Day Surgical Centre
Regulation

HEALTH REGULATION DEPARTMENT
DUBAI HEALTH AUTHORITY

2012
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgment</td>
<td>5</td>
</tr>
<tr>
<td>1. Scope</td>
<td>6</td>
</tr>
<tr>
<td>II. Purpose</td>
<td>6</td>
</tr>
<tr>
<td>III. Definitions</td>
<td>6</td>
</tr>
<tr>
<td>IV. Acronyms</td>
<td>8</td>
</tr>
<tr>
<td>CHAPTER ONE: LICENSURE AND ADMINISTRATIVE PROCEDURES</td>
<td>9</td>
</tr>
<tr>
<td>1. Registration and Licensure Procedures</td>
<td>10</td>
</tr>
<tr>
<td>2. Facility Name</td>
<td>11</td>
</tr>
<tr>
<td>3. Final Inspection and Issuing the License</td>
<td>11</td>
</tr>
<tr>
<td>4. Management Responsibilities</td>
<td>12</td>
</tr>
<tr>
<td>5. Compliance Review</td>
<td>12</td>
</tr>
<tr>
<td>6. Application for License Renewal</td>
<td>13</td>
</tr>
<tr>
<td>7. Temporary Suspension of the License</td>
<td>13</td>
</tr>
<tr>
<td>8. Voluntary Cancellation of the License</td>
<td>13</td>
</tr>
<tr>
<td>9. Null and Void License</td>
<td>13</td>
</tr>
<tr>
<td>10. Changes/Modifications Requiring DHA Approvals</td>
<td>14</td>
</tr>
<tr>
<td>11. Renovations and Additions to DSC Building</td>
<td>14</td>
</tr>
<tr>
<td>CHAPTER TWO: DAY SURGICAL CENTRE DESIGN REQUIREMENTS</td>
<td>15</td>
</tr>
<tr>
<td>12. General Design Considerations</td>
<td>16</td>
</tr>
<tr>
<td>13. Reception and Waiting Area</td>
<td>17</td>
</tr>
<tr>
<td>14. Consultation and Examination Rooms</td>
<td>17</td>
</tr>
<tr>
<td>15. Treatment Rooms</td>
<td>18</td>
</tr>
<tr>
<td>16. Procedure Room (Level II Anesthesia)</td>
<td>18</td>
</tr>
<tr>
<td>17. Operating Theatre (level III anesthesia)</td>
<td>19</td>
</tr>
<tr>
<td>18. Observation Room(s)</td>
<td>21</td>
</tr>
<tr>
<td>19. Health Records</td>
<td>21</td>
</tr>
<tr>
<td>20. Administrative Activities</td>
<td>21</td>
</tr>
<tr>
<td>21. Equipment and Supply Storage</td>
<td>21</td>
</tr>
<tr>
<td>22. Clinical Laboratory Requirements</td>
<td>22</td>
</tr>
<tr>
<td>23. Diagnostic Imaging Requirements</td>
<td>22</td>
</tr>
<tr>
<td>CHAPTER THREE: DAY SURGICAL CENTRE STANDARDS</td>
<td>24</td>
</tr>
<tr>
<td>CLUSTER ONE: PATIENT CARE</td>
<td>25</td>
</tr>
<tr>
<td>Cluster</td>
<td>Section Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>24</td>
<td>Patient Assessment</td>
</tr>
<tr>
<td>25</td>
<td>Outpatient Care</td>
</tr>
<tr>
<td>26</td>
<td>Ethical Considerations</td>
</tr>
<tr>
<td>27</td>
<td>Surgical Care</td>
</tr>
<tr>
<td>28</td>
<td>Anesthesia and Sedation care:</td>
</tr>
<tr>
<td>29</td>
<td>Critical Care Services</td>
</tr>
<tr>
<td>30</td>
<td>Surgical Services</td>
</tr>
<tr>
<td>31</td>
<td>Emergency Services</td>
</tr>
<tr>
<td>32</td>
<td>Discharge / Transfer Planning</td>
</tr>
<tr>
<td>33</td>
<td>Clinical Laboratory Services</td>
</tr>
<tr>
<td>34</td>
<td>Diagnostic Imaging</td>
</tr>
<tr>
<td>35</td>
<td>Medications Management</td>
</tr>
<tr>
<td>36</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>37</td>
<td>Allied Health Services</td>
</tr>
<tr>
<td>38</td>
<td>Nutrition Services</td>
</tr>
<tr>
<td>39</td>
<td>Laundry</td>
</tr>
<tr>
<td>40</td>
<td>Sanitary Services</td>
</tr>
<tr>
<td>41</td>
<td>External Services</td>
</tr>
<tr>
<td>42</td>
<td>Care for Deceased Patients</td>
</tr>
<tr>
<td>43</td>
<td>Patient Safety Solutions</td>
</tr>
<tr>
<td>44</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>45</td>
<td>Falls Management Program</td>
</tr>
<tr>
<td>46</td>
<td>Patient’s Rights and Responsibilities</td>
</tr>
<tr>
<td>47</td>
<td>Informed Consent</td>
</tr>
<tr>
<td>48</td>
<td>Patient Education</td>
</tr>
<tr>
<td>49</td>
<td>Disabled People Rights</td>
</tr>
<tr>
<td>50</td>
<td>Health Records</td>
</tr>
<tr>
<td>51</td>
<td>Telephone or Verbal Orders</td>
</tr>
</tbody>
</table>
52. Health Record Management Systems 50
53. Retention of Health Records 50

CLUSTER EIGHT: ADMINISTRATIVE STANDARDS:

54. Monitoring Quality of Service 52
55. Complaints System 52
56. Reporting Sentinel Events and Major Incidences 53
57. Statistics and Data Collection 53

CLUSTER NINE: HUMAN RESOURCES AND STAFF

58. Human Resources Practices 55
59. Healthcare Professionals Minimum Requirements 55
60. Credentialing and Privilege System 56

CLUSTER TEN: FACILITY MANAGEMENT

61. Medical Equipment and Supplies 57
62. Safety Management Systems 57
63. Fire Safety 58
64. Hazardous Substances and Dangerous materials 58
65. Waste and Environmental Management 59
66. Emergency and Disaster Management 59
67. Security Management 60

Appendix 1: List of procedures/surgeries can be performed in DSC setting 61
Appendix 2: Anesthesia Medication for Level II DSC 65
Appendix 3: Mandatory Emergency Medications for Level II Anesthesia 66
Appendix 4: Classification of Patients Physical Status 67
Appendix 5: Second line emergency medication list (optional) 68
Appendix 6: Ventilators Specifications 69
Appendix 7: Mandatory Emergency Medications for Level III Anaesthesia 70
Appendix 8: Sample of DAMA Form 71
Appendix 9: Health Care Workers Immunization Recommendations 72

References 73
Acknowledgment

Dubai Health Authority (DHA) is pleased to present the DHA Day Surgery Centers’ Regulation which represents a milestone towards fulfilling the DHA strategic objectives in providing “A world class integrated health system that ensures excellence in health and healthcare for the Emirate of Dubai and promotes Dubai as a globally recognized destination for healthcare”.

This Regulation places an emphasis on facility design and services criteria with a focus on quality of services and safety of professionals based on the local and federal laws in addition to international accreditation standards.

Therefore, this document provides a base for the Health Regulation Department (HRD) to assess the Day Surgery Centers’ performance in Dubai and to ensure safe and competent delivery of services. It will also assist the Day Surgery Centers in developing their quality management systems and in assessing their own competence to ensure compliance with DHA regulatory requirements and the United Arab Emirates (UAE) federal laws.

The Day Surgery Centers’ Regulation was developed by the Health Regulation Department (HRD) in collaboration with Subject Matter Experts whose contributions have been invaluable. The Health Regulation Department would like to gratefully acknowledge those professionals and to thank them for their dedication to quality in health and their commitment in undertaking such a complex task.

The Health Regulation Department
Dubai Health Authority
I. Scope

This regulation specifies requirements for licensure, competence and safety particular to Day Surgery Centers (DSC) subject to licensure under the Dubai Health Authority (DHA) establishment law, including governmental, semi governmental, private and clinical laboratories operating in free zone areas.

This Regulation may be amended from time to time at the discretion of DHA, and will be referred to as the Day Surgery Center Regulation. The latest edition of the document shall be accessed through the DHA website www.dha.gov.ae

II. Purpose

The DHA is the sole responsible entity for regulating, licensing and monitoring all healthcare facilities and healthcare professionals in the Emirate of Dubai. Through the development, establishment, and enforcement of this regulation, which matches best practices for DSCs, the DHA will ensure provision of the highest levels of quality of laboratory services at all times.

III. Definitions

Adverse Event is defined as unanticipated, undesirable or potentially dangerous occurrence in a health care organization.

Assisted Reproductive Techniques (ART) shall mean the process of intercourse is bypassed either by insemination (for example, artificial insemination) or fertilization of the oocytes in the laboratory environment (i.e., in vitro fertilization). These techniques include but are not limited to the following procedures: Intra Uterine Insemination (IUI), In vitro Fertilization (IVF), Intracytoplasmic Sperm Injection (ICSI), Gamete Intra-fallopian Transfer (GIFT), Zygote Intra-fallopian Transfer (ZIFT).

Day Surgery Centre (DSC) is a freestanding office based surgery centre mainly providing surgical procedures and services (including dental procedures) for patients who do not require hospitalization or overnight stay. The procedure/surgery does not require more than 18 hours inclusive of preparation, the surgery itself and recovery. DSC may provide outpatient services for other medical specialties.

Deep Sedation shall mean a medically controlled state of drug induced depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes, and includes the inability to maintain a patent airway independently and to respond purposefully to physical stimulation or verbal command. Cardiovascular function is usually maintained

Disabled People shall mean people with personal condition(s) or situation(s) that could make it difficult for them to participate fully in their health care. It includes individuals with disabilities such as (physical, intellectual or sensory), age affected (either elderly or very young), affected by trauma or affected by medications/drugs.
**General Anesthesia** shall mean a controlled state of drug-induced unconsciousness accompanied by a loss of protective reflexes, including loss of the ability to maintain a patent airway independently or to respond purposefully to physical stimulation or verbal command. Major regional blocks including, but not limited to, spinal, epidural or caudal injection of any drug which has analgesic, anesthetic or sedative effects are in the same category as general anesthesia.

**Healthcare professional** shall mean healthcare personal working in healthcare facilities and required to be licensed as per the applicable laws in United Arab Emirates.

**Health Care Worker** (HCW) shall mean an individual employed by the health facility whether directly or by contract with another entity to provide direct or indirect patient care. This includes but is not limited, healthcare professionals, medical and nursing students, administrative staff and contract employees who either work at or come to the health facility site.

**Medical Complaints** shall mean expressions of dissatisfaction or concern about health care services, made by patients or their relatives.

**Moderate sedation** shall mean a drug induced state that allows patients to tolerate unpleasant therapeutic or diagnostic procedures while maintaining adequate cardio-respiratory function.

**Light Sedation (Anxiolysis):** shall mean a drug induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Licensure** means issuing a license to operate a health facility to an individual, government, corporation, partnership, Limited Liability Company (LLC), or other form of business operation that is legally responsible for the facility’s operation.

**Patient** is any individual who receives medical attention, care or treatment by any healthcare professional or gets admitted in a health facility.

**Patient Safety Solutions** are defined as: "Any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care."

**Risk Management** is defined as a logical and systematic method of establishing the context, identifying, analyzing, evaluating, treating, monitoring and communicating risks associated with any activity, function or process in a way that will enable organizations to minimize losses and maximize opportunities.

**Sentinel Event** is defined as an unanticipated occurrence involving death or major permanent loss of function unrelated to the nature course of the patient illness or underlying condition.
IV. Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGO</td>
<td>Clinical Governance Office</td>
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<tr>
<td>DAMA</td>
<td>Discharge Against Medical Advice</td>
</tr>
<tr>
<td>DHA</td>
<td>Dubai Health Authority</td>
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<td>DSC</td>
<td>Day Surgery Centre</td>
</tr>
<tr>
<td>FGI</td>
<td>Facility Guidelines Institute</td>
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<tr>
<td>ED</td>
<td>Economic Development</td>
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<tr>
<td>EMT</td>
<td>Emergency Medical Technicians</td>
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<tr>
<td>FANR</td>
<td>Federal Authority Nuclear Regulation</td>
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<tr>
<td>HCW</td>
<td>Healthcare Worker</td>
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<tr>
<td>HRD</td>
<td>Health Regulation Department</td>
</tr>
<tr>
<td>HVAC</td>
<td>Heating, Ventilation and Air Conditioning</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>LLC</td>
<td>Limited Liability Company</td>
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<tr>
<td>MEP</td>
<td>Mechanical Electrical Plumbing</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER ONE: LICENSURE AND ADMINISTRATIVE PROCEDURES
A person or entity must obtain a license from Dubai Health Authority (DHA) to operate a Day Surgery Centre (DSC) in the Emirate of Dubai. This applies to governmental and semi governmental, private health facilities and facilities operating in free zone areas.

1. **Registration and Licensure Procedures**

1.1 Health Regulation Department shall receive applications to open Day Surgery Centre in the Emirate of Dubai according to the applicable laws regarding this issue. For further information [click here](#) to see article 4 and 5 of the Federal Law number 2/1996 concerning Private Health Facilities.

1.2 Submission of an application to the Health Regulation Department (HRD) is a requirement for licensure in order to establish a new Day Surgery Centre in the Emirate of Dubai. The health facility licensing procedures are described in the Health Regulation section of the DHA website. For further information [click here](#) or visit [www.dha.gov.ae](http://www.dha.gov.ae).

1.3 In case of establishing a new DSC, the application file shall include both the preliminary and final architectural plans with specifications showing the proposed general location, accessibility, physical features of the site, means of electrical and water supply, sewage disposal and other utilities, including the following:

1.3.1 The land plot allocated to the new DSC shall be approved for commercial use by Dubai Municipality (DM).

1.3.2 The DSC buildings shall have easy and independent access to its premises however, if the DSC is located in commercial building; the facility shall have hospital-type elevators to accommodate patient bed (at least 5 feet 8 inches (1.73 meters) wide by 9 feet (2.74 meters) deep).

For further information regarding the DSC physical requirements see the Office Surgical Facilities section in the Facility Guidelines Institute (FGI) or visit [www.fgiguidelines.org](http://www.fgiguidelines.org).

1.4 Upon receipt of a completed applicant's file, the HRD will conduct a detailed review of the submitted material to determine compliance and suitability for further processing.

1.5 The HRD shall issue an Initial Approval letter for a new Day Surgery Centre with defined services and restrictions particular to the applicant request.

1.6 This letter will be required to complete the centre licensing procedures by local and federal authorities such as The Department of Economic Development (DED) and the Federal Authority of Nuclear Regulation (FANR).

1.7 In case of Rejection of application, a detailed list of issues will be provided for corrective action and the DSC is required to re-submit a new application with applicable fees.

For further details regarding the application form, ownership, licensure procedures, application fee and re-submission fee please [click here](#) or visit the Health Regulation in the DHA website [www.dha.gov.ae](http://www.dha.gov.ae).
2. **Facility Name**

2.1 During the initial registration process, the name of the DSC will be tentatively under the owner name.

2.2 Each health facility shall be designated by a permanent and distinctive name which shall not be changed without prior notification.

2.3 Name of the DSC shall not tend in any way to mislead the public as to the type or extent of care provided by the facility.

3. **Final Inspection and Issuing the License**

3.1 A request for Final Inspection shall be submitted by the applicant, upon which an onsite pre-operational assessment will be conducted by HRD.

3.2 Applicant shall submit the detailed scope of services provided in the DSC along with final layout in Auto-Cad format prior to final inspection.

3.3 To obtain the DHA facility license, the applicant must meet the following:

3.3.1 Appoint a Medical Director.

3.3.2 Employ a sufficient number of qualified and DHA licensed consultant/specialist physicians and other healthcare professionals to satisfy the facility functional program and to meet patient needs for all services/procedures provided in the facility.

3.3.3 Install and operate medical equipments required for provision of the DSC services in accordance with manufacturers’ specifications.

