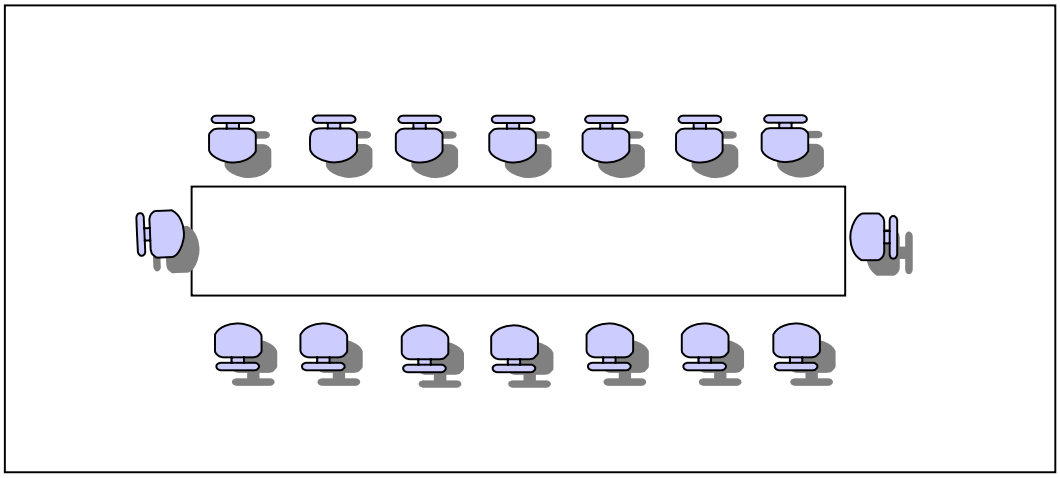
Room Schematic: (1 Room - Separate in Lab)
Sessions-Document Review, Personnel File & Data Entry



(1 Room - Separate)
Session-Leadership Interview



(1 Room - Separate)
Session-Staff Interview



Hospital Survey Activities

Surveyor Planning Session

This time is set aside for the surveyor(s) to review and discuss pertinent data and plan the survey agenda. The surveyor(s) review the following:

- List of departments/units/areas/programs/services within the organization (scope of services)
- An organization chart and map of the organization
- List of discharged patients (with diagnosis)

Survey Activity	Participants		Location & Room Requirements
	CBAHI Surveyors	Hospital Staff	
Planning Session	**Administrator** **Physician** **Nurse** **Pharmacy** **Infection Control** **Laboratory** **FMS**		**Auditorium or designated room for surveyors**

Opening Conference

The objective of the opening conference is to officially start the survey visit through the presentation of essential hospital information and CBAHI visit plan.
CBAHI team leader will present the flow of the visit as well as the team members present. On the other hand, the hospital leadership will introduce the hospital scope of services, directions and strategies as well as the surveyors' counterpart in order to facilitate the smooth flow of the survey process. The hospital presentation is expected to highlight the improvement initiatives.
Moreover, any modification in the agenda will be agreed on at the end of this session.

NOTE 1 : The 1st document surveyors need to review and clarify as a team is the hospitals' policy management system (policy on policies), which is addressed in LD.28. The hospital should introduce their system in the opening conference.

NOTE 2 : If there is confusion regarding certain applicability and scope of services, the Surveyors Team Leader may request a short meeting with hospital director or medical director for further clarification of the scope of activities that were doubted.

Survey Activity	Participants		Location & Room Requirements
	CBAHI Surveyors	Hospital Staff	
Opening Conference	**Administrator** **Physician** **Nurse** **Pharmacy** **Infection Control** **Laboratory** **FMS**	**Hospital Administrator** **Medical Director** **Nursing Director** **Quality Management Director** **Pharmacy Director** **Infection Control Director** **Laboratory Director** **Safety Director**	**Auditorium or conference room,** **(1) LCD Projector** **(1) Laptop Computer** **Extension Cords** **Laser Pointer** **Screen** **Microphones** **Podium**

Debriefing and Closing Conference

The survey process progress and initial outcome are communicated to the hospital through two formal sessions: Debriefing (beginning of day 2), and the Closing Conference.

During of the debriefing, the hospital will be informed on pending issues in order to ensure those items are provided within the survey period. Any notes on the day activity are clarified.

The closing conference is aimed to provide the hospital with an initial overview on the outcome of the survey. The survey team will present key findings for the hospital strength and areas for improvement. In addition to hospital leadership, it is encouraged that various hospital staff (especially those at supervisory levels) attend these sessions.

List of Required Documents

- The hospital is expected to prepare binders to facilitate the review of their documents in relation to compliance to the CBAHI National Hospital Standards.
- The binders to be organized according to the list provided in this guide.
- Electronic access during the survey day is also acceptable provided the list is based on the sequence required in this guide.
- The list reflects the arrangements based on the surveyor conducting review (not solely based on the chapters).
- It is very much encouraged that the surveyor counter-part is oriented to the document arrangement.

Document Review General Guidelines

1. The scope of this activity is to ensure hospital adherence to the CBAHI requirements, especially that most standards main requirements are the presence of policies and/or completion of certain records
2. If a needed document is not available the surveyor will ask the hospital representative to present it preferably within the survey day. The hospital will be given chance to present any missing evidence within the survey period.
3. Evidence of compliance (policy or records) must be presented within the specialty survey day (by the end of day 2)
4. Required documents such as Policies and plans should be:
    - 1-4.1 Documented in the approved hospital format
    - 1-4.2 Approved by concerned leaders
    - 1-4.3 Current
    - 1-4.4 Meets the elements of the standards

SURVEY REQUIRMENTS (DOCUMENT REVIEW ACTIVITY)

Survey Activity	Participants		Location & Room Requirements
	CBAHI Surveyors	**Hospital Staff**	
Document Review	Administrator Physician Nurse	1. Quality Management Staff (2) 2. Physician counterpart 3. Nurse	(1) Room with Core, IC, PH) (3) Laptop Computers Extension Cords for the Laptops (1) Table (1) Table - for Docs (5) Chairs
	Pharmacy	Pharmacy QI Designee	(1) Room with Core, PH, IC) (1) Laptop Computers Extension Cords for the Laptops (1) Table (1) Table - for Docs (2) Chairs
	Infection Control	Infection Control Practitioner	(1) Room with Core, IC, PH) (1) Laptop Computers Extension Cords for the Laptops (1) Table (1) Table - for Docs (2) Chairs
	Laboratory (in Lab)	Lab QI Digenesis	(1) Room in the Laboratory (1) Laptop Computers Extension Cords for the Laptops (1) Table (1) Table - for Docs (1) Chair
	FMS (in 2nd room)	Safety Officer	(1) Room separate from other Specialties (1) Laptop Computers Extension Cords for the Laptops (1) Table (1) Table - for Docs (2) Chairs

LIST OF THE DOCUMENTS

Required Document – Administrator		
SN	**Std No**	**Required Documents**
1	LD.1.	MOH License (NA for MOH hospitals)
2	LD.1.	Civil Defense certificate
3	LD.2. LD.3.	Hospital updated Organization Chart identified the leadership groups with names
4	LD.4. LD.25.	Leadership committee terms of reference, minutes
5	LD.7.	Mission, vision, value statement
6	LD.8.	Hospital Scope of Services
7	LD.8.	Nursing scope of service
8	LD.9.	3 year strategic plan (with action plan)
9	MOI.5. MOI.6.	Any documents or data used in planning
10	QM.27.	Analyzed data reports reflecting qualified staff.
11	LD.24. NR.5. QM.4.	Capital and Operating budget.
12	LD.13. LD.14.	Committee management policy and procedure (or equivalent).
13	LD.14. LD.10. LD.11. LD.12. NR.6.	Generally all hospital committees files should be available: - Terms of reference - Meeting minutes 6 months - Annual evaluation - Committee Recommendation , Approved action taken by leadership or concerned parties - Any training providing by the committee
14	QM.28.	Minutes or other documents of hospital standing committees reflect trending of data with external organizations for benchmarking.
15	QM.28.	Minutes or other documents of hospital standing committees reflect trending of data over time for internal comparison.
16	LD.38.	Departmental, general Staff meeting minutes " from last six months ".
17	LD.38.	Sample of multidisciplinary/interdepartmental policies.
18	LD.38.	Hospital newsletter.
19	PFR.23.	Research committee terms of reference.
20	PFR.23.	Meeting minutes of Research Committee.
21	LD.28.	Policy on policies and procedures development and maintenance.
22	LD.26. LD.40.	Departmental manual of (medical record, human resources, quality management, social worker, and information technology
23	LD.40. QM.12.	Sentinel event policy and reportable events.
24	LD.40. NR.36. QM.11.	Hospital incident reporting system (OVR) policy and form.
25	LD.40.	Administrative policies and procedures -Child Abuse.
26	LD.40. NR.9. PFR.2.	Administrative policies and procedures defining roles in Patient family rights.
27	LD.40. LD.19.	Code of conduct.

Required Document – Administrator		
SN	**Std No**	**Required Documents**
28	LD.40. PFR.16. PFR.6.	Policy for high risk treatment and procedures requiring informed consent.
29	LD.40. PFR.18.	No code or don't resuscitate policy.
30	LD.40.	Dress code policy.
31	LD.43.	Employee manual.
32	LD.46.	Job descriptions management policy.
33	LD.46.	Job descriptions format includes.
34	LD.58.	Duty manager job description.
35	LD.20.	Employee conflict resolution policy.
36	LD.44.	Policy for handling staff complaints.
37	LD.39.	Policy that outlines the roles and responsibilities for handling all incoming requests.
38	MR.11.	Policy on completion of medical records.
39	MR.11.	Policy of delinquent files.
40	LD.60.	A policy to handle cases of suspected child abuse, criminal acts.
41	LD.45.	A written program for recruitment, retention, and development of staff.
42	LD.61.	Staffing plan/schedule.
43	LD.47.	Hospital credentialing policy.
44	NR.17.	A written and approved plan for retention.
45	NR.17.	Nursing retention plan monitoring mechanism (i.e. satisfaction surveys, complaints processing).
46	NR.16.	A written program for Nursing recruitment
47	LD.56.	Probationary period staff evaluation policy.
48	LD.57.	Annual evaluation policy and evaluation form.
49	LD.48.	Attendance records that all new employees attend a mandatory general hospital orientation.
50	LD.48.	General hospital orientation program.
51	LD.50.	Departmental orientation policy.
52	LD.52. LD.55.	Educational plan/academic program schedule.
53	LD.55.	Training needs assessment process.
54	LD.51.	Any documents related to financial sponsorship or time off for staff to attend educational events.
55	LD.53.	Any document shows department head recommends educational needs based on performance evaluation.
56	LD.15.	Staff attendance records of education on patient and family rights.
57	QM.21.	Hospital-wide QM education program.
58	QM.9. QM.30.	Quality improvement projects
59	QM.9.	Attendance records/certificates of Hospital leaders in quality activities.
60	LD.62.	Any documents related to the contract monitoring process and corrective actions for improvement are taken when standards are not met.
61	QM.2. QM.5.	QM organizational chart.
62	QM.7. QM.14.	Hospital wide Quality Management and Patient Safety Plan

Required Document – Administrator		
SN	**Std No**	**Required Documents**
63	QM.14.	Patient safety team/committee terms of reference or other document that reflects membership and functions required.
64	QM.8. MR.26. QM.29.	Terms of reference and meeting minutes - Quality Management " from last six months ".
65	LD.35.	Any documents related to any improvement actions based on QI committee recommendations (meeting minutes, memos, reports, QI projects, etc).
66	QM.6.	Quality/risk management reports or other documents.
67	QM.11.	Aggregated incident reports.
68	QM.13.	Minutes and/or reports of previous sentinel event handled according to policy including development of root cause analysis and an action plan.
69	QM.22.	Approved list of measurements and indicators to be monitored in the hospital.
70	QM.23.	Any documents related to monitoring of structure measurements (indicators) (report, minutes. etc)
71	QM.24.	Any documents related to monitoring of process measurements (indicators) (report, minutes. etc)
72	QM.25.	Any documents related to monitoring of outcome measurements (indicators) & (report, minutes. etc)
73	SC.1.	Social work department organizational chart.
74	MOI.1.	Information management plan.
75	LD.37.	Any documents related to Leaders support the hospital wide Management of Information (MOI) plan after the MOI plan
76	MOI.3.	Any documents related to Collaboration between MOI staff with department heads.
77	MOI.4.	Data management documents that involving (data element definition, establishing time frame, data analysis and the type and report routing).
78	MOI.9.	Written policy on maintenance of data and information confidentiality.
79	MOI.10.	Infectious diseases reports OR any other reports that are contributed to external databases in accordance with Saudi laws or regulations.
80	MR.14.	Medical record department organization chart.
81	MS.36.	Medical Record Documentation Guidelines
82	MR.10.	Policy for medical records content.
83	MR.20.	Policy on the release of medical records from the medical record department.
84	MR.4.	Policy/ mechanism to identify authorized staff to make entries in medical records.
85	MR.6.	Policy on the storage and retention of records.
86	MR.6.	Policy on the confidentiality, integrity, and security of medical records.
87	MR.7.	Policy on medical records protection.
88	MR.22.	Written guidelines on legible and clear handwriting, and error correction of entries into the medical record.
89	LD.16.	Policy to govern the General consent form use and completion.
90	PFR.17.	Policy to deal with patients who refuse treatment, or discontinuing treatment.
91	PFR.25.	Policy on providing emergency care to patients regardless of availability of fund.
92	PFR.1.	Terms of references of Patient Rights/Advocacy Committee.
93	PFR.11.	Patient Complaints handling/management policy.
94	PFR.11.	Patient complaints trend reports and any improvement action taken patient satisfaction trend reports and any improvement action taken.
95	PFR.11.	Terms of references of Patient Compliant Committee.
96	PFR.12.	Ongoing patient satisfaction surveys policy and forms.
97	LD.17.	Letter of assignment, job description, and/or scope of services of the entity in-charge of

Required Document – Administrator		
SN	**Std No**	**Required Documents**
		patient compliant process. Any documents related to improvement actions based on patient complaints.
98	PFR.13.	Safe keeping of patient belongings policy.
99	PFR.19.	Pain Management policy.
100	PFR.22.	Organ donation policy.
101	PFR.21.	Written brochures and religious Fatwa on organ donation.

