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Acknowledgment

Dubai Health Authority (DHA) is pleased to present the DHA Hospital 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 hospitals’ performance in Dubai and to ensure safe and competent delivery of services. It will also assist the hospitals 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 Hospital 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 applies to every hospital inclusive of both General and Specialty hospitals subject to licensure under the Dubai Health Authority (DHA) establishment law which includes governmental and semi governmental, private hospitals and hospitals operating in free zone areas.

The DHA reserves the right to amend the Hospital Regulation stipulated herein without prior notice; the latest version of the regulation shall be published in 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 operating Hospitals, the DHA will ensure provision of the highest levels of quality and healthcare services at all times.

III. Definitions

**Accreditation** shall mean that process of evaluation conducted by international accredited organizations approved by the International Society for Quality in Health Care (ISQua) in which certification of competency and quality of service is given to a hospitals.

**Adverse Event** shall mean any 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). This includes but not limited to following procedures: Intra Uterine Insemination (IUI), In vitro Fertilization (IVF), Intracytoplasmic Sperm Injection (ICSI), Gamete Intra-fallopian Transfer (GIFT), Zygote Intra-fallopian Transfer (ZIFT).

**Cohorting** shall refer to grouping of infectious patients and nursing them within an area of a hospital ward. This is widely recommended as a strategy for controlling transmission of healthcare acquired infection and is often recommended as an overflow strategy when single room isolation is not available. The practice of ‘cohorting’, in common with other isolation procedures, is associated with successful infection control interventions

**Conventional Radiography (General Radiology)** shall mean images of the skull, chest, abdomen, spine, and extremities produced by the basic radiographic process.

**Diagnostic Imaging Services** shall mean the medical service that utilizes imaging examinations with or without ionizing radiation to affect diagnosis. Techniques include radiography, tomography, fluoroscopy, ultrasonography, mammography, interventional
radiography (IR), computed tomography (CT), Positron emission tomography (PET) Scan and Nuclear Medicine.

**Functional Program** shall mean a detailed plan prepared by the hospital investors and management which describes the project purpose, delivery of care model, facility and service users, layout/operational planning, physical environment, projected operational use and demand, Relevant operational circulation patterns, departmental operational relationships and patient/resident, staff, and family/visitor needs.

**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 means an individual employed by the hospital, (whether directly, by contract with another entity), provide direct or indirect patient care, this includes but not limited, healthcare professionals, medical and nursing students, administrative staff and contract employees who either work at or come to the hospital site.

**Hospital** shall mean a healthcare facility licensed by the Dubai Health Authority for providing diagnosis, treatment and inpatient medical care for patient.

**Medical Complaint** shall mean expressions of dissatisfaction or concern about a health care service made by patients, or their relatives.

**Licensure** shall mean issuing a license to operate a health facility to an individual, government, corporation, partnership, limited liability company, or other form of business operation that is legally responsible for the facility’s operation.

**Outcome** relates to the state of health of the individual or population resulting from their interaction with the healthcare system. It can include lifestyle improvements, emotional responses to illness or its care, alterations in levels of pain, morbidity and mortality rates, and increased level of knowledge.

**Patient** shall mean any individual who receives medical attention, care or treatment by any healthcare professional or 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."

**Process** relates to what is actually done for the service user and how well it is done. Process indicators measure the activities carried out in the assessment and treatment of service users and are often used to measure compliance with recommended practice, based on evidence or the consensus of experts.

**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

ASHRAE : American Society of Heating, Refrigerating and Air Conditioning Engineers
CCU : Coronary Care Unit
CGO : Clinical Governance Office
CT : Computer Tomography
DAMA : Discharge Against Medical Advice
DHA : Dubai Health Authority
DM : Dubai Municipality
DED : Department of Economic Development
FANR : Federal Authority Nuclear Regulation
FGI : Facility Guidelines Institute
HCW : Healthcare worker
HEPA : High Efficiency Particulate Air
HRD : Health Regulation Department
HVAC : Heating, Ventilation and Air Conditioning
IAP : International Accreditation Program.
ICU : Intensive Care Unit
ISQua : International Society for Quality in Health Care
LLC : Limited Liability Company
MEP : Mechanical, Electrical, and Plumbing
MOH : Ministry of Health
MRI : Magnetic Resonance Images
NICU : Neonatal Intensive Care Unit
OT : Operation Theatre
RM : Registered Midwife
RN : Registered Nurse
WHO : World Health Organization
CHAPTER ONE: LICENSURE AND ADMINISTRATIVE PROCEDURES
1. **Registration and Licensure Procedures**

A person or entity must obtain a license from Dubai Health Authority (DHA) to operate a Hospital in the Emirate of Dubai. This applies to any organization whether governmental, semi governmental, private or operating in free zone areas.

1.1 Health Regulation Department (HRD) shall receive applications to operate hospitals 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 HRD is a requirement for licensure in order to establish a new hospital in the Emirate of Dubai. The health facility licensing procedures are described in the Health Regulation section of the DHA website www.dha.gov.ae

1.3 The application shall include the hospital’s proposed function program along with a detailed feasibility study and floor plans drawings.

1.4 In case of building a new hospital, the application file must include two sets of drawings as hard copies in addition to two sets of AutoCad CD, drawings shall specify the following:

1.4.1 Site Plan at scale 1/200
1.4.2 Site boundaries / affection plan
1.4.3 Surrounding streets and accesses
1.4.4 Car parking (on ground and in building / structure)
1.4.5 Number of cars / staff / patients / visitors as per DM standards
1.4.6 Car access to parking / routes to entrances
1.4.7 Ambulance access / routes
1.4.8 Helipad (if applicable)
1.4.9 Pedestrian accesses and ramps
1.4.10 Drop off zone(s)
1.4.11 Service route / parking / clean / dirty
1.4.12 Total land area
1.4.13 Total built up area
1.4.14 Foot print area
1.4.15 Service building
1.4.16 Landscape areas
1.4.17 All floor plans must be at scale 1/100
1.4.18 Elevations and sections must be at scale 1/100
1.4.19 3D drawings are optional
1.5 The basic hospital building specifications include but are not limited to the following:

1.5.1 Free standing buildings.
1.5.2 Easy access to roads and assume independent access to the premises.
1.5.3 Independent Heating, Ventilation and Air Conditioning (HVAC), and Mechanical Electrical Plumbing (MEP) and Fire service.

1.6 The land plot allocated for the hospital shall be approved for commercial use by Dubai Municipality (DM).

1.7 The applicant must review the facility design to ensure compliance with “DHA Health Facility Guidelines: Planning, Design, Construction and Commissioning” published in DHA website www.dha.gov.ae. Upon receipt of a completed applicant's file, the HRD shall conduct a detailed review of the submitted material to determine compliance and suitability for further processing.

1.8 The HRD shall issue an Initial Approval letter for the hospital, with defined services and restrictions particular to the applicant circumstances.

1.9 This letter will be required to complete the hospital licensing procedures by local and federal authorities including but not limited to:

1.9.1 The Department of Economic Development (DED) in Dubai or equivalent licensing bodies (i.e. free zones authorities).
1.9.2 Federal Authority for Nuclear Regulation (FANR).
1.9.3 Dubai Municipality (DM)

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

For further details concerning licensure procedures, application fee and design re-submission fee please click here or visit the Health Regulation in the DHA website www.dha.gov.ae

2. Hospital Name

2.1 During the initial approval process, the name of the hospital will be tentatively under the owner’s name, till applicant is issued the health facility trade license.

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

2.3 Name of the hospital 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 To obtain the DHA hospital license, the applicant must meet the following:

3.2.1 Appointment of a Medical Director.
3.2.2 Employment of a sufficient number of qualified and licensed consultant/specialist physicians and other healthcare professionals to satisfy the hospital proposed functional program and to meet patient needs for all services/procedures provided in the hospital.

3.2.3 Install and operate medical equipment required for provision of the proposed hospital services in accordance with manufacturer specifications.

3.2.4 Develop policy and procedure documents for the following:
   3.2.4.1 Infection control measures and hazardous waste management
   3.2.4.2 Medication management
   3.2.4.3 Patient health record
   3.2.4.4 Medical emergency action plan and
   3.2.4.5 Patient discharge/transfer plan.

3.2.5 Maintain Charter of Patients’ rights and responsibilities noticeably posted on the hospital premises at least in two languages (Arabic and English).

3.2.6 Provide evidence of FANR license to use the Ionizing Radiology equipment in the facility or FANR registration number.

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

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

3.2.9 Clearly display hospital signage and direction for different services provided in the hospital at least in two languages (Arabic and English).

3.2.10 Clearly displayed hazardous signs aimed to restrict access for the safety of patients, visitors and staff.

3.2.11 Designate secured areas for the collection of medical waste, general storage facilities for supplies and equipment and storing area for hazardous materials.

3.2.12 Provide a sufficient number of toilets for patients, their families, and staff.

3.2.13 Provide at least one toilet for disabled individuals in each floor.

3.2.14 Maintain hospital accessible for handicapped and disabled individuals.

3.2.15 The hospital safety plan, design and equipments shall comply with the fire safety requirements by the Dubai Civil Defence Department.

3.3 A license shall be issued to a specific licensee for a specific location(s) and shall not be transferable. The license shall be issued only for the premises and the individual owner, operator or to the corporate entity responsible for its governance, as identified in the application.

3.4 The hospital facility license is valid for one year.

3.5 Every license shall state the name and address of the hospital, the Economic Development license number, the period of licensure validity, the specific service(s) that the hospital is licensed to deliver.
3.6 The Hospital license shall be visibly posted on the premises.

4. **Management Responsibilities**

   Upon obtaining the license the hospital 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 conduct random inspections to audit the hospital to determine the facility compliance with the Hospital Regulation, and take appropriate action if required.

   5.2 The HRD inspectors and/or any duly authorized representative may conduct regular onsite inspections to ensure compliance with the relevant DHA regulations.

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

   5.4 After every inspection in which non-compliance to the DHA regulations 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 Hospital management shall submit to the HRD a written plan of correction of violations cited within fifteen days after receiving the noncompliance letter stating the identified violations.

6. **Application for License Renewal**

   6.1 Application for renewal of the hospital license must be submitted not less than 30 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 hospital will be subjected to financial penalties and may lead to null and void of the hospital license.

6.3 DHA hospital license will be renewed for a period of one year after fulfilling the HRD requirements for re-licensure assessment. License renewals shall require operator compliance with DHA post operational assessment inspection requirements.

7. Temporary Suspension of the License

7.1 If identified that any hospital service poses an imminent risk to the safety of patients, employees or visitors of the facility; the HRD shall assess the hospital operations or specific service.

7.2 HRD may recommend to the Director General of DHA the temporary suspension of the hospital license or specific services.

7.3 The Director General of DHA shall form an investigative committee and may issue a decree of suspension.

8. Voluntary cancellation of the License

8.1 In case the hospital wishes to cease operations then a signed request by the hospital owner must be submitted at least (30) days before closure of the hospital. The hospital management shall comply with existing regulations regarding cancellation of the health facility license.

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 (LLC), 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 LLC, etc.

10. Changes/Modifications Requiring DHA Approvals

10.1 The hospital management shall obtain prior approval from the HRD for the following changes or modifications which include but are not limited to:

10.1.1 Ownership

10.1.2 Medical Director

10.1.3 Hospital trade name

10.1.4 Hospital location
10.1.5 Increase or decrease of bed capacity
10.1.6 Introducing new clinical services
10.1.7 Relocation of clinical services.
10.1.8 Temporary or permanent suspension of clinical services
10.1.9 Major construction or renovation work in the facility
10.1.10 Adding an extension or annex to the existing hospital building
10.1.11 Temporary closure of the hospital

11. Renovations and Additions to Hospital Building

11.1 Any change or addition in the premises shall require prior review and approval by the DHA and amendment of the hospital license.

11.2 The hospital management must submit an application file including both the preliminary and final architectural plans with specifications showing the proposed change or addition.

11.3 Any alterations or additions to an existing hospital building shall comply with the construction standards and building codes of the Dubai Municipality (DM) 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: HOSPITAL DESIGN REQUIREMENTS
12. General Design Considerations

This section contains elements that are common to most types of hospitals. Additional specific requirements are located in Section Two of this chapter.

12.1 The hospital building shall be freestanding facility; located on a main road, access to the premises must be easy and convenient both to people using both public transportation and vehicles.

12.2 The hospital shall provide parking on the premises to satisfy the needs of both patients and staff. Such parking area shall be acceptable to the local authorities having jurisdiction e.g. DM and Road and Traffic Authority (RTA).

12.3 Consideration must be given to the anticipated disabled patients as determined by the functional program of the hospital.

12.4 Signage shall be provided to direct people unfamiliar with the facility to entrances and parking areas.

12.5 Departments size and layout shall depend on the functional program requirements and organization of services within the hospital.

12.6 Combination or sharing of some hospital functions shall be permitted; provided the layout does not compromise safety standards nor medical and nursing practices.

12.7 Hospital design shall ensure appropriate levels of patient acoustical and visual privacy and dignity throughout the care process. In multiple-bed rooms, visual privacy from casual observation by other patients and visitors shall be provided for each patient.

12.8 The design, construction, renovation, expansion, equipment, and operation of health care facilities are subject to provisions of several local and federal laws environmental pollution control. This includes 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.

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

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

12.11 Stairways flooring shall have slip-resistant surfaces

12.12 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.

12.13 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.

12.14 Selected flooring surfaces shall be easy to maintain, readily cleanable, and appropriately wear-resistant for the location.
12.15 Wall finishes shall be washable, moisture-resistant and smooth, wall finish treatments shall not create ledges or crevices that can harbour dust and dirt.

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

12.17 Floor drains shall not be installed in operating and delivery rooms. If floor drain is installed in Cystoscopy, it shall contain a non-splash, horizontal-flow flushing bowl beneath the drain plate.

12.18 Wired glass; or plastic, break-resistant material that creates no dangerous cutting edges when broken shall be used in certain areas such as glass doors and sidelights.

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

12.20 All doors between corridors, rooms, or spaces subject to occupancy shall be of the swing type or shall be sliding doors.

12.21 Patient’s room door swings should be oriented to provide patient privacy.

12.22 Curtains used throughout the hospital shall be washable/cleanable, fireproof and maintained clean at all times.

12.23 Each patient shall have access to a toilet room without having to enter a corridor.

12.24 Bedpan-washing fixtures shall be installed in dedicated rooms, separate from patient care areas unless located in a toilet room.

13. Operation Theatre

13.1 At least two Operation Theatres (OT) shall be available in a general hospital. Each operating room shall have a minimum clear floor area of 37.16 square meters (400 square feet).

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

13.3 The OT entrance door must 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.

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

13.5 The floors and walls should be anti-static, heat resistant, anti-bacterial, anti-fungal and resistant to disinfectants.

13.6 Operation room shall be equipped with the following:

   13.6.1 Multi purpose operation table
   13.6.2 Anesthesia machine with adequate vital sign monitors (minimum of one back up anesthesia machine).
   13.6.3 Adequate medical gases supply
   13.6.4 X-Ray Viewer
   13.6.5 Cautery equipment
   13.6.6 ECG machine
   13.6.7 Emergency/crash cart.
13.6.8 Suction machine
13.6.9 Pulse oximeter
13.6.10 Appropriate size pediatric medical equipment must be available if services are provided to infants/children
13.6.11 Calling station

13.7 Operation table location shall permit easy movement of patients’ trolleys however, if obstetric services are provided, an extra dedicated OT is recommended.

13.8 Adequate ventilation and air exchange (with at least 25 air changes per hour as per American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) requirement) shall be maintained in the operation room which should be at positive pressure relative to the adjacent preparation areas.

13.9 Minimum of two air supply inlets with proper contamination control filters i.e. High Efficiency Particulate Air (HEPA) filters delivered at or near the ceiling, which should not be directed over the operation table, in addition to a minimum of two exhaust outlets located near floor level, bottom exhaust outlets should be at least 75mm above the floor. Differential pressure indicating device, humidity indicator, and thermometers should be installed and should be located for easy observation.