3.3.4 Provide a documented policy and procedures for the following:

3.3.4.1 Infection control measures and hazardous waste management

3.3.4.2 Medication management

3.3.4.3 Patient health record

3.3.4.4 Emergency action plan and

3.3.4.5 Patient discharge/transfer.

3.3.5 Maintain Charter of Patients rights and responsibilities conspicuously posted on the facility premises in two languages;

3.3.6 Provide evidence of FANR license to use the ionizing radiology equipments in the facility or FANR registration number;

3.3.7 Maintain adequate lighting and utilities, including temperature controls, water taps, sinks and drains, lighting, electrical outlets and communications.

3.3.8 Keep floors, work surfaces, and other areas clean and neat.

3.3.9 Clearly display signage and direction for rooms and services provided in the facility at least in two languages (Arabic and English).

3.3.10 Clearly designate areas in the facility with prominently displays notifications of hazards signs, aim to restrict access for the safety of patients and staff.
3.3.11 Designate secured areas for the collection of medical waste, general storage facilities for supplies and equipment and storing area for hazardous materials.

3.3.12 Provide a sufficient number of toilets for patients, their families, and staff, including access for disabled individuals.

3.3.13 Keep the facility accessible for disabled individuals;

3.4 Based on the onsite assessment and after meeting the DHA requirements and recommendation (if any), a DHA license will be issued by the Health Regulation Department. The DSC facility license is valid for one year.

3.5 Every license shall state the name and address of the DSC, the Department of Economic Development (DED) license number, the period of licensure validity, the specific service(s) that the DSC is licensed to deliver.

3.6 The DSC license shall be clearly posted on the facility premises.

4. **Management Responsibilities**

Upon obtaining the license the DSC management must fulfill certain obligations which include:

4.1 Comply with all federal and local laws and regulations.

4.2 Take necessary measures to distribute new DHA circulars and announcements among all facility professionals.

4.3 Cooperate with HRD inspectors and/or any duly authorized representative and provide requested documentation or files.

4.4 Avoid giving misleading information and false statements which may lead to legal action against professionals or the health facility.

4.5 Settling of any violation fines related to professionals or the health facility.

4.6 Maintaining malpractice insurance for all licensed healthcare professionals as per article 25 and 26 of the UAE Federal Law number 10/2008 concerning Medical Liability.

4.7 Use the DHA Infectious Diseases Notification Service to report communicable disease required by the UAE Federal Law number 27/1981 concerning the Prevention of Communicable Diseases.

4.8 Obtain prior approval from the Ministry of Health (MOH) for media and advertisement materials. For further information regarding the media and advertisement materials approval procedures and requirements please visit the MOH website [www.moh.gov.ae](http://www.moh.gov.ae)

5. **Compliance Review**

5.1 At any time and upon reasonable cause, HRD may audit the DSC to determine the facility compliance with the DHA regulation, and take appropriate action if required.

5.2 The onsite inspections may be scheduled or un-announced.

5.3 The DSC shall cooperate with HRD inspectors and/or any duly authorized representative and provide requested documentation/file.

5.4 After every inspection in which non-compliance to the DHA licensure and regulatory standards has been identified, the authorized inspectors shall issue an onsite copy of the field inspection report followed by a letter stating the identified violations.
5.5 DSC management shall submit to the HRD a written plan of correction of violations cited within fifteen days after receiving the noncompliant letter stating the identified violations.

5.6 Violation fines shall be settled by the health facility.

5.7 A follow up visit maybe conducted by the HRD to confirm the correction.

6. Application for License Renewal

6.1 Application for renewal of the DSC license must be submitted not less than 15 days prior to expiration of the license and shall conform to all renewal requirements.

6.2 The applicant's failure to file the renewal licensing application within the given time shall result in expiration of the current license on its last effective date. In such cases, the DSC will be subjected to financial penalties and may lead to null and void of the facility license.

6.3 HRD will renew the facility license for a period of one year after fulfilling the DHA requirements.

For further details regarding health facility license renewal procedures and requirements visit Health Regulation site in DHA website www.dha.gov.ae

7. Temporary Suspension of the License

7.1 If the DSC operations or specific service(s) (if identified) poses an imminent risk to the safety of patients or healthcare professional working in centre, the Director General of Dubai Health Authority (DHA) may issue an order of suspension of the DSC license services pending a final decision from an investigative committee.

8. Voluntary Cancellation of the License

8.1 Cancellation of the DSC license request shall be signed by the owner of the DSC and must be submitted at least (30) days before closure.

8.2 The DSC management shall comply with applicable DHA Policies and Standards regarding cancellation of the health facility license.

For further details regarding health facility license cancellation procedures visit Health Regulation site in DHA website www.dha.gov.ae

9. Null and Void License

9.1 As per the UAE Federal Law number 2/1996 concerning Health Facilities, the health facility license is considered null and void by force of law in the following conditions:

9.1.1 Transferring the health facility ownership to a different individual, corporation, Limited Liability Company (L.L.C.), etc.

9.1.2 Closure of the facility for a period of six months without presenting a valid and justified reason(s).

9.1.3 The health facility is not operating for a period of six consecutive months from the date of issuing the facility license.

9.1.4 Cancellation or liquidation of health Facility Corporation, partnership or Limited Liability Company (L.L.C.), etc.
10. Changes/Modifications Requiring DHA Approvals

10.1 The DSC management shall obtain prior approval from the HRD for the following changes or modifications, this includes but not limited to:

10.1.1 Ownership
10.1.2 Medical Director
10.1.3 DSC trade name
10.1.4 Facility location
10.1.5 Increase or decrease of bed capacity
10.1.6 Introducing new surgical services.
10.1.7 Relocation of existing services such as clinical laboratory or diagnostic imaging services.
10.1.8 Adding an extension, major construction or renovation work in the facility.
10.1.9 Temporary closure of the DSC.

11. Renovations and Additions to DSC Building

11.1 Renovating or addition to an existing DSC building, applicant shall submit an application file including both the preliminary and final architectural plans with specifications showing the proposed renovation or addition.

11.2 All construction, alterations or additions to an existing DSC building shall comply with the construction standards of the Dubai Municipality (DM) building code and meet the DHA Health Facilities Guidelines: Planning, Design, Construction and Commissioning.

For further information regarding the DHA Health Facilities Guidelines please click here or visit the Health Regulation site in DHA website www.dha.gov.ae
CHAPTER TWO:
DAY SURGICAL CENTRE DESIGN REQUIREMENTS
12. General Design Considerations

12.1 The DSC facilities are used primarily by patients who are able to travel or be transported to the facility for treatment, including those confined to wheelchairs. These facilities may be a freestanding facility such as villa, or in a multiple-use commercial building containing DSC facility.

12.2 The site and access to any health care facility shall be convenient both to people using public transportation and vehicles.

12.3 Freestanding DSC facilities shall provide parking in the facility premises to satisfy the needs of patients and staff, such parking area shall be acceptable to the local authorities having jurisdiction e.g. Road and Traffic Authority and Dubai Municipality.

12.4 Consideration shall be given to the anticipated special needs patients as determined by the functional program of the facility.

12.5 Signage shall be provided to direct people unfamiliar with the facility to entrances and facility parking areas (if provided).

12.6 Each facility design shall ensure appropriate levels of patient acoustical and visual privacy and dignity throughout the care process, consistent with needs established in the functional program.

12.7 The design, construction, renovation, expansion, equipment, and operation of health care facilities are all subject to provisions of several local and federal laws, environmental pollution control, this include but not limited to hazardous waste materials storage handling, and disposal; medical waste storage and disposal; asbestos use in building materials, elimination the use of Mercury and chlorofluorocarbons (CFCs) in health care, etc.

12.8 Public corridors shall have a minimum width of 1.52 meters (5 feet). Items such as provisions for drinking water, vending machines, etc., shall not restrict corridor traffic or reduce the corridor width below the required minimum.

12.9 The minimum door opening width for patient use shall be 86.36 centimeters (2 feet 10 inches). If the facility serves patients confined to wheelchairs, the minimum width of door openings to rooms shall be 3 feet 8 inches (1.12 meters).

12.10 Door swings should be oriented to provide patient privacy.

12.11 The minimum ceiling height shall be 2.39 meters (7 feet 10 inches).

12.12 Color contrast between walls, floors, and doors shall be considered as it may reduce falling risk of blurred vision patients.

12.13 Selected flooring surfaces shall be easy to maintain, readily cleanable, and appropriately wear-resistant for the location.

12.14 Stairways flooring shall have slip-resistant surfaces.

12.15 Slip-resistant flooring products shall be considered for flooring surfaces in wet areas (e.g. ramps, shower and bath areas) and areas that include water for patient services.

12.16 Carpet cannot be used in examination and treatment rooms, if used in patient waiting areas and corridors carpet shall be glued or stretched tight and free of loose edges or wrinkles.
12.17 Wall finishes shall be washable, moisture-resistant and smooth, wall finish treatments shall not create ledges or crevices that can harbor dust and dirt.

12.18 Joints for floor openings for pipes and ducts shall be tightly sealed.

12.19 Highly polished flooring, walling or finishes that create glare shall be avoided.

13. Reception and Waiting Area

13.1 A reception/information counter or desk shall be located to provide visual control of the entrance to the outpatient unit and shall be immediately apparent from that entrance, the information counter should provide access to patient files and records.

13.2 Male and Female waiting area for patients and escorts shall be under staff control, waiting area shall provide privacy for people waiting in the area.

13.3 Waiting area shall be provided with provision of drinking water and public telephone.

13.4 The seating area shall contain not fewer than two spaces for each examination and/or treatment room.

13.5 Where proper pediatrics service provided a separate, controlled area for pediatric patients shall be provided.

13.6 Wheelchairs shall be accommodated within the waiting area.

13.7 Toilet(s) for public use shall be conveniently accessible from the waiting area without passing through patient care or staff work areas or suites. A hand-washing station shall be provided in the toilet room.

14. Consultation and Examination Rooms

14.1 Room space requirements shall depend on the services provided but at least shall meet the following:

14.1.1 Consultation and examination room(s) (in the same room) such as medical, obstetrical, dental or similar shall have a minimum floor area of 12 square meters (129 square feet).

14.1.2 Consultation room(s) only (without examination) such as nutrition, homeopathy shall have a minimum floor area of 9 square meters (96.8 square feet).

14.2 Room arrangement shall permit a minimum clearance of 81.28 centimeters (2 feet 8 inches) on both sides and at one end of the examination table, bed, or chair.

14.3 A counter or shelf space for writing and documentation shall be provided.

14.4 A hand-washing station with a hands-free regulator (tap)\(^1\) and liquid or foam soap dispensers shall be provided in all examination room(s). Sinks shall be designed with deep basins, made of porcelain, stainless steel, or solid surface materials.

14.5 Hand sanitation dispensers shall be provided in addition to hand-washing stations.

14.6 Provisions for hand drying shall be available at all hand-washing stations.

\(^1\) Such as Single-lever or wrist blade devices, Sensor-regulated water fixtures or Sensor-regulated faucets with manual temperature control.
15. Treatment Rooms

15.1 Rooms for minor treatments, procedures and casting, if provided, shall have a minimum floor area of 11.15 square meters (120 square feet). The minimum room dimension shall be 3 meters (9.8 feet).

15.2 Room arrangement shall permit a minimum clearance of 91.44 centimetres (3 feet) at each side and at the foot of the bed.

15.3 The treatment rooms shall be equipped with:

15.3.1 Hand-washing station.

15.3.2 Documentation space or counter for writing.

15.3.3 A lockable refrigerator for medication use.

15.3.4 Locked storage for controlled drugs (if used).

16. Procedure Room (Level II Anesthesia)

16.1 There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to patients and all monitoring equipment.

16.2 Procedure room specifications and requirements shall includes:

16.2.1 The space requirements for procedure room in level II DSC shall be at least 16 square meters. Extra space might be required based on the type of procedure and sedative agents used.

16.2.2 Procedure rooms shall be designed for visual and acoustical privacy for the patient.

16.2.3 Dedicated hand-washing station with hands-free controls shall be available.

16.2.4 Floor covering in the procedure room shall be monolithic and joint free.

16.3 Recovery area

16.3.1 Recovery bed(s) (at least one bed for each procedure room) with a minimum clear floor area of 9 square meters for each bed.

16.3.2 Convenient access to hand-washing stations shall be provided.

16.3.3 Nurse control and charting area that provides view of patient positions shall be provided.

16.3.4 Provisions for patient privacy such as cubicle curtains shall be provided.

16.3.5 Patient toilet which shall permit accessibility from patient holding or directly from procedure room(s) or both.

16.4 Diagnostic services shall be provided either on-site or off-site.

16.4.1 The following equipments shall be provided:

16.4.2 Medical gases station or outlets for oxygen and vacuum (suction) shall be available in the procedure room.

16.4.3 Airway equipment: appropriate sized oral airways, endo-tracheal tubes, laryngoscopes, normal masks and laryngeal masks.
16.4.4 Defibrillator
16.4.5 Double tourniquets if the practice performs Bier blocks
16.4.6 Pulse oximeter
16.4.7 Electrocardiographic (ECG) monitor
16.4.8 Temperature monitoring system for procedures lasting more than 30 minutes
16.4.9 Blood pressure apparatus with different size cuffs
16.4.10 Emergency crash cart

16.5 A refrigerator for pharmaceuticals and double-locked storage for controlled substances shall be provided

For further information regarding the DSC physical requirements see the Office Surgical Facilities section and Gastrointestinal Endoscopy Facilities in Facility Guidelines Institute (FGI) or visit www.fgiguidelines.org.

17. Operating Theatre (level III anesthesia)

17.1 The number of operating theatres and recovery beds and the sizes of the support areas shall be based on the expected surgical workload, the OT in DSC shall meet the following requirements:

17.2 There should be sufficient space to accommodate all necessary equipment and personnel and to allow for expeditious access to patients and all monitoring equipment. The space requirements for such operation rooms shall be at least 33 square meters.

17.3 Operation theatre entrance door should be wide (about 2.13 meters width) preferably consisting of two parts, which can be opened in either sides or automatic one. Independent dirty exit is recommended in OT

17.4 The floor, ceiling, and walls must be created by a continuous connection. Interior surfaces should be constructed of materials that are monolithic and impervious to moisture.

17.5 The floor and walls should be anti-static, heat resistant, anti-bacterial, anti-fungal and resistant to chemicals used for disinfection purposes.

17.6 Operating theatre temperature shall be maintained between 18-22 °C with room humidity between 40-60%

17.7 Anesthesia scavenging systems: Each space routinely used for administering inhalation anesthesia and inhalation analgesia shall be served by a scavenging system to vent waste gases.

17.8 Operation room shall be equipped with the following:

17.8.1 Multi purpose operation table with patient straps.
17.8.2 Anesthesia machine with adequate vital sign monitors.
17.8.3 Adequate medical gases supply
17.8.4 X-Ray Viewer
17.8.5 Cauterization equipment
17.8.6 ECG machine
17.8.7 Emergency cart shall be available with defibrillator, necessary drugs and other CPR equipment
17.8.8 Suction machine
17.8.9 Pulse oximeter
17.8.10 Emergency call system

17.9 Adequate ventilation and air exchanges with recommended 15 air changes per hour (acceptable range is 12 -20 air changes per hour as per American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) requirement) shall be maintained in the operation room (Operating theatre should be at positive pressure relative to the adjacent preparation areas).

17.10 Minimum of two air supply inlets with proper High Efficiency Particulate Arresting (HEPA) filters (delivered at or near the ceiling and should not be directed over the surgery table) and minimum of two exhaust outlets (located near floor level, bottom exhaust outlets should be at least 75mm above the floor).

17.11 The temperature and relative humidity set points should be adjustable. Differential pressure indicating device, humidity indicator, and thermometers should be installed and should be located for easy observation.

17.12 High efficiency filters should be installed in the air handling system, with adequate facilities provided for maintenance, without introducing contamination to the delivery system or the area served. Staff changing area (separate male and female area) shall contain special entrance for the staff and suitable place for change of clothes with a minimum of one toilet for the staff in this area. Toilets air pressure should be kept negative pressure with respect to any adjoining areas and should have minimum 10 air changes per hour.

17.13 The scrub facility shall be located next to operation room, ceiling surface or tiles at this area shall be smooth, washable and free of particular matter that can be contaminated.

17.14 Clean and dirty utility rooms should be available for proper segregation, processing and storage of instruments

17.15 Sterilizing area (if provided within the facility) can be located near operating theatre area with adequate high-speed autoclave machine. Operation instruments and trolleys can be arranged at this area

17.16 Air pressure in sterilizing area should be kept negative pressure with respect to any adjoining areas and should have minimum 10 air changes per hour. Relative humidity should be maintained at 30% to 60%. High efficiency filters should be installed in the air handling system, with adequate facilities provided for maintenance, without introducing contamination to the delivery system or the area served.