Required Document – Medical		
SN	**Std No**	**Required Documents**
1	LD.8.	The written departmental scope of service.
2	LD.40.	- Administrative policies and procedures - Admission, transfer and discharge. - Administrative policies and procedures - Transfer to another facility.
3	MS.2.	Job Description Medical Director.
4	MS.3.	Organization chart.
5	MS.5.	Monthly meeting minutes with department heads.
6	MS.6.	Sample of multidisciplinary policies with Medical Director review & approval (n=10).
7	MS.8.	Meeting minutes between Medical Director/Quality Director and Nursing Director.
8	MS.9.	- Policy for care of vulnerable patients (immune-compromised, comatose, elderly, and care of terminally ill). - Policies (guidelines) for security and safety for care of vulnerable dependent patients
9	MS.10.	Meeting minutes between Medical Director/.Quality Director/Nursing Director to discuss patient safety issues (implement the patient safety plan issues).
10	MS.11.	- Sample of root cause analysis. - Actions taken for all near misses
11	MS.17.	Department heads job descriptions, Sample policy procedures.
12	MS.12.	Medical Director/department heads and Quality Director monitoring activities for: evidence of monitoring for the following: - Patient assessments - Adverse events - Conscious sedation - Quality of medical records - Sentinel events - High risk services and procedures
13	MS.13.	Medical Director/department heads and Quality Director monitoring activities for: evidence of monitoring for the following: - Morbidity and Mortality - Blood and blood product usage - Outcome of surgeries - Any discrepancies between pre operative and postoperative diagnoses - Appropriateness of admissions from the emergency room - Appropriateness of admissions from the outpatient area
14	MS.15.	Meeting minutes with actions for guiding and prioritizing the services needed as well as review of minutes by the Medical Director. Meeting minutes that contain department head sharing findings for deficiency correction with Medical Director.
15	MS.18.	Department heads job descriptions.
16	MS.20.	Samples of departmental meeting minutes.
17	MS.21.	Scope of services booklet in department.
18	MS.23.	Sampling of quality improvement projects in medical departments. Meeting minutes with actions for guiding and prioritizing the services needed as well as review of minutes by the Medical Director. Meeting minutes that contain department head sharing findings for deficiency correction with Medical Director.
19	MS.25.	List of staff certified in BCLS, ACLS, Policy CPR team, CPR form.
20	MS.26.	Policy CPR team, CPR form.
21	MS.27.	CPR committee minutes.
22	MS.29.	CPR/ code team schedule. CPR policy that outlines the staff roles and responsibilities of the staff during codes.
23	MS.31.	Medical credentialing and privileging committee terms of reference.
24	MS.36.	Organizational chart for Medical division. Qualification requirements for all categories medical staff. Bylaws or other documents that include: - Membership categories - Roles /responsibilities medical staff - Medical record documentation guidelines - List of medical committees and departments - Conduct of care - How medical staff are promoted, appointed or reappointed - Professional conduct related to ethical issues - Disciplinary

Required Document – Medical		
SN	**Std No**	**Required Documents**
		process including corrective actions and appeals - How privileges are determine: scope of practice for each medical position - Maintaining and updating privileges - Temporary granting or privileges - Process for admission, transfer, referral and discharge
25	MS.37.	Hospital Mortality/Morbidity committee terms of reference.
26	MS.38.	Hospital Mortality/Morbidity committee meeting minutes.
27	MS.39.	Departmental Mortality/Morbidity committee (minutes and attendance).
28	MS.40.	Case selection by department heads in monthly summary reports.
29	MS.41.	Medical Record Review Committee terms of reference.
30	MS.42.	Medical Record Review report.
31	MR.12.	- Any meeting minutes of the Medical Records Review Committee that include an action plan based on the quality management program "from last six months ". - Aggregated, analyzed reports related to the quality management program in medical record unit.
32	MS.45.	Utilization review committee terms of reference and monitoring length of stay and appropriateness of admission
33	MS.46.	Utilization review committee meeting minutes.
34	MS.51.	Tissue review committee or functions of tissue review committee handled by Chief Pathologist/ designee: formation order and minutes. Policy on obtaining and handling specimens and/or tissues.
35	MS.52.	Operating room formation order and committee minutes
36	MS.53.	Approved Operating room policies by OR committee.
37	MS.54.	Policy for admitting patients; routine urgent, emergent, when no bed is available
38	MS.59.	On call duty Rota (Physicians).
39	MS.62.	Staffing plan guidelines/schedules in medical departments.
40	MS.63.	Policy/procedure medical assessments.
41	MS.75.	Policies and forms for admission and discharge criteria for intensive care. Policies and forms for transfers within the hospital. Policies and forms for admission of patients from the emergency room.
42	MS.77.	Day surgery policies.
43	MS.84.	Written policy and procedures on patient transfer to other hospitals when the required care is beyond the scope of service provided
44	MS.89.	Policy/procedure patient transfer to other hospitals. Physician certified in BCLS/preferably ACLS, qualified physician or paramedic for emergency transfer.
45	MS.87.	Availability of a qualified physician or paramedic for emergency transfer.
46	NR.57.	Availability of written multidisciplinary policy and procedure on patient transfer within the facility.
47	AN.2.	OR staffing plan and schedule outlined that one Anesthetist is physically present throughout the operation.
48	AN.4.	Policy for proper storage and handling of anesthetic agents.
49	AN.5.	Anesthesia department head recommends anesthesia equipment.
50	AN.13.	Availability of Anesthetist in charge of the Recovery Room (schedule).
51	AN.16.	Collaboration between head of Anesthesia and the OR/RR Nurse Manager in preparing policy & procedures of Recovery Room (counter signature).
52	AN.25.	Written policy on conscious sedation approved by the head of Anesthesia, the Nurse Manager, and the appropriate department heads.
53	ICU.6.	Availability of medical staffing plan based on patient volume and acuity for ICU.
54	ICU.8.	Availability of written critical care admission and discharge criteria.
55	ICU.9.	24-hour critical care coverage by physician (i.e. schedule).

Required Document – Medical		
SN	**Std No**	**Required Documents**
56	CCU.7.	Availability of medical staffing plan based on patient volume and acuity for CCU.
57	CCU.9.	Written CCU admission and discharge criteria.
58	CCU.10.	Availability of 24-hour CCU coverage by in-house physicians (CCU schedule).
59	CCU.11.	Regular inspection of intubation and ventilation tools and equipment.
60	CCU.14.	- Written policy and procedure on Coronary Angiogram. - Written policy and procedure on temporary and permanent pace maker. - Written policy and procedure on conscious sedation.
61	NICU.6.	Availability of NICU medical staffing plan based on patient volume and acuity.
62	NICU.8.	Written NICU admission and discharge criteria.
63	NICU.9.	24-hour coverage of NICU by physicians (work schedule).
64	OR.2.	There is a policy for patient acceptance into the operating room (OR) that is written collaboratively with the Chief of Surgery, Chief of Anesthesia, and the Nurse Manager (head nurse).
65	L&D.3.	Availability of medical staffing plan for L&D unit based on patient volume and acuity.
66	L&D.5.	Written criteria for admission to and discharge from the L&D unit.
67	L&D.6.	Comprehensive written multidisplinary policy and procedures - Ante partum hemorrhage. - The use of Syntocinon. - Caesarian section and repeated C-section. - Emergency hysterectomy. - Fetal distress. - Sedation used. - Spinal and epidural anesthesia. - The use of CTG monitors. The use of episiotomy.
68	L&D.7.	Comprehensive written multidisplanary policy and procedures - Ante partum hemorrhage. - The use of Syntocinon. - Caesarian section and repeated C-section. - Emergency hysterectomy. - Fetal distress. - Sedation used. - Spinal and epidural anesthesia. - The use of CTG monitor. -The use of episiotomy.
69	L&D.11.	L&D medical staff duty Rota or staffing plan.
70	HM.6.	Written criteria for admission to and discharge from Haemodialysis unit.
71	ER.6.	Written policy and procedures on patient triage and prioritization.
72	ER.7.	Availability of medical staffing plan for emergency department based on patient volume and acuity.
73	ER.9.	Written multi-disciplinary policy and procedures - Management of medico-legal cases. - Patients who leave against medical advice. - Care of patients not competent to care for themselves Care of minors. - Patients who leave without being seen. - Protocols for some of the important and common emergencies; asthma, chest pain, coma, stroke, tetanus etc.
74	ER.12.	Policy of obtaining an emergency CAT scan for trauma cases within 30 minutes.
75	ER.14.	Written policy on calling consultants for opinions in the ER.
76	ER.20.	Availability of emergency physician in-house 24-hours daily (schedule).
77	ER.23.	Written policy on patients transfer to another hospital when the required care is not available.
78	RD.2.	Written policies and procedures on all available radiology services.
79	RD.3.	There are written protocols for the following procedures - Angiogram. - Cat Scan. - MRI Interventional procedure. - Fluoroscopy – Contrast agent reaction.
80	RD.7.	There is 24-hour coverage by a radiologist and a technologist.

Required Document – Medical		
SN	**Std No**	**Required Documents**
81	RD.11.	There is a radiation safety protocol or plan in place that includes the following: - All equipment is inspected and checked regularly with the experienced Safety Officer. - All radioactive material is used according to the guidelines and the Safety Officer oversees the activity in the unit. - Safety warnings are posted on the doors. - Women are checked for the possibility of being pregnant prior to having X-ray tests and the X-ray form demands that the physicians check this point. - Personnel are monitored for radiation exposure.
82	RD.12.	There is a protocol that all patients going for any interventional procedure have: -The physician explains the risks and the benefits of the procedure to the patient. -The consent form is signed by the patient. -The patient's coagulation parameters are checked: e.g. PT, PTT, platelets. -Any history of previous allergic reactions are included as part of the history. -The physician writes the request for the procedure with details about the chief history and point out the reason why the procedure is needed.
83	RD.16.	Written policy for immediate reporting of "panic findings" to requesting team.
84	BC.3.	Written admission and discharge criteria to burn unit.
85	BC.6.	The medical staffing plan for Burn Unit is based on patient volume and patient acuity.
86	BC.11.	There is 24-hour coverage by a physician.
87	BC.12.	Written policies and procedures to guide care in the Burn Unit.
88	BC.13.	Written protocols on management and treatment of - Inhalation injury. - Varying degrees of burns. - Infection.
89	BC.18.	Written policies on the use of skin graft and synthetic graft.
90	MRO.4.	The Radiation oncology unit is staffed with the following appropriate personnel: - Medical Physicist. - Dosimeters. - Radiation therapist. - Mould room technician. - Radiation officer.
91	MRO.5.	The Radiation Oncology unit has a written safety plan which includes: - Periodic inspection, maintenance and calibration of the linear accelerator and other radiation equipment. - Guidelines on how to inspect and monitor the medical equipment. - Management of nuclear material used for therapeutic and diagnostic purposes, especially in regard to its handling, storing, and transportation. - Monitoring of the treatment with I131 for radiation exposure in the vicinity.
92	MRO.8.	There is written criteria for patient admission to, and discharge from an oncology unit prepared jointly by the medical and nursing staff.
93	MRO.10.	A multidisciplinary committee, including the nurse manager for the unit and nursing educator, oversees and guides the ongoing administrative and clinical functions of the area. - The committee meets at least four times a year. - The committee assists in developing, reviewing, and revising policies and procedures for the provision of patient care. - The committee ensures enforcement of these policies. - The committee chairperson or oncologist director of this committee signs off, in addition to nursing, on any policies and/or procedures that have any direct or indirect involvement of physician role.