13.10 Operating room temperature shall be maintained between 18-22 °C with room humidity between 35-70% and the temperature and relative humidity set points should be adjustable.

13.11 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.

13.12 The scrub facility shall be located adjacent to the operation room(s). Ceiling, surfaces or tiles at this area shall be smooth, washable and free of particular matter that can be contaminated.

13.13 Staff changing area shall be separate for males and females. It must contain special entrance for the staff and suitable place for changing 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.

13.14 Sterilizing area can be located near operating room(s) with adequate high-speed autoclave machine. Additional equipment for drying the tools before sterilization may also be provided however, they must be well secured to avoid injuries. Biomedical engineers must keep indicators such as chemical tubes or strips to ensure the quality of autoclaving. Operation instruments and trolleys can be arranged at this area.

13.15 Sterilizing area air pressure 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.

13.16 An independent and adequate induction room can be provided at operation facility.

13.17 Suitable 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)

13.18 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).

13.19 Recovery area must be properly equipped with at least one bed for each operation room. Each recovery area shall be at least 9.0 square meters per bed.

13.20 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.

13.21 Back-up emergency power supply sufficient to ensure patient protection and safety in the event of an emergency power cut should be available.

14. Critical Care

14.1 All general hospital shall provide Critical Care services; this may include Intensive Care Unit (ICU), Coronary Care Unit (CCU), Neonatal Intensive Care Unit (NICU) or Burns Unit.

14.2 Number of beds per critical care services shall be based on many factors such as: type of services provided in the hospital, bed occupancy rate, etc. In general the hospital should provide one critical care bed for each operation theater, but it should not be less than one critical care bed for every 20 general beds.

14.3 The critical care unit has the following necessary equipment and supplies:

14.3.1 Ventilators (see appendix 1 regarding ventilator specifications)

14.3.2 Tracheotomy set

14.3.3 Emergency/crash cart with a plastic breakable seal that can be easily removed during emergency. It must be equipped with defibrillator, necessary drugs and other CPR equipment and test strips. A log book must be nearby to indicate the maintenance and regular check of the crash cart and its components.

14.3.4 Pulse Oximetry and vital signs monitor.
14.3.5 Transfusion pumps
14.3.6 Vital Signs Monitors.
14.3.7 Blood gas analyzer with capability for electrolytes measuring should be available in the hospital (preferably at ICU facility)

14.4 The critical care beds must be supplied with medical gases outlets (02, 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.

14.5 Adequate ventilation and air exchange, with at least 6 air changes per hour as per ASHRAE requirement, shall be maintained in Intensive Care Unit area. Intensive Care Unit should be kept at positive pressure relative to the adjacent areas. The area temperature should be maintained at 21 °C 24 °C and relative humidity 30 % to 60% and should be adjustable. 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.

15. Airborne Infection Isolation (AII) Room

15.1 The hospital should specify airborne infection isolation (AII) room(s) for treatment of infectious diseases based on the needs of specific community and patient populations served by the hospital.

15.2 At least one airborne infection isolation room in the critical care area shall be provided in all general hospitals.

15.3 Isolation rooms design requirements shall include but not limited to the following:

15.3.1 Each patient room shall contain only one bed
15.3.2 The isolation room should be independent from other critical care area.
15.3.3 A separate toilet with bathtub (or shower) shall be provided for each patient room.
15.3.4 A hand-washing station shall also be provided for each patient room
15.3.5 Additional hand-washing or hand rub station outside the room entrance maybe provided.
15.3.6 AII room perimeter walls, ceilings, and floors, including penetrations, shall be sealed tightly so that air does not infiltrate the environment from the outside or from other spaces
15.3.7 An area for gowning and storage of clean and soiled materials shall be located either directly outside or inside the entry door to the patient room.
15.3.8 There should be an oxygen source and first-aid kit available inside the room
15.3.9 Isolation Room Instruments shall include: Intravenous solutions, needles of various gauges, lumbar puncture kit, liver biopsy kit, liver abscess aspiration kit and pleural fluid and ascitic fluid aspiration kit.

15.4 An airborne infection isolation room shall be provided in or near at least one level of nursery care. It shall be separated from the nursery unit with provisions for observing the infant from adjacent nurseries or control area(s). The requirements
of this room shall comply with the general requirements of All mentioned above in 15.3 except for 15.3.3.

15.5 Adequate ventilation and air exchange, with at least 12 air changes per hour as per ASHRAE requirements, shall be maintained in the Isolation Room. The room should be kept at negative pressure relative to the adjacent areas. The area temperature should be maintained at 24 °C plus or minus 1 °C. 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.

16. Emergency Area

General Hospital emergency area must fulfill the following requirements:

16.1 **Emergency Entrance:** A well-marked, easily accessible entrance at ground level for both emergency vehicles and pedestrian access.

16.2 **Waiting Area:** Patients and visitors waiting area(s) must be located in away that can be under direct observation of the reception staff, triage station, or control station, with access to a public phone.

16.3 **Consultation room with space area not less than 12 square meters. It must be fitted with a wash basin and the attached faucet can be sensor-regulated or single-lever elbow operated. Care shall be taken in location and arrangement of fittings to provide the clearance required for operation of blade-type handles.**

16.4 **One Triage room.**

16.5 **Observation bed area** with suitable patient privacy

16.6 **Minimum of two treatment rooms**

16.7 **Resuscitation Area** with adequate space area, appropriate equipment and emergency medication. Door shall be 2.0 meters width and consists of two parts opening on both sides.

16.8 **Patient toilet:** minimum one for male and another for female

16.9 At least one dedicated toilet for handicapped patients/visitors equipped with safety hand rails and suitable hand washing sink

16.10 **Storage areas:** for general medical/surgical supplies, medications and equipment. The area shall be under staff control and out of the path of normal traffic.

16.11 **Ambulance vehicle:** well-equipped ambulance vehicle(s) should be ready with qualified medical staff for patient transportation if required, for more details see ambulance requirements in DHA website [www.dha.gov.ae](http://www.dha.gov.ae)

16.12 **Sufficient electrical outlets** to meet medical equipment functional requirements. Electrical outlets must be clearly labeled and connected to an emergency power supply.

16.13 **Source of Oxygen:**

16.13.1 There should be in each location a reliable source of oxygen.

16.13.2 Oxygen piped from a central source is strongly recommended
16.13.3 There should be backup supply of oxygen equivalent to at least a full cylinder.

16.14 Adequate ventilation and air exchange, of at least 6 air changes per hour as per ASHRAE requirements, shall be maintained in Emergency/Casualty Department. Emergency/Casualty Department should be kept at equal pressure relative to the adjacent areas. The area temperature should be maintained at 24 °C plus or minus 1 °C and relative humidity 30% to 50% and should be adjustable. 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. Delivery Suite

17.1 Obstetrical program models vary widely in their delivery methodologies. The models are essentially of three types:

17.1.1 Traditional Model
17.1.2 Labor-Delivery-Recovery (LDR) Model
17.1.3 Labor-Delivery-Recovery-Postpartum (LDRP) Model

17.2 The obstetrical unit shall be located and designed to prohibit nonrelated traffic through the unit. LDR rooms may be located in a separate LDR suite, as part of the cesarean delivery suite, and in the postpartum unit.

17.3 When cesarean delivery rooms are located within the obstetrical suite, access and service arrangements shall be such that neither staff nor patients must travel through the cesarean delivery area to access other services.

17.4 LDR and LDRP rooms shall have a minimum clear floor area of 31.57 square meters (340 square feet) with a minimum clear dimension of 3.96 meters (13 feet). This includes an infant stabilization and resuscitation space with a minimum clear floor area of at least 3.7 square meters (40 square feet). The rooms shall be equipped with the following:

17.4.1 Hand washing sink
17.4.2 Satisfactory equipment and supplies required for delivery
17.4.3 Call systems
17.4.4 Medications

17.5 Each LDR or LDRP room should be for single occupancy.

17.6 Postpartum unit shall be constructed to meet the needs of the functional program and shall have a minimum clear floor area of 150 square feet (13.94 square meters).

17.7 Newborn nursery equipped with adequate infant beds and incubators for the premature babies.

17.8 Adequate ventilation and air exchange, with at least 25 air changes per hour as per ASHRAE requirements, shall be maintained in Delivery Suite area. Delivery Suite should be kept at positive pressure relative to the adjacent areas. The area

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1 LDRP and LDR is a single-room maternity care in one room, equipment is moved into the room as needed, rather than moving the patient to the equipped room.
temperature should be maintained at 20 - 23 °C and relative humidity 45% to 55% and should be adjustable. 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.

18. Inpatient Service Areas

All hospitals shall provide inpatient service in distinct areas. The following requirements shall be provided:

18.1 Each inpatient room shall include enough space for patient bed(s) and other medical equipment.

18.2 Walls shall be painted with lead free color with no sharp edges. Window in patient room is required.

18.3 Single-patient rooms should be at least 3.65 meters (12 feet) wide by 3.96 meters (13 feet) deep (approximately 160 square feet or 14.86 square meters) exclusive to toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules. These spaces should accommodate comfortable furniture for one or two family members without blocking staff member access to patients.

18.4 In shared inpatient rooms, the enclosed area for each bed shall be provided with curtains to ensure patient privacy. Such area should be at least 7.5 square meters (80 square feet). The curtains must be washable/cleanable, fireproof and maintained clean at all times.

18.5 A hand-washing station for the exclusive use of the staff shall be provided to serve each patient room and shall be placed outside the patient toilet room.

18.6 Door opening to inpatient bedrooms shall be wide enough for easy movement of bed or stretcher, a minimum clear width of 1.12 meters (3 feet 8 inches) with a frame that is 2.13 meters (7 feet) high is required.

18.7 In multi-storey hospital buildings, adequate family visiting areas shall be provided at each floor.

18.8 Patient beds shall be of good quality, foldable and mobile. Next to each bed there shall be a food table and a bedside cabinet/locker.

18.9 Calling system shall be next to each bed.

18.10 Adequate electrical sockets for each bed are required.

18.11 A reading light shall be provided for each patient.

18.12 Suitable area for toileting, bathing, dressing and hand washing (minimum of one toilet for inpatient room with three beds and one toilet in private inpatient rooms).

18.13 Appropriate dedicated area for medical equipments, medications and supplies shall be provided near the inpatient area.

18.14 Overnight accommodation for family members can be provided in private inpatient bedrooms.

18.15 Adequate ventilation and air exchange, with at least 6 air changes per hour as per ASHRAE requirements, shall be maintained in inpatient care area. Inpatient care area should be kept at positive pressure relative to the adjacent areas. The area
temperature should be maintained at 24 °C or less and relative humidity 30 % to 60% and should be adjustable. 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.

19. Outpatient Areas

Outpatient Department/Services shall be in a distinct area on the hospital premises that consist of the following:

19.1 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.

19.2 Male and Female waiting area for patients and escorts shall be under staff visual control

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

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

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

19.6 Wheelchairs shall be accommodated within the waiting area.

19.7 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

19.8 Consultation, Examination and Treatment Rooms space requirements shall depend on the services provided but at least shall meet the following:

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

19.8.2 Consultation room(s) where no examination is performed such as in nutrition and homeopathy shall have a minimum floor area of 9 square meters (96.8 square feet).

19.8.3 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.

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

19.8.5 Hand washing stations shall be provided. The hand-washing station must be equipped with a sensor-regulated or single-lever elbow operated faucet and appropriate soap dispensers Sinks shall be designed with deep basins, made of porcelain, stainless steel, or solid surface materials.

19.8.6 Hand sanitization dispensers shall be provided in addition to hand-washing stations.

19.8.7 Provisions for hand drying shall be available at all hand-washing stations.
19.9 Treatment rooms for minor procedures, specific treatment or casting shall have:

19.9.1 A minimum floor area of 11.15 square meters (120 square feet). The minimum room dimension shall be 3 square meters (9.8 feet).

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

19.9.3 Hand-washing station shall be provided in all treatment rooms.

19.9.4 Documentation space or counter for writing shall be provided.

19.9.5 A lockable refrigerator for medication use.

19.9.6 Locked storage for controlled drugs (if used)

19.10 Consultation, examination and treatment rooms should maintain adequate ventilation and air exchange, with at least 6 air changes per hour as per ASHRAE requirements, shall be maintained in Outpatient Service area. Outpatient Service area should be kept at positive pressure relative to the adjacent areas. The area temperature should be maintained at 23 °C plus or minus 1°C and relative humidity 30% to 60% and should be adjustable. 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.

19.11 Use of the toilet room provided within the examination and treatment room shall be permitted for specimen collection.

20. Clinical Laboratory

20.1 Clinical Laboratory facilities shall be provided for the performance of tests. Each lab must be able to cover the following minimum specialties: hematology, clinical chemistry, Immunology and serology, microbiology, anatomic pathology, cytolopathology, and blood banking to meet the expected workload in the hospital functional program.

20.2 Certain procedures may be performed on-site or provided through a contractual arrangement with external laboratory service. These procedures/tests must be documented.

20.3 A specimen collection facility may be located outside the clinical laboratory area. The blood collection area shall have a work counter, space for patient seating, and hand-washing stations.

20.4 The urine and feces collection facility shall be equipped with a water closet and hand-washing station.

20.5 Laboratory work areas shall include sinks with water and access to vacuum, gases, tele/data service, and electrical service as needed.

20.6 Chemical safety provisions. These shall include emergency shower, eye-flushing devices, and appropriate storage for flammable liquids, etc

20.7 Facilities and equipment shall be provided for terminal sterilization of contaminated specimens before transport (autoclave or electric oven)

20.8 Laboratory fume hoods shall meet the following general standards:
20.8.1 An average fan velocity of at least 75 feet per minute (0.38 meters per second).
20.8.2 Connection to an exhaust system to the outside that is separate from the building exhaust system.
20.8.3 Location of an exhaust fan at the discharge end of the system.
20.8.4 Inclusion of an exhaust duct system of noncombustible corrosion-resistant material as needed to meet the planned usage of the hood.

20.9 If radioactive materials are employed, facilities for long-term storage and disposal of these materials shall be provided.

20.10 Storage facilities for reagents, standards, supplies, and stained specimen microscope slides, etc. shall be provided.

20.11 Refrigerated blood storage facilities

20.12 Lounge, locker, and toilet facilities shall be conveniently located for male and female laboratory staff.

20.13 Adequate ventilation and air exchange, with at least 6 air changes per hour as per ASHRAE requirements, shall be maintained in all Clinical Laboratory service area. The Laboratory area should be kept at positive pressure relative to the adjacent areas. The area temperature should be maintained at 21 °C to 24 °C and relative humidity 30% to 60% and should be adjustable. 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 further detail and other requirements regarding Clinical Laboratory requirements visit Health Regulation site in DHA website [www.dha.gov.ae](http://www.dha.gov.ae) to see the DHA Clinical Laboratory Licensure and Regulatory Standards.

### 21. Diagnostic Imaging

21.1 Radiology and diagnostic imaging services performs examinations and produces images from non-invasive or minimally invasive procedures performed on patients in specially equipped examination rooms.

21.2 The imaging modalities associated with the Radiology Service include conventional radiography (general radiology), Fluoroscopy, Computer Tomography (CT), Magnetic Resonance Images (MRI) Interventional Radiology (IR), Ultrasound, and Mammography.

21.3 Hospital must provide conventional radiography (general radiology), ultrasound services and CT within the premises of the hospital to meet the patient needs.

21.4 Patient convenience and accessibility should be considered for the planning and design of the Radiology Department.

21.5 Conventional radiography room size shall be at least 15 square meters. Room entrance shall not be less 1.20 cm and 2 meters height with shielded door. At least one designated patient gowning area for patient changing with safe storage for valuables and clothing shall be provided. The gowning area shall be at least 1.5 meters x 1.2 meters with immediate access to the conventional radiography room.
21.6 Ultrasound room size shall not be less than 7 square meters, with minimum of one examination bed. Patient toilet shall be accessible within the ultrasound room.