17.17 Dedicated medical store area shall be located in operation facility, adequate number of all types of intravenous solutions, emergency medications, required anesthesia medications, etc shall be maintained. Store's air pressure should be kept positive pressure with respect to any adjoining areas and should have minimum 4 air changes per hour. Relative humidity should be maintained at 30% to 60%. High efficiency filters should be installed in the air handling system, with adequate facilities provided
for maintenance, without introducing contamination to the delivery system or the area served. (Operation theater medication should be regularly checked for expiry)

17.18 Sufficient supply of different medical gases should be available and adequate for procedure(s) performed (centralized medical gas system in accordance to HTM 2022 or its equivalent internationally accepted standard is preferable).

17.19 **Recovery area** shall be equipped to meet the patient need (minimum of one bed for each operation room). Reliable source of oxygen, suction, resuscitation, and emergency drugs must be available also.

17.20 Back-up emergency power supply sufficient to ensure patient protection in the event of an emergency must be available.

17.21 Recovery area air pressure should be kept at balanced pressure with respect to any adjoining areas and should have minimum 6 air changes per hour. Relative humidity should be maintained at 45% to 55%. High efficiency filters should be installed in the air handling system, with adequate facilities provided for maintenance, without introducing contamination to the delivery system or the area served.

For details regarding space requirements, emergency electrical power supply requirements [click here](#) to see the DHA Health Facilities Guidelines: Planning, Design, Construction and Commissioning.

18. **Observation Room(s)**

18.1 The room(s) location shall be convenient to a nurse station or control area. Patient's observation rooms shall have a minimum floor area of 7.43 square meters (80 square feet) with hand-washing station

19. **Health Records**

19.1 Filing cabinets and storage shall be provided for the safe and secure storage of patient's health records with provisions for easy retrieval.

19.2 Provisions shall be made for securing health records.

20. **Administrative Activities**

20.1 Each DSC shall make provisions to support administrative activities, filing and clerical work as appropriate. Administrative areas provided may include the following:

20.2 Clerical space or rooms for typing and clerical work.

20.3 Multiuse rooms for conferences, meetings, and health education.

21. **Equipment and Supply Storage**

21.1 The DSC shall make provisions for the following requirements:

21.1.1 A dedicated waste collection and storage area.

21.1.2 General storage area for supplies and equipments.

21.1.3 Special storage for staff personal belongings with lockable drawers or cabinets.

21.1.4 Storage areas for non-clinical records, documents, and office supplies.
22. Clinical Laboratory Requirements
   22.1 Phlebotomy rooms shall have seating space, a work counter, a hand-washing/hand hygiene provision and a reclining chair or gurney for patients who may become unsteady. Blood collection area shall have a minimum floor area of 7.43 square meters (80 square feet).
   22.2 When the clinical laboratory tests are performed on site, a separate and dedicated room for this purpose shall be provided.
   22.3 Laboratory area for basic haematology and biochemistry tests shall have a minimum clear floor area of 15 square meters (161.4 square feet). Extra spaces may be required for advanced test.
   22.4 Work counters and equipment space shall be provided to accommodate all on-site tests identified in the functional program of the facility.
   22.5 Work counters shall be sufficient to meet equipment specifications and laboratory technician needs and have the following:
      22.5.1 Hand-washing stations and counter sink(s).
      22.5.2 Communications service
      22.5.3 Electrical service
   22.6 Laboratory area shall have appropriate facilities for storage and refrigeration of blood, urine, and other specimens
   22.7 Storage cabinet(s) or closet(s) for the Clinical Laboratory.
   For further information regarding the laboratory services see the Clinical Laboratory Regulation published in the Health Regulation section of the DHA website www.dha.gov.ae

23. Diagnostic Imaging Requirements
   23.1 Diagnostic imaging services and procedures may be performed in DSC; imaging modalities may be conducted including Conventional Radiography (general radiology), Computer Tomography (CT), Magnetic Resonance Images (MRI), Ultrasound and Mammography.
   23.2 Patient convenience and accessibility should be an integral part of the planning and design of the Diagnostic Imaging services provided
   23.3 Every health facility providing ionizing radiation services shall take all necessary steps to restrict as far as reasonably practicable the extent to which his employees or other persons are exposed to ionizing radiation.
   23.4 Radiation protection requirements shall be incorporated into the specifications and the building plans. The health facility may need a certified physicist or a qualified expert to specify the type, location, and amount of radiation protection to be installed in accordance with the final approved layout and equipment selections.
   23.5 Sharing support areas for diagnostic imaging services (e.g. control desk, reception area, consultation area) is permitted if required by the functional program of the health facility.
For further information regarding the Diagnostic Imaging services see Diagnostic Imaging Services Licensure and Regulatory Standards published in the Health Regulation section of the DHA website www.dha.gov.ae
CHAPTER THREE:
DAY SURGICAL CENTRE STANDARDS
CLUSTER ONE: PATIENT CARE

24. Patient Assessment

24.1 An effective patient assessment process aims to be comprehensive, includes multidisciplinary teams and is based on clinical and priority needs of each individual patient. Such assessment shall result in identification and decisions regarding the patient's condition and continuation of treatment as the need arise.

24.1.1 The DSC shall have policies and procedures on patient assessment:

24.1.2 On admission
24.1.3 Following a change of health status
24.1.4 After a fall

24.1.5 When patient is transferred from one level of care to another.

24.2 The patient assessment shall include, but not limited to, medical history, physical, social and psychological assessment and identification of patients at risk.

24.3 Patients conveying personal health information during any assessment should be accommodated in an area where privacy is assured.

24.4 Discharge preparation starts at admission and includes various persons, information and resources. Consider discharge preparation:

24.4.1 The pickup person
24.4.2 Travel distance to home
24.4.3 “No driving” policies
24.4.4 Conditions at home, such as stairs, access to toilet or bedroom
24.4.5 The carer’s contact details and their awareness of possible issues and requirements following discharge
24.4.6 Contact numbers after discharge, such as the doctor or emergency contact
24.4.7 Discharge arrangements regarding home care where this is identified as required and available

24.5 Healthcare professionals should use a formal risk assessment process to assess skin integrity and risk of falls of patients.

24.6 A comfortable care environment shall be provided in the facility with focus on patient privacy. The plan of care must be determined and delivered in partnership with the patient and when relevant, patient's family/patient representative/legal guardian, to achieve the best possible outcomes.

24.7 The patient has the right to refuse the plan of care but this has to be documented and signed by the patient.

24.8 Patient’s participation may include:

24.8.1 Procedure date and admission/discharge time
24.8.2 Physician selection
24.8.3 Treatment preparation
24.8.4 Choice of wound care or dressing type
24.8.5 Post-discharge transport

24.9 Care shall be delivered by DHA-licensed and competent individuals and competent multidisciplinary teams and based on the best available evidence.

24.10 A comfortable treatment environment is provided in the facility with focus on patient privacy.

24.11 When patients remain in the facility for observation; food appropriate for the patient and consistent with his or her clinical care shall be provided to the patient.

25. Outpatient Care

25.1 Outpatient Services, if provided, must be under the direction of a qualified individual(s), as determined by the DSC and must be responsible for the quality and scope of outpatient services

25.2 The outpatient care shall be provided in a distinct area on the DSC premises.

25.3 The initial medical assessment may include, but not limited to: the reason for the visit, vital signs, medical history, pain assessment, physical, and psychological assessment of patient's needs.

25.4 The initial assessment of a dental patient will gather general medical history information while focusing on the reason for the dental visit and any complaint.

25.5 When relevant patient’s care assessment is conducted outside the Outpatient Care facility, the facility defines a documented process for obtaining and using outside assessment findings.

26. Ethical Considerations

26.1 Healthcare professionals working in the facility should be aware of their ethical responsibilities and comply with the ethical code of conduct which is governed by the principle of patient centeredness where the patient is the center of all activities.

26.1.1 Healthcare professionals should maintain patient’s information confidentiality at all times.

26.1.2 Referring physicians are strongly prohibited from taking any commission for referring patient to specific clinical laboratory or diagnostic imaging service provider.

26.1.3 Unnecessary diagnostic imaging investigations and laboratory testing must be avoided as they pose serious health implications and a financial burden to the individual and community.

27. Surgical Care

27.1 Surgical services and procedures shall be performed by qualified physicians (specialist/consultant) in an environment that ensures patient safety.

27.2 Surgical procedures to be undertaken should be within the scope of practice, training, expertise of the healthcare professionals, and the capabilities of the DSC.
27.3 All healthcare professionals shall hold an active DHA license.

27.4 As overnight stay is not permitted, the DSC operations and procedures should be of a duration and degree of complexity that will permit patients to recover and be discharged from the facility in less than 18 hours.

27.5 Patients who have pre-existing medical or other conditions that may be at particular risk for complications should be referred to a hospital for the procedure and administration of anaesthesia.

28. **Anesthesia and Sedation care:**

Different anesthetic techniques are emerging that are appropriate to the DSC, the level of anesthesia used should be appropriate for the patient, the surgical procedure, the education and training of the healthcare professionals authorized to provide anesthesia, and DSC available equipments. DSC may provide anesthesia services in the following levels:

**Level I Anaesthesia**

Minor procedures performed under topical or local anesthesia, not involving drug-induced alteration of consciousness other than minimal preoperative anti-anxiety medications (e.g. mole removals or incision and drainage of superficial abscesses, etc.) Such procedures can be performed by DHA licensed physicians or dentist within his/her the scope of practice.

**Level II Anaesthesia**

Procedures that require administration of light or moderate sedation/analgesia necessitate intra-operative and post-operative monitoring. Such sedation commonly involves intravenous administration of drugs with anxiolytic, hypnotic, analgesic, and amnesic properties either alone or as a supplement to a local or regional anesthetic.

The surgical procedures are limited to those in which there is only a small risk of surgical and anaesthetic complications, and hospitalization as result of these complications is unlikely such as endoscopic procedures (Esophagogastroduodenoscopy, Colonoscopy, Cystoscopy, Sigmoidoscopy, Bronchoscopy), Dental Procedures, Assisted Reproductive Techniques (ART).

**Level III Anaesthesia**

Include procedures that require or reasonably should require, the use of deep sedation/analgesia, general anesthesia, or major conduction blockade (e.g. liposuction or laparoscopy). The known complications of the surgical procedure may be serious or life threatening.

Major regional blocks including, but not limited to, spinal, epidural or caudal injection of any drug which has analgesic, anesthetic or sedative effects are in the same category as level III general anesthesia.

For detail list of procedures/surgeries which can be performed in DSC setting see appendix1. Other procedures that might be appropriate for DSC but not specifically mentioned in the list, may be carried out after seeking written permission from the Medical Director of the DSC.

28.1 **Requirements for level II Anesthesia**

28.1.1 *Physician/Dentist* shall be DHA-licensed specialist or consultant and shall be responsible for Providing a safe environment for the DSC.
28.1.2 Maintaining a valid DHA license with practical training and/or a course on sedation/analgesia use\(^2\).

28.1.3 Understanding the pharmacology of the agents that are administered, the role of pharmacological antagonists for opioids and benzodiazepines.

28.1.4 Establishing a patent airway and positive pressure ventilation if required.

28.1.5 Maintaining an active Advanced Cardiac Life Support (ACLS) certification if treating adults or Pediatric Advanced Life Support (PALS) if treating children.

28.1.6 Rescuing patients whose level of sedation becomes deeper than initially intended\(^3\).

28.1.7 Comply with the written clinical privileges to perform procedures in the DSC. *If any of the above points is not met, an anaesthetist must administer the sedative medication.*

28.1.8 **Registered Nurse,** Anesthesia technicians or Endoscopy Technician shall be responsible for monitoring patients receiving light/moderate sedation/analgesia and assisting the treating physician. He/she shall be competent, licensed by DHA and hold training in the following:

28.1.8.1 Basic Life Support (BLS)

28.1.8.2 Insertion of Intravenous (IV) lines.

28.1.8.3 Assessment and monitoring patients under sedation.

28.1.8.4 Pain assessment and management.

28.1.8.5 Medicine preparation and administration which includes understanding of pharmacology of the agents that are administered, as well as the role of pharmacological antagonists for opioids and benzodiazepines.

28.1.9 The DSC maintains a policy on proper storage and handling of anesthesia agent, the facility must abide by the Ministry of Health (MOH) regulation on storage, handling and records maintaining of narcotic and controlled medications.

28.1.10 Only the following **Sedative/analgesic agents and Medications** can be used in level II Anesthesia:

28.1.10.1 Oral Anxiolytics such as Alprazolam (Xanax), Chlordiazepoxide (Librium), Clonazepam (Klonopin), Diazepam (Valium), Lorazepam (Ativan)

28.1.10.2 Midazolam 5mg Injection (Dormicum) (not more than 5 mg)

28.1.10.3 Diazepam 5mg Injection (Valium) (not more than 5 mg)

28.1.10.4 Tramal 100mg/2ml Injection

28.1.10.5 Chloral Hydrate

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\(^2\) The practical training shall be conducted in a hospital with consultant anesthetist and with hand-on sedation/analgesia use. (Document proofing such training shall be maintained in the facility).

\(^3\) Because sedation is a continuum, it is not always possible to predict how an individual patient will respond to sedation. Patient who requires any airway assistance, or who has stopped following commands has progressed to a level of sedation that is beyond the scope of practice of physicians and nurses without specific anesthesia training.
28.1.10.6 Pethidine Hydrochloride (injection of 50mg/ml)
28.1.10.7 Fentanyl Injection (100mcg per 2 ml)
28.1.10.8 Alfentanil Injection 1mg/2ml
28.1.10.9 Inhalation Anesthesia by Nitrous Oxide
28.1.10.10 Local Anesthetics injection or spray e.g. Xylocaine (Lidocaine)
28.1.10.11 Anexate (Flumazenil) Injection and Naloxone Injection (400mcg/ml) must be maintained in the facility as benzodiazepines antagonist and opioid antagonist respectively.

List of Anaesthesia Medication for Level II DSC is available in appendix 2.

28.1.11 Mandatory Emergency Medication for Level II Anesthesia is available in appendix 3.

28.1.12 **Patient Selection Criteria:** Appropriate evaluation of the patient’s medical history and physical assessment shall be conducted by the treating physicians. Current medications and drug allergies should be documented.

28.1.13 The patient shall be in physical status permit him/her for the procedure/surgery, for further information regarding the patient physical status and patient appropriateness for DSC procedure/surgery see the classification of patient physical status as per American Association of Anesthesiologists (ASA) in appendix 4. Only patients that meet ASA 1 and ASA 2 criteria can be admitted for treatment in DSC.

28.1.14 Patients not meeting ASA1 nor ASA2 should be referred to hospital, this include, but not limited to:

- 28.1.14.2 Patients with history of sleep apnea.
- 28.1.14.4 Patients with history of drug or alcohol abuse.
- 28.1.14.9 Morbid obesity

28.1.15 For elective procedures, patient should be in fasting status. In urgent care or other situations when gastric emptying is impaired, the potential for pulmonary aspiration of gastric contents must be considered in determining the timing of the intervention and the degree of sedation /analgesia.

28.1.16 Documentation of Sedative/Analgesic care shall be performed by the supervising physician or dentist administering the sedative agents. While anesthesia care is a continuum, it is usually viewed as consisting of pre, intra and post-anesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review. The record should include documentation of:
28.1.17 Informed consent shall be obtained by the treating physician/dentist before the procedures/surgery and after a discussion of the complication risks, benefits and alternatives as per the Federal Law number 10/2008 concerning Medical Liability.

28.1.18 Pre-anesthesia evaluation includes:

28.1.18.1 Patient interview to review: Medical history, Allergy history, Anesthesia history, Medication history, Family history and Social history.

28.1.18.2 Physical examination.

28.1.18.3 Review of diagnostic investigations (e.g., laboratory, ECG, X-Ray)

28.1.18.4 Verification of NPO status

28.1.18.5 Assignment of patient physical status based on the American Society of Anesthesiologists (ASA); (see appendix 4). Only patients that meet ASA 1 and ASA 2 criteria can be admitted for treatment in DSC.