Required Document – Medical		
SN	**Std No**	**Required Documents**
94	PS.3.	Written admission and discharge criteria. Written policy and procedures to address management and care of violent, depressed, suicidal, and psychotic patients
95	PS.4.	Policy and procedures to address management and care of violent, depressed, suicidal, and psychotic patients.
96	RS.1.	The hospital has a Respiratory Therapy unit, with 24-hour coverage.
97	RS.3.	Policy and procedures guide the work in the unit and includes but is not limited to: - Use of equipment. Pulmonary function test. - Coughing and breathing exercise. - Obtaining arterial blood gasses. - Mechanical ventilator support. - Dealing with open T.B. cases.
98	RS.5.	Availability of well structured education and training program for respiratory therapists.
99	RH.3.	Clearly written rehabilitation scope of service.
100	RH.10.	Space and equipment are recommended by head of department.
101	RH.14.	Policies and procedures cover: - Safety measures. - Infection control guidelines. - Communication with the physicians.
102	RH.15.	Policies and/or protocols exist for the management of: - Strokes. - Hip replacements. - Knee replacements. - Back pain.
103	AM.1.	Written Ambulatory Care scope of service.
104	AM.4.	Policies and procedures cover: - Verification of patient identification at each visit. - Infection control guidelines. - Use of any sedation.
105	AM.11.	Written hospital-wide conscious sedation policy.
106	DN.3.	There is a written scope of service for the Dental Unit.
107	DN.11.	Written policy on the use of conscious sedation.

Required Documents – Nursing		
SN	**Std No**	**Required Documents**
1	MS.28.	Nurses, physicians, pharmacists, respiratory technicians are trained on the process of calling a code.
2	MS.28.	Standardize the crash carts throughout the organization. Develop a protocol or policy and procedure on the location of contents, when contents are to be checked, what to do with expired contents, the number of contents depending on usage, process of locking the cart with identification band, who is to check, and log for signatures and defibrillator check strips.
3	NR.1.	One document that illustrates hierarchy of organization and nursing department. Names and titles on nursing organization chart.
4	NR.3.	Hospital mission, vision, values, and goals; nursing mission, vision, values, and goals (both should support each other).
5	NR.4.	A plan that outlines a mechanism for decision making (example SWOT analysis); goals and objectives identifying responsible departments or people (example, an education goal would be implemented and monitored by nursing education.
6	NR.7.	Overview of nursing department scope of service.
7	NR.8.	Standards of care for each unit; found in unit policy and procedure manuals.
8	NR.9.	Administrative policy and procedure; should be in collaboration with nursing department & signature; in leadership manual (admission policy and procedure).
9	NR.9.	In nursing policy and procedure manual.
10	NR.9.	Multidisciplinary policy and procedure in nursing manual; collaboration with medical & signature.
11	NR.9.	Include in hospital Patient and Family Education policy and procedure.
12	NR.9.	Administrative policy and procedure; collaboration with nursing department & signature.
13	NR.9.	Administrative policy and procedure; collaboration with nursing department & signature; in leadership manual (admission and discharge policy and procedure).
14	NR.10.	Sample of staff meeting minutes from last six months in one binder.
15	NR.10.	Sample nursing director and head nurses meeting minutes from last six months in one binder.
16	NR.11.	Quality plan reflects goals of QM hospital plan.

Required Documents – Nursing		
SN	**Std No**	**Required Documents**
17	NR.11.	Nursing department must demonstrate one indicator from this list that they are monitoring with data.
18	NR.12.	Evidence that the one indicator are implemented and monitored in analysis reports; evidence to demonstrate what improvements have been made using the data (example QI project / FOCUS PDCA).
19	NR.14. NR.15.	Include in nursing administration staffing plan policy and procedure.
20	NR.15. BC.7. CCU.8. ER.8. ICU.7. L&D.4. NICU.7.	Staffing plan for nursing department and unit specific staffing plans in one binder.
21	NR.15.	Unit schedule, personnel files, competency assessments.
22	NR.15. NR.18.	Included in staffing plan.
23	NR.19.	Scheduling policy and procedure in nursing manual; include all items listed.
24	NR.20.	In education policy and procedure; in nursing office and / or on units.
25	NR.21.	In education policy and procedure in education manual; on education calendar.
26	NR.27.	Samples of requisitions from year prior to survey (that is, if survey is conducted October 2008, requisitions from October 2007 to October 2008).
27	NR.32.	Collaborative par level policy and procedure with laundry, warehouse, pharmacy, etc. in nursing manual.
28	NR.32.	Documentation of checklists of compliance with par level policy and procedure; in unit manuals.
29	NR.42.	Nursing assessment policies and procedures for admission of adults, pediatrics, day surgery, haemodialysis, OPD, dental, ICU, ER or other areas of service in hospital.
30	NR.43.	Include reassessment policies and procedures in the nursing assessment policy and procedure.
31	NR.44.	Nursing collaborative policy and procedure on care plan using nursing diagnoses; form

Required Documents – Nursing		
SN	**Std No**	**Required Documents**
		used in documentation.
32	NR.54.	Multidisciplinary policy and procedure with nursing, medical, pharmacy, security, etc.; restraint check form used in documentation.
33	NR.55.	Written policy and procedure on newborn identification (preferably include in Multidisciplinary policy and procedure in L&D manual).
34	NR.64.	Education policy and procedure detailing education program; training based on needs assessment; competency based nursing program; master education calendar; sample of curriculum for activities; qualifications for teachers; unit specifics should go in the unit education manual.
35	NR.65.	Education policy and procedure outlining overview of competency program; probationary assessment, yearly assessment, individual unit competencies; sample of curriculum used for teaching; schedule of teaching on master education calendar; identify who assesses and qualification; unit competencies should go in the unit education manual.
36	PFE.1.	Identified in multidisciplinary policy and procedure in PFE manual; curriculum for teaching staff; documentation tool; scheduled lectures on policy.
37	LD.18.	Multidisciplinary education plan that involves all stakeholders in the patient education activities; (preferably found in the PFE manual)
38	LD.18.	Documented in the education plan; found on PFE form.
39	PFE.9.	Comprehensive written guidelines for health educators. (preferably combine in PFE policy and procedure).
40	ICU.4.	All policies and procedures related to ICU care in policy and procedure manual.
41	CCU.3.	All policies and procedures related to CCU care in policy and procedure manual.
42	NICU.3.	All policies and procedures related to NICU care in policy and procedure manual.
43	OR.4.	Infection control guidelines in Infection Control manual and OR manual.
44	OR.5.	OR patient acceptance criteria/checklist.(preferably found in OR policy and procedure manual).
45	OR.9.	Written policy and procedures for sponge and instrument count.(preferably found in OR policy and procedure manual).
46	L&D.10.	Written protocol of scope of practice for nurse midwives

Required Documents – Nursing		
SN	**Std No**	**Required Documents**
47	MRO.6.	Collaborative policies with medical and nursing and safety officer; all policies and procedures In Radiation Safety manual.
48	MRO.7.	Documentation of education curriculum; scheduled on master nursing continuing education calendar; attendance for last two classes.
49	PS.4.	Multidisciplinary policy and procedure with nursing, medical, pharmacy, security, etc.
50	PS.7.	Competency assessment documentation for nursing staff; documentation to show physicians, security, etc. are also trained on the procedures as outlined in the policy.
51	DT.5.	Dietary Manual of all policies and procedures in standard.

Required Documents - LAB

SN	Std No	Required Documents – LAB
1	**LB.2.**	Basic lab and emergency lab services available 24 hr/day, general lab policy. (e.g. scope of services policy, staff working schedules, List of Services/booklet, etc.)
2	**LB.3.**	Lab service guide for departments.
3	**LB.4.**	Organization Structure Chart
4	**LB.5.**	Orientation Program(Policy)
5	**LB.7.**	Job descriptions for all Lab staff.
6	**LB.6.**	Annual competency assessment program. (Policy & Records).
7	**MS.82.**	Transfusion Reaction policy and report any transfusion transmitted disease.
8	**LB.8.**	Quality control procedure and results for pipets check.
9	**LB.9.**	Quality control procedure and results for thermometer check. Certificate of Thermometric Standard Device.
10	**LB.10.**	Temperature check for all temperature dependent equipment. (Policy & Records).
11	**LB.11.**	Corrective actions taken for fridge temperature changes, Corrective action policy/procedure when temperature exceeds targets for temperature dependent equipment.
12	**LB.12.**	Quality control procedure and results (Records) for balance check and maintenance.
13	**LB.13.**	Quality control procedure and results for centrifuges check and maintenance. Quality control procedure and results for all instrument checks and maintenance (sample).
14	**LB.14.**	Unscheduled maintenance system IPP.

SN	Std No	Required Documents – LAB
15	**LB.16.**	Result reporting system, handling out of range results, approved normal values.
16	**LB.17.**	Records of Monitoring -the turnaround time for routine and STAT tests.
18	**LB.18.**	Lab specimen collection manual.
19	**LB.19.**	Periodic monitoring system and record for specimen identification and labeling.
20	**LB.20.**	Guidelines on specimen collection, transportation and sample preparation. Evidence of distribution to Physician and Paramedical personnel.
21	**LB.21.**	Documentation of selection process of selected outsource lab and list of tests to be outsourced, general lab policy.
22	**ER.13.**.	Log sheet STAT lab results within 30 minutes for critical cases.
23	**LB.22.**	Procedure manuals e.g. sectional policies
24	**LB.23.**	Policy and sample record for Panic value reporting.
25	**LB.24.**	Blood and blood products IPP.
26	**LB.25.**	Policies donor selection, donor consent, aseptic collection method: how to collect, handle and store blood products.
27	**LB.26.**	Policies and procedures care of donor: treating donor adverse reactions, necessary equipment and supplies for immediate assistance, donor selection criteria.
28	**LB.27**.	IPP and Sample of records sheet for blood type, RH, cross match, antibody screening and AB identification. Records for reagent (ABO, Rh, Antibody screen, etc.) Quality Control.
29	**LB.28.**	Sample tracing record for blood unit.
30	**NR.53.**	Issuing and administration of Blood and Blood Products multidisciplinary-policy and procedure.
31	**LB.29.**	Policy for blood ordering, handling of storage and positive identification (units

SN	Std No	Required Documents – LAB
		numbering system).
32	**LB.31.**	Policy adverse transfusion reaction , Adverse transfusion reactions records, Blood Utilization committee minutes
33	**LB.32.**	Policy Blood Utilization and wastage reporting.
34	**LB.35.**	Histopathology and Cytopathology policies/procedures.
35	**LB.36.**	Policy including list of exempted pathology specimens
36	**MS.51**.	Pathology IPP manual, Tissue Review committee minutes,
37	**LB.37.**	Document (Policy and sample record) of review current cytological/histological material with the pertinent previous one.
38	**LB.38.**	Document (Policy and sample record) of reconciled disparities between frozen section, cytology or gross evaluation and final pathology diagnosis.
39	**LB.39.**	Policy that Pathologist examines gross specimen and retention of specimen.
40	**LB.40**.	Documents (Policy and sample record) daily supervision all stages specimen processing and quality monitoring.
41	**MS.67.**	Laboratory values log book (refer to LB.23).
42	**LB.41.**	IPP reporting system.
43	**LB.42.**	Monitored TAT for frozen section and routine specimen (Histology and cytology specimen).
44	**LB.43.**	Document for inclusion of submitted case with the original pathology report for all intradepartmental and extra-departmental consultations.
45	**LB.44.**	Pathology records and materials retention policy.
46	**LB.45.**	Documents and monitoring for unsatisfactory gynecologic specimen and other gynecologic cytopathology results.
47	**LB.46**	Safety officer job description and terms of reference for safety committee.
48	**LB.47**. **LB.46**	Documents for safety officer ensuring lab compliance with FMS standards.