21.7 CT scan room shall be at least 24 square meters. Patient gowning area with safe storage for valuables and clothing shall be provided in the facility. At least one space should be large enough for staff-assisted dressing.

21.8 Sharing support areas for diagnostic imaging services (e.g. Control desk, reception area, and Consultation area) is permitted.

21.9 Diagnostic imaging services must comply with the FANR laws and regulations regarding the use of ionizing radiation and radio active materials. For further information regarding FANR regulations and requirements please visit FANR website www.fanr.gov.ae

21.10 Radiation safety protection requirements shall be incorporated into the specifications and the building plans. To meet the FANR requirements; in certain diagnostic imaging services (e.g. Nuclear medicine, Radiotherapy) the health facility needs 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.

21.11 Adequate ventilation and air exchange, with at least 6 air changes per hour as per ASHRAE requirements, shall be maintained in all Diagnostic Imaging service area. The area should be kept at positive pressure relative to the adjacent areas. The area temperature should be maintained at 21 °C to 24 °C and relative humidity 30% to 60% and should be adjustable. 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 further details regarding Diagnostic Imaging Services requirements visit Health Regulation site in DHA website www.dha.gov.ae to see the DHA Diagnostic Imaging Services Licensure and Regulatory Standards.

22. Pharmacy

22.1 The size and type of services to be provided in the pharmacy shall depend upon the type of drug distribution system used, number of patients to be served, and extent of shared or purchased services.

22.2 The pharmacy shall be located for convenient access, staff control, and security, the pharmacy area shall consist of the following:

- 22.2.1 A room or area for receiving, breakout, and inventory control of materials used in the pharmacy
- 22.2.2 Work counters and space for automated and manual dispensing activities
- 22.2.3 A compounding area. This shall include a sink and sufficient counter space for drug preparation.
- 22.2.4 An area for reviewing and recording
- 22.2.5 An area for temporary storage, exchange, and restocking of carts

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2 Space layouts should be developed in compliance with manufacturer's recommendations because area requirements may vary from machine to machine.
22.2.6 Security provisions for drugs and personnel in the dispensing counter area, if one is provided.

22.3 Secure storage shall be provided for narcotics and controlled drugs as per the Ministry of Health (MOH) laws and regulations.

22.4 If the functional program of the hospital requires dispensing of medication to outpatients, an area for consultation and patient education may be provided.

22.5 A hand-washing station shall be provided either in an anteroom or immediately outside the room where open medication(s) are prepared.

22.6 If intravenous (IV) solutions are prepared in the pharmacy, a sterile work area with a laminar-flow workstation designed for product protection shall be provided.

22.7 The laminar-flow workstation shall include:
   22.7.1 A non-hydroscopic filter rated at 99.97 percent (HEPA), as tested by dioctyl-phthalate (DOP) tests.
   22.7.2 A visible pressure gauge for detection of filter leaks or defects.

22.8 Separate room shall be provided for preparation of Cytotoxic IV admixtures under a Class II: Type B1, B2, B3 or Class III biological safety cabinet.

22.9 Layout of the pharmacy shall preclude unrelated traffic through the IV or cytotoxic preparation rooms.

22.10 Cabinets, shelves, and/or separate rooms or closets shall be provided for bulk and refrigerated storage.

For further details regarding Pharmacy requirements visit Health Regulation site in DHA website www.dha.gov.ae to see Pharmacy Licensure and Regulatory Standards.

23. Allied Health

23.1 Hospital shall provide necessary allied health services to meet patient needs based on the functional program.

23.2 Such services may be provided on the hospital premises or by an external provider with written agreement. The provided services shall be in accordance with DHA standards on allied health services. For further information please visit www.dha.gov.ae

24. Administration Area

The hospital should specify a separate department for administration. It shall have a suitable area for the hospital manager, assistants, administration and finance employees.

24.1 Reception Office: There should be a reception office with minimum of one supervisor to direct and answer the visitor’s enquiries.

24.2 Admission Office: The hospital may have an admission office for inpatients.

24.3 Medical Insurance Office.
CHAPTER THREE: HOSPITAL STANDARDS
CLUSTER ONE: PATIENT CARE

The aim of the Patient Care standards is to ensure that hospitals provide high quality care and caring environment to the patient at all time. Patient Care shall include care from the time that the patient enters the hospital, till the patient is discharged or transferred to another health facility or requires rehabilitative care. The hospital shall ensure the confidentiality of all patient information at all stages of care provision.

25. Patient Assessment

An effective patient assessment process 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.

25.1 The hospital shall have policies and procedure on patient assessment that includes but not limited to:

25.1.1 Collecting information and data on the patient’s physical, psychological, social status, and health history
25.1.2 Analyzing the data and information, including the results of laboratory and imaging diagnostic tests, to identify the patient’s health care needs
25.1.3 Developing a plan of care to meet the patient’s identified needs
25.1.4 The assessment includes patients discharge planning needs early in the hospitalization to include: medication, diet, activities, pain management and equipment.

25.2 Patients with emergent, urgent, or immediate needs are given priority for assessment and treatment. (see appendix 2 Sample of Triage Criteria)

25.3 Pediatric patients are assessed according to their unique needs.

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

26. General Care

26.1 Care should be planned and delivered in partnership with the patient and when relevant, patient's family/patient representative, to achieve the best possible outcomes. Patient participation may include:

26.1.1 Procedure date and admission/discharge time
26.1.2 Physician selection
26.1.3 Treatment preparation
26.1.4 Choice of wound location or dressing type
26.1.5 Post-discharge transport

26.2 Care shall be provided in response to patient needs in a timely manner and in accordance with the international accrediting standards requirements.

26.3 Care shall be delivered by DHA licensed competent individuals and competent multidisciplinary teams
26.4 Care shall be based on the best available evidence, preferably expressed thought explicitly published clinical practice guidelines and pathway of care.

26.5 The hospital management should continuously evaluate clinical care through systematic review and good clinical governance to understand if the best possible outcomes have been achieved for the patient.

26.6 Patients should be encouraged to provide feedback on the care provided. Evaluation practices should reflect that the outcomes of these reviews are acted upon.

26.7 **Pediatric services**, if provided, must be under the direction of a DHA licensed Specialist Pediatrician who must be responsible for the quality and scope of services.

26.8 Each general hospital that provides pediatric care and treatment in a distinct unit must establish and implement written policies and procedures, which include but are not limited to:

   26.8.1 The scope and care of pediatric patient.
   26.8.2 Conditions under which the parent or support persons may stay “in room” with pediatric patient

26.9 Beds location for pediatric patients shall be separate from adult patient and newborn infant.

27. **Outpatient Care**

   27.1 Outpatient Department shall be under the direction of qualified individual(s), as determined by the hospital management who shall be responsible for the quality and scope of provided services.

   27.2 Each hospital providing outpatient service must establish and implement written policies and procedures, which include but are not limited to:

      27.2.1 The scope of care for outpatient services.
      27.2.2 The outpatient registration procedure.
      27.2.3 Procedure for holding patients for observation
      27.2.4 Provision of outpatient services shall be in accordance with physician’s orders.
      27.2.5 Documentation and record filing requirements and procedures to integrate the outpatient record with existing inpatient records (if applicable).

   27.3 The numbers of staff and their qualifications needed to meet patient needs based on the type and volume of the provided services.

   27.4 Equipment and allocation of space for the provision of outpatient services to ensure safety and privacy of patients.

28. **Surgical Care**

   The hospital surgical services and procedures shall be provided by qualified healthcare professionals in an environment that ensures patient safety.

   28.1 Surgical services at the hospital shall meet the following criteria:
28.1.1 A DHA licensed consultant surgeon shall manage surgical services in the hospital; he/she shall be responsible for the quality of the services provided.

28.1.2 Surgeons shall receive privileges from the hospital to perform surgical procedures in the facility.

28.1.3 The degree of complexity of surgical procedures shall be within the hospital capabilities.

28.2 Written policies and procedures must be established to define the following:

28.2.1 Responsibilities for the supervision of the surgical suite and recovery room.

28.2.2 Restrictions on access to the surgical suite and recovery room area.

28.2.3 Circumstances that require the presence of an assistant during surgery.

28.2.4 Availability and administration of blood and blood products.

28.2.5 Requirements for testing and disposal of surgical specimens.

28.2.6 Procedures for handling infectious cases.

28.2.7 Proper attire in the surgical suite and recovery rooms area.

28.3 Proper infection control measures which include but not limited to:

28.3.1 Sterilization and disinfection of equipment and supplies.

28.3.2 Aseptic surveillance and practice.

28.4 Maintenance of operating room records; include but are not limited to:

28.4.1 Name and identification number of each patient.

28.4.2 Date, inclusive of time of the surgical procedure.

28.4.3 Surgical procedure(s) performed.

28.4.4 Name(s) of surgeon/s and assistants if any.

28.4.5 Name of nursing personnel both scrub and circulating nurse.

28.4.6 Type of anesthesia.

28.4.7 Name and title of physician managing anesthesia.

29. Obstetric and Gynaecology

Gynecology, Obstetrical and newborn services, if provided, must be under the direction of DHA licensed Specialist Obstetrics/Gynecologist (OB/Gyn) to direct such services, and who must be responsible for the quality and scope of services.

29.1 Each hospital that provides obstetrical and newborn services must establish and implement written policies and procedures which include but are not limited to the following:

29.1.1 The scope of care for patients receiving gynecological, obstetrical and newborn services.

29.1.2 Care and staff responsibilities during labour including the immediate care that must be provided for the newborn.

29.1.3 The use of oxytocic drugs and administration of anesthetics, sedatives, analgesics and other drugs, devices and biologicals.

29.1.4 Availability and administration of blood and blood products.
29.1.5 Appropriate attire must be worn during labor and delivery and in the nursery;

29.1.6 Admission and discharge procedure

29.2 Drugs, devices, equipment and supplies required for the services shall be immediately available for provision of care.

29.3 A DHA qualified Registered Midwife (RM) should supervise the care including labor, delivery, and nursery area.

29.4 Method for correct identification of the newborn and mother must be followed.

29.5 In case of Cesarean Section deliveries, an informed consent form shall be obtained by the OB/Gyn from the patient or his designated representative (as applicable) excluding life threatening emergency cases.

For further details see Obstetric and Neonatal Services Guideline in DHA website www.dha.gov.ae

30. Anaesthesia and Sedation Care

The level of anesthesia used should be appropriate for the patient condition, the surgical procedure, the proficiency of the anesthetist, and the equipment available in the hospital.

30.1 Anesthesia services at the hospital shall meet the following professionals requirements:

30.1.1 DHA licensed consultant anesthetist shall manage anesthesia services/department in the hospital; he/she is responsible for the safety and quality of the services provided.

30.1.2 Physicians providing anesthesia must be licensed by DHA as anesthetist and working within his/her scope of practice.

30.1.3 In case of specialized operations e.g. pediatrics, neurosurgery, thoracic surgery and cardiac surgery the anesthetist must be at least specialist anesthetist, competent with suitable experience to provide the anesthesia.

30.1.4 All healthcare professionals who administer anesthesia or supervise patient during anesthesia (i.e. physicians, 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.

30.2 Pre-assessment shall be conducted in the anesthesia clinic for all patients requiring more than local anesthesia. This shall include basic investigations such as Complete blood Count (CBC), Blood Glucose level, and coagulation profile.

30.3 The Anesthesia clinic shall be physically available in the hospital and can be run by a nurse and anesthetist.

30.4 The choice of anesthesia agents shall be effective, appropriate, and respond to the specific needs and ensure patients rapid recovery to normal function with maximum efforts to control post-operative pain, nausea, or other side effects.

30.5 Anesthetist must be physically present during the intra-operative period and be available until the patient has been discharged from anesthesia care.
30.6 Physiological 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.

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

30.8 Anesthesia monitoring equipment should be appropriate for the type of anesthesia provided. Provisions should be made also for a reliable source of oxygen, suction, resuscitation equipment, and emergency drugs.

30.9 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.

30.10 Emergency/crash cart shall be available with a plastic breakable seal that can be easily removed during emergency. It must be equipped with defibrillator, necessary drugs and other CPR equipment and test strips. A log book must be nearby to indicate the maintenance and regular check of the crash cart and its components.

30.11 The hospital should maintain suitable equipments to support difficult intubation.

30.12 When anesthesia services are provided to infants and children, the required equipment, medications, and resuscitative capabilities should be appropriately sized for children.

30.13 Hospital shall abide by the Ministry of Health regulation on maintaining narcotic medication records.

30.14 The hospital should maintain a written policy on the following:
   30.14.1 Proper storage and handling of anesthesia/sedative agents
   30.14.2 Conscious sedation.
   30.14.3 Patient care at recovery room.
   30.14.4 Anesthesia infection control for anesthesia machines and all anesthesia process.

30.15 Safety measures shall be implemented against biohazards.

31. Critical Care Services

Critical care services in the hospital shall meet the following requirements:

31.1 Consultant anesthetist or Specialist in critical care licensed by DHA must manage services in the critical care services in the hospital. He/she shall be responsible for the quality and scope of service provided.

31.2 The critical care services must be provided by at least a specialist (under supervision) or General Practitioner (GP) qualified and trained to provide the critical care services.

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3 Anesthetist shall be the only privileged healthcare professional to discharge patient from the recovery room.
31.3 Physicians providing critical care services shall work within their scope of practice and hold active certification in BLS, ACLS and/or PALS.

31.4 Physician coverage for the critical care must be for 24-hour, the physician must be physically present in the hospital vicinity.

31.5 In case of specialized critical care patient e.g. pediatrics, neurosurgery, thoracic surgery and cardiac surgery, such critical care services must be provided by at least a DHA licensed Consultant Anesthetist/Consultant in critical care competent with suitable experience to provide the services.

31.6 For each occupied bed in critical care unit, there must be one Registered Nurse (RN) with suitable training and experience on duty to provide the care needed.

31.7 Critical care services equipments, medications and supplies must be readily available in the unit for immediate and safe provision of care and treatment.

31.8 Emergency/crash cart shall be available with a plastic breakable seal that can be easily removed during emergency. It must be equipped with defibrillator, necessary drugs and other CPR equipment and test strips. A log book must be nearby to indicate the maintenance and regular check of the crash cart and its components.

31.9 Written policies and procedures must be established and implemented which define and describe the scope of critical care services and ensure safe and competent delivery of the services to the patients. Policies shall cover the following areas:

31.9.1 Admission and discharge/transfer policy

31.9.2 Conscious sedation.

31.9.3 Coronary Angiogram.

31.9.4 Temporary and permanent pace maker.

31.10 There should be evidence that critical care nursing receives continuous training with competency assessment (e.g. written test, return demonstration, etc) and education in the following:

31.10.1 Recognizing arrhythmias

31.10.2 Assisting physician in placing central lines or arterial lines.

31.10.3 Obtaining Arterial Blood Gases (ABG).

31.10.4 Reading central venous pressure.

31.10.5 Central Venous Pressure (CVP) line.

31.10.6 Infection control principles.

31.10.7 Blood transfusions.

31.10.8 Exchange transfusion (neonate).

31.10.9 Glasgow coma scale (GSC).

31.10.10 Use of the defibrillator.

31.10.11 Care of patients on ventilators.

31.10.12 Care of patients with Tracheostomy.

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4 Only physicians are privileged for patient’s admission and discharge/transfer
31.11 Critical care airborne infection isolation rooms shall be used for isolating the airborne spread of infectious diseases (e.g., measles, varicella, tuberculosis).

31.12 Use of airborne infection isolation rooms for routine patient care during periods not requiring isolation precautions shall be permitted. Differential pressure requirements shall remain unchanged when the AII room is used for routine patient care.

31.13 HCWs dealing with infectious diseases shall follow the standards and precaution requirements of Centers for Disease Control and Prevention (CDC).