28.1.19 The followings should be present and monitored in patient receiving light sedation (Anxiolysis):

28.1.19.1 Normal respirations, heart rate and blood pressure

28.1.19.2 Normal eye movements;

28.1.19.3 Intact protective reflexes

28.1.20 The following should be present and monitored in patient receiving moderate sedation (injectable sedative/analgesic agents or medications):

28.1.20.1 Normal respirations, heart rate and blood pressure

28.1.20.2 Protective reflexes shall be maintained

28.1.20.3 Ability to maintain a patent airway independently and continuously;

28.1.20.4 Appropriate response by the patient to physical stimulation or verbal command, for example, "open your eyes."

28.1.20.5 The drugs, doses, and techniques used are not intended to produce a loss of consciousness.

28.1.21 All anaesthesia equipments should be maintained, tested, and inspected according to the manufacturer’s specifications. Preventive Maintenance Program (PMP) shall be documented on the machines.

28.2 Requirements for level III Anesthesia

28.2.1 Physician requirements: DHA licensed specialist/consultant anesthetist must manage anesthesia services in the DSC; he/she shall work within his/her scope of practice and shall be responsible for the quality of the services provided.

28.2.2 He/she must maintain valid training in Advanced Cardiac Life Support (ACLS) training if treating adults or Pediatric Advanced Life Support (PALS) if treating children.
28.2.3  **Anesthetist must be physically present** during the intra-operative period and be available until the patient has been discharged from anesthesia care.

28.2.4  **Registered Nurse, Anesthesia technicians requirements**

28.2.4.1  All healthcare professionals who assist in anesthesia administration or supervise patient during anesthesia (i.e. anesthesia technicians and registered nurses in the operation theater) should maintain valid training in Advanced Cardiac Life Support (ACLS) training if treating adults or Pediatric Advanced Life Support (PALS) if treating children.

28.2.4.2  Number of **Registered Nurse** required in the DSC operation area shall be based on the patient needs, DSC activities, and number of operating theatres. Generally not less that three RN per theatre along with at least one RN each shift in the Recovery area.

28.2.5  The following factors should be considered for nursing staffing in the DSC operation area:

28.2.5.1  The reception area

28.2.5.2  Number of operating theatres and recovery areas functioning each day

28.2.5.3  Allowances for leave, public holidays, days off and maternity leave

28.2.5.4  Nature of DSC procedures/surgeries

28.2.5.5  Number of operations performed per shift per day.

28.2.6  The choice of specific **Sedative/anesthetic agents** and techniques should focus on providing anesthetics that will be effective, appropriate, and will respond to the specific needs of patients while also ensuring rapid recovery to normal function with maximum efforts to control post-operative pain, nausea, or other side effects.

28.2.7  Along with level II sedative agents, the following medications can be used in level III Anesthesia:

28.2.7.1  Propofol

28.2.7.2  Remifentanil

28.2.7.3  Ketamine

28.2.7.4  Naloxone Injection (400mcg/ml) must be maintained in the facility as opioid antagonist in case of respiratory depression.

28.2.8  The DSC maintains a policy on proper storage and handling of anesthesia agent, the facility must abide by the Ministry of Health (MOH) regulation on storage, handling and records maintaining of control and narcotic medication.

28.2.9  Second line (optional) emergency medication list shall be available in DSC providing level III anesthesia, for further information see **appendix 5**

28.2.10  **Patient Selection Criteria** (same as type II anesthesia, see point 1.4.5)

28.2.11  **Documentation of Sedation/Anesthesia Care**

28.2.11.1  Informed consent shall be obtained by the treating physician/dentist before the procedures/surgery and after a discussion of the complication
risks, benefits and alternatives as per the Federal Law number 10/2008 concerning Medical Liability.

28.2.11.2 Pre assessment shall be conducted for all patients requiring deep and general anesthesia, the anesthetist shall assess patients prior to the procedure/surgery and carry out certain basic investigations such as CBC, Blood Glucose, and Coagulation Profile.

28.2.11.3 Physiologic monitoring of patients should be appropriate for the type of anesthesia and individual patient needs including continuous monitoring or assessment of ventilation, oxygenation, cardiovascular status, body temperature, neuromuscular function, status, and patient positioning.

28.2.11.4 Anesthesia note/form in the health records shall be used for documentation of all information, anesthesia agent used, dosage, assessment, consent etc.

28.2.12 The DSC shall maintain policies and procedures for the following:

28.2.12.1 Patient care at recovery area and on discharging patients; (only anesthetist is privileged to discharge patient from the recovery area).

28.2.12.2 Difficult intubation.

28.2.12.3 Instrument packing procedures and sterilization

28.2.12.4 Anesthesia infection control policy shall be available and implemented for anesthesia machines and equipments and all anesthesia processes.

28.2.12.5 Safety measures shall be implemented against biohazards.

28.2.12.6 In case of specialized operations such as pediatric surgery, the anesthetist must be competent and experienced to provide the specialized anesthesia services. The anesthesia equipments, monitoring devices, emergency medications, and resuscitative equipment must be appropriately for pediatric patients.

28.2.13 Its highly recommended from patient safety prospect, all DSC procedures and surgeries shall not exceed 6 hours, and that all procedures be completed by 3.00 pm

28.2.14 All anesthesia equipment should be maintained, tested, and inspected according to the manufacturer’s specifications. Preventive Maintenance Program (PMP) shall be documented on the machines

29. Critical Care Services

29.1 DSC (level III) shall provide basic setup for an Intensive Care Unit (ICU), the anesthetist/intensivist shall manage the ICU services in the DSC; he/she shall be responsible for the quality and scope of service provided. Critical care services in DSC shall meet the following requirements:

29.2 All physicians performing procedure/surgery must have an active certification in BLS, ACLS and/or PALS.
29.3 There must be one competent Registered Nurse (RN) with suitable training and experience in critical care on duty to provide the critical care services if required. There is evidence of the competency and training shall include the following:

29.3.1 Recognizing arrhythmias
29.3.2 Assisting physician in placing central lines or arterial lines.
29.3.3 Obtaining blood gases ABG’s.
29.3.4 Central Venous Pressure (CVP) line.
29.3.5 Infection control principles.
29.3.6 Glasgow coma scale (GSC).
29.3.7 Training in using defibrillator and care of patients on ventilators.

29.4 At least one designated bed in the facility shall be provided with ICU following requirements:

29.4.1 The critical care beds must be supplied with medical gases outlets (O2, Air, Suction), enough numbers of electrical outlets, examination lights. Supply of medical gases should be available and centralized medical gas system shall be according to HTM 2022 or its equivalent internationally accepted standard.

29.4.2 Ventilators (see appendix 6 regarding ventilator specifications)
29.4.3 Tracheostomy set
29.4.4 Emergency crash cart that includes all emergency supplies and medications.
29.4.5 Defibrillator machine
29.4.6 Pulse Oximetry and vital signs monitor.
29.4.7 Infusion pumps
29.4.8 Vital Signs Monitors.
29.4.9 Blood gas analyzer with capability for electrolytes measuring should be available in the DSC.

29.5 Critical care services equipments and supplies must be immediately available in the DSC for immediate and safe provision of care and treatment required.

29.6 Mandatory Emergency Medication for Level III Anesthesia shall be available in the DSC for further information regarding the medication list see appendix 7.

29.7 Written policies and procedures must be established and implemented which define, describe the scope of critical care services and ensure safe and competent delivery of the services to the patients.

30. Surgical Services

Surgical services shall be provided by qualified surgeons who are authorized by their scope of practice and have received privileges to perform surgical procedures by the DSC management.

30.1 Type of procedures/surgeries conducted in the DSC and their degree of complexity shall be within the DSC capabilities.
30.2 Written policies and procedures must be established and implemented which define and describe the scope of surgical services and ensure safe and competent delivery of surgical services to the patients. Policies shall cover but are not limited to the following areas:

30.2.1 Informed consent
30.2.2 Patient assessment
30.2.3 Techniques of various modes of sedations
30.2.4 Appropriate patient monitoring
30.2.5 Response to complications
30.2.6 Use of reversal agents
30.2.7 Time out
30.2.8 Restrictions on access to the surgical suite and recovery room area
30.2.9 Proper attire in the surgical suite and recovery rooms area
30.2.10 Responsibility for the supervision in the OT and recovery area.
30.2.11 Discharging patient
30.2.12 Sterilization and disinfection of equipment and supplies
30.2.13 Infection control policies

30.3 Maintenance of operating theatre records shall include, but are not limited to:

30.3.1 Name and identification number of each patient
30.3.2 Date, inclusive of time of the surgical procedure
30.3.3 Surgical procedure(s) performed and Time out.
30.3.4 Name(s) of surgeon(s) and assistants if any
30.3.5 Name of nursing personnel (scrub and circulating)
30.3.6 Type of anesthesia
30.3.7 Name and title of person managing anesthesia
30.3.8 Requirements for testing and disposal of surgical specimens.
30.3.9 Circumstances that require the presence of an assistant during surgery
30.3.10 Procedures for handling infectious cases

31. Emergency Services

31.1 At minimum each DSC shall have provision for basic emergency management for illness and/or injuries occurred for patient, healthcare professionals, employees or visitors which needs immediate emergency care and assistance prior to transport to other facility.

31.2 Emergency services must be provided by qualified and licensed physician(s) who are authorized by their scope of practice to provide emergency services and received privileges from the facility to perform specific emergency procedures
31.3 All physicians and nurses working in the emergency area must have active certification in BLS, ACLS and PALS (if pediatric services provided)

31.4 Registered Nurse (RN) providing emergency services in the DSC shall be trained and competent to provide the emergency care needed. Examples of emergency nurse competencies are:

31.4.1 Patient Triage
31.4.2 Operating a Cardiac Monitor
31.4.3 ECG Recording and Interpretation
31.4.4 Pulse Oxymetry
31.4.5 Oxygen Administration
31.4.6 Suctioning
31.4.7 Intravenous cannulation
31.4.8 Medication administration
31.4.9 Emergency services shall be provided during the operational hours of the DSC.

31.5 Emergency drugs, devices, equipment and supplies must be available for immediate use in the emergency area for treating life-threatening conditions.

31.6 Storage areas for general medical/surgical emergency supplies, medications and equipments shall be under staff control and out of the path of normal traffic.

31.7 Policy for maintaining personal items and food in emergency area shall be established and maintained by the facility.

31.8 A record must be kept for each patient receiving emergency services and must be integrated into the patient’s health records, the record shall patient name, date, time and method of arrival, physical findings, care and treatment provided. Name of treating physician and discharging/transferring time

31.9 In compliance with the Federal Law number 10/2008 concerning Medical Liability, all emergency patients arriving at the emergency area should receive emergency services required for stabilization; ill persons shall be promptly assessed and treated or transferred to a hospital capable of providing needed specialized services.

31.10 Ambulance services: well-equipped ambulance vehicle should be ready with licensed, trained and qualified Emergency Medical Technicians (EMT) for patient transportation if required, this service can be outsourced with a written contract with an emergency services provider licensed in Dubai.

31.11 Clear patient transport protocol shall be maintained

31.12 List of medical equipment and medicines required in DSC emergency area:

31.12.1 Defibrillator
31.12.2 Emergency Cart with Emergency medicines
31.12.3 Resuscitation Kit, Cardiac board and Oral airways
31.12.4 Laryngoscope with blades
31.12.5 Diagnostic set
31.12.6 X-ray viewer
31.12.7 Patient trolley with IV stand
31.12.8 Nebulizer
31.12.9 Refrigerator for medication
31.12.10 Floor Lamp (Operating light mobile)
31.12.11 Sets of instruments which shall include suturing set, dressing set, foreign body removal set or minor set and cut down set
31.12.12 Disposable supplies which shall include suction tubes (all sizes), tracheostomy tube (all sizes), intravenous cannula (different sizes), IV sets, syringes (different sizes), dressings (gauze, softrulle, etc.), crepe bandages (all sizes), splints (Thomas splints, cervical collars, finger splints),
31.12.13 All types of fluids (e.g. D5W, D10W, Lactated Ringers, Normosol R, Normosol M, Haemaccel, etc.), Glucometer and Alcohol meter.
31.13 Medico-legal forms including Discharges Against Medical Advice (DAMA) form (Sample of DAMA form is available in appendix 8)
31.14 Sufficient electrical outlets to satisfy monitoring equipment requirements, including clearly labeled outlets connected to an emergency power supply.
31.15 Reliable source of Oxygen
31.16 Portable vital signs monitor (ECG, Pulse-Oximetry, Temperature, NIBP, EtCO2)
31.17 Portable transport ventilator with different ventilation mode (IPPV, SIMV, spontaneous, PS).
31.18 Suction apparatus.

32. Discharge / Transfer Planning

32.1 Processes for admission, discharge and transfer of care shall address the needs of the patient for ongoing care. Inadequate planning may result in discharging patient with inappropriate levels of care which may lead to undesirable complications and readmissions.
32.2 The DSC shall maintain written policies and procedures concerning the patient discharge/transfer which reflect acceptable standards of practice and compliance with applicable regulations in Dubai.
32.3 Each patient discharge from a the DSC shall receive a written discharge plan, in non-technical language, along with sufficient verbal explanations to assist the patient in understanding the plan and availability of out patient services capable of meeting the patient's discharge needs.
32.4 If patient is transferred to another health facility and in order to insure continuity of patient care, the other facility shall be informed about the case and approval for transfer should be documented in the patient file.
32.5 The treating physician is responsible for the coordination of the timely transfer of appropriate information and discharge notice from the DSC to hospital or another health facility.
32.6 A referral letter shall be given to the patient or family/patient representative. Patient should not be sent under any circumstances to another facility without prior approval.

32.7 Mode of transport should be decided based on the condition of the patient, the treating physician and the ambulance team shall decide who should accompany the patient e.g. EMT, competent physician or trained nurse in emergency/critical care.

32.8 Treating physician should respect patients' choices if he/she decided self discharge, i.e. discharges against medical advice, DAMA form shall be available in the Day surgery centre; DAMA patients shall sign the form before leaving the facility.
CLUSTER TWO: DIAGNOSTIC SERVICES

33. Clinical Laboratory Services

Each DSC must provide clinical laboratory services and these services may be available on the premises or through written agreement to meet the patient’s needs.

33.1 The DSC shall have access to emergency laboratory services including urinalysis, complete blood counts, biochemistry and other necessary emergency laboratory tests as determined by the medical staff.

33.2 All laboratory tests shall comply with the DHA Clinical Laboratory regulation.

33.3 All laboratory equipment shall be calibrated and maintained as per DHA Clinical Laboratory regulation.

33.4 Laboratory services shall be under the direction of a DHA licensed and experienced pathologist.

33.5 At least two full time general laboratory technicians shall be licensed in the DSC to cover the 18 hours DSC duty.

33.6 DSC shall ensure safe and appropriate practice system for sample collection, storage and transportation of blood and other samples.

33.7 A policy shall exist for:

33.7.1 Patient identification

33.7.2 Safe collection of samples

33.7.3 Turnaround time and reporting of results

33.7.4 Communicating critical results.

For further details regarding DHA Clinical Laboratory Regulation visit www.dha.gov.ae

34. Diagnostic Imaging

Each DSC must provide Radiology and Diagnostic Imaging services to meet the patient needs; such services may be available on the premises or with written agreement with an external provider.

34.1 Radiology and diagnostic imaging services must comply with the Federal Authority Nuclear Regulation-FANR laws and regulations regarding the use of ionizing radiation and radioactive materials in the facility. For further information regarding FANR regulations and requirements please visit FANR website www.fanr.gov.ae

34.2 Radiology services in the DSC must be under the supervision of a licensed Consultant/Specialist Radiologist, he/she shall be responsible for the quality and scope of radiology service provided in the facility.

34.3 All x-ray films must be reviewed and interpreted by a Radiologist. Complete reports of the results of x-ray examinations must be kept in files or PACS if the system is digital for not less than five years and a copy must be filed in the patient’s record.

34.4 At least one full time qualified and DHA licensed radiographer shall be available for each shift in the facility to provide the radiography services.
34.5 Radiology services in the facility must be assessed by Radiation Safety officer. For further details regarding radiation protection requirements, see section Radiation protection section in the Health Facilities Guidelines: Planning, Design, Construction and Commissioning

For further details regarding Radiology and diagnostic imaging services please visit Health Regulation site in DHA website www.dha.gov.ae and see the Radiology and Diagnostic Services Licensure and Regulation Standards.
CLUSTER THREE: MEDICATIONS MANAGEMENT AND PHARMACY

35. Medications Management

35.1 Medications shall be managed to ensure safe and effective practice. The DSC must maintain a policy and procedures on medication management consistent with applicable federal legislation in the UAE. Considerations for DSC are:

35.1.1 After admission to the DSC, only medication ordered or approved by the surgeon / anaesthetist should be taken by the patient.