SN	Std No	Required Documents – LAB
49	LB.48	Lab Safety manual
50	LB.49.	Documents of training on how to use fire extinguishers, checking fire alarms, fire extinguishers.
51	LB.50.	Documents of annual electrical checks.
52	LB.57.	Documents of Monitoring fomaldehyde and xylene vapor concentrations.
53	LB.62.	Plan to reduce or eliminate usage of mercury.
54	LB.63.	Monitoring the condition and fit of the HEPA filters for air velocity and smoke patterns.
55	LB.64.	Monitoring fume hood for air velocity and fume patterns.
56	LB.65.	Lab quality management program.
57	LB.67. MS.56.	Lab quality indicator development and evaluation , especially The laboratory monitors the Turn Around Time (TAT).
58	LB.68.	Lab incident and accident reports.
59	LB.69.	System for proficiency testing with external quality assessment program and problem identification and correction.
60	LB.71.	Documents showing cooperation with IC department.
61	LB.72.	Education/training on handling of infectious specimen, disinfection of work area, disposal of infectious material, and clean up of leak or spill.
62	LB.76.	Sample records employee vaccination Hep B.
63	LB.77.	Policy for safe handling of reagents.
64	LB.80.	Policy and documents of implementation for dealing with TB specimens
65	LB.81.	Point of care testing policy and list of point of care testing areas at the hospital. Point of care quality control program and documented evaluation.

SN	Std No	Required Documents – LAB
66	**LB.82.**	POCT detection system for clerical and analytical error and correction. POCT user orientation, training and competency testing.
67	**MS.47.**	Blood utilization committee formation order and meeting minutes.
68	**MS.48**.	Documents that Blood utilization committee approves and monitors policies. Multi-task policies (i.e. Blood Transfusion policies those signed by lab and other departments like nursing).
69	**MS.49.**	Documents that Blood utilization committee approves and monitors policies. Multi-task policies (i.e. Blood Transfusion policies those signed by lab and other departments like nursing).
70	**MS.50.**	Tissue review committee formation order and meeting minutes.
71	**QM.26.**	Lab quality control data, concerned committee minutes.

Required Documents - Facility Management and Safety		
SN	**Std No**	**Required Documents**
1	FMS.1.	The seven FMS Programs/ Plans Safety of the Building Security Hazardous materials and waste disposals Emergencies Fire Safety Medical Equipment Utility Systems
2	LD.29.	Hospital wide safety plan Safety committee (i.e. communications, minuets, reports, action plan).
3	FMS.2.	records availability of budget and invoice
4	FMS.4. LD.30.	No Smoking policy.
5	FMS.5.	Safety Committee Terms Of Reference and Supportive records for the functions of the committee e.g. data analysis incidents/OVR committee recommendations
6	FMS.6.	Quarterly environmental rounds reports
7	FMS.6.	Quarterly facility tours records
8	FMS.7.	Supportive records of Safety Officer communications in writing with all Department Heads/safety representatives
9	FMS.7.	Supportive records of Assignment of departmental Safety Liaison Officers/representative
10	FMS.9.	Civil Defense Gulf Countries Council (GCC) guidelines for the General Safety in the building
11	FMS.20.	Completed OVR form regarding safety of the building, hazardous materials and waste disposals, medical equipment, utility system, and security
12	LD.31.	Approved hospital-wide disaster plan
13	LD.32.	Improvement actions in disaster readiness based on evaluation of disaster drills The taken be leaders
14	LD.32.	Supportive records of Leadership supports the implementation of the disaster plan
15	LD.33.	Communication systems for contacting essential personnel in emergencies"
16	FMS.38.	Comprehensive external disasters emergencies (Code Yellow) plan.
17	FMS.39.	Supportive records of evaluation of External plan drill
18	FMS.39.	Annual external plan drill reports
19	FMS.40.	Annual staff orientation to emergency preparedness.
20	FMS.41.	Comprehensive Internal Emergency plan
21	FMS.42.	Comprehensive evacuation procedure.
22	FMS.44.	Scheduling of annual fire drills
23	FMS.44.	reports and evaluation of Conducted fire drill
24	FMS.45.	Comprehensive fire drill evaluation of all staff on each shift
25	FMS.46.	Staff attendance in fire drill.
26	FMS.47.	All fire drill results and corrective actions
27	HM.9.	Infection Control Manual-HM Policy
28	QM.20.	Fire drill evaluation form.
29	FMS.48.	Annual documentation and evaluation of full fire drill
30	FMS.49.	Inspection Reports for Fire extinguishers, Fire alarm system, Fire Suppression System and Emergency lights
31	FMS.58.	Scheduled staff training program
32	NR.39. FMS.23.	Policies on preventing abduction of children, and neonates/security policy.
33	FMS.24.	How to contact the local police policy.
34	FMS.25.	Security policy on police reportable case
35	FMS.26.	Bomb threat (Code White) policy
36	FMS.27.	security roles in : internal disaster plan, no smoking policy, and external disaster plan
37	FMS.29.	Security rounds reports for each shift
38	FMS.30.	Completed OVR form regarding Security incidents with corrective actions.

Required Documents - Facility Management and Safety		
SN	**Std No**	**Required Documents**
39	FMS.59.	Medical Equipment plan.
40	FMS.59.	Medical Equipment inventory
41	FMS.60.	Policy and procedure of new equipment inspection
42	FMS.60.	Effective PPM plan for medical equipment in use.
43	FMS.62.	Comprehensive policy on proper tagging of medical equipment.
44	FMS.63.	Policy on removal of equipment from service.
45	FMS.64.	Training attendance sheet for staff on medical equipment.
46	FMS.65.	Corrective actions are taken for medical equipment OVRs report.
47	FMS.66.	Equipment upgrading/replacement according to PM data.
48	FMS.67.	Comprehensive Policy and procedure of on equipment repair
49	HM.12.	Supportive record of periodic preventive maintenance of all equipment and instruments
50	FMS.18.	Laser safety policies and procedures
51	FMS.34.	Reporting radioactive leak, spill or exposure to any hazmat
52	FMS.36.	Availability of King Abdulaziz City for Science and Technology License for radioactive material
53	FMS.31.	HazMat management plan
54	FMS.31.	current Departmental/sectional HazMat list
55	FMS.32.	Departmental/sectional Material Safety Data Sheet (MSDS)
56	FMS.32.	Availability of a list of all HazMat chemical used in the hospital.
57	FMS.35.	Staff training record in the use of protective equipment
58	FMS.37.	Waste Management plan
59	FMS.50.	Maintenance record of fire alarm system. This can to be done in the unit visit biomedical or in the unit Just like all other systems records, it should review in the Docs review session.
60	FMS.51.	Reports of Fire Suppression System inspection.
61	FMS.55.	Reports of Emergency lights check. This can to be done in the unit visit biomedical or in the unit Just like all other systems records, it should review in the Docs review session.
62	FMS.68.	PPM of electrical system, generator(s), low current/communication system, elevators. Refrigerators, freezers, air conditioning system. Medical gas and medical suction, domestic water system, fire water system. Boilers and plumbing system and hospital building, pavement and ground
63	FMS.69.	Supportive records of Adequate administrative support for equipment procurement and upgrading.
64	FMS.69.	Supportive records adequate administrative support for building renovation
65	FMS.70.	Comprehensive plan for handling failure of utility, equipment, alarm system, and essential services.
66	FMS.71.	Supportive records Annual testing and evaluation of the emergency plan.
67	FMS.72.	Supportive records of updated electrical system maintenance
68	FMS.74.	Supportive records of Annual inspection of circuit breakers for critical care areas (Operating room, ICU).
69	FMS.74.	Supportive records of Annual inspection of circuit breakers for alarm system and medical gas system.
70	FMS.75.	Supportive records of updated generator maintenance (PPM).
71	FMS.76.	Supportive records of Monthly emergency power testing results on station load for thirty minutes.
72	FMS.76.	Supportive records of that All essential hospital areas are covered by the emergency power testing shall we keep this here or in unit visit Should be in Docs review (Single line

Required Documents - Facility Management and Safety		
SN	**Std No**	**Required Documents**
		diagram)
73	FMS.74.	Circuit breakers for the laboratory and blood storage equipments annual inspection documents.
74	FMS.77.	Supportive records of Weekly emergency power generator testing without load for ten minutes shall we keep this here or in unit visit/ observation As any other system, it should be in doc review.
75	FMS.78.	Supportive records of Annual emergency power generator testing on load bank for 4 hours at 100% load, results are documented.
76	FMS.79.	Records of updated medical gas system maintenance
77	FMS.80.	Supportive records of Periodic testing of medical gas for pressure, leaks, functions, emergency shut off, and labeling
78	FMS.81.	Comprehensive policy for storage, safe handling and delivery of all types of available compressed.
79	FMS.83.	Records of updated HVAC system maintenance.
80	FMS.84.	Supportive records of Periodic testing and controlling air flow and pressure in all critical areas
81	FMS.85.	Supportive records of Regular Control of temperature and humidity in all critical areas.
82	FMS.86.	Water tanker provider contract.
83	FMS.87.	Supportive records of professional code for sewage handling. Shall we keep this here or in unit visit/ observation As any other system, it should be in doc review.
84	FMS.87.	Supportive records of Proper handling and disposal of sewage (Sewage disposal contract). shall we keep this here or in unit visit/ observation Contract copy ----> Docs review
85	FMS.88.	Supportive records of comprehensive utility drawings for utility line control during emergency
86	FMS.88.	Supportive records of Performance evaluation of the utility system and improvement plan.
87	FMS.89.	Supportive records of Regular inspection of all kitchen equipments.
88	FMS.89.	Supportive records of Regular temperature monitoring of the cold room
89	FMS.90.	Supportive records of updated laundry equipment maintenance records.
90	FMS.24.	Lost and Found policy.
91	FMS.24.	Safe keeping of patient belongings policy.

Required Documents – Pharmacy		
SN	**Std No**	**Required Documents**
1	PH.2.	Pharmacy scope of service (mission, vision, values) Pharmacy Organization chart with names Pharmacy work schedule
2	PH.5.	Pharmacy and therapeutics committee file (frame of reference, attendance, minutes).
3	PH.5.	Quality management committee meeting minutes and attendance sheets.
4	PH.5.	Infection control committee meeting minutes and attendance sheets.
5	PH.5.	Safety committee meeting minutes and attendance sheets.
6	MS.43. MS.44.	Pharmacy and Therapeutics Committee Frame of reference.
7	PH.6.	Current Pharmacy manual.
8	PH.7.	Pharmacy workload statistics report for the past 6 month.
9	PH.9. PH.10. PH.11.	Hospital drug formulary book (or access to electronic version)
10	QM.17. MR.24. MR.25. NR.38.	- List of abbreviations, acronyms, and symbols to be permitted and list of those NOT to be used.
11	NR.51. MR.13. NR.52. PH.13. PH.14.	Multidisciplinary policy and procedure on telephone and verbal orders.
12	PH.15.	Prescriber's signature list.
13	PH.16.	Prescribing privileges.
14	PH.17.	Drug recall policy and actual recall records
15	PH.18.	Policy for handling Expired/nearly expired drugs
16	PH.19.	Multidisciplinary policy for handling pharmaceutical sales representatives and free medical samples
17	PH.20.	Multidisciplinary policy on handling non-formulary drug requests. Non-formulary drug requests for the past 6 months
18	PH.21.	Multidisciplinary policy on the use of formulary drugs for un-approved indications. Un-approved indication drug requests for the past 6 months
19	PH.22.	Policy on handling out-of-stock medications.
20	PH.22.	Policy on handling PRN medication orders.
21	PH.23.	Policy on handling patient's own medication
22	PH.24. NR.50.	Multidisciplinary policy and procedure on standardization of crash cart medications, restocking, checking and documentation.
23	AN.28.	Approved list of conscious sedation medications with route, dosage for different age groups.
24	PH.27.	High-risk medication guidelines
25	PH.28.	Policy and procedures on handling outpatient prescriptions
26	PH.31.	Policy on pharmacy staff orientation and continuing education. Documents of staff orientation and continuing education for the past 6 months.
27	PH.32.	Policy on drug storage across the hospital
28	PH.33. PH.34.	Policy on handling inpatient medication orders.

Required Documents – Pharmacy		
SN	**Std No**	**Required Documents**
29	PH.36. PH.37.	Policy on handling drug allergy and ADR reporting.
30	PH.37.	Adverse drug reaction original reports for the past 6 months.
31	PH.38.	Policy on medication error reporting
32	PH.38.	Medication error original reports with root-cause analysis.
33	PH.39.	Policy on monitoring prescribed drugs.
34	NR.46.	Policy and procedures on medication administration (multidisciplinary)
35	PH.40.	Policy on automatic stop of order (ASO)
36	PH.44.	Policy and procedures on extemporaneous preparations
37	PH.45. NR.49.	Policy and procedures on narcotics and controlled substances management
38	PH.49.	Policy and procedures and manual on Intravenous admixture
39	PH.52.	Record of pharmacy monitoring nursing performance on IV admixture.
40	PH.54.	Policy and procedures on handling Chemotherapy orders.
41	MRO.6.	Nursing policy & procedure on chemotherapy administration.
42	PH.57.	Policy and procedures on handling TPN orders
43	PH.58.	Policy and procedures on Drug Information Services
44	PH.61.	Policy on emergency opening of pharmacy after hours.
45	PH.62.	Policy on safe handling of dangerous/hazardous substances. List of dangerous and hazardous substances and MSDS.