31.14 All visitors shall use masks and head caps which shall be discarded inside the room.

31.15 Proper disinfection control and measures must be strictly followed in the hospital.

31.16 Isolation room should be sterilized after discharging patient.

31.17 As per the applicable federal laws, if a physician has a suspicion of certain contagious disease, notification shall be submitted to the DHA; the notification shall include patient name telephone number and address. For further information click here to see the UAE Federal Law number 27/1981 concerning the Prevention of Communicable Diseases.

32. Emergency / Casualty Services

32.1 The emergency area must be located on ground floor, easily accessible, equipped and staffed sufficiently to ensure that ill or injured persons can be promptly assessed and treated or transferred to another hospital capable of providing needed services as per the hospital policy.

32.2 The services must be supervised by qualified and DHA licensed Specialist in Emergency Medicine or Specialist physician with experience emergency services.

32.3 He/she shall be responsible for the quality and scope of emergency services.

32.4 Emergency services must be provided by qualified and trained physicians who receive privileges from the hospital to perform specific emergency procedures.

32.5 Physician coverage for the emergency must be for 24-hour, the physician must be physically present in the hospital vicinity.

32.6 All physicians working in the emergency unit/department must hold active certification in BLS, ACLS and PALS.

32.7 For every four occupied beds in emergency unit/department, there must be at least one DHA Registered Nurse (RN) on duty with suitable training and experience in emergency to provide the care needed.

32.8 All nursing staff working in emergency area shall be certified with BLS, ACLS, and PALS.

32.9 At least qualified and competent DHA registered nurse shall conduct patient’s triage to prioritize patients with immediate needs. A sample of Triage Criteria can be seen in appendix 2.
32.10 As per the applicable laws in UAE, all emergency patients arriving at the emergency unit/department should receive adequate urgent care to stabilize their condition prior to transfer.

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

32.12 A record must be kept for each patient receiving emergency services and must be integrated into the patient’s health records; the emergency record should include the following:

32.12.1 Patient name
32.12.2 Date, time and method of arrival
32.12.3 Physical findings
32.12.4 Care and treatment provided
32.12.5 Name of treating medical practitioner and
32.12.6 Disposition including time

32.13 Patient’s consent must be obtained, written instructions to patients and oral explanation of those instructions should be provided (unless it’s emergency case).

32.14 Emergency unit/department shall be equipped with the following:

32.14.1 Emergency/crash cart shall be available, with a plastic breakable seal that can be easily removed during emergency. It must be equipped with defibrillator, necessary drugs and other CPR equipment and test strips. A log book must be nearby to indicate the maintenance and regular check of the crash cart and its components.

32.14.2 Resuscitation Kit + Cardiac board + Oral airways
32.14.3 Laryngoscope with blades
32.14.4 Diagnostic set
32.14.5 X-ray viewer
32.14.6 Patient trolley with IV stand
32.14.7 Wheelchair
32.14.8 Nebulizer
32.14.9 Autoclave
32.14.10 Refrigerator with temperature control
32.14.11 Floor Lamp (Operating light mobile)
32.14.12 Sets of instruments which shall include suturing set, dressing set, foreign body removal set or minor set and cut down set
32.14.13 Disposable supplies which shall include suction tubes (all sizes), tracheotomy tube (all sizes), catheters (different sizes), IV sets, Blood transfusion set, syringes (different sizes), dressings (gauze, sofratulle, etc.), crepe bandages (all sizes), splints (Thomas splints, cervical collars, finger splints), All types of fluids (e.g. D5W, D10W, Lactated Ringers, Normosol R, Normosol M, Haemaccel, etc.), Glucometer and Alcohol meter
32.14.14 Portable Vital Signs Monitor (ECG, Pulse-Oximetry, Temperature, NIBP, EtCO2)
32.14.15 Portable transport ventilator with different ventilation mode (IPPV, SIMV, spontaneous, PS).
32.14.16 Suction apparatus that meets operating room standards.
32.14.17 Medico-legal forms such as consent forms, DAMA form, etc.

32.15 Each hospital that provides emergency services must establish and implement written policies and procedures such as:
32.15.1 Assessment of emergency patients
32.15.2 Admission from the emergency service to an inpatient unit
32.15.3 Policy for maintaining personal items and food in emergency area

33. Discharge / Transfer Planning

Proper discharge planning is critical to the health and safety of patients, processes for discharge / transfer shall address the needs of the patient for ongoing care. Inadequate planning may result in re-admissions to the hospital and losses of gains made during initial hospitalizations.

33.1 The hospital shall maintain written policies and procedures concerning the patient discharge/transfer which reflect acceptable standards of practice and compliance with applicable regulations in Dubai.

33.2 Each patient discharge from a hospital shall receive a written discharge plan, in non-technical language, along with sufficient oral explanations to assist the patient in understanding the plan and availability of outpatient services capable of meeting the patient's discharge needs.

33.3 If patient is transferred to another health facility and in order to ensure continuity of patient care, the other facility shall be informed about the case and approval for transfer should be documented in the patient's file.

33.4 The treating physician is responsible for the coordination of the timely transfer of appropriate information and discharge notice from the hospital to the other facility.

33.5 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.

33.6 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. Emergency Medical Technician (EMT), competent physician or trained nurse in emergency/critical care.

33.7 Treating physician should respect patients' choices if he/she decided self discharge, i.e. Discharges Against Medical Advice (DAMA).

33.8 DAMA form shall be available in the hospital (Sample of DAMA form is available in appendix 3); DAMA patients shall sign the form before leaving the hospital.
34. End of Life Care

34.1 Each general hospital with more than 25 beds shall provide a mortuary within the hospital premises. The number of body slots per hospital capacity is 1:25.

34.2 Mortuary equipments shall be operated and maintained in accordance with manufacturer specifications and shall meet the medical equipments requirements in this document.

34.3 Mortuary fridge temperature shall be maintained between 2 - 6 °C, the temperature gauges shall be monitored and recorded daily in a log kept near the fridge; records shall be maintained by the unit for at least six months. In case of temperature variation, biomedical engineers/department shall be contacted.

34.4 Mortuary area shall be maintained clean and disinfected on daily basis, infection control policy shall be available and implemented in the mortuary area.

34.5 The hospital shall place a high priority on the care and management of patient and family/patient representative at the end of life.

34.6 The hospital shall have a system to ensure that the care of dying and deceased patients is managed with dignity and comfort.

34.7 The hospital shall maintain also a policy for handling amputated body parts which assure proper management and disposal.

34.8 A written policy and procedure shall exist for the management and care of terminally ill patients consistent with Federal and Local regulations.

34.9 Withholding and withdrawing life sustaining treatment is not permitted even if it’s requested by the patient or his family.

34.10 In case of death, the patient’s family wishes have to be totally respected and considered; requests for relatives/friends to view the deceased are made by ward staff or in the mortuary.

34.11 Deceased's family shall make arrangements with the mortuary for the removal of the deceased from the hospital mortuary.

34.12 The hospital mortuary services shall be responsible for overseeing the transportation of deceased patients from wards/departments. Deceased registration shall be maintained by the hospital.

34.13 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 in mortuary bag.

34.14 Transportation of deceased patient infected with communicable disease shall be conducted according to article 18 of the UAE Federal Law number 27/1981 concerning the Prevention of Communicable Diseases.
CLUSTER TWO: DIAGNOSTIC SERVICES

35. Clinical Laboratory

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

35.2 The hospital must have accessible emergency laboratory service including urinalysis, complete blood counts, blood typing and cross-matching. Adequate blood fridge with temperature gauge and other necessary emergency laboratory work as determined by the medical staff must all be made available.

35.3 Clinical laboratory must be under the direction of a DHA licensed and experienced consultant/specialist pathologist.

35.4 Clinical laboratory design and professional staffing must comply with DHA Clinical Laboratory Licensure and Regulatory Standards. For further details and other requirements regarding DHA Clinical Laboratory Standards visit Health Regulation site in DHA website www.dha.gov.ae.

36. Diagnostic Imaging

36.1 Each hospital must provide diagnostic imaging services to meet the patient needs this include at least conventional radiography (general radiology), ultrasound services and Computer Tomography (CT).

36.2 Other services may be available on the hospital premises or with written agreement with an external provider. If radiology and diagnostic imaging services outsourced to another diagnostic imaging facility, it shall meet the outsourcing requirements.

36.3 Diagnostic imaging services in the hospital must be under the supervision of a licensed and experienced Consultant/Specialist Radiologist, he/she shall be responsible for the quality and scope of radiology service provided in the hospital. The hospital management shall ensure that radiology services provide the following:

36.4 All diagnostic images must be reviewed and interpreted by a licensed Radiologist. Complete reports of the results of images 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.

36.5 All staff performing radiography procedures must be qualified and licensed by DHA.

36.6 Availability of emergency portable radiology service in the hospital premises shall be ensured by the hospital management.

36.7 Diagnostic imaging services in the hospital must be assessed by Radiation Safety Committee/Team.

36.8 Diagnostic imaging services must comply with the Federal Authority Nuclear Regulation-FANR laws and regulations regarding the use of ionizing radiation and...
radio active materials in hospital. For further information regarding FANR regulations and requirements please visit FANR website www.fanr.gov.ae

All diagnostic imaging services must comply with the DHA Diagnostic Imaging Services Licensure and Regulatory Standards. For further details regarding standards visit Health Regulation site in DHA website www.dha.gov.ae

37. Blood Bank

The hospital’s management shall ensure safe and appropriate practice system for prescription, sample collection, storage and transportation and administration of blood and blood components.

37.1 The hospital shall adopt mechanisms to ensure the availability of blood or blood component for all elective procedures with anticipated need of blood.

37.2 A policy shall exist for:

37.2.1 Availability of blood or blood component for all elective procedures with anticipated need of blood

37.2.2 The safe collection and identification of the pre-transfusion patient blood sample

37.2.3 Prescription and documentation of blood component therapy

37.2.4 Safe administration and appropriate monitoring of blood or blood component therapy

37.2.5 Ensuring written consent is obtained

37.2.6 A process for refusal of transfusion.

37.2.7 Transportation and storage conditions of blood components including availability and proper maintenance of the blood fridge which must be provided with a temperature gauge for daily monitoring and recording on a provided log.

37.3 Hemolytic transfusion reaction involving administration of blood or blood components having major blood group incompatibilities (ABO or Rh) is considered as sentinel event and should be reported immediately.

The policy shall comply with the UAE Cabinet Decision number 28 of 2008 regarding Blood Transfusion Regulation. For further information click here to see the Cabinet Decision number 28 of 2008 or visit the Health Regulation in DHA website www.dha.gov.ae
CLUSTER THREE: SUPPORT SERVICES

38. Nutrition Services

38.1 Strict hygienic conditions should be maintained in the hospital kitchen during preparing, storing and serving food. Such services may be provided on the hospital premises or by an external provider with written agreement. However, if such services are out-sourced it should fulfill the DHA and DM hygiene requirements.

38.2 An experienced, qualified and DHA licensed clinical dietitian with at least bachelors’ degree in nutrition shall supervise this service. The clinical dietitian shall be responsible for the following:

38.2.1 Patient’s consultation and visits.
38.2.2 Nutritional screening, assessment and reassessment
38.2.3 Developing nutritional care plan
38.2.4 Highlight “food-drug interaction” to physicians and document this in the patient’s health record.
38.2.5 Making recommendations related to patient dietary needs.
38.2.6 Follow-up with patient care team when an abnormality is recognized during screening.
38.2.7 NPO (Nothing by Mouth) monitoring.
38.2.8 Education of patients and their families in addition to other members of the health care team.
38.2.9 Developing food menus.
38.2.10 Evaluating and documenting patient’s dietary intake when certain patients are on special diets

38.3 Catering Service area ventilation and air exchange shall be maintained with at least 10 air changes per hour as per ASHRAE requirements. Catering Service area should be kept at positive pressure relative to the adjacent areas. 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.

39. Laundry Services

39.1 Hospital shall provide laundry services either on the hospital premises or by an external provider with written agreement. If the laundry is in-house it shall be fully equipped with machines used for cleaning and washing clothes, sheets and covers.

39.2 Adequate ventilation and air exchange, with at least 10 air changes per hour as per ASHRAE requirements, shall be maintained in Laundry Service area. Laundry Service area should be kept at negative pressure relative to the adjacent areas. 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.
40. Sanitary Services

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

40.2 Clean Bathrooms for outpatients should be provided (separate for men and women), 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 Hand rubs must be available in the toilets and patient rooms.

40.4 All hospital drainage and sewage should be connected to general sewerage and be according to DM regulations.

41. External Services

41.1 External services provider shall be managed effetely 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 organization e.g. Radiology, laboratory, oncology, pathology, allied health, transport, laundry, food, cleaning, maintenance, security, and education.

41.2 While a contracted or services agreement is important for both the healthcare facility and service provider to ensure good quality services, the fundamental responsibility for quality shall remain with the main healthcare facility. The health facility should outline in its services agreements / contracts exactly what services what level of services is expected and evidence with compliance with that service’s regulatory or industry standards e.g. compliance with DM standards for laundry or food services.
CLUSTER FOUR: SAFETY

42. Patient Safety

Worldwide, the delivery of health care is challenged by a wide range of safety problems. Hospitals shall provide safe care and services by focusing efforts on reducing harm to patients and staff.

42.1 The hospital shall develop a system for reducing the incidence of harm. The most common causes of harm in health systems were identified by the World Health Organization (WHO) patient safety solutions. It aims to save lives and prevent medical errors.

42.2 The patient safety solutions must not only be developed and disseminated in the hospital, the hospital must also demonstrate evidence of implementation.

42.3 The International Steering Committee approved nine solutions for dissemination. The nine patient safety solutions are:
   42.3.1 Look-alike, sound-alike medication names
   42.3.2 Patient identification
   42.3.3 Communication during patient hand-over
   42.3.4 Performance of correct procedure at correct body site
   42.3.5 Control of concentrated electrolyte solutions
   42.3.6 Assuring medication accuracy at transitions in care
   42.3.7 Avoiding catheter and tubing misconnections
   42.3.8 Single use of injection devices
   42.3.9 Improved hand hygiene to prevent nosocomial infections

42.4 The hospital shall actively identify and manage the risks associated with patient safety; appendix 4 gives strategies which should be considered in the hospital to ensure the implementation of suitable patient safety solutions as recommended by the WHO.

43. Infection Control

Hospitals must have an infection control and prevention program to identify and reduce the risks of acquiring and transmitting infections among patients, healthcare personnel, and visitors.

43.1 The hospital should have an infection control manual which includes infection prevention and control program. The manual is reviewed annually and updated as necessary.

43.2 The infection control and prevention program should have appropriate policies and procedures that meet international infection control and prevention guidelines.

43.3 The infection control program shall support safe practice and ensure a safe environment for patients, healthcare workers (HCWs) and hospital visitors.
43.4 The hospital has a designated and qualified infection control professional(s)/committee to oversee the infection and prevention control program.

43.5 When appropriate the infection control professional(s)/committee consults with someone who has expertise in infection prevention and control in order to make informed decisions.

43.6 The hospital should conduct regular pre-induction training sessions on prevention and control of infections for appropriate categories of new staff before joining the respective departments.

43.7 The hospital should conduct regular “in-service” and educational training sessions on the prevention and control of infections for all concerned categories of staff at least once in a year.

43.8 The hospital should have a process for the education of patients and families on infection prevention and control.

43.9 The hospital should monitor and report and share the information with the staff and service providers on trends of infections and track infection rates including healthcare associated (nosocomial) infections.

43.10 The infection prevention and control program should focus on adherence to standard precautions at all times and include equipment cleaning and sterilization practices, laundry and linen management, kitchen sanitation and food handling issues.

43.11 The healthcare facility shall identify, manage and control infections

43.11.1 The healthcare facility must have policies, procedures and guidelines on ventilation, isolation, cohorting (as necessary) and other precautions to prevent and contain the spread of infectious diseases.

43.11.2 The healthcare facility must have a process to promptly detect suspected healthcare associated infections (HAIs) within the facility.