35.1.2 A written record for the dosages of drugs and the timing of their administration should be entered into a health record.

35.1.3 Special arrangements should be in place for post-discharge medications with clear written instructions, for example suitable analgesia should be provided for at least the first day after discharge.

35.1.4 The DSC should facilitate access to discharge medication where it is not provided by the facility.

35.2 Potential medication risks are identified. Look-alike, sound-alike medications must be identified and segregated.

35.3 The DSC shall promote safe storage and use of potassium chloride, other concentrated electrolyte solutions and high alert medications. A policy shall be available for the management of such medications.

35.4 The order of concentrated electrolyte solutions and high alert medications shall be restricted, storage and documentation requirements shall be strictly followed.

35.5 A standardized list of approved abbreviations for medications shall be used throughout the DSC and shall be maintained.

35.6 A multidisciplinary team shall oversee and ensure the proper management of medication safety in the DSC.

35.7 Healthcare professionals should have access to published guidelines for medication management.

36. Pharmacy

Pharmacy services should be provided in the DSC to meet the needs of patient directly or through written agreement, and must be under the supervision of an experienced and licensed pharmacist by DHA.

36.1 The storage, control, handling, compounding and dispensing of drugs, devices and biological materials shall be according to the applicable MOH law and regulations.

36.2 Provisions shall be made for storage and preparation of medications administered to patients.

36.3 Double locked storage for controlled substances shall be provided as per the MOH requirements.

36.4 Drugs, devices and biologicals must be stored in locked areas according to the manufacturer’s instructions for temperature, light, humidity or other storage
instructions, and it must be removed from the pharmacy or storage area only by designated staff according to the DSC policies and UAE regulations. A specific refrigerator for pharmaceuticals shall be provided.

36.5 Convenient access to hand-washing stations shall be available

36.6 Emergency drugs, devices and biologicals as determined by the healthcare professional staff must be available for use at designated locations when an emergency occurs. Up to date and accurate records must be kept on the receipt and disposition of all controlled substances. The supply of drugs, devices and biologicals and controlled substances must be protected and restricted to use for legally authorized purposes only.

36.7 The supply of drugs and devices must be checked on a regular basis to ensure expired, mislabeled, unlabelled or unusable products are not available for patient use and are disposed accordingly.
CLUSTER FOUR: SUPPORT SERVICES

37. Allied Health Services

37.1 The DSC may provide necessary allied health services to meet patient needs and based on the type services provided in the facility, such services may be available on the premises or with written agreement with an external provider.

37.2 Allied health services shall be provided by competent and licensed healthcare professionals. The management shall support the Allied healthcare professionals education and training, such training shall ensure competency in specific area e.g. lifting and manual handling, Infection control, Fire training, CPR training.

37.3 Each type of allied health services provided in the facility shall fulfill DHA criteria for that particular service. For further information please visit Health Regulation site in DHA website.

38. Nutrition Services

38.1 Nutrition services shall be provided by the DSC either on the premises or with written agreement with an external provider, If provided internally, firm hygienic conditions should be maintained in the DSC kitchen during preparing, storing and serving food.

39. Laundry

39.1 DSC shall provide a laundry services either inside the facility or outsource the service, the laundry shall be fully equipped with machines used for cleaning and washing clothes, sheets and covers.

40. Sanitary Services

40.1 Clean and hygienic water supply should be provided in the DSC, water tanks should be maintained, clean and well closed.

40.2 Clean bathrooms for outpatients should be provided (separate for male and female), every bathroom should have at least one washbasin and commode with soap and hand dryer. All the staff and patients’ toilets should be kept clean. Water drainage and sanitation should be hygienic.

40.3 All DSC drainage and sewage should be connected to general sewerage and be according to Dubai Municipality regulations.

41. External Services

41.1 External services provider shall be managed effectively to provide safe, quality care and services. Many healthcare facilities use external contractor and / or services to provide specific services that are essential to the ongoing operation of the DSC e.g. nutrition, laundry, cleaning, maintenance, transport, and security. Some clinical services provided by an external contractor such as radiology, pathology and allied health.

41.2 While a contracted service agreement is important for both the healthcare facility and services provider to ensure quality maintenance of the services, the fundamental responsibility for quality still rest with the contracting healthcare facility. The facility should precisely outline in its services agreements / contracts, the type and standard of
the services expected and evidence of compliance with regulatory bodies such as Dubai Municipality standards for laundry or nutrition services.

42. Care for Deceased Patients

Death in a DSC would be considered a sentinel event. However, occasionally patients will die in a DSC. A policy for mortuary management covering this rare and tragic event shall be available in the facility.

42.1 In case of patient death, the DSC shall be responsible for overseeing the transportation of deceased patients from the DSC to mortuary.

42.2 The DSC shall maintain a policy in handing dead bodies which assure respect and dignity of the deceased.

42.3 All dead bodies shall be considered infectious, strict infection control measures shall be considered during cleaning the body. Body should be cleaned and wrapped/placed on mortuary bag.

42.4 Patient’s family willing has to be totally respected and considered; requests for relatives/friends to view the deceased shall be arranged by the DSC staff or in the mortuary.

42.5 Deceased registration shall be maintained by the DSC.
CLUSTER FIVE: SAFETY

43. Patient Safety Solutions

43.1 The DSC shall ensure that the correct patient receives the correct procedure on the correct site. A policy and protocol shall exist for ensuring correct patient, correct procedure and correct site.

43.2 Correct patient, correct procedure and correct site information shall be provided to healthcare professionals, patients and when relevant, patient's family/patient representative.

43.3 The DSC management should encourage the use of at least two identifiers (e.g. name and date of birth) to verify a patient’s identity upon admission or transfer to another health facility or other care setting and prior to the administration of care. Neither of these identifiers should be the patient’s room number.

43.4 The DSC management should standardize the approaches to patient identification among different facilities within a health-care system. For example, use of white ID bands on which a standardized pattern or marker and specific information (e.g. name and date of birth) could be written, or implementation of biometric technologies.

43.5 The delivery of health care is challenged by a wide range of safety problems; DSC shall provide safe care and services by focusing efforts on reducing harm to patients and staff. The most common causes of harm in health system were identified by the World Health Organization (WHO) patient safety solutions. It aims to save lives and prevent medical errors. The International Steering Committee approved nine patient safety solutions for dissemination. The nine patient safety solutions are:

43.5.1 Look-alike, sound-alike medication
43.5.2 Patient identification
43.5.3 Communication during patient hand-over
43.5.4 Performance of correct procedure at correct body site
43.5.5 Control of concentrated electrolyte solutions
43.5.6 Assuring medication accuracy at transitions in care
43.5.7 Avoiding catheter and tubing misconnections
43.5.8 Single use of injection devices
43.5.9 Improved hand hygiene to prevent health care-associated infection

43.6 The DSC shall actively identify, manage risks and implement strategies associated with patient safety, to ensure suitable patient safety solutions by the WHO. Click here to access the nine Patient Safety Solutions published by the World Health.

44. Infection Prevention and Control

44.1 The infection control system shall support safe practice and ensures a safe environment for patients, healthcare workers and the DSC visitors. Infection control system shall address factors related to the spread of infections among professional/patient and prevention which includes, but not limited to:

44.1.1 Hand hygiene/hand washing
44.1.2 Cleaning/disinfection/sterilization
44.1.3 Restriction of jewelry, nail polish and false nails
44.1.4 Vaccination
44.1.5 Surveillance
44.1.6 Monitoring/investigation of demonstrated or suspected spread of infection within a DSC.

44.2 Infection control policies shall address the specific infection risks and hazards in the DSC, covering all aspects of infection control, including but not limited to:

44.2.1 The basic measures for infection control
44.2.2 The procedures for minimizing risk
44.2.3 Use of standard precautions and additional precautions in certain cases
44.2.4 Environmental cleaning, single-use items and reprocessing of sterile instruments.

44.3 The DSC management shall designate a person/committee who’s competent and received proper training to ensure that infection control is meeting appropriate standards

44.4 DSC healthcare professional should attend training on risks and prevention of infection.

44.5 Post-exposure prophylaxis protocols shall be available in the DSC.

44.6 Each DSC should formulate and implement a comprehensive immunization policy for all HCW's and shall arrange the vaccination of HCW's at no cost. Recommended immunizing agents and immunization schedules for HCW's is available in appendix 9. Proof of current HCW's immunization for the recommended agent should be maintained along with a central system to track the vaccination status of HCW's.

44.7 As per the Federal Law number 27/1981 concerning the Prevention of Communicable Diseases, communicable diseases must be reported to the relevant department in DHA. Information should be readily available to healthcare professionals on what diseases to report and where and how they should be reported.

44.8 External service providers and visitors shall be advised of the DSC infection control requirements. Surveillance to ensure maintenance of a clean and safe environment of resources such as air conditioning units and water cooling towers should be conducted by the DSC management.

45. Falls Management Program

45.1 The incidence of falls and fall injuries shall be minimized through a falls management program. A policy shall exist for falls management. Patients shall be assessed for risk of falls:

45.1.1 On admission
45.1.2 Following a change of health status
45.1.3 After a fall.

45.2 Falls prevention information is provided to staff, patients and patient's family/patient representative.

45.3 Appropriate falls reduction strategies should be implemented by the DSC according to identified risk factors.
CLUSTER SIX: PATIENT AND FAMILY RIGHTS:

46. Patient’s Rights and Responsibilities

46.1 Patient Rights and Responsibilities must comply with federal and local regulation regarding Patient Rights and Responsibilities, for further information regarding this subject please click here or visit the Health Regulation in DHA website.

46.2 Patients shall have the right to full disclosure of health services cost. Cost information can be displayed in the form of price leaflet/brochure or any other form feasible for the DSC.

46.3 All health facilities shall ensure the Charter of Patients’ Rights and Responsibilities communicated and displayed in at least two languages – Arabic and English – in all patient care and waiting areas and posting on the Facility’s website, if any. Additional languages may be used if required based on patients’ cultural and linguistic diversity and backgrounds.

46.4 The DSC shall ensure that patients are aware and understand their responsibilities regarding the procedures/surgery, including but not limited to fasting times, medications, financial issues and consent to not driving post-operatively.

46.5 Patients should be given the opportunity to participate in decisions involving their healthcare when such participation is not contraindicated.

46.6 Patients have the right to request information about a physician’s scope of practice and license. An identification badge or DHA license shall be maintained by all healthcare professionals during working hours.

46.7 Patients or his/her designated person should be provided information concerning the patient’s diagnosis, evaluation, treatment options, and prognosis. Patients have a right to obtain comprehensive medical report based on their personal medical records along with copies of all investigations reports.

46.8 Patients have the right to refuse any diagnostic procedure or treatment and be advised of the medical consequences of that refusal.

46.9 The DSC must have an effective program for handling of patient complaints. Complaints made by a patient or by patient’s family should be investigated, documented including the resolution of the complaint.

46.10 The patient and the DSC have the right to change or transfer the patient care responsibility from one specialist/consultant to other with clear justification.

46.11 Patient satisfaction surveys shall be carried out regularly.

46.12 The DSC shall develop a policy regarding patient’s belongings.

47. Informed Consent

47.1 As per article (7) of the Federal Law number 10/2008 concerning Medical Liability and the Cabinet Decision No. (33) of 2009 promulgating the bylaw of the medical liability law Informed consent shall be obtained by the treating physician and after a discussion of the complication risks, benefits and alternatives of procedures/surgery (excluding emergency cases).
47.2 If the patients lack the full capacity (e.g. less than 18 years old) informed consent shall be taken from their relatives up to the fourth degree, before the procedure/surgery is performed.

47.3 Consent documentation shall be maintained in the patient's health record.

47.4 Patients shall be provided with comprehensive and accessible information concerning treatment/procedure and alternatives.

47.5 The DSC shall clearly define investigations, treatment and procedures that require patient consent.

47.6 Informed consent formed shall be maintained in the patient's health record. Consent form should be bilingual and should contain the following:

47.6.1 The diagnosis, if known
47.6.2 The name of proposed procedure or treatment
47.6.3 The risks and benefits of proposed procedures or treatment
47.6.4 Alternatives, and the risks and benefits of alternatives
47.6.5 Statement that procedure was explained to patient or guardian
47.6.6 Date and time consent is obtained
47.6.7 Name and signature of the treating physician/dentist.
47.6.8 Signature of person witnessing the consent

47.7 All contents of the “Informed consent forms” should comply with the Cabinet Decision No. (33) of 2009 promulgating the bylaw of the Medical Liability Law, click here to see the law or visit www.dha.gov.ae

47.8 Fertility consent forms shall comply with Federal Law number 11/2008 concerning Fertility Centres Law and the Cabinet Decision No. (36) of 2009 promulgating the bylaw of the Fertility Centres Law, click here to see the law or visit www.dha.gov.ae

47.9 Healthcare professionals working on the DSC shall be informed about the consent policy.

47.10 Where consent is obtained by the visiting community physician, the DSC management shall ensure that the signed consent form is received and filed in the patient health record.

48. Patient Education

48.1 Patients and their family have the right for knowledge and health education in order to assist them to participate in care and take decisions about their health status.

48.2 Health education program and materials shall be available for patients and families in the DSC including but not limited to demonstration on infection control for patient, pre-operative and post-operative preparations, medicines utilization, care of surgical wound etc.

48.3 Patient and their families should receive information/leaflet about their illnesses and potential complications that may happen latter.

48.4 Health education program may be assigned to competent staff e.g. dieticians, nurse educator.
49. Disabled People Rights

49.1 In compliance with the federal law number 29 for 2006 regarding Disabled People Rights, all health facilities shall be made accessible to accommodate disabled individuals. The following special needs requirements are mandatory:

49.1.1 Disable parking within or next to the DSC premises
49.1.2 Wheelchair ramps within the DSC building
49.1.3 Accessible physical examination rooms.
49.1.4 Disable-accessible rest room within the DSC facility building.
CLUSTER SEVEN: HEALTH INFORMATION MANAGEMENT

50. Health Records
The health record is a legal document that should accurately outline the total needs, care and management of patients. It facilitates communication, decision making and evaluation of care and protects the legal interests of the patient, clinician and the clinic.

50.1 A legible, complete, comprehensive, and accurate health record must be maintained for each patient.

50.2 The patient’s health record should include medical history, physical examination, any pertinent progress notes, operative reports, investigation reports and communication with the patient or the patient’s representatives. It should highlight allergies and untoward drug reactions.

50.3 Health records shall include:

50.3.1 Patient’s demographics
50.3.2 A unique identifier for health records
50.3.3 A system to alert staff to patients of the same name
50.3.4 Identification of patients with challenging behaviors
50.3.5 The identity of the healthcare professional that made the entry.
50.3.6 Complete, legible notes of treatment and care given, medications prescribed and diagnostic tests ordered
50.3.7 Diagnostic test results and a record of when results were received.
50.3.8 Operation reports and anesthetic records.
50.3.9 Copies of signed informed consent given by the patient or his/her relatives up to the fourth degree (if lacking the capacity).

50.4 Medical reports should be signed and stamp by the treating physician. Time and date must be mentioned.

50.5 All information relevant to a patient should be readily available to authorized healthcare professionals or in the event that a patient is transferred.

50.6 Patient information should be treated as confidential and protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

51. Telephone or Verbal Orders

51.1 The most error-prone communications are patient care orders given verbally and those given over the telephone. The DSC shall implementing clinical protocols which minimize the use of verbal and telephone orders.

51.2 Telephone or verbal communications by authorized healthcare professional such as report back of clinical laboratory critical tests results are accepted and shall be transcribed by qualified healthcare professional.

51.3 The day surgery centre shall develop a policy and/or procedures that address the accuracy of verbal and telephonic communications. The policy must specify the situations when verbal and telephone orders are accepted.
51.4 Telephone or verbal communications must be documented immediately by the healthcare professional that receives the order and should be authenticated within 24 hours by the healthcare professional that is responsible for ordering or evaluating the service furnished.

52. Health Record Management Systems

Information management systems include records management, collection, use and storage of information, data management and Integration of information and communication technology.

52.1 Each DSC must maintain health records and reports in a manner to ensure accuracy and easy retrieval.

52.2 Based on the DSC activity and number of patient and storing methodology a health record room or area with adequate staff, supplies and equipment shall be provided in each DSC.