Required Documents – Infection Control		
SN	**Std No**	**Required Documents**
1	IC.1.	Hospital Organizational Chart
2	IC.1.	Infection Control Manual - Statement of Authority
3	IC.2.	Infection Control Manual- Scientific References
4	IC.8.	Infection Control Manual
5	IC.25.	Infection Control Manual- Pest Control policy
6	IC.27.	Infection Control Manual- morgue policy
7	IC.37.	- Infection Control Manual- Construction renovation policy - Evidence of Infection control team reviews & supervises construction projects - Evidence of the infection control team review of Routine fungal cultures at the end of construction work
8	IC.38.	Infection Control Manual & last 3 Infection Control Committee meeting minutes.
9	IC.38.	Infection Control Manual - Policies for Care of indwelling urinary catheters, Care of peripheral & central venous catheters and Respiratory care
10	IC.45.	Infection Control Manual - Employees' health immunization, and post exposure prophylaxis
11	IC.45.	Infection Control Manual &/or Staff Health Policy and Procedures
12	IC.47.	- Policies on identification of exposures to TB, Varicella & sharp injuries. - Policies on post exposure management. - OVRs for needle-prick & sharps injuries exposure and follow-up - Summary Lists of PPD conversion rates and sharp injury conversion rates - Evidence of monitoring the staff exposure to any infectious agent (i.e. TB or others) and the action taken.
13	IC.7.	Infection Control Manual, Departmental Scope of Service, Policy Statement
14	IC.7.	Infection Control Department Personnel Job descriptions
15	IC.16.	Infection Control Manual-standard precautions
16	IC.39.	Infection Control Manual- PPE
17	IC.14.	Infection Control Manual- Sharps disposal
18	IC.26.	Infection Control Manual- Waste Management
19	OR.11.	Infection Control Manual - OR Policy
20	BC.14.	Infection Control Manual- Burn Unit Policy
21	IC.35. HM.7.	Infection Control Manual- HM Policy
22	DN.10.	Infection Control Manual- DN Policy
23	IC.31.	Infection Control Manual- Laundry Policy/Guidelines
24	IC.19.	Infection Control Manual/ CSSD IPPs
25	IC.24.	Infection Control Manual/ Housekeeping IPPs & List of chemicals used
26	IC.24.	Infection Control Manual/ Housekeeping IPPs
27	IC.30.	Infection Control Manual/ Kitchen Manual
28	PH.12.	Infection Control Manual/ Pharmacy IPPs
29	IC.11.	Infection Control Manual, last 3 Infection Control Committee meeting minutes &/or documentation of distributed reports of infection rates.
30	IC.11.	Infection Control Manual & completed surveillance data collection sheets
31	NR.9.	Updated General Infection Control policies
32	IC.5.	Evidence of Administration support to Infection Control program, (action taken based on requirements)
33	IC.18.	Documented approval of Infection Control Department for purchasing sterilization

Required Documents – Infection Control		
SN	**Std No**	**Required Documents**
		equipment and related supplies.
34	IC.44.	Infection Control Manual- MOH Notification
35	HM.10.	Monthly microbiologic testing of haemodialysis water available on the unit.
36	IC.46.	Infection Control Manual and/or Staff Health IPPs
37	IC.46.	Infection Control Manual and/or Staff Health IPPs.
38	IC.46.	OVRs for needle-prick and sharps injuries exposure and follow-
39	NR.68.	Documentation of actions taken
40	IC.12. IC.13.	Infection Control Manual and last 3 Infection Control Committee meeting minutes
41	IC.6. LD.21.	Minutes of the Last 3 Infection Control Committee Meetings
42	IC.6.	Infection Control Committee Terms of Reference, Membership List, Agenda & Minutes of the last 3 Committee Meetings
43	MS.30.	Documents for supporting the Infection Control Director: approving required resources, enforcing recommendations, communication with MOH for infectious diseases.
44	MS.9.	Policy for care of vulnerable patients (immunocompromised, comatose, elderly, and care of terminally ill).
45	LD.22.	Last 3 Infection Control /Safety Committee Meeting minutes (indicating such incidents)

Interview Activities

During the CBAHI survey the following interview sessions are held:

1. Leadership interview
2. Staff interview
3. Pharmacy and Therapeutics interview
4. Infection Control interview
5. Safety Committee interview
6. Laboratory leadership interview

The hospital has the flexibility to assign a representative in any session if there is any dual responsibility for any of the requested attendees. Priority should be for the most relevant assignment e.g.: The Infection Control Practitioner is the same person who represents the Infection Control department in the Safety Committee. The Infection Control Practitioner should be present at the Infection Control coinciding session.

The following lists the personnel expected to be present at the interview activities.

Survey Activity	Participants		Requirements
	CBAHI Surveyors	Hospital staff	
Leadership	**Administrator** **Physician** **Nurse**	1. Hospital Director 2. Administrator Director 3. Medical Director 4. Nursing Director 5. Clinical support directors 6. Human Resource Director 7. Management of Information Director. 8. Medical Records Director 9. Patient Affair Director 10. Quality Management Director 11. 2 to 3 Heads of Medical Departments	**(1) Room** **(1) Long Table** **08 Chairs** **03 Extra Chairs**
Staff	**Physician** **Nurse**	1. Physicians (3) from different departments: 1 Resident 1 Specialist 1 Consultant	**(1) Room** **(1) Table** **12 Chairs** **03 Extra Chairs**

		2. Dentist (1) 3. Staff Nurses (2) 4. Dietitian (1) 5. Social Worker (1) 6. Education and training staff (1) 7. Patient Relations (1) 8. Nurse Aide (1) 9. Medical Records Staff (1) 10. Ward Clerk (1) 11. Housekeeper (1)	
Pharmacy	**Pharmacy**	1. Pharmacy Director 2. Pharmacy Quality Coordinator 3. P & T Committee members 4. Other staff as needed	**Same room to be utilized & requirements as Document Review Session (extra chairs to be added)**
Infection Control	**Infection Control**	1. Infection Control Chairman 2. Infection Control practitioner 3. Selected members 4. Staff Health 5. Other staff as needed	**Same room to be utilized & requirements as Document Review Session (extra chairs to be added)**
Laboratory	**Laboratory**	1. Laboratory Director 2. Laboratory Safety Officer 3. Laboratory Quality Coordinator 4. other staff as needed	**Same room to be utilized & requirements as Document Review Session (extra chairs to be added)**
FMS	**FMS**	**1. Safety Committee Chairman** **2. Utility Manager** **3. Safety Officer** **4. Biomedical In-charge** **5. Security Manager** **6. Hazardous Material In-charge**	**Same room to be utilized & requirements as Document Review Session (extra chairs to be added)**

Medical Records Review

Hospital medical records reflect the implementation of the care process and medical services interventions. Medical records will be evaluated based on the standards listed in the following forms:

1. Closed medical record review (Medical)
2. Closed medical record review (Administrator)
3. Closed medical record review (Nursing)
4. Closed medical record review (Infection Control)
5. Closed medical record review (Laboratory)
6. Open medical record review (Medical)
7. Open medical record review (Administrator)
8. Open medical record review (Nursing)
9. Open medical record review (Pharmacy)

Medical Records Review General Guidelines

Hospitals are requested to have the list of the last month discharge patients ready by the Surveyors Planning Session on day 1.

- Required medical record list will be requested after the Opening Conference based on the month discharged cases.
- Hospitals to clarify their documentation guidelines prior to the medical records review session to smooth the process.

SURVEY REQUIRMENTS (MEDICAL RECORDS REVIEW ACTIVITY)

Survey Activity	Participants		Location & Room Requirements
	CBAHI Surveyors	**Hospital Staff**	
Medical Record (Closed)	Administrator Physician Nurse	1. Quality Management Staff 2. Medical record counterpart 3. Physician 4. Nurse	**Same room to be utilized & requirements as Document Review Session**
	Infection Control	Infection Control Practitioner	**Same room to be utilized & requirements as Document Review Session**
	Laboratory	Lab QI Digenesis	**Same room to be utilized & requirements as Document Review Session**
Medical Record (Open)	Physician Nurse	1. Physician 2. Nurse	**During unit visit**
	Pharmacy	**Pharmacy QI Designee**	**During unit visit**

Review of Medical Records ADMINISTRATOR – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____

Requirements	Medical Records													Average
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	
MS.58. The physicians use the assigned hospital code number and preferably a stamp that is used to identify him/her for medication prescriptions and in all entries in the patients file.														
MS.61. Physician order sheet and only physicians write orders on it.														
MS.84. There is transfer communication between the transfer and receiving hospital.														
QM.16. The process of verification, marking and time out is documented in the medical records in a checklist or other form.														
PFR.10. The informed consent is signed by the patient or his/her designee as defined by hospital policy and witnessed before any procedures using a legible written name.														
PFR.15. Patients and/or their designees involved in making decisions are documented in the medical records (signed consent forms).														

Review of Medical Records ADMINISTRATOR – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____

Requirements	Medical Records													Average
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	
PFR.19. Documentation of pain assessment and management in the medical records (documentation of assessment of pain on admission, reassessments of pain, pain relief, response of patient to pain management and appropriate interventions Patient education on how to minimize pain, Documentation of patient education for management of chronic pain, referrals to pain clinic).														
PFR.23. Implementation of informed consent process for patients involved in research (patients consent form is designed).														
SC.4. Patient's psycho-social needs are determined in collaboration with physicians and nurses.														
SC.5. The social needs assessment is considered for the plan of care.														
SC.6. There is appropriate patient education on available assistance from agencies.														
SC.7. The social workers assess and help the financial needs of the patient.														

Review of Medical Records ADMINISTRATOR – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____

Requirements	Medical Records													Average
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	
SC.8. The social workers assess patient's home situation and non-compliance to treatment (via patient interview or home visit).														
SC.9. The social workers assess the patient's emotional and psychological factors affecting the self care plan.														
SC.10. The social worker assists in the discharge planning process.														
SC.11. Social worker facilitates the continuity of care.														
SC.12. The social worker evaluates patients' disabilities and helps reduce its impact.														
SC.13. There is complete documentation of social worker services activities in the patient's medical record.														
AM.9. Availability of signed consent for any outpatient procedure.														

Review of Medical Records ADMINISTRATOR – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____

Requirements	Medical Records													Average
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	
MR.3. Completed face sheet in the medical record.														
MR.3.There is a complete and unified medical record contents (complete demographics, history and physical examination, details of the present illness, past, social, and family histories, clinical review by body systems, psycho/social needs, diagnostic and therapeutic orders, informed consent, reports of procedures, tests, and their results, assessment, clinical progress, diagnosis, impression, and plan of care revisions, discharge summary).														
MR.4. All entries are dated, and timed and identity of staff making the entry can be verified by name or ID number.														
MR.5. Availability of standardized diagnosis and procedure codes (ICD9 or ICD10, CPT, or DRG), and standardized symbols and its definitions.														
MR.9. Separation of medical chart contents for each hospitalization episodes.														
MR.10. The Medical Record is complete: containing history, physical, all physician orders, progress notes, typewritten Histopathology														

Review of Medical Records ADMINISTRATOR – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____

Requirements	Medical Records													Average
	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	
report, and typewritten Radiology report, discharge summary, physicians and nurse's progress notes, all physician orders are signed (sampled medical records).														
MR.11. There is completion of medical records within 30 days of patient discharge.														
MR.19. There is a typewritten discharge summary (in all examined medical record sample).														
MR.21. There is documentation on the face sheet of all essential patient information, allergies and code status.														
MR.22. All medical record entries are clear and legible (medical record sample review).														

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
1.	MS.63. There is a complete medical assessment for patients according to their severity index (assessment on admission, attending physician sees patients within 24 hours for routine and 4 hours for urgent cases including social and psychological needs).												
2.	MS.65. The pain intensity, frequency, location, and the type of pain experienced by the patient (e.g. sharp/dull) is assessed, managed and documented in the medical record.												
3.	MS.66. The patients are seen by their consultant at least daily for routine and any time while significant change or deterioration happens.												
5.	MS.68. Comprehensive plan of care is documented in the patient record.												
6.	MS.68. Documented plan of care includes all patient education provided to the patient on his/her plan of care and the anticipated outcomes, including the benefits and associated risks (e.g. for proposed surgery, procedures, treatment, etc).												
7.	MS.72. The consultations requests clearly state the question of the consultation or define the services requested, from the consultant, and are handled in a timely and appropriate manner.												
8.	MS.73. The consultants respond within 24 hours for routine cases and 30 minutes for emergency cases after receiving proper.												