43.11.3 The healthcare facility shall promote voluntary reporting by all personnel and provides the appropriate training and information for the reporting process.

43.11.4 The healthcare facility must have a process for isolation of patients with communicable diseases that may put others at risk of infection.

43.11.5 The healthcare facility must define isolation which may include a private room, isolation facilities or a negative pressure room.

43.11.6 The personnel must be educated and trained in the handling of patients with infections.

43.11.7 The healthcare facility must report infection surveillance, prevention and control information to the appropriate public health authorities in accordance with law and regulation.

43.12 The healthcare facility must have hand hygiene guidelines that are a fundamental part of the infection prevention and control plan and are evidence based and must ensure:
43.12.1 Hand washing facilities in all patient care areas must be accessible to patients, healthcare providers and visitors.

43.12.2 Access to safe continuous water supply at all faucets and access to necessary supplies (e.g. soap, paper towels) to perform hand washing must be made available.

43.12.3 The personnel, patients and visitors must have access to alcohol-based hand rubs at the point of care and service delivery areas.

43.12.4 The personnel and visitors must have access to personal protective equipment (e.g. gloves, masks) if necessary.

43.12.5 The healthcare facility must provide education on proper hand hygiene techniques.

43.12.6 Promotional hand hygiene reminders must be on display in the workplace.

43.12.7 The healthcare facility must audit and document the personnel compliance with hand hygiene and shares the results with all of the personnel.

43.13 The healthcare facility and the infection control professional(s) must be responsible for surveillance activities in identified areas hence:

43.13.1 High risk areas in the healthcare facility must be identified and surveillance activities are appropriately directed to these areas.

43.13.2 Collection of surveillance data must be an ongoing process and must be reported to the appropriate authorities in the case of reportable communicable diseases according to the applicable laws and regulations.

43.13.3 Surveillance activities include monitoring the effectiveness of housekeeping services.

43.13.4 The healthcare facility must have policies and procedures that oversee the cleaning and disinfection of medical equipment, devices, supplies and the environment of care and the handling, management and disposal of biomedical and other waste.

43.13.5 The healthcare facility must ensure that the environment of care is clean and disinfected.

43.13.6 Laundry and linens must be cleaned and disinfected in a manner that minimizes the risk of contamination to staff and patients.

43.13.7 The organization must have a process for the management, handling and disposal of sharps and needles according to the healthcare facility’s policies and procedures and the applicable laws and regulations.

43.13.8 The sharps containers must be collected in puncture proof, non-reusable containers according to the healthcare facility’s policies and procedures.

43.13.9 The healthcare facility must have a process for the management, monitoring and disposal of expired supplies.

43.13.10 The healthcare facility must have a proper process for waste disposal that reduces the risk of infection.

43.13.11 The healthcare facility must have a proper process for the management and handling of bio-medical and other types of waste.
43.13.12 Appropriate personal protective measures must be used by all categories of staff handling bio-medical waste and any materials contaminated with body fluids.

43.13.13 The healthcare facility must follow Occupational Health and Safety guidelines according to the laws and regulations for the work restrictions for healthcare personnel and service providers with communicable diseases.

43.14 There are policies and procedures that guide the cleaning and disinfection of the healthcare facility:

43.14.1 The healthcare facility addresses the roles of the staff responsible for cleaning and disinfecting the physical environment.

43.14.2 If the cleaning service is contracted to external providers, there must be a mechanism in place to define the role of the contracted staff and verification of the quality of services provided.

43.15 The healthcare facility must have processes for the management and handling of contaminated materials and equipment:

43.15.1 Policies and procedures must guide the appropriate handling of contaminated linen, infectious materials and hazardous waste according to applicable laws and regulations.

43.15.2 The healthcare facility must have the appropriate containers for handling, managing and transporting contaminated materials to an appropriately designated area.

43.15.3 If reprocessing and sterilization may be contracted to an external provider, the healthcare facility regularly monitors the quality of the services provided.

43.15.4 The healthcare facility must verify that the external provider follows appropriate standards of practice for reprocessing and sterilization according to guidelines, laws and regulations.

43.16 Staff and service providers shall store, prepare and handle food appropriately:

43.16.1 The healthcare facility must have policies and procedures for the storing, handling and preparation of food.

43.16.2 Food storage, handling and preparation must be monitored even if food is made using pre-prepared mixes or ingredients or if the preparation is done off-site.

43.16.3 If food services are contracted to external providers the healthcare facility must have a mechanism to define and verify the quality of the storage, preparation and handling of food by the external provider.

43.17 The healthcare facility takes appropriate actions to control outbreaks of infections:

43.17.1 The infection control and prevention plan must include comprehensive guidance, policies and procedures that address the protection of patients and healthcare personnel and the handling of outbreaks of infections.

43.17.2 The infection control and prevention plan includes a process and methodology to investigate outbreaks of infectious diseases.
43.17.3 The healthcare facility coordinates planning for outbreaks with the overall planning for disasters and emergencies

43.18 The hospital workers shall refrain from storing food items in any fridge found in the patients’ service areas which is used for storing medications or medical equipment.

44. **Pressure Ulcer Prevention**

44.1 The hospital shall maintain and implement a policy for the prevention and management of pressure ulcers.

44.2 The incidence and impact of pressure ulcers shall be minimized through pressure ulcer prevention and management strategy.

44.3 Education programs and information regarding pressure ulcer should be developed and evaluated by a multidisciplinary team in the hospital.

44.4 Screening and assessment tool should be available in the hospital.

44.5 Healthcare professionals shall use a pressure ulcer risk assessment tool to assess patients.

45. **Patients’ Falls Management Program**

45.1 The incidence of falls and fall injuries shall be minimized through a falls management program.

45.2 A policy shall exist for falls management. Patients shall be assessed for risk of falls:

45.2.1 On admission

45.2.2 Following a change of health status

45.2.3 After a fall.

45.3 Falls prevention information must be provided to staff, patients and patient's family/patient representative.

45.4 Appropriate falls reduction strategies should be implemented by the hospital according to identified risk factors.
CLUSTER FIVE: MEDICATIONS MANAGEMENT AND PHARMACY

46. Medications Management

46.1 Medications shall be managed to ensure safe and effective practice. The hospital must maintain policies and procedures on medication management consistent with applicable federal legislation in the UAE.

46.2 The hospital shall maintain a standardized list of approved abbreviations for medications used throughout the facility.

46.3 Potential medication risks must be identified, evaluated and acted upon.

46.4 A multidisciplinary committee shall oversee and ensure the proper management of medication safety in the hospital.

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

47. Pharmacy

Pharmacy services must be provided to meet the needs of patients directly or through written agreement with outsource services. The pharmacy services must be under the supervision of an experienced and DHA licensed pharmacist.

The hospital management shall ensure that pharmacy services provide the following:

47.1 The storage, control, handling, compounding and dispensing of drugs, devices and biological material should be according to the MOH regulations.

47.2 Emergency drugs and devices as determined by the medical 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.

47.3 All controlled drugs must be stored in a locked area to prevent access by unauthorized individuals. Only authorized personnel may have access/keys to the locked area.

47.4 Drugs and devices must be stored 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 hospital policies and MOH regulations.

47.5 The supply of drugs, devices and biologicals must be checked on a regular basis to eliminate expired, mislabeled, unlabelled or unusable products and dispose of them appropriately.

47.6 Information related to drug indications for use, interactions, contraindications, side-effects, toxicology, adequate dosage, and medication administration routes must be readily available to all pharmacy staff.

47.7 Adequate ventilation and air exchange, with at least 4 air changes per hour as per ASHRAE requirements, shall be maintained in Pharmacy services area. Pharmacy services area should be kept at positive pressure relative to the adjacent areas. The area temperature should be maintained at 23 °C plus or minus 1 °C and relative...
humidity 30% to 60% and should be adjustable. 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 further information regarding the pharmacy requirements visit the Health Regulation in DHA website www.dha.gov.ae
CLUSTER SIX: PATIENT AND FAMILY RIGHTS

48. Patient’s Rights and Responsibilities

The hospital shall ensure that the rights and responsibilities that patient have in health care delivery are recognized by the hospital, and communicated to consumers.

48.1 Patients should be treated with respect, consideration, and dignity.
48.2 The patient has the right to privacy and confidentiality.
48.3 Patients, or a designated person when appropriate, should be provided information concerning the patient’s diagnosis, evaluation, treatment options, and prognosis.
48.4 Patients should be given the opportunity to participate in decisions involving their healthcare when such participation is not contraindicated.
48.5 Patients have the right to refuse any diagnostic procedure or treatment and be advised of the medical consequences of that refusal.
48.6 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.
48.7 Patients have a right to obtain a copy of their personal medical records.
48.8 Patients shall have the right to full disclosure of health services cost prior to performance of any treatment/procedures.
48.9 Service cost information may be displayed in the form of price leaflet/brochure or any other form feasible for the hospital.
48.10 Patient Rights and Responsibilities must be posted in strategic areas within the facility for easy access. The hospital must comply with all DHA regulations regarding Charter Of Patient Rights and Responsibilities.

For further information please click here or visit www.dha.gov.ae

48.11 A written policy in the hospital shall be available which shall identify the roles and responsibilities of each hospital staff in concerning of patients and families rights.
48.12 The hospital must have an effective program for managing patients’ complaints.
48.13 The hospital shall investigate complaints made by a patient or by patient’s family, and must document both the existence of the complaint and the resolution of the complaint. A specialized committee may be assigned this task.
48.14 The patient and the hospital shall have the right to change or transfer the patient care responsibility from one consultant to other with clear justification.
48.15 Patients’ satisfaction surveys may be carried out regularly and action must be taken upon the results in terms of further improvement of the care.
48.16 The hospital shall develop a policy regarding patients’ belongings, with emphasis on; under anesthesia, unconscious, comatose, drowsy and severely traumatized patients.
48.17 The hospital shall develop a policy about treatment refusal by patient, and inform the patient about the possible expected outcomes of that refusal.

49. Patient Education

49.1 Patients and their families have the right for knowledge and health education in order to make informed decisions while participating in their care process.

49.2 Patient education program shall be developed and available at the hospital. The program shall include nature of education, methodology, timing and frequency.

49.3 Health education program materials shall be available for patients and families in the hospital, this may include but not limited to the following:

49.3.1 Demonstration on infection control for patient, medicines utilization, personal equipment use, care of surgical wound, and so forth.

49.3.2 Guideline materials related to pre-operative and post-operative preparations, radiology procedures, laser pre-treatment, and so forth.

49.3.3 Assigning health education program to competent staff e.g. diabetes educators, patient educators, dieticians, nurse educator.

49.3.4 Patients and their families receive information/leaflet about their illnesses and potential complications that may happen latter.

49.3.5 Patient education form

49.4 Patient education needs assessment and educational activities should be done and documented in the patient medical records

50. Linguistic Diversity

Dubai is a multicultural city, and the residents speak a range of different languages. Understanding cultural, religious and language needs is an integral element to providing responsive health care.

50.1 The hospital should accommodate the needs of these people when they are patients. This may include providing a nutritionally balanced vegetarian meal for vegetarian patients, providing information brochures in several languages and providing accessible translator list in the hospital.

51. Disabled People Rights

Disabled individual (also known as special needs) refer to a personal condition or situation that could make it difficult for a patient to participate fully in their health care. The personal condition or situation could include disability (which may include physical, intellectual or sensory disability), age affected (either elderly or very young), affected by trauma or affected by medications / drugs.

51.1 All hospitals shall be made accessible to accommodate disabled individuals in compliance with the federal law number 29 for 2006 regarding Disabled People Rights, The following special needs requirements are mandatory:

51.1.1 Handicapped parking within the hospital premises

51.1.2 Wheelchair ramps within the hospital building

51.1.3 Accessible physical examination rooms.
51.1.4 Male and female handicapped-accessible rest room in each floor within the hospital building.
CLUSTER SEVEN: HEALTH INFORMATION MANAGEMENT

Data and information shall meet the hospital needs and support the delivery of quality care and services. The principles of good information management are the same regardless of the size and type of hospital and the complexity of the information technology. There are increasing requirements for information management to support hospital performance and health care delivery.

52. 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, physician and the hospital.

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

52.2 Health records may be created and maintained in written paper or electronic format, or a combination of both, and must contain sufficient information to clearly identify the patient, to justify the diagnosis and treatment and to document the results accurately.

52.3 A health record should include a medical history, physical examination, any pertinent progress notes, operative reports, laboratory reports, radiology reports and communication with other patient personnel. It should highlight allergies and untoward drug reactions, such information shall ensure the safe and effective delivery of health care.

52.4 Each patient health record must contain at least, but not limited to the following information, where applicable:

52.4.1 Identification data
52.4.2 A unique identifier for health records
52.4.3 A system to alert staff to patients of the same name
52.4.4 Time and date of seeing the patient
52.4.5 Full Patient History which includes but not limited to: (Chief complaint, Present illness, Social and psychological review, Medication Allergies, Family History of illnesses, Present complaint and Previous complaints, Past medical history)
52.4.6 Physical examination and system review
52.4.7 Admission diagnosis
52.4.8 All pathology/laboratory and radiology reports
52.4.9 Properly executed informed consent forms
52.4.10 Physicians orders
52.4.11 Pain assessment
52.4.12 Documentation of all care and treatment, medical and surgical, signed and stamped by attending physician
52.4.13 Histopathology and tissue reports
52.4.14  Progress notes of all disciplines
52.4.15  Discharge summary
52.4.16  Discharge card: must be given to the patient on discharge without charge.
52.4.17  Autopsy findings; and death certificate
52.4.18  Advanced Directives (if available)
52.4.19  Patient education
52.4.20  Vaccination records (for paediatric patients)
52.4.21  Police care clearance.

52.5  Identification of patients with challenging behaviors shall be identified in the health records

52.6  Health records must contain entries which are dated, legible and indelibly verified. The author of each entry must be identified and authenticated. Authentication must include: official stamp, signature, written initials, or computer entry.

52.7  Copies of signed informed consent for surgical procedures or specific treatment given to the patient (e.g. chemotherapy) shall be maintained in the patient’s health records.

52.8  Relevant findings from assessments performed outside the health facility should be included in the patient assessment process and health record.

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

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

52.11 Health records should be organized in a consistent manner that facilitates continuity of care. Discussions with patients concerning the necessity, appropriateness and risks of proposed surgery/procedure, as well as discussion of treatment alternatives, should be incorporated into a patient’s health record as well as documentation of informed consent.

53. Informed Consent

53.1  As per article (7) of the Federal Law number 10/2008 concerning Medical Liability Law, informed consent shall be obtained by the treating physician from the patient or his Designated representative (as applicable) and after a discussion of the complication, risks, benefits and alternatives of procedures/surgeries (excluding emergency cases).

53.2  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.

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

53.4  The hospital management shall clearly define investigations, treatment and surgical procedures that require patient consent.
53.5 The hospital management must develop an internal consent policy and procedures that are consistent with the federal legislation including procedures for individuals lacking the capacity of making informed decisions.

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

53.6.1 The diagnosis, if known
53.6.2 The name of proposed procedure or treatment
53.6.3 The risks and benefits of proposed procedures or treatment
53.6.4 Alternatives, and the risks and benefits of alternatives
53.6.5 Statement that procedure was explained to patient or guardian
53.6.6 Date and time consent is obtained
53.6.7 Name and signature of the treating physician/dentist.
53.6.8 Signature of person witnessing the consent

53.7 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](http://www.dha.gov.ae) to see the law or visit [www.dha.gov.ae](http://www.dha.gov.ae)

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

53.9 Healthcare professionals working in the hospital shall be informed and educated about the consent policy.

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

54. Telephone or Verbal Orders

The most error-prone communications are patient care orders given verbally and those given over the telephone.

54.1 The hospital shall develop a policy and/or procedures that address the accuracy of verbal and telephonic communications

54.2 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.

54.3 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, providing or evaluating the service furnished.