52.3 Health records shall be maintained in the custody of health facility and shall be available to a patient or his/her designated representative through the attending healthcare professional at reasonable times and upon reasonable notice.

52.4 Health Record must be maintained for every patient, including patient attending emergency or outpatient service in the DSC. Health records must contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately.

52.5 Records refer to all clinical and non-clinical records, both electronic and paper-based.

52.6 The DSC shall maintain a records management policy and system that ensure:

52.6.1 The secure, safe and systematic storage of data and records
52.6.2 Timely and accurate retrieval of records stored on or off-site
52.6.3 Patient privacy when information contained in records is release or communicated for care
52.6.4 Retention of records
52.6.5 Destruction of records is in compliance with all relevant DHA regulations and guidelines (incinerating or shredding for hard copy records, wiping disks clean or the disks physically destroyed for electronic records).

52.7 The DSC shall ensure that each patient is allocated a specific unique identifier, and where multiple records for the patient exist they are cross-referenced.

52.8 Clinical classification is undertaken for all inpatient admissions in accordance with the International Classification of Disease 10 (ICD10). The DSC shall ensure that coders have access to the ICD10 standards.

For further information regarding Health Records see Health Records Guidelines visit Health Regulation section in DHA website www.dha.gov.ae

53. Retention of Health Records

The DSC management shall be responsible for retention of patient health records, health records retention time shall be as follows:
53.1 Retain the health records of UAE local patients up to 10 years and of non-local patients up to 5 years after the most recent patient visit/admission to the DSC.

53.2 The Day surgery centre would retain the following health records in the original form for the period specified:

53.2.1 The health records of medico-legal cases up to 20 years and then entered into the image processing system and destroyed.

53.2.2 Files of deceased patients to be stored for 5 years then imaged and destroyed.

53.2.3 Patient health records of certain major diseases and incidents selected by the administrations and/or requested by the consultants for academic, research and administrative purposes may be retained for longer periods than specified.

53.2.4 Dental Record needs to be stored for 10 years.

For further information regarding health records completion, retaining, and destruction see Health Records Guidelines in the DHA website www.dha.gov.ae
CLUSTER EIGHT: ADMINISTRATIVE STANDARDS:

54. Monitoring Quality of Service

54.1 The DSC management shall be responsible for quality of care and shall support improving the outcomes of care and service delivery. A framework for continuous quality improvement exists which may include:

54.1.1 Customer focus-patient needs are recognized
54.1.2 Evidence of outcome data are used for evaluation
54.1.3 Striving for best practice the DSC compares its performance with others and improves as a result of that comparison

54.2 Feedback from patients, employee or others may be positive or highlight opportunities for improvement, the DSC management should support such activities

54.3 Complaints management policies and educational plan should be part of the quality program, helping to identify any concerns and allowing opportunities for improvement.

54.4 Identification of a person or a team responsible for coordinating quality management activities and the means of reporting to the administrator or governing body of the DSC.

54.5 The DSC management should continuously evaluate clinical care and outcomes thought systematic review and good clinical governance. Variation from the expected outcome can measure the quality of care delivered. Some measures may include:

54.5.1 Recovery within best practice or appropriate timeframe
54.5.2 Wound healing time
54.5.3 Complication rate
54.5.4 Incidence of pain, nausea and vomiting
54.5.5 Incidence of treatment related side effects
54.5.6 Incidence of changes to patient mobility arising directly from the procedure

54.6 Prior to discharge, healthcare professionals shall discuss and documented the outcomes of care with the patient and when relevant, patient's family/patient representative.

54.7 Patients should be encouraged to provide feedback on the care provided; care evaluation when appropriate shall be conducted with the patient and family/patient representative.

55. Complaints System

Complaints (medical and non medical) shall be managed to ensure improvements in delivery of the healthcare system.

55.1 Complaint management policies shall exist and be communicated to patients and staff.

55.2 Patients, patient's family and/or patient representative shall be provided with information about complaint and feedback processes.

55.3 Each DSC shall develop a written procedure that assures prompt and complete investigations of all complaints which are filed against healthcare professional or employees in the facility.
55.4 Complaints related to medical issues must be reported to clinical governance office (CGO) in HRD.
55.5 The complaint files shall be available during an audit by the HRD surveyors

56. Reporting Sentinel Events and Major Incidences

Unanticipated, undesirable or potentially dangerous occurrence in a health care organization might occur; each DSC shall develop a written sentinel event policy

56.1 The DSC shall report to the HRD sentinel events and major incidences which occur on the premises, this includes but not limited to the following:

56.2 Any incident following surgery or administration of anesthesia that results in patient death.
  56.2.1 Surgical and nonsurgical invasive procedures on the wrong patient, wrong site, or wrong procedure
  56.2.2 Unintended retention of a foreign object in a patient after surgery or other procedure
  56.2.3 A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall
  56.2.4 Serious criminal acts such as assault, homicide, or other crime resulting in patient death or major permanent loss of function occurred inside the DSC premises
  56.2.5 Full or partial evacuation of the DSC for any reason
  56.2.6 Fire in the DSC premises

56.3 In support of DHA mission to continuously improve the safety and quality of health care provided to the public, the HRD shall conduct reviews of the DSC activities in response to sentinel events

56.4 Sentinel events and major incidences shall be reported immediately but not later than three (3) working days of event occurrence.

56.5 Means of reporting sentinel events and major incidences shall including a written official letter to the Director of HRD either by courier or hand delivery.

56.6 The DSC management shall prepare a written evaluation of its response to the sentinel event or a thorough and realistic root cause analysis with action plan, the response should be submitted to the Director of HRD either by hand or courier within 45 calendar days of the event or of becoming aware of the event.

57. Statistics and Data Collection

57.1 Each licensed DSC shall submit to the Health Regulation Department in DHA the following outcome data on a quarterly basis:
  57.1.1 Number of readmissions within 48 hours after discharge for the same diagnosis.
  57.1.2 Number of patients who cannot be discharged/transfered at the end of day
  57.1.3 Number of successful Assisted Reproductive Techniques (ART) (if applicable).
  57.1.4 Number of successful assisted fertilization technique (if applicable).
  57.1.5 Number of patients Discharged Against Medical Advice (DAMA)
57.1.6 Number of fall incidents.

57.2 Each DHA-licensed DSC shall submit to the Health Data and Information Analysis Department in DHA the following data on a monthly basis:

57.2.1 The total number of patients attending the outpatient clinics of the DSC based on International Classification of Diseases (ICD-10) and by nationality, gender and age group.

57.2.2 The total number of dental treatments for each specialty and by patient nationality, gender and age group.

57.2.3 The total number of inpatients in the facility by nationality, gender and age group.

57.2.4 Inpatients services including the number of admissions, discharges, and deaths (if any).

57.2.5 Number of attendance to Traditional, Alternative and Complementary Medicine (TCAM) clinics (if any) by patient nationality, gender and age group.

57.2.6 Type and number of operations/procedures performed in the facility based on specialty and type (elective, emergency) and operations/procedures type (major, minor).

57.2.7 The total number of registered manpower in the health facility by nationality, gender and age group.

57.2.8 Total number of laboratory tests performed in the facility by type, patient nationality, gender and age group.

57.2.9 Total number of Radiology diagnostic procedures performed by type, patient nationality, gender and age group.

57.2.10 The total number of immunization provided in the facility by type, patient nationality, gender and age group.

57.3 As per the Article no.20 of the Cabinet Decision number (36) of 2009 promulgating the bylaw of the Licensing Fertility Centre law, the center shall maintain data on performance measures.

57.4 The Health Regulation Department may at anytime request for additional data as deemed necessary.
58. Human Resources Practices

58.1 Human resources management and DSC management shall support quality health care, a competent workforce and a satisfying working environment for employees. Human resources management includes:

58.1.1 Planning and Recruitment
58.1.2 Continuing performance development
58.1.3 Employee support systems
58.1.4 Effective workplace relations

58.2 Human resources practices should be supported by policies and procedures with systems that influence employee's behaviors, attitudes and performance.

58.3 The recruitment selection and appointment system shall ensure that the skill mix and competence of staff meet the DSC needs.

58.4 The DSC shall maintain accurate and complete personnel records for all employee, including training records, such records shall be maintained and kept confidential.

58.5 Continuing Professional Development (CPD) activities shall be documented, evidence of a learning and development system shall ensure the skill and competence of staff by allocation.

58.6 Structured and uniform system concerning orientation, professional retention and performance evaluation should be maintained.

59. Healthcare Professionals Minimum Requirements

59.1 All healthcare professionals in the DSC must hold an active DHA professional license and work within their scope of practice.

59.2 Appropriate and sufficient number of healthcare professionals are required to be on duty at all times to diagnose, plan, supervise and evaluate patient care.

59.3 The number of licensed healthcare professionals assigned to each health service in the DSC shall be determined by DSC management and consistent with DSC services, bed capacity and types of care provided.

59.4 Healthcare professionals assignments must meet the following:

59.4.1 At least one full time licensed specialist/consultant anaesthetist shall be available to supervise and manage the anaesthesia services in level (III) DSC.

59.4.2 One full time or part time specialist/consultant physician shall be responsible for each type of service in the DSC. For further information regarding the licensing requirements for specialist and consultant please click here or visit Health Regulation section in DHA website www.dha.gov.ae

59.4.3 One specialist, specialist (under supervision) or General Practitioner (G.P.) shall be available in the DSC premise covering each service till the last patient leave the facility.

59.4.4 Number of specialist (under supervision) or GP shall be based on DSC activities and number of patients.
59.4.5 There shall be a sufficient number of registered nurses on duty to plan, supervise and provide nursing care.

59.4.6 One full time or part time DHA licensed pathologist shall be supervising and managing the clinical laboratory services in the DSC.

59.4.7 At least one laboratory technician shall be available in each shift; he/she shall be responsible for the basic laboratory services.

59.4.8 One full time or part time specialist/consultant radiologist shall be available to supervise and manage the radiology services in the DSC.

59.4.9 At least one licensed radiographer in the DSC

59.4.10 Availability of allied healthcare professionals shall be based on DSC activities and number of patients. To be determined by DSC management to ensure the appropriate coverage of all medical services.

59.5 All healthcare professionals providing patient care must maintain valid training/certification in basic Cardiopulmonary Resuscitation (CPR) or Basic Life Support (BLS) or Advanced Cardiac Life Support (ACLS).

60. Credentialing and Privilege System

60.1 The DSC management is responsible for ensuring services are provided by competent health professionals, defining the scope of practice for a clinician (privileging) is the outcome of matching the clinician’s qualifications, skills, experience and competence with the required services and the role and capabilities of the DSC.

60.2 All healthcare professionals must hold active DHA professional license and work according to their scope of practice.

60.3 Credentials and privileges team shall be established in the DSC to assure that processes for credentialing and privileging shall support safe, quality health care. The team shall develop and implement clear credentialing and privilege policies and procedures. Credentials and privileges shall be applicable also for community and visiting physicians.

60.4 A copy of healthcare professional medical education, training, experience, licensing and privileges shall be maintained the human recourse file. List of procedures that physicians are allowed to do in the facility shall be maintained also.

60.5 All physicians shall have their scope of clinical practice (privilege) reviewed at regular intervals throughout the period of their employment and appointment.

60.6 Credentials and privileges team shall develop a policy for the safe introduction of new procedures.
CLUSTER TEN: FACILITY MANAGEMENT

61. Medical Equipment and Supplies

61.1 Accurate and safe clinical equipment is an essential requirement in the provision of health services. Medical equipments shall be installed and operated in accordance with manufacturer specifications.

61.2 The DSC shall maintain effective Preventive Maintenance (PM) as per the manufacturer recommendations (at least 95% of medical equipments shall receive PM), the PM shall include the following:
   61.2.1 Electrical safety testing for patient related equipment.
   61.2.2 Each piece of equipment has a checklist for its maintenance schedule, failure incidence, repairs done.
   61.2.3 The DSC shall have a written policy to perform inspection on all new equipment prior to operational use.

61.3 Statistical data of Preventative Maintenance (PM) for upgrading/ replacing of equipment should be maintained.

61.4 The DSC shall maintain copy of operator and safety manuals of all medical equipment and inventory list with equipment location.

61.5 The DSC shall maintain written policy for tagging medical equipment which include:
   61.5.1 PM with testing date and due date
   61.5.2 Inventory number
   61.5.3 Safety checks

61.6 The DSC shall maintain a written policy on removal of equipment from service.

61.7 The DSC shall eliminate the use of extension cords.

61.8 The DSC healthcare professionals (physician's, nurses, and allied health) shall be trained to operate the medical equipment assigned to them and the hazards attached to it.

61.9 Reporting of medical equipment incidents and corrective actions taken shall be maintained in the DSC.

62. Safety Management Systems

62.1 DSC shall ensure that the health care environment is safe, functional, supportive and effective for patients, family and staff members.

62.2 The DSC leadership shall plan and budget for all necessary support and resources to improve safety.

62.3 The DSC shall designate a safety officer person(s) with skills and experience responsible for the operation and implementation of the safety program.

62.4 The safety management systems policies shall comply with the related federal and local regulation in UAE, the safety officer shall undertaken appropriate training relevant to jurisdictional requirements.
62.5 The safety management system shall include fire safety, hazardous waste, emergencies, security.
62.6 External service providers shall be supplied with relevant information and comply with the DSC health and safety requirements.
62.7 Staff shall be educated and provided with information on waste management, fire safety, hazardous substances and their responsibilities.
62.8 Orientation on the safety measures shall include in the induction program of new staff.
62.9 The facility shall abide with the prevention and safety measures required by Dubai Civil Defense.
62.10 DSC management shall ensure the compliance with Federal Authority Nuclear Regulation-FANR rules and regulations regarding the use of ionizing radiation and radioactive materials in DSC.

63. Fire Safety
63.1 Fire is a potential risk for all healthcare organizations, and is very critical where immobile patients are in locations that are difficult to evacuate. To respond to fire risk the DSC should:
   63.1.1 Establish a fire safety plan for early detection, confining, extinguishment, rescue and alerting the Dubai Civil Defense
   63.1.2 Establish a No Smoking policy
   63.1.3 Assess the fire risks to the facility
   63.1.4 Understand and manage risks associated with the facility’s location and physical structures
   63.1.5 Maintain and test fire protection and emergency communication systems
   63.1.6 Train staff to respond to a fire event in the building
63.2 Monitor whether adequate numbers of suitably trained staff are posted across all shifts to respond appropriately to a fire event
63.3 Rehearse emergency scenarios to assess preparedness

64. Hazardous Substances and Dangerous materials
64.1 The DSC shall have policies and procedures on the procurement, management and disposal of dangerous materials and hazardous substances and shall comply with local regulations.
64.2 There should be adequate space and ventilation for safe handling of dangerous materials and hazardous substances.
64.3 Each DSC shall have a current list of hazardous substances and dangerous materials used in their area, the list covers:
   64.3.1 Purpose of use
   64.3.2 The responsible person
   64.3.3 Permitted Quantity
64.4 All substances shall be clearly labeled; this includes corrosives, acids, toxic material, hazardous gases and anesthetic gases.
64.5 Employees dealing with hazardous substances shall have protective clothes or equipment as required.

64.6 Hazardous substances shall be properly labeled and maintained on a register of all hazardous substances in the workplace. Labels should never be altered and substances should be stored in their original containers.

64.7 Material Safety Data Sheets (MSDS) shall be available for employees at point of use and for Civil Defense in case of emergency.

65. Waste and Environmental Management

65.1 Waste and environmental management should support safe practice and a safe environment. The DSC shall develop and implement a waste and environmental management policy. The policy shall include segregation and disposal of DSC clinical waste in a responsible manner in accordance with each local regulations of the Emirate of Dubai.

65.2 The waste management policy shall cover handling, storing, transporting, and disposing all kinds of waste such as:

65.2.1 Clinical waste
65.2.2 Chemotherapeutic waste
65.2.3 Radioactive waste
65.2.4 Hazardous gases
65.2.5 Anaesthetic gases

65.3 Proper storage and containers for disposing waste material shall be maintained.

65.4 Contracting with a specialized company to transport and destroy medical waste materials shall be according to the conditions issued by Public Health Department in Dubai Municipality.

65.5 Disposing medical liquids, drugs, solutions and dangerous chemical materials into usual sewage disposal is prohibited.