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
9.	MS.74. All procedures performed on patients (on the ward, in the X-ray department, or in the operating room) have a complete description entered in the medical record and includes the patient outcome.												
10.	MS.82. There is Patient education regarding benefits and risk of transfusion.												
11.	MS.91. There is patient and family education prior to discharge.(patient illness, self care and support, medication use, equipment, emergency all, referral, transfer).												
12.	AM.7. Patient education by the attending physician (including nature of illness, diagnosis, treatment plan, and medications) in the patient own language.												
13.	AM.8. Patient education on expected length of stay, any surgery to be done, benefits and complications of the treatment plan (including surgery) and cost attached.												
14.	AM.9. Patient education on outpatient procedures.												
15.	AM.9. Follow up appointment after outpatient procedures.												
16.	AM.5. A comprehensive history and physical examination by the attending physician on the first visit.												

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
17.	AM.6. Documentation in the medical record of history, physical examination, diagnosis, and problem list.												
18.	AM.10. Documentation of anesthesia administered (type, dose, and appropriateness).												
19.	AM.11. Compliance with the hospital-wide conscious sedation policy.												
20.	ER.22. Reading all ECGs ordered by Cardiologist (or internist) within 24 hours.												
21.	MS.67. There are reporting X-ray results on time (X-ray logbook).												
22.	RD.5. There is reporting of all radiologic studies within 24 hours by the radiologist.												
23.	RD.8. The radiologist reads and reports all ultrasound studies.												
24.	RD.13. There is medical record documentation of the detailed pre and post interventional procedure by the radiologist.												
25.	RD.13. There is medical record documentation that the patient informed about the potential benefits and risks of the procedure.												
26.	MS.92. There is continuity of care after discharge.												

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
27.	MS.93. There is a comprehensive discharge summary report provided to the patient (reason for admission, diagnosis, hospitalization summary, and medication list, outcome of surgeries, discharge condition, discharge medications, special care, & copy of discharge summary).												
28.	MS.83. There is adequate pain relief after surgery through pain assessment and adjusting pain medications according to patient response.												
29.	AN.18. Qualified Anesthetists discharge patients from the Recovery room-RR form.												
30.	AN.30. Conscious sedation is only used for patients having short diagnostic or therapeutic procedures.												
31.	AN.32. Physician history and physical examination within the first 4 hours of admission												
32.	AN.33. Physicians perform and document a physical exam for vital signs, age and weight and ECG findings.												
33.	ICU.15. Clear documentation of the patients status, plan of care, medications, and special care requirements at the discharged from the ICU.												
34.	CCU.13. The receiving team on the floor is informed about the patients status at discharge from the CCU by the ICU physician.												

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
35.	CCU.13. Documentation of plan of care, medications and special instructions on patient discharged from the CCU.												
36.	L&D.15. A partogram is used for every patient who is in labor.												
37.	MS.76.EC1 Medical record documentation of patient transfer information from one service to another (includes: reason for admission, diagnosis, hospitalization summary, medication list, transfer condition, transfer reason).												
38.	MS.85. There is a comprehensive assessment of patient needs during transfer.												
39.	MS.86. There is a completed hospital transfer form documenting the following; reason for the patients admission, diagnosis, summary of hospitalization, medication list, condition at the time of transfer, reason for transfer, and copy of the patients Laboratory investigation and X-rays are sent with the patient to avoid further delay in treatment.												
40.	MS.88. There is continuous monitoring of patient during transfer by a qualified physician.												
41.	MS.90. There is communication between hospital staff and the attending physician for proper patients discharge process.												

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
42.	ER.10. Implementation (full documentation) of emergency assessment sheet/form with time of arrival, means of arrival, vital signs, history of illness, allergies, physical assessment and reassessments, suspected diagnosis, investigations, treatments, time of consultation and arrival of consultation service, time of admission to a unit and/or discharge from ER and patient condition at time of discharge or transfer to unit other facility.												
43.	BC.5. Social service support to burn unit (sample medical records).												
44.	BC.5. Rehabilitation services support the burn unit (sample medical records).												
45.	PS.10. Medical Record documentation of plan of patient care.												
46.	RS.6. Written physician order for respiratory therapy (including dose, frequency and route).												
47.	RS.6. There is monitoring of patient's clinical response to treatment.												
48.	RH.6. There is rehabilitation treatment based on referral order.												
49.	RH.7. There is a documented assessment of all referred cases.												
50.	RH.8. There is a clear documentation of treatment plan and measurable goals.												

Review of Medical Records PHYSICIAN – CLOSED RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
50.	RH.9. There is clear documentation of referral reason, initial assessment, treatment plans, achieved goals, response to treatment.												
51.	RH.11. The medical records contain evidence of interdisciplinary planning to meet the patient needs.												
52.	RH.12. There is documentation of patient's response to therapy.												
59.	DN.7. Patient education (on the nature of the problem, treatment and procedure, time needed and cost).												
60.	DN.8. Comprehensive Patient Dental record which includes detailed medical history and management plan, allergy history, chronic illnesses/ blood disorders, chief complaints, treatment plan, x-rays needed, anesthesia dose, tooth treated and material used.												
61.	DN.12. Implementation of hospital policy and procedures for general anesthesia for dental procedures requiring general anesthesia.												

Review of Medical Records NURSE – CLOSED RECORD

Medical Records Numbers

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ Date: _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
	MEDICAL STAFF AND PROVISION OF CARE (MS)												
1.	**MS.64.** **There is a documented complete nutritional screening for patients**												
	NURSING (NR)												
2.	**NR.41.** **Implementation of nursing documentation.**												
3.	**NR.42.** **Comprehensive written nursing assessment.**												
4.	**NR.54.** **There is compliance with patient restraint policy.**												
5.	**NR.56.** **Implementation of new born verification process at discharge (bracelet matching, mother education on baby care).**												
6.	**NR.57.** **Implementation of patient transfer policy within the facility.**												
7.	**NR.58.** **There is patient and family education (at discharge and referral).**												
8.	**NR.60.** **Availability of written criteria for assessment and reassessment of pain intensity, pain character, frequency, location and duration also, patient education.**												

Review of Medical Records NURSE – CLOSED RECORD

Medical Records Numbers

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ Date: _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
9.	NR.60. Documentation of pain management.												
	FAMILY EDUCATION (PFE)												
10.	PFE.2. The medical and nursing staff is knowledgeable on patient/family education (i.e. meeting minutes that address PFE, educational plan for each patient in Medical Record).												
11.	PFE.4. Patient/family education is documented in the medical record.												
12.	PFE.6. There is comprehensive patient education needs assessment (assessment of literacy skills, learning needs, readiness and ability to learn. provision of educational materials and assessment of patient understanding).												
13.	PFE.7. Medical records documentation of patient response to education.												
14.	PFE.8. The instructions are provided to the family/caregiver of patient populations (comatose patient, neonate/infant, Mentally disabled or impaired).												
15.	PFE.10. There is patient/family involvement in the care provided to him/her (informed consent, care decision, financial implications of care choices).												
16.	PFE.11. There is comprehensive nurses provision and documentation of patient/family education (assessing motivation, medications, safe use of medical equipment, activities of daily living, and return demonstrations with feedback).												

Review of Medical Records NURSE – CLOSED RECORD

Medical Records Numbers

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ Date: _____MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
	PSYCHIATRY (PS)												
17.	PS.6. There is written comprehensive medical order for patient restraint (need assessment, restrain type, duration and length of time restraints used are specified).												
18.	PS.7. There is appropriate restraint application, assessment and timely reassessment (at least every hour).												
19.	PS.7. There is appropriate interventions (impaired circulation, adverse reactions to major tranquilizers).												
	DIETARY SERVICE (DT)												
20.	DT.3. Comprehensive nutritional assessment within 24 hours for all patients at nutrition risk.												
21.	DT.4. Comprehensive nutritional plan of care (including therapeutic monitoring, nutritional adjustment, and documentation of clinical response).												
22.	DT.6. There is physician ordering of therapeutic hospital diets.												
23.	DT.6. There is physician ordering of therapeutic discharge diets.												
24.	DT.7.												

Review of Medical Records NURSE – CLOSED RECORD

Medical Records Numbers

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
	There is a patient response to education.												
25.	**DT.7.** **Dietitians participate in the discharge process (including cultural issues, mental status and ability to eat).**												
	REHABILITATION (RH)												
26.	**RH.13.** **There is patient education (plan of care, rehabilitation exercises).**												

Review of Medical Records
INFECTION CONTROL – CLOSED RECORD

✓ = Met
x = NM
NA = Not Applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
			YES	NO												
INFECTION CONTROL (IC)																
1.	**IC.45** Employee's health is in accordance with scientific recommendations and the Ministry of Health guidelines. ▪ IC.45.1 There is written policies and procedures that address employees' health, their immunization, and post exposure prophylaxis. ▪ IC.45.2 There is a clinic to provide counseling and medical services related to screening, immunization, and post exposure management. ▪ IC.45.3 The screening and immunization data are kept in staff medical records.															
IC.45. **Employees' medical records reflect required staff immunization.**																

Review of Medical Records
INFECTION CONTROL – CLOSED RECORD

✓ = Met
x = NM
NA = Not Applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
			YES	NO												
2.	**LD.22** The leadership ensures that Staff Health Clinic implements the following processes to avoid the transmission of infection by: • LD.22.1 performing the necessary investigations following needle stick or sharps injury and this data is collected for trending and reported at the Safety committee and Infection control committee. • LD.22.2 conducting pre-employment physicals on every staff member as required by the Ministry of Health (e.g.., Hepatitis screen & etc.). • LD.22.3 ensuring that all staff can have an appropriate immunization and protection in the various work areas. • LD.22.4 maintaining a current file on each hospital employee with the required immunization record.															
LD.22. **There are staff medical record files on each hospital employee in Staff Health Clinic includes pre-employment physicals as required by the MOH.**																
LD.22. **The current employee health file includes required immunization record and any investigations following needle stick or sharps injury.**																

✓ = Met
X = NM
NA = Not Applicable

Review of Medical Records LABORATORY – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
			YES	NO												
1.		**MS.82.** Physicians ensure that the following process is implemented for patients who will receive blood and/or blood products and:														
		MS. 82.1**.** Provides information and education to the patient about the need for blood, and the benefits and the associated risks involved in receiving blood.														
		MS. 82.2**.** Obtains consent from the patient and documenting this in the patient's medical record.														
		MS. 82.3**.** Administration of blood strictly according to hospital policy as outlined by the Blood Utilization Review committee.														
		MS. 82.4**.** Monitors for any side effects or disease transmitted resulting from blood administration.														
MS.82. The administration of blood is in line with the policy approved by the Blood Utilization Review committee.																
MEDICAL RECORDS (MR)																
2.		**MR.23.** All laboratory results are seen and signed by a physician before being filed in the patients' record while the patient is on the Ward.														

✓ = Met
X = NM
NA = Not Applicable

Review of Medical Records LABORATORY – CLOSED RECORD

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
			YES	NO												
MR.23. **All laboratory results signed by a physician before medical record filing while patient is on the ward.**																
3.	**LB.30**	Blood is ordered only by authorized physician.														
LB.30. **Blood is ordered only by authorized physician.**																
4.	**LB.41**	The pathology report includes all the relevant information for proper patient management, and is signed by a qualified histopathologist and / or cytopathologist. (Presence of IPPs in pathology reporting is highly recommended to provide consistency in reporting).														
LB.41. **Adequate, proper and approved pathology report (by histopathologist).**																

Medical Records Open Format

Review of Medical Records ADMINISTRATOR – OPEN RECORD

✓ = Met
X = NM
NA = Not Applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
			YES	NO												
PATIENT AND FAMILY RIGHTS (PFR)																
1.	**PFR.3**	The patient is provided with continuous and organized healthcare at all levels of treatment.														
			YES	NO	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
PFR.3. **There is a uniform and organized healthcare at all levels of treatment. "Continuous care reflected in the medical records" (same are provided to all patients).**																

Review of Medical Records PHYSICIAN – OPEN RECORD

Medical Records Numbers

Name of Surveyor: _____ **Date:** _____ MRN ➔

✓ = Met
X = NM
NA = not applicable

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
	MEDICAL STAFF AND PROVISION OF CARE (MS)												
1.	MS.55. All medical records review that patients are admitted under a Consultants name, as, (MRP), (AP).												
2.	MS.69. The plan of care is revised and adjusted appropriately according to any change in the patient condition and this is documented in the patient medical record.												
4.	MS.71. Files reviewed are documented daily complete progress notes that include the provisional diagnosis, treatment, and plan of care.												
5.	MS.77. Implementation of Day Surgery policies.												
6.	MS.78. There are medical assessments for patients who are admitted for surgery.												
7.	MS.79. There is pre operative investigation and results documented for patients who are admitted for surgery.												
8.	MS.80. There is medical record documentation of complete and timely preoperative anesthesia assessment (except during extreme emergencies) to determine good candidates for surgery.												
9.	MS.81.												