55. Retention of Health Records

Health Information Management section/unit in the hospital shall be responsible for retention of patient health records, health records retention time shall be as follows:
55.1 Health Records of UAE national patients must be retained up to 10 years after the most recent patient visit/admission to the health facility.

55.2 Health Records for expatriate patients must be retained up to 5 years after the most recent patient visit/admission to the health facility.

55.3 The health care facilities should retain the following records in the original form for the period specified:

- 55.3.1 The health records of medico-legal cases up to 20 years, such records may then be entered into the Image Processing System and destroyed.

- 55.3.2 Files of deceased patients to be stored for 5 years, such records may then be entered into the Image Processing System and destroyed.

- 55.3.3 The patient health records of certain major diseases and incidents selected by the administrations and requested by the consultants for academic, research, and administrative purposes may be retained for longer periods than specified.

- 55.3.4 Dental records need to be stored for 10 years for both UAE nationals and expatriate patients after the most recent patient visit/admission to the health facility.

For further information regarding health records completion, retention, and destruction see Health Records Guidelines in the DHA website [www.dha.gov.ae](http://www.dha.gov.ae)

56. Health Record Management

- 56.1 Based on the hospital 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 hospital.

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

- 56.3 Health Records must be maintained for every patient, including newborn infants, admitted for care in the hospital or treated in the emergency or outpatient services.

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

- 56.5 Health records shall be safely stored to provide protection from loss, damage, and unauthorized use.

- 56.6 The hospital shall maintain a records management policy and system that ensure:
  - 56.6.1 The secure, safe, and systematic storage of data and records
  - 56.6.2 Timely and accurate retrieval of records stored on or off-site
  - 56.6.3 Patient privacy when information contained in records is released or communicated for care
  - 56.6.4 Retention of records
  - 56.6.5 Destruction of records is in compliance with all relevant health records regulations and guidelines (incinerating or shredding for hard copy
records, wiping disks clean or the disks physically destroyed for electronic records).

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

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

For further information regarding Health Records see Health Records Guidelines in the DHA website www.dha.gov.ae
CLUSTER EIGHT: ADMINISTRATIVE STANDARDS

The hospital administration leads the hospital in its commitment to improving performance and ensures the effective management of corporate and clinical risks.

57. Monitoring Quality of Service

The hospital’s commitment to improve the outcomes of care and service delivery can be demonstrated by a continuous quality improvement culture, such culture will not exist in an organization without effective leadership for quality.

57.1 The governing body, clinicians and managers are responsible for promoting a culture of continuous improvement in quality of services provided at the hospital that is consistent with its goals and is integrated into the hospital organization. The characteristics of an improving hospital include:

57.1.1 Customer focus where patient needs are recognized
57.1.2 Leadership which is consisting of governing body representatives, clinical and administrative managers that are accountable and responsible and commitment to improving performance is demonstrated
57.1.3 A culture of improving-management and staff continually striving for improvement
57.1.4 Evidence of outcomes where outcome data are used for evaluation
57.1.5 Striving for best practice where the hospital benchmarks its performance with others and improves as a result of that comparison

57.2 The hospital shall establish a Quality Council / Committee / improvement teams its membership will include governing body leadership and participation, governing body endorsement of framework for quality improvement shall be demonstrated.

57.3 The hospital shall show also evidence of continuous quality improvement plans (strategic and operational plans), quality improvement policy, reports of quantitative and qualitative performance data, complaints management policies, and educational plan.

57.4 Every licensed hospital shall establish a quality management program appropriate to the size and type of services and shall submit to DHA for review a plan that includes the following elements:

57.4.1 A general description of the types of cases, problems, or risks to be reviewed and criteria for identifying potential risks, including without limitation any incident reporting that may be required by local or federal regulations in United Arab Emirates to be reported to DHA.
57.4.2 Identification of the personnel or committees responsible for coordinating quality management activities and the means of reporting to the administrator or governing body of the hospital.
57.4.3 A description of the method for systematically reporting information to a person designated by the hospital within a timely period.
57.4.4 A description of the method for investigating and analyzing the frequency and causes of individual problems or risks and patterns of problems.
57.4.5 A description of the methods for taking corrective action to address the problems, including prevention and minimizing problems or risks.
57.4.6 A description of the method for the follow-up of corrective action to determine the effectiveness of such action.
57.4.7 DHA shall audit the quality management program to determine its compliance.

58. Hospital Accreditation

58.1 Achieving Accreditation is part of the objectives of the Dubai Strategic Plan 2015 and as per the DHA Hospital Accreditation Policy. Hospitals shall be accredited by an international accrediting organization holding active International Accreditation Program (IAP) awards by the International Society for Quality in Health Care (ISQua).

58.2 Hospitals shall submit written evidence to the HRD demonstrating their accreditation achievement or intention of initiating the accreditation process before the end of December 2012.

58.3 Evidence should include an action plan, contract agreement, or any other tool to ensure that the process of accreditation is taking place in the concerned organization.

59. Risk Management

59.1 The hospital shall have an integrated hospital-wide risk management policy and system to ensure that corporate and clinical risks are identified, minimized and managed.

59.2 Hospitals should establish a policy and a system that identifies, analyses, evaluates, treats and continuously monitors and reviews risks.

59.3 Corporate and Clinical risk management strategies may includes activities such as:
59.3.1 Human resources planning
59.3.2 Occupational health and safety strategies
59.3.3 Clinical audit processes
59.3.4 Retrospective patient record review
59.3.5 Mortality and morbidity reviews

60. Complaint System

Complaints whether medical or non medical shall be managed to ensure improvements in delivery of the healthcare system.

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

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

60.3 Each hospital shall develop a written procedure that ensures prompt and complete investigations of all complaints which are filed against the hospital healthcare
professional or employees. The procedure shall include, at a minimum, the following provisions:

60.3.1 Designation of a senior member of the hospital administration as the person responsible for overseeing the investigation of complaints lodged.

60.3.2 Written process and procedures of complaints investigation which shall include a process of fact-gathering, creation of a complaint file, investigation carried out and outcome of investigation including action taken, if any.

60.3.3 Notification of the complainant of the outcome of the investigation.

60.3.4 Complaints related to medical issues must be reported to Clinical Governance Office (CGO) in HRD on quarterly basis

60.3.5 The complaint files shall be available during any audit by the HRD surveyors

61. Reporting Sentinel Events and Major Incidents

Each hospital shall develop a written sentinel event policy to deal with any unanticipated, undesirable or potentially dangerous occurrences that might happen.

61.1 The hospital shall report to the HRD any sentinel event and major incidents which occur on the premises, this includes but not limited to the following:

61.1.1 Any incident following surgery or administration of anesthesia that results in patient death.

61.1.2 Surgical and non-surgical invasive procedures performed on the wrong patient, wrong site, or wrong procedure.

61.1.3 Death that is unanticipated or not related to the natural course of the patient's illness or underlying condition, or that is the result of an error.

61.1.4 A patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall

61.1.5 Unintended retention of a foreign object in a patient after surgery or other procedure

61.1.6 Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO or Rh).

61.1.7 Serious criminal acts such as assault, homicide, or other crime resulting in patient death or major permanent loss of function occurred inside the hospital premises

61.1.8 Full or partial evacuation of the hospital for any reason

61.1.9 Fire on the hospital premises

61.2 Sentinel events and major incidents shall be reported immediately and not later than three (3) working days after event occurrence.

61.3 Means of reporting sentinel events and major incidents shall include a written official letter to the Director of HRD either by courier or by hand delivery. Reporting should be consistent with applicable patient confidentiality.

61.4 The hospital management shall prepare a written evaluation of its response to the sentinel event or provide a thorough and realistic root cause analysis with action
61.5 In support of DHA mission to continually improve the safety and quality of health care provided to the public, the HRD may conduct reviews of the facility activities in response to sentinel event or major incident.

62. Mortality Cases Reporting

62.1 Mortality cases shall be reported within ten (10) days of the date of occurrence of the event. The original patient health record must be provided to the CGO in the HRD along with a death notification form, either by courier or hand delivery. The original patient health record shall be submitted along with the report.

62.2 Death notification form shall be electronically competed within seven days; the form is available in DHA website, click here to access the Birth and Death Notification system of visit DHA website www.dha.gov.ae.

62.3 Reporting to the HRD does not exclude the hospital from its responsibility to immediately report cases to Dubai Police as required e.g. any patient visited the Emergency Department with suspected suicidal attempt, physical injury with suspect of abuse or neglect, etc.

63. Data Collection and Statistics

63.1 Each DHA licensed hospital shall submit to the HRD the following outcome data on quarterly basis:

63.1.1 Number of patient readmission within 48 hours after discharge for the same diagnosis.

63.1.2 Number of patients Discharged Against Medical Advice (DAMA)

63.1.3 Number of patients who cannot be discharged/transferred due to unavailability of suitable accommodation in governmental hospitals.

63.1.4 Number of successful Assisted Reproductive Techniques (ART) (if applicable).

63.1.5 Number of fall incidents in the hospital.

63.1.6 Number of disaster and fire drills conducted (per year)

63.2 Each DHA licensed hospital shall submit to the Health Data and Information Analysis Department in DHA the following statistical data on a quarterly basis (see appendix 5):

63.2.1 The total number of inpatients in the hospital based on International Classification of Diseases (ICD-10) and by nationality, gender and age group.

63.2.2 Inpatients services including the number of admissions, discharges, and deaths.

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

63.2.4 The total number of dental treatments for each dental specialty by patient nationality, gender and age group.
63.2.5 Number of attendance to Traditional, Alternative and Complementary Medicine (TCAM) clinics (if any) by patient nationality, gender and age group.

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

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

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

63.2.9 Total number of Radiology diagnostics procedures performed in the hospital by type, patient nationality, gender and age group.

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

63.3 The Health Regulation Department may at anytime request for additional data as deemed necessary.
64. Governing Body

The hospital governing body shall be legally responsible for the quality of patient care services, for the conduct and obligations of the hospital as an institution and for ensuring compliance with all UAE Federal and Local laws in the Emirate of Dubai.

64.1 The hospital shall have a governing body responsible for directing the operation of the hospital in accordance with its mission. If a hospital does not have an organized governing body, then the person or persons responsible for the conduct of the hospital shall carry out the functions. The hospital governing body shall be responsible for the following:

64.1.1 Leading the organization to ensure the provision of quality and safe services through strategic and operational planning and development. The organizational strategic plan shall be documented including vision, mission and values of the organization.

64.1.2 Obtain and maintain active accreditation for the hospital as part of the strategic objective of Dubai Strategic Plan 2015.

64.1.3 Develop governance through a formal organizational structure which should be made known to all staff.

64.1.4 The governing body shall adopt written organization bylaws reflecting its legal responsibility and accountability towards the patients and its obligation to the community it serves. The bylaws shall specify at least the following:

64.1.4.1 The duties and responsibilities of the governing body

64.1.4.2 The relationships and responsibilities of the governing body, hospital administration, and the medical staff, and the mechanism established by the governing body for holding such parties accountable

64.1.4.3 The mechanisms for adopting, reviewing and revising governing body by-laws

64.1.4.4 The mechanisms for the formal approval of the organizations bylaws and rules of the medical staff and its departments in the hospital

64.2 Take appropriate and necessary measures to comply with all local and federal regulatory requirements and monitor performance to address any compliance deficiencies where identified.

64.3 Support the development of organizational code of ethics and clinical policies and procedures to assist the organization to provide safe and quality care and appoint responsible staff for developing and reviewing the organization documents.

64.4 Ensures that the hospital leadership team and medical staff shall have access to all regulations and clinical policies related to health services

64.5 Ensure that the hospital has well structured and uniform system concerning orientation, recruitment and professional retention.
64.6 Support continuous education and professional development of the staff by allocation of special funds for these activities.

64.7 Support the development of a system of quality assessment and assurance that effectively strives for continuous quality improvement.

64.8 Manage the contracts of external service providers to maximize quality of care and service delivery.

64.9 Manage an effective staff evaluation system for the staff during the probationary period as well as annual evaluation of the staff.

64.10 Ensures that the hospital has suitable technical committees under medical director supervision.

64.11 Ensure that input is sought from patient, care givers and the community in planning, delivery and evaluation of the health service.

64.12 Ensure the availability of sufficient resources and professional staff all the time for provision of safe health care services in the organization.

64.13 Ensure that all functional responsibilities of all healthcare professionals and personnel is defined and delineated. Policies and procedures for oversight of healthcare professionals and personnel should be in place.

64.14 Obtain the required approvals from the concerned authority for any changes/modifications on the hospital scope of services and/or buildings.

65. Medical Director

65.1 The hospital Medical Director shall be a DHA licensed physician or dentist authorized to practice the profession in Dubai or qualified person with certificate in hospital management and relevant experience in hospital administration.

65.2 Hospital services should be administered in a manner to ensure the provision of high-quality healthcare services while recognizing patient rights. The Medical Director responsibilities include, but not limited to the following:

65.2.1 Ensuring that all healthcare professionals should have active and appropriate licensure by DHA and have necessary training and skills to deliver medical services provided in the hospital.

65.2.2 Ensuring that the hospital provides ongoing clinical training courses for healthcare professional in different area based on the professional competency assessment and performance evaluation e.g. good clinical care, manual handling, instrument handling, sterilization, fire safety training, physical and chemical hazard control in health facilities, etc.

65.2.3 Ensuring that all personnel (non healthcare professional) assisting in the provision of healthcare services in the hospital must be appropriately trained, qualified, supervised, and sufficient in number to provide appropriate care.

65.2.4 Developing clear internal process for gathering and submitting to DHA healthcare professional's credentials (license, education, training and experience).
65.2.5 Ensuring a defined process for physician's privileges in the hospital, and maintaining records of credential outcomes and privileges.

65.2.6 Ensuring that all healthcare professionals are informed of and follow the hospital bylaws, clinical policies and procedures.

65.2.7 Ensuring that an orientation program is established and implemented in the hospital.

65.2.8 Providing response to any inspection report or requirements by the Dubai Health Authority.

65.2.9 Leading the hospital organization in its commitment to improve performance by managing near misses, incidents, complaints and feedback. The hospital must demonstrate an incident reporting policy and system, with evidence of implementation.

65.2.10 Ensuring the hospital has a policy to handle suspected child abuse, polices and criminal act cases.

65.2.11 Reporting all infectious diseases according to DHA approved list.

65.2.12 Reporting to the HRD sentinel events.

65.2.13 Providing the DHA with the annual required hospital data and statistics.

66. Director of Nursing Service

66.1 Each hospital shall establish a nursing service under the direction DHA licensed registered nurse, who holds a minimum of a Masters degree in nursing or administration with at least five years experience in nursing practice; where at least two years were in an administrative or supervisory capacity.

66.2 Registered nurses shall be assigned to supervise nursing care and nursing aid according to a written staffing plan which provides for adequate coverage of all nursing units during each shift.

67. Hospital Technical Committees

67.1 Based on the hospital activities, bed capacity and clinical services provided, the hospital shall maintain suitable technical committees under the medical director’s supervision.

67.2 The committees shall meet on regular basis to coordinate and improve the provision of care. The meeting minutes shall be documented with tasks and responsibilities clearly delineated.

67.3 The technical committees in the hospital should include, but not limited to the following committees:

67.3.1 Infection control committee
67.3.2 Credentials and privileges committee
67.3.3 Health and Safety committee
67.3.4 Morbidity and mortality committee
67.3.5 Blood utilization and transfusion review committee
68. Credentialing and Privilege System

Defining the scope of practice for a physicians and dentist (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 hospital.

68.1 The hospital governing body and the medical director are responsible for ensuring services are provided by competent and DHA licensed health professionals.

68.2 To ensure credentialing and privilege processes supports provision of safe and quality health care, Credentials and Privileges Committee shall be established in the hospital.

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

68.4 The committee shall develop and implement clear credentialing and privilege policies and procedures. Credentials and privileges shall be applicable also for community and visiting physicians.