65.6 Cleanliness throughout the DSC shall be maintained by trained domestic staff.

66. Emergency and Disaster Management

66.1 The DSC shall develop a plan and policies for dealing with and managing emergencies and internal disasters, which shall include:

66.1.1 Duties and responsibilities of healthcare professionals and employees in the DSC
66.1.2 Identifying the responsible person who announces the emergency state and calls local authority.
66.1.3 The triage areas, their locations, and triage action cards.
66.1.4 Names of all staff called, including their contact

66.2 The DSC shall conduct Emergency practice / drill exercises including fire and evacuation aiming to test the following:

66.2.1 The timely response of staff to the emergency call
66.2.2 The efficiency of the communication system, e.g. bleeps, mobile phone and over head paging system
If all staff can perform their expected roles
The time taken to evacuate patients and beds

There are evacuation maps posted in the DSC indicating locations of:
- You are here
- Fire extinguishers
- Fire hose reel/cabinets
- Escape routes
- Assembly points
- Fire exits
- Call points break glass / pull station

External service providers shall comply with the DSC requirements for the prevention of emergencies.

Staff is educated and trained at orientation and annually in fire and evacuation.

Security Management

Security management shall support safe practice and a safe environment.
The facility management may assign specific personnel to take care of security in the DSC, or may ensuring security by installing CCTV camera or other means of surveillance.

Security personnel (if available) should be educated and provided with information in relation to security risks and responsibilities and oriented on their scope of work, fire safety and emergency codes.

There is a security policy, which includes identification of all of the following by badge:
- The DSC staff
- Temporary employees
- Contractor staff

There are written policies on the following that includes but not limited to:
- Lost and found items
- Safe keeping of patient belongings.
- How to contact the local police, in case of need

Restricting access to sensitive areas by Security Personnel / Security System such as operating area.

Major security risks shall be identified in the DSC.

External service providers are supplied with relevant information and comply with the DSC security controls.
Appendix 1: List of procedures/surgeries can be performed in DSC setting

<table>
<thead>
<tr>
<th>No</th>
<th>Specialty / Procedure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Anal procedures – dilatation/ fissure-in-ano/ banding haemorrhoids</td>
</tr>
<tr>
<td>2</td>
<td>Breast lump excision</td>
</tr>
<tr>
<td>3</td>
<td>Circumcision</td>
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<tr>
<td>4</td>
<td>Epididymal cyst excision</td>
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<tr>
<td>5</td>
<td>Excision varicocele</td>
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<td>6</td>
<td>Ganglions</td>
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<tr>
<td>7</td>
<td>In-growing toe-nail</td>
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<tr>
<td>8</td>
<td>Laparoscopic cholecystectomy/ Gastric Banding (in patients with anesthetic grade ASA 1 and 2 patients)</td>
</tr>
<tr>
<td>9</td>
<td>Laparoscopy</td>
</tr>
<tr>
<td>10</td>
<td>Repair hernias – inguinal/epigastric/ femoral/ incisional/umbilical</td>
</tr>
<tr>
<td>11</td>
<td>Temporal artery biopsy</td>
</tr>
<tr>
<td>12</td>
<td>Testicular fixation and Orchidopexy</td>
</tr>
<tr>
<td>13</td>
<td>Varicose vein surgery</td>
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<tr>
<td>14</td>
<td>Vasectomy</td>
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<tr>
<td><strong>Neurosurgery</strong></td>
<td></td>
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<tr>
<td>1</td>
<td>Epidural Steroid Injections/Block</td>
</tr>
<tr>
<td>2</td>
<td>Selective Nerve Root injections</td>
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<tr>
<td><strong>Obstetric /Gynecology</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Bladder distension</td>
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<tr>
<td>2</td>
<td>Cautery to cervix</td>
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<tr>
<td>3</td>
<td>Dilatation and curettage</td>
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<td>4</td>
<td>Endometrial ablation</td>
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<td>5</td>
<td>Endometrial biopsy</td>
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<tr>
<td>6</td>
<td>Excision urethral caruncle</td>
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<td>7</td>
<td>Fenton's procedure</td>
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<td>8</td>
<td>Hysteroscopy</td>
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<td>9</td>
<td>Labial procedures/Bartholin's</td>
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<tr>
<td>10</td>
<td>Laparoscopic - diathermy endometriosis/division adhesions/aspiration ovarian cyst/dye test</td>
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<tr>
<td>11</td>
<td>Polypectomy</td>
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<tr>
<td>12</td>
<td>Insertion and removal of IUCD</td>
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<tr>
<td>13</td>
<td>Tension free vaginal tape</td>
</tr>
<tr>
<td>14</td>
<td>Urethral dilatation</td>
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<tr>
<td><strong>Assisted Reproductive Techniques (ART)</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Intra Uterine Insemination (IUI)</td>
</tr>
<tr>
<td>2</td>
<td>In vitro Fertilization (IVF)</td>
</tr>
<tr>
<td>3</td>
<td>Intracytoplasmic Sperm Injection (ICSI)</td>
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<tr>
<td>4</td>
<td>Gamete Intra-fallopian Transfer (GIFT)</td>
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<tr>
<td>5</td>
<td>Zygote Intra-fallopian Transfer (ZIFT)</td>
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<tr>
<td>No</td>
<td>Specialty / Procedure Name</td>
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<tr>
<td>Oral Surgery</td>
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<tr>
<td>1</td>
<td>Apicoetomy</td>
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<tr>
<td>2</td>
<td>Biopsy of oral lesions/swellings</td>
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<tr>
<td>3</td>
<td>Excision of oral cysts</td>
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<tr>
<td>4</td>
<td>Exposure and bonding of impacted incisors</td>
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<td>5</td>
<td>Exposure of impacted canines</td>
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<tr>
<td>6</td>
<td>Extraction of wisdom teeth</td>
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<td>7</td>
<td>Full dental clearance</td>
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<td>8</td>
<td>Removal of impacted canines</td>
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<td>9</td>
<td>Surgical extraction of other teeth</td>
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<tr>
<td>10</td>
<td>Dental implants</td>
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<tr>
<td>Orthopaedic Surgery</td>
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<tr>
<td>1</td>
<td>Amputation digit</td>
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<tr>
<td>2</td>
<td>Diagnostic Arthroscopy (knee)</td>
</tr>
<tr>
<td>3</td>
<td>Carpal Tunnel decompression</td>
</tr>
<tr>
<td>4</td>
<td>Casting, splinting, bracing, change of plaster</td>
</tr>
<tr>
<td>5</td>
<td>DeQuervain's release</td>
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<tr>
<td>6</td>
<td>Trigger finger/thumb release</td>
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<tr>
<td>7</td>
<td>Examination under anesthesia</td>
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<tr>
<td>8</td>
<td>Excision of local skin lesion</td>
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<tr>
<td>9</td>
<td>Serial casting for limbs/spine deformities</td>
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<tr>
<td>10</td>
<td>Arthroscopic Meniscal (Repair Knee)</td>
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<tr>
<td>11</td>
<td>Arthroscopic Meniscectomy</td>
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<tr>
<td>12</td>
<td>Arthroscopic Chondroplasty (knee)</td>
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<tr>
<td>13</td>
<td>Arthroscopic Plica Excision (Knee)</td>
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<tr>
<td>14</td>
<td>Arthroscopic Lateral Release (Knee)</td>
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<tr>
<td>15</td>
<td>Arthroscopic Patellar MPFL Reconstruction (Knee)</td>
</tr>
<tr>
<td>16</td>
<td>Arthroscopic Medial Plication (Knee)</td>
</tr>
<tr>
<td>17</td>
<td>Arthroscopic Micro Fracture (Ankle, Knee)</td>
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<tr>
<td>18</td>
<td>Arthroscopic Anterior Fat Pad Decompression (Knee)</td>
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<td>19</td>
<td>Arthroscopic Knee Notch Plasty</td>
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<tr>
<td>20</td>
<td>Implant Removal (Minor)</td>
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<tr>
<td>21</td>
<td>Closed Reduction of Fracture/ Dislocation</td>
</tr>
<tr>
<td>22</td>
<td>Closed Reduction + Percutaneous Fixation</td>
</tr>
<tr>
<td>23</td>
<td>Shoulder Arthroscopy</td>
</tr>
<tr>
<td>24</td>
<td>Arthroscopic Subacromial Decompression (Shoulder)</td>
</tr>
<tr>
<td>25</td>
<td>Arthroscopic Decompression of Calcified Tendinitis</td>
</tr>
<tr>
<td>26</td>
<td>Arthroscopic Slap Lesion Debridement/ Repair</td>
</tr>
<tr>
<td>27</td>
<td>Arthroscopic Decompression + Rotator Cuff repair</td>
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<tr>
<td>28</td>
<td>Arthrodesis of Small joints</td>
</tr>
<tr>
<td>29</td>
<td>Arthroscopic Debridement/ Loose Body Removal 9Knee, Shoulder, Elbow, Wrist, Ankle)</td>
</tr>
<tr>
<td>30</td>
<td>Correction of Hallux Valgus (Soft Tissue)</td>
</tr>
<tr>
<td>31</td>
<td>Open Reduction of Fracture/Fixation (Small Bone)</td>
</tr>
<tr>
<td>32</td>
<td>Tendon repair (Minor)</td>
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<tr>
<td>33</td>
<td>Tenolysis of trigger Finger (One, Two)</td>
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<tr>
<td>34</td>
<td>Dupuytren's Contracture</td>
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<tr>
<td>No</td>
<td>Specialty / Procedure Name</td>
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<td>----</td>
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<tr>
<td>35</td>
<td>Claw Toe Reconstruction (One toe, Two Toes)</td>
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<tr>
<td>36</td>
<td>Bunionectomy</td>
</tr>
<tr>
<td><strong>Otolaryngology (E.N.T.)</strong></td>
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</tr>
<tr>
<td>1</td>
<td>Adenoidectomy</td>
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<tr>
<td>2</td>
<td>Antrostomy</td>
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<tr>
<td>3</td>
<td>Biopsy mouth/tongue/ear</td>
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<td>4</td>
<td>Cautery/out fracture inferior turbinate</td>
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<tr>
<td>5</td>
<td>Division tongue-tie</td>
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<tr>
<td>6</td>
<td>Excision lymph nodes</td>
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<td>7</td>
<td>Grommets</td>
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<td>8</td>
<td>Intranasal polypectomy</td>
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<td>9</td>
<td>Laryngoscopy</td>
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<td>11</td>
<td>Pharyngoscopy/oesophagoscopy</td>
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<td>12</td>
<td>Removal submandibular calculus</td>
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<tr>
<td>13</td>
<td>Sinus washout</td>
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<td>14</td>
<td>Submucous diathermy</td>
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<td>15</td>
<td>Tonsillectomy</td>
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<tr>
<td>16</td>
<td>Tymanoplasty</td>
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<tr>
<td>17</td>
<td>Uvulectomy</td>
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<tr>
<td><strong>Ophthalmology</strong></td>
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<tr>
<td>1</td>
<td>Cataract extraction</td>
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<tr>
<td>2</td>
<td>BCC Excision and skin graft</td>
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<tr>
<td>3</td>
<td>Blepharoplasty</td>
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<td>4</td>
<td>Sling Procedure</td>
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<tr>
<td>5</td>
<td>Chalazion</td>
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<tr>
<td>6</td>
<td>Conjunctiva Biopsy</td>
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<tr>
<td>7</td>
<td>Conjunctival Suture Removal</td>
</tr>
<tr>
<td>8</td>
<td>Cryotherapy</td>
</tr>
<tr>
<td>9</td>
<td>Ectropian and Entropian</td>
</tr>
<tr>
<td>10</td>
<td>Electrolysis</td>
</tr>
<tr>
<td>11</td>
<td>Epilation of lashes</td>
</tr>
<tr>
<td>12</td>
<td>Gold Weight Insertion</td>
</tr>
<tr>
<td>13</td>
<td>Hughes Flap and Release</td>
</tr>
<tr>
<td>14</td>
<td>Intraocular lens implantation</td>
</tr>
<tr>
<td>15</td>
<td>Peripheral Indectomy</td>
</tr>
<tr>
<td>16</td>
<td>Pteryguim</td>
</tr>
<tr>
<td>17</td>
<td>Ptosis</td>
</tr>
<tr>
<td>18</td>
<td>Punctal Plug Insertion</td>
</tr>
<tr>
<td>19</td>
<td>Second Stage Reconstructions</td>
</tr>
<tr>
<td>20</td>
<td>Syringe and Probe</td>
</tr>
<tr>
<td>21</td>
<td>Tarsorrhapsy</td>
</tr>
<tr>
<td>22</td>
<td>Temporal Artery Biopsy</td>
</tr>
<tr>
<td>23</td>
<td>Three Snip Procedure</td>
</tr>
<tr>
<td>24</td>
<td>Trabecelectomy (glaucoma)</td>
</tr>
<tr>
<td>25</td>
<td>Vitrectomy</td>
</tr>
<tr>
<td>No</td>
<td>Specialty / Procedure Name</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>1</td>
<td>Belly button surgery (or umbilicoplasty/navel surgery)</td>
</tr>
<tr>
<td>2</td>
<td>Blepharoplasty</td>
</tr>
<tr>
<td>3</td>
<td>Breast surgeries such as Breast implants, Breast uplift, Breast reduction</td>
</tr>
<tr>
<td>4</td>
<td>Calf and Cheek implants</td>
</tr>
<tr>
<td>5</td>
<td>Ear surgery (otoplasty/pinnaplasty)</td>
</tr>
<tr>
<td>6</td>
<td>Fat implant/ fat transfer</td>
</tr>
<tr>
<td>7</td>
<td>Hair transplants</td>
</tr>
<tr>
<td>8</td>
<td>Liposuction (or lipoplasty/liposculpture)³</td>
</tr>
<tr>
<td>9</td>
<td>Lip implants</td>
</tr>
<tr>
<td>10</td>
<td>Rhinoplasty</td>
</tr>
<tr>
<td>11</td>
<td>Scalp surgery</td>
</tr>
<tr>
<td>12</td>
<td>Urology</td>
</tr>
<tr>
<td>1</td>
<td>Adhesiolysis</td>
</tr>
<tr>
<td>2</td>
<td>Bladder neck incision</td>
</tr>
<tr>
<td>3</td>
<td>Circumcision</td>
</tr>
<tr>
<td>4</td>
<td>Cysto-diathermy bladder</td>
</tr>
<tr>
<td>5</td>
<td>Calculi extraction</td>
</tr>
<tr>
<td>6</td>
<td>Excision hydrocele</td>
</tr>
<tr>
<td>7</td>
<td>Hernia repairs</td>
</tr>
<tr>
<td>8</td>
<td>Lithoclast</td>
</tr>
<tr>
<td>9</td>
<td>Locate/remove JJ stent</td>
</tr>
<tr>
<td>10</td>
<td>Biopsies</td>
</tr>
<tr>
<td>11</td>
<td>Orchidopexy</td>
</tr>
<tr>
<td>12</td>
<td>Prostate - Plasma kinetic vaporisation/ trans urethral resection/ biopsy</td>
</tr>
<tr>
<td>13</td>
<td>Suprapubic catheter</td>
</tr>
<tr>
<td>14</td>
<td>Testicular and penile prosthesis</td>
</tr>
<tr>
<td>15</td>
<td>Urethral dilatation</td>
</tr>
</tbody>
</table>

³ Liposuction in DSC should be limited to 5000 ml of total aspirant to include supernatant fat and fluid. A Foley catheter should be inserted if more than 4000 ml of liposuction is proposed, and concurrent procedures should be avoided if the volume of aspirant exceeds the recommended limit.
## Appendix 2: Anesthesia Medication for Level II DSC

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oral medication</td>
<td>Alprazolam Xanax 0.25mg; 0.5mg; 1mg</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Chlordiazepoxide Librium</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Clonazepam Klopin</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Diazepam Valium 10 mg</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>Midazolam (Dormicum) 7.5mg; 15mg</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Chloral Hydrate</td>
</tr>
<tr>
<td>7</td>
<td>Injectable medication</td>
<td>Inj Midazolam Dormicum 15mg/ 5ml</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Inj Diazepam 10mg/2ml</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Pethidine Hydrochloride 50 mg per 1 ml</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Pethidine Hydrochloride 100 mg per 2 ml</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Fentanyl 100mcg per 2 ml</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>Alfentanil 1mg/2ml</td>
</tr>
</tbody>
</table>
Appendix 3: Mandatory Emergency Medications for Level II Anesthesia