Review of Medical Records PHYSICIAN – OPEN RECORD

Medical Records Numbers

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
	All patients undergoing surgery (except extreme during emergencies) have a preoperative assessment which include; History and physical examination, the preoperative diagnosis, Laboratory and X-ray results if applicable, signed consent.												
	ANESTHESIA (AN)												
10.	AN.10. Comprehensive pre-anesthesia assessment that includes risk category, any consultations needed, anesthesia plan are documented in the Anesthesia assessment form not more than 30 days prior to surgery.												
11.	AN.11. Availability of complete Anesthesia form (anesthetic agent, dosage, techniques, blood administered, investigations, unusual events, status of patient at the end of the procedure: IV fluids given.												
12.	AN.19. Monitoring patients physiological status during and after surgery (including time of admission and time of discharge, vital signs, level of consciousness, unusual events, oxygen saturation, and ECG).												
13.	AN.34. Availability of a physician who performs physical exam and constantly and continuously monitors the patient.												
14.	AN.34. Constant and continuous monitoring and documentation of level of consciousness, vital signs, oxygen saturation and skin color.												
15.	AN.35. Physician documentation of patient status post procedure including vital signs, level of consciousness, and ECG.												
16.	AN.35.												

Review of Medical Records PHYSICIAN – OPEN RECORD

Medical Records Numbers

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ Date: _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total NOT MET	Standard Score
	Physician discharge order or transfers the patient back to the unit with follow up instructions.												

Review of Medical Records NURSE – OPEN RECORD

Name of Surveyor: _____ **Date:** _____ MRN ➔

SN	Standard Documentation Requirement	1	2	3	4	5	6	7	8	9	10	Total Not Met	Standard Score
	NURSING (NR)												
1.	NR.43. Implementation of nursing reassessment.												
2.	NR.44. Implementation of written plan of care (the care plan is interdisciplinary and is reviewed each shift or when significant changes occur).												
3.	NR.45. Adherence to preoperative preparation (preoperative checklist contains evidence of proper ID process for the patients, type of operation/surgeons name, site or surgery and marking, x-ray jacket for accompanying the patient to surgery, lab results, pre anesthesia sheet. History and physical, blood requirements).												
	ANESTHESIA (AN)												
4.	AN.12. Continuous monitoring of patients during surgery including vital signs, end tidal CO2, and ECG.												
5.	AN.14. Post anesthesia monitoring of patients in the Recovery room.												
6.	AN.20. Monitoring post anesthesia status with documentation.												
7.	AN.36. The nurse carries out the physician instructions including assessment/reassessment of vital signs, oxygen saturation, level of consciousness, pain, fluid tolerance, and voiding.												
8.	AN.36. The nurses perform discharge patient and family education including follow ups and emergency number to call.												

Review of Medical Records PHARMACIST – OPEN RECORD

Name of Surveyor: _____Date: _____ MRN

✓ = Met
X = NM
NA = not applicable

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total Not Met	Standard Score
			YES	NO												
MEDICAL RECORDS (MR)																
1.	**MR.24**	The hospital prepares a list of prohibited abbreviations not to be used (JCHAO Patient Safety Goals) and it is recommended and approved by related committee such as the Pharmaceutical &Therapeutic Committee and Medical Records Review Committee.														
MR.24. There is medical records compliance with the prohibited abbreviation List (all sampled medical records).																
2.	**MR.25**	The hospital prepares a list of approved abbreviations as suggested by Ministry of Health to be used in the institution (MOH) and it is recommended by the Medical Records Review Committee.														
MR.25. There is medical records compliance with the approved medical abbreviation list (all sampled medical records).																
NURSING (NR)																
3.	**NR.38**	Nurses only accept a standardized and approved list of abbreviations when receiving orders or documenting in patient file as approved by the hospital authority. NR.38.1 There is a written approved & signed abbreviation list.														
NR.38. Nursing adherence to approved abbreviation list.																
QUALITY MANAGEMENT AND PATIENT SAFETY (QM																

Review of Medical Records PHARMACIST – OPEN RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____Date: _____ MRN

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total Not Met	Standard Score
			YES	NO												
4.	**QM.17.**	There is a standardized list of abbreviations, acronyms, and symbols that are ermitted for use in the hospital and it includes a list of abbreviations, acronyms, and symbols NOT to be used.														
QM.17. Prohibited abbreviations, acronyms, and symbols are not used in medical records.																
NURSING (NR)																
5.	**NR.52**	There is a policy and procedure that addresses the verbal order by physicians that includes but is not limited to: NR.52.1. A verification "repeat back" of the entire order to the physician by the nurse receiving the order. NR.52.2 Signature by the physician immediately after the emergency is over and before the physician leaves the unit for the verbal orders.														
NR.52. **There is compliance with verbal orders policy.**																
MEDICAL RECORDS (MR)																
6.	**MR.13**	There is a written policy on verbal and telephone orders and includes: MR.13.1 Not considering a record complete before the attending physician or his designee signs off on the entire verbal and telephone orders.														
MR.13. **There is timely authentication of verbal and telephone orders according to the policy.**																
7.	**NR.51**	There is a policy and procedure that addresses the telephone orders by physicians that includes but is not limited to: NR.51.1 A verification "read back" of the entire order to the physician by the person														

Review of Medical Records PHARMACIST – OPEN RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____ **Date:** _____ MRN

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total Not Met	Standard Score
			YES	NO												
		receiving the order on the phone. NR.51.2 All telephone orders signed by the physician within 24 hours. NR.51.3 Verification by two nurses with signatures.														
NR.51. There is compliance with telephone orders.																
PHARMACY (PH)																
8.	**PH.16**	There is an updated list of prescribers and their prescribing privileges. PH.16.1 The list contains medical staff specialties and their prescribing privileges. PH.16.2 The list clearly defines prescribing privileges especially for narcotics, controlled drugs, psychotropics, chemotherapeutics, and high risk medications, etc. PH.16.3 The list is updated every year and whenever a new medical staff joins. PH.16.4 Clear copy of the privilege list is available to pharmacy staff in each drug dispensing area. PH.16.5 Pharmacy staff is aware of the list. PH.16.6 There is clear evidence of proper implementation.													
PH.16. There is proper implementation of prescribing privileges (Check at least 5 medical records for compliance).																
9.	**PH.11**	The Hospital formulary provides guidance to antibiotic use. PH.11.1 Antibiotic utilization guidelines and/or restriction are included in a separate section. PH.11.2 Evidence of implementation by prescribers of the antibiotic utilization guidelines. PH.11.3 Antibiotic dispensing as per antibiotic hospital policy (dosing, duration,														

Review of Medical Records PHARMACIST – OPEN RECORD

✓ = Met
X = NM
NA = not applicable

Name of Surveyor: _____Date: _____ MRN

SN	Standard Number	Standard Documentation Requirement	Applicable Standard		1	2	3	4	5	6	7	8	9	10	Total Not Met	Standard Score
			YES	NO												
	restriction, etc.).															
PH.11. **Antibiotic prescribing as per antibiotic hospital policy (restriction or prescribing privileges).**																
10.	**DN.13** The need for antibiotic prophylaxis is assessed for each patient.															
DN.13. **Assessment of the need for prophylactic antibiotics for each patient.**																
11.	**PH.40** The pharmacy has a system for automatic stop orders (ASO): PH.40.1 Written policy and procedure for handling automatic stop orders. PH.40.2. All physician orders are valid for 7 days unless shorter period is specified. PH.40.3. ASO for all drugs at time of surgery. PH.40.4. ASO for antibiotics as per hospital policy. PH.40.5. Daily orders for anticoagulants (e.g. intravenous heparin, warfarin). PH.40.6. Daily order for any continuous intravenous drips (e.g. dopamine, dobutamine, KCL, NTG, fentanyl, midazolam, etc.) PH.40.7. ASO for IV, IM, and oral controlled medications.															
PH.40. **There is compliance with ASO at the time of surgery (sample medical records, MAR, and Pharmacy drug profile).**																
PH.40. **There is compliance with ASO for anticoagulants, continuous intravenous drips, narcotics and controlled medications (Sample medical records, MAR, and Pharmacy drug profile).**																

Personnel File Review

Hospitals are encouraged to have the personnel files of the listed positions ready prior to the Personnel file review session (as reflected in the agenda)

Personnel file review general guideline

1. The scope of the personnel file review is the completeness of documentation of the recruitment, orientation, evaluation, continuing education, privileges and competencies process and monitoring.
2. Organizations may have different ways for documentation of these processes and may have more than one location for the filling of these processes. These Issues should be clarified prior to starting of the session.
3. Hospitals are to encourage presenting the needed documentation in one location to ensure comprehensiveness of personnel data and history during his/her employment in the organization.

Location and Room Requirements: Same room to be utilized and requirements as Document Review Session

Hospitals are <u>encouraged</u> to identify (and arrange their personnel files) the following elements in their personnel files:

1	Curriculum Vitae	
2	Degree certificates, professional certificates	
3	Letter of appointment (for leadership positions)	
4	Job Description, signed	
	License in line with job	
5	Country of origin	
6	Credentialing process documentation (checklist or communications)	
7	Saudi council registration	
	Performance evaluation	
8	Probationary period evaluation	
9	Annual/Yearly evaluation	
10	Competency assessment	Nursing required 1. Probationary 2. annually assessment
11	Privileging application and approval (for medical staff)	
	Orientations	
12	Hospital wide	
13	Departmental	
14	Unit (nurse)	
15	Safety Orientation (may be part of the Hospital wide)	
16	Continuing education	
17	Training in specialty	
18	Continuing Education	
19	Confidentiality statement, signed	
	Other documents	
20	Other documents such as: Contracts, copy of staff ID, copy of Hospital ID, Leaves, recognitions and disciplinary actions to be included according to the hospital Personnel Record Maintenance policy	

Personnel File Review Listing– Administrator

1. Hospital Director
2. Quality Management Director
3. Director of Administration Affair / Designee
4. Finance Director
5. Human Resource / Personnel Director
6. Medical Record Director
7. Medical Record Staff
8. Social Manager
9. Social worker (staff)
10. Duty Manager
11. New hires (3 Files). At least 1
12. Selected personnel records (3)

Personnel File Review Listing - Physician

1. Medical director
2. Head of Department for Anesthesia/ Senior Anesthetist
3. Head of Department of Burn Care
4. Head of Department for CCU & Cardiologist
5. Head of Department for Dental
6. Head of Department for Emergency Room
7. Head of Department for Hemodailysis
8. Head of Department for ICU, PICU
9. Head of Department for NICU
10. Head of Department for Obstetric Gynecology

11. Locum or part time Physician staff
12. Head of Department for Medical Radiation Oncology
13. Head of Department for Operating room
14. Head of Department for Psychiatry
15. Head of Department for Radiology
16. Head of Department for Rehabilitation
17. Head of Department of Respiratory Therapist
18. Surgeon

Personnel File Review Listing – Nursing

1. Nurse Leader/Director
2. Nurse Aide
3. Nursing Supervisor
4. Charge Nurse Medical Ward
5. Staff Nurse Surgical Ward
6. Nurse Educator
7. Head Nurse ICU
8. Head Nurse CCU
9. Head Nurse NICU
10. Head Nurse OR
11. Head Nurse L&D
12. Midwife
13. Head Nurse Haemodialysis
14. Head Nurse ER
15. Head Nurse Burn Unit
16. Head Nurse Oncology Unit
17. Head Nurse Psychiatry
18. Dietitian
19. Head Nurse OPD / Ambulatory Care

Personnel File Review Listing – Infection Control

1. All infection control staff members
2. CSSD Supervisor
3. CSSD Technician
4. Random sample from all other staff: two nurses, one physician, one administrative, and one support services
5. Catering staff health certificates as per the government regulations

Personnel File Review Listing - FMS

1. Safety Officer
2. Safety Coordinator
3. Security Officer
4. Security guard
5. Electrical Engineer
6. Mechanical Engineer
7. Logistics
8. House keeper
9. (3) New hires files

Personnel File Review Listing - Pharmacy

1. Pharmacy Director
2. Inpatient Pharmacy supervisor
3. Intravenous admixture service supervisor (or in-charge)

4. IV medication Nurse
5. TPN Pharmacist
6. Chemotherapy Pharmacist
7. Drug Information Center Pharmacist (or in charge)
8. Quality Improvement (QI) Pharmacist
9. Pharmacy technician or assistant pharmacist (2)

Personnel File Review Listing -Laboratory

1. Laboratory Director
2. 7 files: Random sample of laboratory staff from each section (that is, microbiology, blood bank, pathology, etc.)
3. Laboratory Quality Management Officer
4. Lab safety officer

Unit visit

Based on the information in the survey application, the survey agenda will specify the units, departments and other areas to be visited during the survey process. Hospitals are expected to have their key personnel present (per schedule) during their respective area visit. Surveyor's counterpart is usually the assigned hospital personnel to guide the surveyor to the various survey sites. During this activity, hospital staff are interviewed, facilities are observed and records are checked to ensure hospital compliance to the CBAHI national standards requirements

FMS unit visit: The following areas will be visited by the Facility Management and Safety:

Hospital roof, kitchen, laundry, generator, electrical room, medical gases room, workshops, main store , Reverse Osmosis plant, biomedical work shop, L&D area, Normal Newborn Unit/Nursery, NICU, ICU, OR, CSSD, patient room and bathroom, waste collection room, staircases, corridors, main entrances, emergency exits, isolation room, ambulance, disaster command center, and 1 to 3 nurse station.