68.5 The committee shall cooperate with hospital human recourse unit/department to ensure maintenance of copy of healthcare professional medical education, training, experience, licensing and privileges in the human recourse file. List of procedures that physicians are allowed to do in the facility shall be maintained.

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

68.7 Credentials and Privileges Committee shall develop a policy for the safe introduction of new interventions.
CLUSTER TEN: HUMAN RESOURCES MANAGEMENT

Human resources management and Hospital leadership shall support quality health care, a competent workforce and a satisfying working environment for staff. Proper human resources management in the hospital shall ensure that HCWs are recruited and managed in a manner that supports the provision of quality and safe care and services.

69. Human Resource Practices

Human resource practices should be supported by policies and procedures with systems that influence employees’ behaviors, attitudes and performance.

69.1 The hospital shall show evidence of supporting human resources planning, addressing the current and future hospital needs.

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

69.3 Evidence of a learning and development system to ensure the skill and competence of staff by allocation.

69.4 Continuing Professional Development (CPD) activities are to be documented.

69.5 Structured and uniform system concerning orientation, professional retention and performance evaluation shall be maintained.

70. Medical Staff Minimum Requirements

Sufficient numbers of medical staff are required to be on duty at all times to diagnose, plan, supervise and evaluate patient care.

70.1 The number of DHA licensed medical staff assigned to each health service in the hospital shall be determined by senior management and consistent with the functional program of the hospital.

70.2 All Medical staff in the hospital shall be holding an active DHA license and work within their scope of practice.

70.3 Each clinical department must have a designated head, medical staff assignment must meet the following:

70.3.1 At least one full time consultant shall be available to manage each of the following specialties: medical, surgical, pediatric, obstetrics and gynecology.

70.3.2 One specialist or consultant physician shall be available for other department/services in the hospital.

70.3.3 One specialist (under supervision) or General Practitioner (GP) shall be available in the hospital premise covering each department/services, this includes both public holidays and weekends.

70.3.4 Number of GPs or specialists (under supervision) shall be based on the hospital’s activities and number of patients.

70.3.5 In-patient beds responsibilities for GP or specialists (under supervision) physicians shall not exceed ten beds per physician in general wards.
70.3.6 Sufficient number of registered nurses on duty at all times to plan, supervise and evaluate nursing care. The hospital shall meet DHA Nursing Staff ratio (appendix 6) as minimum nursing staffing requirements.

70.3.7 The number of DHA licensed registered nurses and nurse assistance assigned to each department/service shall be consistent with the types of nursing care needed. See staffing matrix decision making guideline in general hospital (appendix 7).

70.3.8 One full time specialist/consultant Pathologist shall be available to manage the clinical laboratory services in the hospital.

70.3.9 At least three DHA licensed medical laboratory technologist shall be available to in the hospital to provide basic laboratory services.

70.3.10 One full time specialist/consultant Radiologist shall be available to manage the diagnostic imaging services in the hospital.

70.3.11 At least three licensed radiographer shall be available to shall be available to in the hospital to assist in the provision of diagnostic imaging services.

70.3.12 To provide mammography services at least one female radiographer is required.

70.3.13 Availability of allied healthcare professionals shall be based on hospital activities and number of patients. To be determined by senior management to ensure the appropriate coverage of all medical services to all departments and ensuring staff availability for all three shifts, morning, afternoon, nights, and vacations.

**71. Healthcare Professionals Certification Requirements**

71.1 All healthcare professionals who provide patient care shall maintain valid training/certification in basic Cardiopulmonary Resuscitation (CPR) or Basic Life Support (BLS).

71.2 All healthcare professionals working in Critical Care services area and Operation Theater should maintain a valid training/certification in Advanced Cardiac Life Support (ACLS).

71.3 Healthcare professionals working in specific area **must be competent** and maintain specific training or certification such as:

71.3.1 Nurses and physicians in NICU suite: Neonatal Resuscitation Program (NRP)

71.3.2 Midwives and physicians in labor suits: continuous training program on Cardiotocographic (CTG) machine

71.3.3 Nurses in OT: training in assessment and monitoring patients under sedation.

71.3.4 Nurses in OPD: Pain assessment and management and Insertion of Intravenous (IV) lines.

**72. Health Care Workers Immunization Requirements**

The hospital must ensure whenever possible that proper measures are taken for prevention of infections. Many HCWs are at risk of exposure to vaccine-preventable diseases.
72.1 Each hospital shall have a comprehensive policy to oversee the vaccination and immunizations for all HCWs.

72.2 The Hospital shall arrange the vaccination of HCWs at no cost.

72.3 The hospital shall provide the HCWs and the patients with the appropriate immunizations when there is serologic evidence of no immunity to the specific communicable diseases recognized by federal laws and regulations.

72.4 Optimal use of immunizing agents because of their contact with patients or infective material from patients, for safeguarding the health of workers and protecting patients from becoming infected through exposure to other infected workers. Recommended immunizing agents and immunization schedules for HCW's is available in appendix 8, such agents should be considered during immunization policy development.

72.5 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.
CLUSTER ELEVEN: FACILITY MANAGEMENT

Hospitals shall ensure that the health care environment is safe, functional, supportive and effective for patients, family and staff members. A safe hospital requires a systematic program to determine priorities and eliminate risks.

73. Hospital Safety Management Systems

73.1 The hospital leadership shall plan and budget for all necessary support and resources to improve safety in the facility.

73.2 The hospital shall establish a multidisciplinary Health and Safety committee.

73.3 The safety management systems and hospital policies shall comply with the relevant federal and local regulations.

73.4 The safety management system shall include fire safety, hazardous waste management, emergency plans, security, and any other risks.

73.5 The hospital management shall designate one full time trained safety officer.

73.6 External service providers may be supplied provided they are provided with relevant information and comply with the hospital health and safety requirements.

73.7 Staff shall be provided with information and educated about their responsibilities and on hazardous substances and waste management procedures, fire safety.

73.8 Orientation on the safety measures shall be included with the induction program for new staff.

73.9 The hospital shall abide with the prevention and safety measures required by Dubai Civil Defense Department.

73.10 Leadership shall ensure the compliance with FANR rules and regulations regarding the use of ionizing radiation and radio-active materials in hospital and all the protection and safety measures pertaining to this matter.

74. Fire Safety

Fire is a potential risk for all healthcare organizations, and is very problematic especially where immobile / disabled patients are in locations that are difficult to evacuate. To respond to fire risk the hospital should:

74.1 Establish a fire safety plan according to the Dubai Civil Defense Department requirements for early detection, confining, extinguishing, and rescue.

74.2 Establish a defined arrangement for alerting the authorities

74.3 Establish and implement a No Smoking policy

74.4 Assess the risks to the facility that is posed by fire

74.5 Understand and manage risks associated with the facility’s location and physical structures

74.6 Maintain fire safety equipment and test fire protection and emergency communication systems
74.7 Train staff to respond to a fire event in the building
74.8 Monitor whether adequate numbers of suitably trained staff are distributed across all shifts to respond appropriately to a fire event
74.9 Rehearse emergency scenarios to assess preparedness

75. Hazardous Substances and Dangerous Goods

The hospital shall have policies and procedures on the procurement, management and disposal of dangerous goods and hazardous substances and shall comply with local regulations.

75.1 Hospital should ensure there is adequate space and ventilation for safe handling of hazardous materials.

75.2 Each department shall have a current and updated list of hazardous substances and dangerous goods used in their area, the list covers:
   75.2.1 Purpose of use
   75.2.2 The responsible person
   75.2.3 Permitted Quantity

75.3 All substances shall be clearly labeled; this includes anti-neoplastic drugs and radioactive material. All corrosives, acids, and toxic material, hazardous gases and vapors, anesthetic gases.

75.4 Hospital facilities dealing with hazardous substances shall have protective clothes or equipment as required.

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

75.6 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.

76. Waste and Environmental Management

Waste and environmental management supports safe practice and a safe environment. The hospital shall develop and implement a hospital-wide waste and environmental management policy. The policy shall include segregation and disposal of hospital clinical waste in a responsible manner in accordance with each local regulations of the Emirate of Dubai.

76.1 The waste management policy shall cover handling, storing, transporting, and disposing all kinds of waste such as:
   76.1.1 Clinical waste
   76.1.2 Chemotherapeutic waste
   76.1.3 Radioactive waste
   76.1.4 Hazardous gases
   76.1.5 Anesthetic gases

76.2 Waste management streams shall be identified and signage is displayed.

76.3 Proper storage and containers for disposing waste material.
76.4 Contracting with a specialized company to transport and destroy medical waste materials shall be according to the conditions issued by Dubai Health Authority and Dubai Municipality.

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

76.6 Cleanliness throughout the hospital shall be maintained by trained domestic staff.

77. Medical Equipment and Supplies

Functional, 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.

77.1 The hospital shall maintain effective Preventive Maintenance (PM) as per the manufacturer recommendations (at least 95% of medical equipment in the hospital shall receive PM), the PM shall include the following:

77.1.1 Electrical safety testing for patient related equipment.

77.1.2 Each piece of equipment has a checklist for its maintenance schedule, failure incidence and repairs done.

77.1.3 The hospital shall have a written policy to perform inspection on all new equipment prior to operational use.

77.2 The hospital shall have of the following:

77.2.1 Safety manuals at biomedical workshops.

77.2.2 Operator manual for equipments at each department/section using the equipment.

77.3 The hospital shall maintain written policy for tagging medical equipment.

77.3.1 PM with testing date and due date

77.3.2 Inventory number

77.3.3 Removal from service

77.3.4 Safety checks

77.4 The hospital shall maintain a written policy on removal of equipment from service.

77.5 The hospital shall eliminate the use of extension cords

77.6 The hospital healthcare professionals (physicians nurses, allied health) shall be trained to operate the medical equipment assigned to them and the hazards attached to it, training includes the following:

77.6.1 New equipment

77.6.2 Staff transferred from section to another

77.6.3 New recruited staff

77.6.4 Reoccurrence of misusing equipment

77.7 The Hospital shall maintain an inventory of all hospital equipment and their location.
77.8 There is statistical Preventative Maintenance (PM) data for upgrading/ replacing of equipment.

77.9 Reporting of medical equipment incidents and corrective actions taken shall be maintained in the hospital.

78. Emergency and Disaster Management

The hospital shall develop a hospital-wide policy for managing emergencies and disaster ensuring business continuity.

78.1 The hospital shall develop plans for dealing with external disasters emergencies in the community, the plans shall include:

78.1.1 Numbers and action cards.

78.1.2 Duties and responsibilities of hospital leader, department heads, and chief of units.

78.1.3 The Triage areas, their locations, and triage action cards.

78.1.4 Identifying the responsible person who announces the emergency state and calls local authority.

78.1.5 Names of all staff called, including their contact

78.1.6 The control room location and the person in Likely emergencies shall be identified and response and evacuation plans are prominently displayed.

78.2 The hospital shall conduct regular emergency practice / drill exercises including fire and evacuation to test the following:

78.2.1 The timely response of staff to any emergency call

78.2.2 The efficiency of the communication system, e.g. bleeps, mobile phone and over head paging system

78.2.3 If all staff can perform their expected roles

78.2.4 The time taken to evacuate patients and beds

78.3 The hospital administration shall ensure the availability of the needed supplies and equipment in case of external disaster, e.g. medical Bags, drugs, and mobile monitors

78.4 The hospital shall have plans to deal with the Internal Disasters emergencies, the plan shall include:

78.4.1 Names of all the staff called in case of disaster, their contact numbers, and action cards.

78.4.2 The control room’s location and the position of the person in charge

78.4.3 The duties and responsibilities of hospital leader, department heads, and chiefs of units

78.4.4 The procedure for relocation of patients

78.4.5 Identifying the responsible person who announces the emergency state and calls local authority

78.5 There are hospital-wide posted evacuation maps indicating locations of:

78.5.1 You are here

78.5.2 Fire extinguishers
78.5.3 Fire hose reel/cabinets
78.5.4 Fire blankets
78.5.5 Escape routes
78.5.6 Assembly points
78.5.7 Fire exits
78.5.8 Call points break glass / pull station

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

78.7 Staff are educated and trained at orientation and annually in fire and evacuation.

78.8 There is documented evidence that an authorized external provider undertakes a full fire inspection in accordance with applicable legislation

79. Security Management

Security management in the hospital shall support safe practice and a safe environment.

79.1 There are specific personnel assigned to take care of security.

79.2 Security personnel are educated and provided with information in relation to security risks and responsibilities they have a written job description, oriented on their scope of work, fire safety and emergency codes as appropriate to the size of the hospital.

79.3 There is a hospital-wide security policy, which includes identification of all of the following by badge:

79.3.1 Hospital Staff
79.3.2 Temporary Employees
79.3.3 Contractor Staff

79.4 There are written policies on the following that include, but not limited to:

79.4.1 Lost and Found items
79.4.2 Safe keeping of patients’ belongings
79.4.3 How to contact the local police, in case of need

79.5 Restricting access to sensitive areas by Security Personnel / Security System, like: Delivery, NICU, Nursery, Female Floors, Operating Room and CSSD

79.6 The hospital shall have written policy related to Involvement of police in Trauma, Motor vehicle accidents; drug addiction cases, manslaughter cases and violent patient.

79.7 The hospital maintain written policies on preventing abduction of children, and neonates

79.8 Major security risks shall be identified in the hospital.

79.9 External service providers are supplied with relevant information and comply with the hospital security controls.
Appendix 1: Ventilators Specifications

1. **Ventilators**: shall be used for all patients’ categories (pediatric and adult) and upgradeable for further options including 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 events, alarm limits, gases, ventilation parameters supply pressures, lung parameters, ventilator setting.
   1.8. Mobile on trolley with interchangeable plug in battery modules
Appendix 2: Sample of Triage Criteria

All patients presenting to the Emergency Area, shall be triaged by a Registered Nurse and assigned a triage category in accordance with the Triage Guidelines based on 5 Triage Levels.