The quantities listed represent the minimum mandatory quantity of medications required. Auto-Injectors are preferred in crashed cart.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Qty</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inj. Adrenaline 1:1000</td>
<td>5</td>
<td>Anaphylaxis or acute angio-oedema</td>
</tr>
<tr>
<td>2</td>
<td>Inj. Atropine 600mcg</td>
<td>10</td>
<td>Bradycardia, Organophosphate and Carbamate overdose</td>
</tr>
<tr>
<td>3</td>
<td>Inj. Diazepam 10mg/2ml</td>
<td>2</td>
<td>Status epilepticus</td>
</tr>
<tr>
<td>4</td>
<td>Rectal Diazepam</td>
<td>2</td>
<td>For children with Status epilepticus</td>
</tr>
<tr>
<td>5</td>
<td>Morphine Injection 10mg/1ml</td>
<td>2</td>
<td>For MI patients</td>
</tr>
<tr>
<td>6</td>
<td>Flumazenyl (Anexate) 0.5mg/5ml</td>
<td>2</td>
<td>Benzodiazepines antagonist</td>
</tr>
<tr>
<td>7</td>
<td>Naloxone 400mcg per 1 ml</td>
<td>2</td>
<td>Respiratory depression, opioid antagonist</td>
</tr>
<tr>
<td>8</td>
<td>Inj. Amiodarone 50mg/MI</td>
<td>2</td>
<td>Tachyarrhythmia, cardiac arrest</td>
</tr>
<tr>
<td>9</td>
<td>Inj. Dextrose 50%, 50ml</td>
<td>2</td>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>10</td>
<td>Inj. Chlorpheniramine 10mg/MI</td>
<td>5</td>
<td>Adjunctive treatment in anaphylaxis</td>
</tr>
<tr>
<td>11</td>
<td>Inj. Furosemide 20mg/2ml</td>
<td>3</td>
<td>Relief of pulmonary oedema</td>
</tr>
<tr>
<td>12</td>
<td>Inj. Hydrocortisone 100mg/2ml</td>
<td>3</td>
<td>Acute asthma attack and post anaphylaxis</td>
</tr>
<tr>
<td>13</td>
<td>Inj. Dopamine 200mg/5ml</td>
<td>2</td>
<td>Hypovolaemic shock cardiogenic shock, CHF</td>
</tr>
<tr>
<td>14</td>
<td>Inj. Aminophylline 250mg/10ml</td>
<td>2</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>15</td>
<td>Inj. Salbutamol 500mcg/MI</td>
<td>2</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>16</td>
<td>Inj. Glucagon 1mg</td>
<td>2</td>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>17</td>
<td>Salbutamol Aerosol Inhalation Nebules</td>
<td>1 Box</td>
<td>Asthma attack</td>
</tr>
<tr>
<td>18</td>
<td>Regular insulin</td>
<td>1 Box</td>
<td>For the treatment of Hyperglycaemia</td>
</tr>
<tr>
<td>19</td>
<td>Nitro-glycerine</td>
<td>1 Box</td>
<td>First line treatment for chest pain.</td>
</tr>
<tr>
<td>20</td>
<td>Magnesium sulfate</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Clopidogrel</td>
<td>1 Box</td>
<td>First line treatment for chest pain.</td>
</tr>
<tr>
<td>22</td>
<td>Aspirin 325mg tablets</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Adenosine</td>
<td>6</td>
<td>Supraventricular tachycardia (SVT)</td>
</tr>
<tr>
<td>24</td>
<td>IV Fluids such as Ringer Lactate, Dextrose Water, Dextrose Saline, Normal Saline.</td>
<td>5 each</td>
<td>For hypovolemia</td>
</tr>
<tr>
<td>25</td>
<td>Water for injection</td>
<td>1 Box</td>
<td>To mix hydrocortisone inj, etc.</td>
</tr>
<tr>
<td>26</td>
<td>EpiPen Jr. (for child less than 30 kilograms)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Epinephrine (Auto-Injectors)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Normal Saline 10 ml</td>
<td>10</td>
<td>For flushing after Adenosin etc</td>
</tr>
</tbody>
</table>

\[ The patient should not be charged for more than the published current federal price list. \]
Appendix 4: Classification of Patients Physical Status

As per American Society of Anaesthesiologists (ASA) patient’s physical status is classified into the following:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Physical Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA 1</td>
<td>Normal, healthy patient</td>
</tr>
<tr>
<td>ASA 2</td>
<td>Patient with mild systemic disease that does not limit physical activity</td>
</tr>
<tr>
<td>ASA 3</td>
<td>Patient with severe systemic disease that limits normal activity</td>
</tr>
<tr>
<td>ASA 4</td>
<td>Patient with severe systemic disease that is a constant threat to life; not appropriate for DSC procedure/surgery</td>
</tr>
<tr>
<td>ASA 5</td>
<td>Moribund patient not expected to survive with or without the operation; not appropriate for DSC procedure/surgery</td>
</tr>
</tbody>
</table>
**Appendix 5: Second line emergency medication list (optional)**

Second line medication can be available in a DSC setting, the quantities shall be limited as per the patient need and facility services. No stocking of medication is allowed within the facility premises.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Qty</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lignocaine 4% topical solution</td>
<td>2</td>
<td>For surface anesthesia-30ml</td>
</tr>
<tr>
<td>2</td>
<td>Lignocaine or Marcaine (plain and with Adrenaline)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Chlorpheniramine Maleate Inj 10mg/MI-1ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Promethazine Hydrochloride Inj 25mg/MI-1ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Dexamethasone Injection 4mg/MI-1ml</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Phenytoin Injection 250mg/5ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Procitroperazine Mesylate Inj</td>
<td>2</td>
<td>MOH Controlled Drug – A</td>
</tr>
<tr>
<td></td>
<td>Silver Sulfadiazine (Topical)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Tetanus Toxoid Injection</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Hyoscine Butyl Bromide injection</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Vitamin K 10mg/MI Injection</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Tramadol 100 Mg Injection</td>
<td>2</td>
<td>MOH Controlled Drug – A</td>
</tr>
<tr>
<td>12</td>
<td>Diclofenac Na 75 mg injections and suppositories</td>
<td>5 each</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Antipyretics e.g. pracaetamol Syrup, tablets, suppositories, injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Captopril 25 mg</td>
<td>10</td>
<td>For hypertension</td>
</tr>
<tr>
<td>15</td>
<td>Metoclopramide or a choice of antiemetics.</td>
<td>5</td>
<td>Injections, tablets or suppositories.</td>
</tr>
<tr>
<td>16</td>
<td>Epinephrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Glycopyrrolate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Heparin sodium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Digoxin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Procainamide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Dantrolene sodium</td>
<td>20 ampoules</td>
<td>If agents known to trigger malignant hyperthermia are administered.</td>
</tr>
</tbody>
</table>
Appendix 6: Ventilators Specifications

1. **Ventilators**: shall be used for all patients’ categories (Pediatric and adult) and upgradeable for further options include all ventilation modes:
   
   1.1. IPPV (pressure controlled, volume controlled)
   
   1.2. Supported ventilation (volume support, pressure support, PEEP, CP AP, automatic tube compensation, sign)
   
   1.3. Combined ventilation (SIMV, BIPAP, Auto flow, apnea ventilation)
   
   1.4. Non-invasive ventilation modes (through face mask, helmet).
   
   1.5. Nebulizer function
   
   1.6. Open lung tools
   
   1.7. Monitoring for alarm limits, gases ventilation parameters supply pressures, lung parameters, events, ventilator setting
   
   1.8. Mobile on trolley with interchangeable plug in battery module
## Appendix 7: Mandatory Emergency Medications for Level III Anaesthesia

<table>
<thead>
<tr>
<th>No.</th>
<th>DESCRIPTION</th>
<th>QTY</th>
<th>REMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inj. Adrenaline 1:1000</td>
<td>5</td>
<td>Anaphylaxis or acute angio-oedema</td>
</tr>
<tr>
<td>2</td>
<td>Inj. Atropine 600mcg</td>
<td>3</td>
<td>Bradycardia</td>
</tr>
<tr>
<td>3</td>
<td>Inj. Diazepam 10mg/2ml</td>
<td>2</td>
<td>Status epilepticus</td>
</tr>
<tr>
<td>4</td>
<td>Inj. Amiodarone 50mg/Ml</td>
<td>2</td>
<td>Tachyarrhythmia, cardiac arrest</td>
</tr>
<tr>
<td>5</td>
<td>Inj. Dextrose 50%, 50ml</td>
<td>2</td>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>6</td>
<td>Inj. Chlorpheniramine 10mg/Ml</td>
<td>5</td>
<td>Adjunctive treatment in anaphylaxis</td>
</tr>
<tr>
<td>7</td>
<td>Inj. Furosemide 20mg/2ml</td>
<td>3</td>
<td>Relief of pulmonary oedema</td>
</tr>
<tr>
<td>8</td>
<td>Inj. Hydrocortisone 100mg/2ml</td>
<td>3</td>
<td>Acute asthma attack and post anaphylaxis</td>
</tr>
<tr>
<td>9</td>
<td>Inj. Dopamine 200mg/5ml</td>
<td>2</td>
<td>Hypovolaemic shock cardiogenic shock, CHF</td>
</tr>
<tr>
<td>10</td>
<td>Inj. Aminophylline 250mg/10ml</td>
<td>2</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>11</td>
<td>Inj. Salbutamol 500mcg/Ml</td>
<td>2</td>
<td>Bronchospasm</td>
</tr>
<tr>
<td>12</td>
<td>Inj. Glucagon 1mg</td>
<td>2</td>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>13</td>
<td>Salbutamol Aerosol Inhalation Nebules</td>
<td>1 Box</td>
<td>Asthma attack</td>
</tr>
<tr>
<td>14</td>
<td>Water for Injection</td>
<td>1 Box</td>
<td>To mix hydrocortisone inj, etc.</td>
</tr>
<tr>
<td>15</td>
<td>Inj. Naloxone 400mcg/Ml 1ml</td>
<td>4</td>
<td>Respiratory depression, opioid antagonist</td>
</tr>
<tr>
<td>16</td>
<td>Inj. Lignocaine 20mg/Ml</td>
<td>2</td>
<td>MI</td>
</tr>
<tr>
<td>17</td>
<td>Inj. Calcium Chloride 10%</td>
<td>2</td>
<td>Cardiac resuscitation</td>
</tr>
<tr>
<td>18</td>
<td>Inj. Dextrose Saline</td>
<td>2</td>
<td>For infusion, IV</td>
</tr>
<tr>
<td>19</td>
<td>Inj. Sodium Bicarbonate 8.4%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Inj. Xylocard bolus 2% 100mg/5ml</td>
<td>2</td>
<td>MI</td>
</tr>
<tr>
<td>21</td>
<td>Calcium Gluconate 10%</td>
<td>2</td>
<td>Cardiac resuscitation</td>
</tr>
<tr>
<td>22</td>
<td>Dobutamine 250mg</td>
<td>2</td>
<td>Cardiac failure</td>
</tr>
<tr>
<td>23</td>
<td>Verapamil 5mg/2ml</td>
<td>3</td>
<td>Arrhythmia</td>
</tr>
<tr>
<td>24</td>
<td>Inj. Potassium Chloride 20mmol/10ml</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Xylocard IV Drip 20%</td>
<td>2</td>
<td>arrhythmia</td>
</tr>
<tr>
<td>26</td>
<td>Adenosine 3mg/MI 2ml</td>
<td>5</td>
<td>Tachycardia</td>
</tr>
<tr>
<td>27</td>
<td>Atenolol 0.5mg/MI 10ml</td>
<td>2</td>
<td>MI and atrial fibrillation</td>
</tr>
<tr>
<td>28</td>
<td>Sodium Chloride 0.9%, 10ml</td>
<td>3</td>
<td>To flush between medications</td>
</tr>
<tr>
<td>29</td>
<td>Vasopressin 20 Units/Ml</td>
<td>2</td>
<td>Cardiac arrest, diabetic emergency</td>
</tr>
<tr>
<td>30</td>
<td>Morphine Sulphate 10mg/ml (Narcotic Drug)</td>
<td>2</td>
<td>To be kept in separate looked cupboard</td>
</tr>
<tr>
<td>31</td>
<td>Diphenhydramine HCL 500 mg total (50mg/ml 5 vial)</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 8: Sample of DAMA Form

**DISCHARGE AGAINST MEDICAL ADVICE**

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Age</th>
<th>Sex</th>
<th>Ward</th>
</tr>
</thead>
</table>

| **Health Card No.** | **Date:......................... Time:................. Hrs.** |

I, the undersigned, Mr./Mrs./Miss. .................. hereby certify that I discharge myself / my wife / husband / son / daughter ( ) from Rashid Hospital against the advice of attending doctor. I acknowledge that I have been informed of the risks involved and hereby release the hospital authorities from all responsibilities for any ill-effects which may result from this action.

I further understand that the patient will not be re-admitted to this hospital without the approval of the treating doctor or hospital authorities.

<table>
<thead>
<tr>
<th>Attending Doctor</th>
<th>Signed (Patient or nearest relative)</th>
</tr>
</thead>
</table>

Signature:

Witnessed by: Relationship:

Authorization must be signed by the Patient or by the nearest relative in the case of a minor or when patient is physically or mentally incompetent.

DHA - R - 10

DISCHARGE AGAINST MEDICAL ADVICE
### Appendix 9: Health Care Workers Immunization Recommendations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Indications</th>
<th>Dose Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEPATITIS B recombinant vaccine</td>
<td>3-dose schedule, IM in the deltoid 2\textsuperscript{nd} dose given 1 month after 1\textsuperscript{st} dose 3\textsuperscript{rd} dose given 4 months</td>
<td>Workers at risk of exposure to blood and body fluids</td>
</tr>
<tr>
<td>INFLUENZA vaccine (inactivated)</td>
<td>Annual single-dose vaccination, IM, with current vaccine</td>
<td>Workers who have contact with patients at high risk or working in chronic-care facilities; workers age 50 or over or who have high risk medical conditions</td>
</tr>
<tr>
<td>MEASLES live-virus vaccine</td>
<td>1 dose SC; 2\textsuperscript{nd} dose at least 4 weeks later.</td>
<td>Workers born during or after 1957 without documentation of (1) receipt of two doses of live vaccine on or after their first birthday, (2) physician-diagnosed measles or (3) laboratory evidence of immunity. Vaccine should also be considered for all workers, including those born before 1957, who have no proof of immunity.</td>
</tr>
<tr>
<td>MUMPS live-virus vaccine</td>
<td>1 dose SC; no booster</td>
<td>Workers believed to be susceptible can be vaccinated; adults born before 1957 can be considered immune.</td>
</tr>
<tr>
<td>RUBELLA live-virus vaccine</td>
<td>1 dose SC; no booster</td>
<td>Male female workers who lack documentation of receipt of live vaccine on or after their first birthday or who lack laboratory evidence of immunity. Adults born before 1957 can be considered immune, except women of child bearing age.</td>
</tr>
<tr>
<td>VARICELLA-ZOSTER live-virus vaccine</td>
<td>Two 0.5mL doses SC; 4-8 wks if age 13 or older.</td>
<td>Workers without reliable history of varicella or laboratory evidence of varicella immunity.</td>
</tr>
</tbody>
</table>
References
1. UAE Federal Law number 2/1996 concerning Private Health Facilities
2. UAE Federal Law number 10/2008 concerning Medical Liability
3. The Cabinet Decision number (33) of 2009 promulgating the bylaw of the Medical Liability law.
4. UAE Federal Law number 11/2008 concerning Licensing Fertility Centre and the Cabinet Decision number (36) of 2009 promulgating the bylaw of the Licensing Fertility Centre law.
5. UAE Federal Law number 27/1981 concerning the Prevention of Communicable Diseases
6. UAE Cabinet Decision number 28 of 2008 regarding Blood Transfusion Regulation
7. DHA Private Healthcare Standards
13. Day surgery operational guidelines 2002 issued by the Department of Health, UK
14. EQuIP for Day Surgical Hospital Standards and guidelines of the Australian Council on Healthcare Standard – ACHS
15. Office-Based Surgery Rules published by the Alabama Board of Medical Examiners website http://www.alabamaadministrativecode.state.al.us/docs/mexam/10MEXAM.htm and accessed on 23rd May, 2011.
16. The National Hospital Standards of the Central Board of Accreditation for Health Institutions (CBAHI), Kingdom of Saudi Arabia.