IC unit visit: The following areas will be visited by the Infection Control

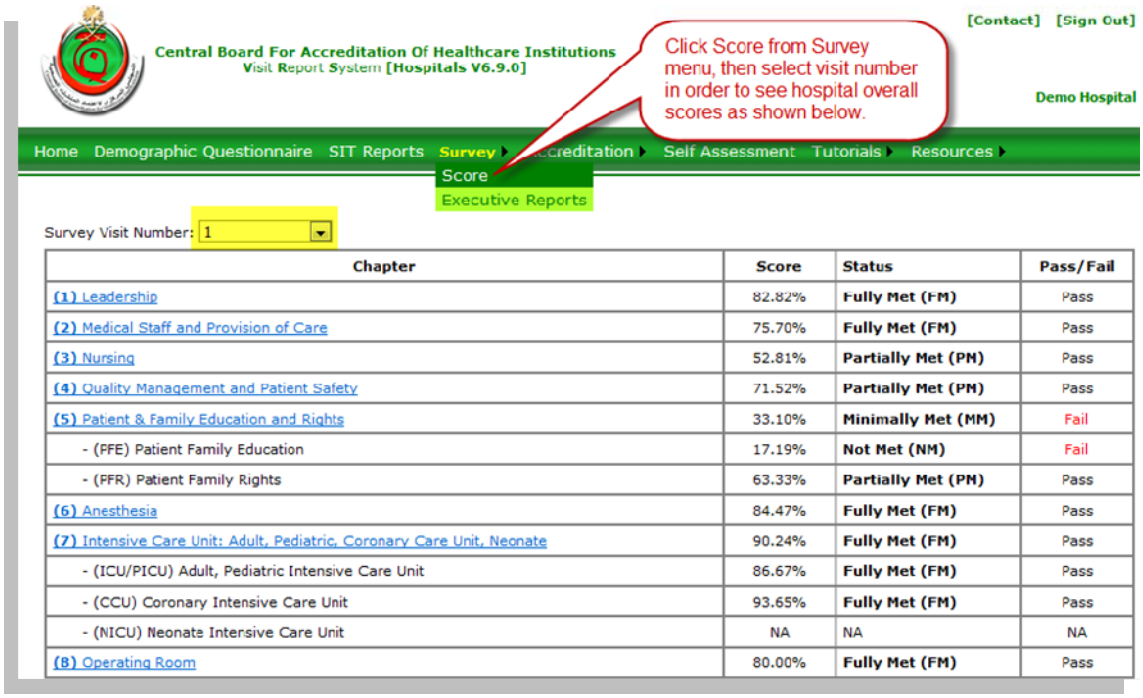
Operating Room, CSSD, Haemodialysis/ renal-dialysis (if applicable), Kitchen, Infection Control department, Isolation rooms, Staff health, Burn unit (if applicable), Laundry, Endoscopy (if applicable), Inpatient ward/unit, and Dental (if applicable)

Pharmacy unit visit: The following areas will be visited by the Pharmacy team

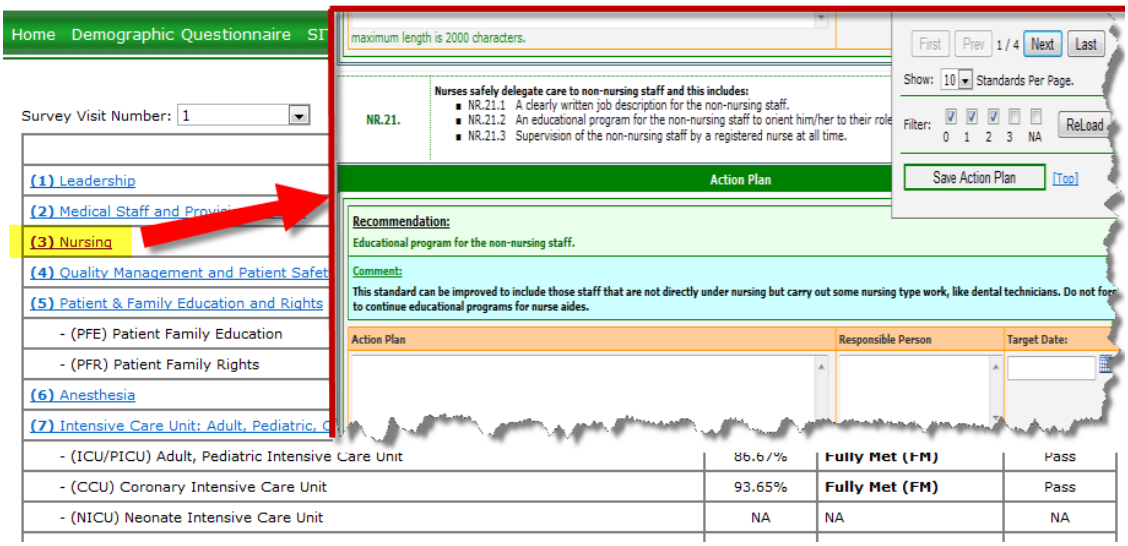
Outpatient pharmacy, ER pharmacy, inpatient pharmacy, Satellite pharmacies, IV admixture room, Chemotherapy admixture room, Narcotic room, Emergency room, Outpatient clinics, ICUs, Adult medical ward, pediatrics ward, and operating theater.

Hospital Survey Report

Hospitals will be able to access their survey report through their "hospital portal". The report face-sheet will show the overall final score and the scores of each chapter.



Chapter	Score	Status	Pass/Fail
(1) Leadership	82.82%	Fully Met (FM)	Pass
(2) Medical Staff and Provision of Care	75.70%	Fully Met (FM)	Pass
(3) Nursing	52.81%	Partially Met (PM)	Pass
(4) Quality Management and Patient Safety	71.52%	Partially Met (PM)	Pass
(5) Patient & Family Education and Rights	33.10%	Minimally Met (MM)	Fail
- (PFE) Patient Family Education	17.19%	Not Met (NM)	Fail
- (PFR) Patient Family Rights	63.33%	Partially Met (PM)	Pass
(6) Anesthesia	84.47%	Fully Met (FM)	Pass
(7) Intensive Care Unit: Adult, Pediatric, Coronary Care Unit, Neonate	90.24%	Fully Met (FM)	Pass
- (ICU/PICU) Adult, Pediatric Intensive Care Unit	86.67%	Fully Met (FM)	Pass
- (CCU) Coronary Intensive Care Unit	93.65%	Fully Met (FM)	Pass
- (NICU) Neonate Intensive Care Unit	NA	NA	NA
(8) Operating Room	80.00%	Fully Met (FM)	Pass



- (ICU/PICU) Adult, Pediatric Intensive Care Unit	86.67%	Fully Met (FM)	Pass
- (CCU) Coronary Intensive Care Unit	93.65%	Fully Met (FM)	Pass
- (NICU) Neonate Intensive Care Unit	NA	NA	NA

Hospital Survey Feedback

Hospitals are requested to complete a Hospital Survey Feedback form after the survey visit has been completed.

The hospital leadership may assign the Quality office to gather the feedback from the surveyors' counterparts and complete the form based on their feedback.

The hospital should complete the Start Date of Survey, End Date of Survey, and Name of Person(s) Completing the Feedback form.

The form consists of the following sections:

THE SURVEY, which includes the overall satisfaction with the survey experiences as well as the Surveyor Performance.

The hospital should rate the above elements using the following Rating Scale:

1. Extremely dissatisfied
2. Very dissatisfied
3. Somewhat dissatisfied
4. Neutral
5. Somewhat satisfied
6. Very satisfied
7. Extremely satisfied

Hospitals are encouraged to complete the **COMMENTS** sections and may categorize it to (Areas for Improvement),and strength (Strength) in order for CBAHI to be aware of the hospitals opinion and suggestions for further improvement of its Survey process as well as the surveyors skills and abilities.

Kingdom of Saudi Arabia
Council of Health services
Central Board for Accreditation
of Healthcare Institutions
General Secretariat

المملكة العربية السعودية
مجلس الخدمات الصحية
المجلس المركزى لإعتماد المنشآت الصحية
الأمانة العامة

Rating Scale:
1 – Extremely dissatisfied
2 – Very dissatisfied
3 – Somewhat dissatisfied
4 – Neutral
5 – Somewhat satisfied
6 – Very satisfied
7 – Extremely satisfied

Organization Name:
Start Date of Survey:
End Date of Survey:
Name of Person(s) Completing the Survey:

	1	2	3	4	5	6	7
THE SURVEY							
1. What is your level of satisfaction with the onsite visit?	☐	☐	☐	☐	☐	☐	☐
2. What is your level of satisfaction with the surveyor team?	☐	☐	☐	☐	☐	☐	☐
Surveyor Performance							
2. 1 How would you rate that team as a whole in terms of interpersonal skills? *(ability to relate to others, attentive listening, approachability, positive non-verbal and 2-way communication)*	☐	☐	☐	☐	☐	☐	☐
2. 2 How would you are the team as a while in terms of professional maturity? *(respectful, ethical principles, confidentiality, unbiased/open approach)*	☐	☐	☐	☐	☐	☐	☐
(self-confidence)	☐	☐	☐	☐	☐	☐	☐
(Professionalism)	☐	☐	☐	☐	☐	☐	☐

Hospital Survey Feedback

	1	2	3	4	5	6	7
2.3 How would you are the team as a whole in terms of flexibility *(ability to adjust to change, accommodating)*	☐	☐	☐	☐	☐	☐	☐
2.4 How would you rate the team as a whole in terms of consultative skills? *(readily provides advice, encouraging org to solve problems, sharing information based on experience & expertise)*	☐	☐	☐	☐	☐	☐	☐

(If any team member scores higher or lower than the team rating, please indicated name, rating and comments under appropriate category)

OVERALL SATISFACTION

3. What is your level of satisfaction with your recent accreditation experience?	☐	☐	☐	☐	☐	☐	☐

COMMENTS *(Areas for Improvement)*

COMMENTS *(Strength)*


Kingdom of Saudi Arabia المملكة العربية السعودية
المجلس المركزي لاعتماد المنشآت الصحية
Central Board of Accreditation for Healthcare Institutions
Health Services Council
مجلس الخدمات الصحية
The Central Board of Accreditation for Healthcare Institutions
Certifies that:
Sample
Passed the Survey process for
National Accreditation Standards for Hospitals and
is so Accredited for Two Years from this date:.....
For Quality and Safety of their provided Medical Services.
يشهد المجلس المركزي لاعتماد المنشآت الصحية بأن
Sample
قد اجتاز عملية التقييم ونجح في تطبيق المعايير الوطنية للمستشفيات
ولذا منح شهادة الاعتراف بجودة وأمان الخدمة الطبية المقدمة منه
ولمدة سنتين من تاريخ.....
د. عبد الله بن عبد العزيز الربيعة
وزير الصحة
و رئيس مجلس الخدمات الصحية
د. محمد بن حمزة خشيم
رئيس المجلس المركزي لاعتماد المنشآت
الصحية

Hospital Accreditation Department Contact list

CBAHI - Hospital Accreditation Department (HAD)

Phone: 920012512 Ext: 2235
Mobile: 0558922271 - 0558922273
E-mail: had@cbahi.org

- To inquire about any information relating to your completed Application for Survey, survey date or schedule, or assistance with specific problems related to your accreditation.
- To inquire about any information relating to education programs.

Management of Information (MOI) Department Contact list

To inquire about any information relating to hospital reporting system

www.cbahi.org/hsa

Director of Management of Information Department
Phone: 920012512 Ext: 1204
Mobile: 0558922264
Email: gammash@cbahi.org