The triage levels are as follows:

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>ONE: Resuscitation/Immediate</th>
<th>TWO: Emergent/Very Urgent</th>
<th>THREE: Urgent</th>
<th>FOUR: Less Urgent</th>
<th>FIVE: Non-urgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Immediate limb or life threatening condition</td>
<td>Potential life threatening condition</td>
<td>Potentially serious but not life threatening</td>
<td>Non acute status, delay in treatment will not cause serious harm</td>
<td>Non acute status could have been treated in OPD office.</td>
</tr>
<tr>
<td>Intervention Needed:</td>
<td>Immediate</td>
<td>0-15 minutes</td>
<td>&lt; 30 min</td>
<td>1 hour</td>
<td>2 hours</td>
</tr>
<tr>
<td>Time to MD</td>
<td>Immediate</td>
<td>≤15 min</td>
<td>≤30 min</td>
<td>≤1 hour</td>
<td>≤ 2 hours</td>
</tr>
<tr>
<td>Reassessment at triage and/or Main Department</td>
<td>Continuous</td>
<td>q 3-5 min</td>
<td>q 20-30 min</td>
<td>q 1 hour</td>
<td>q 1 hour</td>
</tr>
</tbody>
</table>

Examples of Level 1

- Cardiac Arrest
- Respiratory Arrest
- Severe respiratory distress with SpO2 < 90
- Critically injured trauma patient who presents unresponsive
- Overdose with a respiratory rate of 6
- Severe respiratory distress with agonal or gasping-type respirations
- Severe bradycardia, hypotension or tachycardia with signs of hypoperfusion
- Trauma patient who requires immediate crystalloid resuscitation
- Chest pain, pale, diaphoretic, blood pressure of 70 palpatory
- Weak and dizzy, heart rate 30
- Anaphylactic reaction
- Baby that is flaccid
- Unresponsive with strong odor of alcohol
- Hypoglycemia with a change in mental status

Examples of Level 2

- Active chest pain, suspicious for coronary syndrome but does not require an immediate life-saving intervention, stable
- A needle stick in a health care worker
- Signs of a stroke, but does not meet level 1 criteria
- A rule-out ectopic pregnancy, hemo-ynamically stable
- A patient on chemotherapy and therefore immunocompromised, with a fever
- A suicidal or homicidal patient
- Confused: Inappropriate response to stimuli, decrease in attention span and memory
- Lethargic: Drowsy, sleeping more than usual, responds appropriately when stimulated
- Disoriented: The patient is unable to answer questions correctly about time, place or person
- New onset of confusion in an elderly
- The 3 month old whose mother reports the child is sleeping all the time.
- The adolescent found confused and disoriented

Examples of level 3

- FB aspiration, cough present, but no distress with swallowing.
- Known asthmatic with shortness of breath or worsening of symptoms, SpO2 >95%
- Inhalation of toxic substance; no distress
- History of coughing up pink mucous
- Headache– severe pain scale 8-10
- Head injury – high risk mechanism, GCS 15, no LOC, vomiting
- Known seizure disorder – seizure prior to emergency visit, not actively seizing
- Shunt dysfunction – patient irritable; not acutely ill
- Extremity fracture
- Multiple joint pains with fever, hip pain with fever
- Tight Cast with neuro-vascular impairment
- Severe abdominal pain, stable vital signs
- Rectal bleeding with abdominal pain, no signs/ symptoms of shock
- Difficulty swallowing, possible FB, no respiratory distress
- Abdominal trauma – complaints of mild discomfort
- Signs/ symptoms of appendicitis, abdominal pain, fever
- GI bleeding with normal vital signs
- Vaginal bleed – no signs of shock
- Inguinal bulge – sudden onset; patient acutely distressed
- Non – painful testicular swelling
- Inability to urinate for more than eight hours
- Gross swelling of penis: unable to void.
- Flank pain, not in severe distress

Examples of level 4

- FB aspiration – no cough – appears well
- Minor chest injury without rib pain or respiratory difficulty – no shortness of breath – may have bruising
- Difficulty swallowing; no respiratory difficulty
- Hyperventilation >40/min
- Chronic or repeating headache ( no acute distress)
- Minor head trauma – no LOC/ no vomiting
- Back pain – minor back pain “pulled something” – muscle spasms, localized back pain (4 – 7/ 10)
- Possible extremity fracture
- Swollen “hot” joint
- Tight cast – no neurovascular impairment
- Abdominal pain with vomiting or diarrhea (alone) – does not appear ill, no signs of dehydration
- Rectal bleeding – small amount, fever and/or diarrhea
- Constipation and abdominal cramps.

Examples of level 5

- Nasal congestion associated with cold symptoms
- Insomnia
- Phobias
- Chronic back pain, minor discomfort pain <4/10
- Chronic extremities pain
- Vomiting/diarrhoea – no pain/no dehydration
- Localized rash, chronic rash.
- Minor abrasions, contusions
- Sore throat, laryngitis, minor mouth sores, possible fever
- Allergy – hay fever causing nasal congestion
- Sinus problems
- Vague eye pain, chronic eye pain
- Minor trauma not necessarily acute
- Blood pressure daily monitoring
Appendix 3: Sample of DAMA Form

Date:......................... Time:....................... Hrs.

1. 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.

Attending Doctor:............................................................... Signed:............................................................... (Patient or nearest relative)

Signature: ............................................................... Relationship:............................................................... Witnessed by: ............................................................... Signature: ............................................................... 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.
Appendix 4: Patient Safety Solutions

1. Look-Alike, Sound-Alike (LASA) Medication Names

Confusing drug names is one of the most common causes of medication errors and is a worldwide concern. With tens of thousands of drugs currently on the market, the potential for error created by confusing brand or generic drug names and packaging is significant.

The following strategies should be considered to ensure that the hospital actively identifies and manages the risks associated with LASA medications by:

1.1 Annually reviewing the LASA medications used in the hospital

1.2 Implementing clinical protocols which:

   1.2.1 Minimize the use of verbal and telephone orders.

   1.2.2 Emphasize the need to carefully read the label each time a medication is accessed and again prior to administration, rather than relying on visual recognition, location, or other less specific cues.

   1.2.3 Emphasize the need to check the purpose of the medication on the prescription/order and, prior to administering the medication, check for an active diagnosis that matches the purpose/indication.

   1.2.4 Include both the nonproprietary name and the brand name of the medication on medication orders and labels, with the nonproprietary name in proximity to and in larger font size than the brand name.

1.3 Developing strategies to avoid confusion or misinterpretation caused by illegible prescriptions or medication orders, including those that:

   1.3.1 Require the printing of drug names and dosages.

   1.3.2 Emphasize drug name differences using methods such as “tall man” lettering.

1.4 Storing problem medications in separate locations or in non-alphabetical order, such as by bin number, on shelves, or in automated dispensing devices.

1.5 Using techniques such as boldface and color differences to reduce the confusion associated with the use of LASA names on labels, storage bins and shelves, computer screens, automated dispensing devices, and medication administration records.

1.6 Developing strategies to involve patients and their caregivers in reducing risks through:

   1.6.1 Providing patients and their caregivers with written medication information, including medication indication, nonproprietary and brand names, and potential medication side effects.

   1.6.2 Developing strategies to accommodate patients with sight impairment, language differences, and limited knowledge of health care.

   1.6.3 Providing for pharmacist review of dispensed medications with the patient to confirm indications and expected appearance, especially when dispensing a drug that is known to have a problematic name.
1.7 Ensuring that all steps in the medication management process are carried out by qualified and competent individuals.

2. Patient Identification

The widespread and continuing failures to correctly identify patients often leads to medication, transfusion and testing errors; wrong person procedures; and the discharge of infants to the wrong families. The following strategies should be considered by the hospital:

2.1 Emphasize the primary responsibility of healthcare professionals to check the identity of patients and match the correct patients with the correct care (e.g. laboratory results, specimens, procedures) before that care is administered.

2.2 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 hospital or other care setting and prior to the administration of care. Neither of these identifiers should be the patient’s room number.

2.3 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.

2.4 Provide clear protocols for identifying patients who lack identification and for distinguishing the identity of patients with the same name. Non-verbal approaches for identifying comatose or confused patients should be developed and used.

2.5 Encourage patients to participate in all stages of the process.

2.6 Encourage the labeling of containers used for blood and other specimens in the presence of the patient.

2.7 Provide clear protocols for maintaining patient sample identities throughout pre-analytical, analytical, and post-analytical processes.

2.8 Incorporate training on procedures for checking/verifying a patient’s identity into the orientation and continuing professional development for healthcare professionals.

3. Communication During Patient Handovers

Gaps in hand-over (or hand-off) communication between patient care units, and among care teams, can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm for the patient. The following strategies should be considered by the hospital:

3.1 Ensure that the hospital implements a standardized approach to hand-over communication between staff, change of shifts and among different patient care units in the course of a patient transfer. Suggested elements of this approach include:

3.1.1 Use of the SBAR (Situation, Background, Assessment, and Recommendation) technique.

3.1.2 Allocation of sufficient time for communicating important information and for staff to ask and respond to questions without interruptions wherever possible (repeat-back and read-back steps should be included in the hand-over process).
3.1.3 Provision of information regarding the patient’s status, medications, treatment plans, advance directives, and any significant status changes.

3.1.4 Limitation of the exchange of information to that which is necessary to providing safe care to the patient.

3.2 Ensure that the hospital implement systems which ensure at the time of hospital discharge that the patient and the next health-care provider are given key information regarding discharge diagnoses, treatment plans, medications, and test results.

3.3 Incorporate training on effective hand-over communication into the educational curricula and continuing professional development for healthcare professionals.

4. **Performance of Correct Procedure at Correct Body Site**

Cases of wrong procedure or wrong site surgery that are considered totally preventable are largely the result of miscommunication and unavailable, or incorrect, information. A major contributing factor to these types of errors is the lack of a standardized preoperative process. The following strategies should be considered by the hospital:

4.1 Establish the performance of correct surgery at the correct body site as a healthcare facility safety priority that requires leadership and the active engagement of all frontline practitioners and other healthcare professionals.

4.2 Ensure that healthcare organizations have in place protocols that:

   4.2.1 Provide for verification at the pre-procedure stage of the intended patient, procedure, site, and, as applicable, any implant or prosthesis.

   4.2.2 Require the individual performing the procedure to unambiguously mark the operative site with the patient’s involvement, to correctly identify the intended site of incision or insertion.

   4.2.3 Require the performance of a “**time-out**” with all involved staff immediately before starting the procedure (and the related anesthetic). The time-out is to establish agreement on the positioning of the intended patient on the procedure table, procedure, site, and, as applicable, any implant or prosthesis.

5. **Control of Concentrated Electrolyte Solutions**

While all drugs, biologicals, vaccines and contrast media have a defined risk profile, concentrated electrolyte solutions that are used for injection are especially dangerous. The hospital shall ensure that systems and processes in place wherein:

5.1 The promotion of safe practices with potassium chloride and other concentrated electrolyte solutions is a priority and where effective organization risk assessments address these solutions.

5.2 Potassium chloride is treated as a controlled substance, including requirements that restrict ordering and establish storage and documentation requirements.

5.3 Ideally, removal of concentrated electrolyte solutions from all nursing units is accomplished, and these solutions are only stored in specialized pharmacy preparation areas or in a locked area. Potassium vials, if stored in a specialized
patient care area, must be labeled individually with a visible florescent warning label that alerts for: “MUST BE DILUTED”.

5.4 When a pharmacist or pharmacy preparation area is not available to store and prepare these solutions, only a trained and qualified individual (physician, nurse, pharmacy technician) prepares the solutions.

5.5 After solution preparation, there is an independent verification of the electrolyte solution by a second trained and qualified individual. The organization should establish a checklist that is used for the independent verification. Checklist items should include concentration calculations, infusion pump rates, and correct line attachments.

5.6 The prepared solution is labeled with a “HIGH RISK WARNING” label prior to administration.

5.7 An infusion pump is used to administer concentrated solutions. If an infusion pump is not available, other infusion devices, such as buretrol administration tubing (tubing with an inline receptacle that limits the volume that will flow into the patient), may be considered for use, but infusions of concentrated solutions must be monitored frequently.

5.8 An organizational safety infrastructure supports the training of qualified individuals through policies, procedures, best practices, and annual recertification.

5.9 Physician orders include the rates of infusion for these solutions.

6. Assuring Medication Accuracy at Transitions in Care

Medication errors occur most commonly at transitions. “Medication reconciliation” is a process designed to prevent medication errors at patient transition points. The following strategies should be considered by the hospital:

6.1 Ensure that health-care organizations put in place standardized systems to collect and document information about all current medications for each patient and provide the resulting medication list to the receiving caregiver(s) at each care transition point (admission, transfer, discharge, outpatient visit). Suggested information to be collected includes:

   6.1.1 Prescription and non-prescription (over-the-counter) medications, vitamins, nutritional supplements, potentially interactive food items, herbal preparations, and recreational drugs.

   6.1.2 The dose, frequency, route, and timing of last dose, as appropriate. Whenever possible, validate the home medication list with the patient and determine the patient’s actual level of compliance with prescribed dosing.

   6.1.3 The source(s) of the patient’s medications. As appropriate, involve the patient’s community pharmacist(s) or primary care provider(s) in collecting and validating the home medication information.

6.2 Ensure that the hospital have clear policies and procedures in place that require:

   6.2.1 That the patient’s current medication list be displayed in a consistent, highly visible location (for example, the patient’s chart) so that it is easily accessible to clinicians who are writing drug orders.
6.2.2 The use of the home medication list as a reference when ordering medications at the time of treatment in a clinic or emergency unit or upon admission to an inpatient service.

7. Avoiding Catheter and Tubing Mis-Connections

The design of tubing, catheters, and syringes currently in use is such that it is possible to inadvertently cause patient harm through connecting the wrong syringes and tubing and then delivering medication or fluids through an unintended wrong route. The hospital should have systems and procedures in place which:

7.1 Emphasize to non-clinical staff, patients, and families that devices should never be connected or disconnected by them. Help should always be requested from clinical staff.

7.2 Require the labeling of high-risk catheters (e.g. arterial, epidural, intrathecal). Use of catheters with injection ports for these applications is to be avoided.

7.3 Require that caregivers trace all lines from their origin to the connection port to verify attachments before making any connections or reconnections, or administering medications, solutions, or other products.

7.4 Include a standardized line reconciliation process as part of handover communications. This should involve rechecking tubing connections and tracing all patient tubes and catheters to their sources upon the patient’s arrival in a new setting or service and at staff shift changes.

7.5 Bar the use of standard Luer-connection syringes to administer oral medications or enteric feedings.

7.6 Incorporate training on the hazards of misconnecting tubing and devices into the orientation and Continuing Professional Development (CPD) of physicians and healthcare professionals

8. Single Use of Injection Devices

One of the biggest global concerns is the spread of Human Immunodeficiency Virus (HIV), the Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV) because of the reuse of injection needles. The following strategies should be considered by the hospital:

8.1 Promote the single use of injection devices as a healthcare facility safety priority that requires leadership and the active engagement of all frontline healthcare professionals.

8.2 Develop ongoing training programs and information resources for health care workers that address:

8.2.1 Infection control principles, safe injection practices, and sharps waste management.

8.2.2 The effectiveness of non-injectable medications.

8.2.3 The education of patients and their families about alternatives to using injectable medications (e.g. oral medication).

8.2.4 New injection technologies (e.g. “needle-less” systems).
8.3 Evaluate and measure the effectiveness of healthcare professionals training on injection safety.

8.4 Provide patients and their families with education regarding:
   8.4.1 Treatment modalities that is as effective as injections in order to reduce injection use.
   8.4.2 Transmission of blood borne pathogens.
   8.4.3 Injection safety practices.

8.5 Identify and implement safe waste management practices that meet the hospital needs.

9. Improved Hand Hygiene to Prevent Health Care-Associated Infection (HAI)

It is estimated that at any point in time more than 1.4 million people worldwide are suffering from infections acquired in hospitals. Effective hand hygiene is the primary preventive measure for avoiding this problem. The following strategies should be considered by the hospital:

9.1 Promote hand hygiene adherence as a health care facility priority; this requires leadership and administrative support and financial resources.

9.2 Adopt at the hospital level the nine recommendations of the WHO Guidelines on Hand Hygiene in Health Care (Advanced Draft), in particular the implementation of multidisciplinary, multimodal hand hygiene improvement strategies within health care facilities that incorporate:
   9.2.1 Provision of readily accessible alcohol-based hand rubs at the point of patient care.
   9.2.2 Access to a safe continuous water supply at all taps/faucets and the necessary facilities to perform hand hygiene.
   9.2.3 Education of health-care workers on correct hand hygiene techniques.
   9.2.4 Display of promotional hand hygiene reminders in the workplace.
   9.2.5 Measurement of hand hygiene compliance through observational monitoring and feedback of performance to healthcare professionals.
### Appendix 5: DHA Statistical Data Reporting Format

#### PHYSICIANS IN HEALTH SECTOR BY DESIGNATION, SPECIALITY & NATIONALITY GROUPS

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**Note:**
- Nationalities: UAE Arabs, Asians, Others, Total
- Specialties: Medical, Cardiology, Cardiac Surgery, etc.
- Designations: Spec. (Specialist), G.P (General Practitioner), Total
- Nationality %: Calculated based on the total number of physicians per specialty and national group.
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### Appendix 6: DHA nursing staff ratio requirements for General Hospital

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<td>Registered Nurse to patient ratio per shift</td>
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<td></td>
<td>Charge Nurse</td>
</tr>
<tr>
<td>1</td>
<td>General Ward</td>
<td>1:4 per shift (+ or-) 1-2 Nurses to be added to the total number.</td>
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<td>2</td>
<td>Psychiatric Ward</td>
<td>Same as above, preferred to be Mental Health Nurse</td>
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<td>3</td>
<td>Orthopedic</td>
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<tr>
<td>4</td>
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<td>Registered Nurse to patient ratio per shift</td>
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<td></td>
<td>Charge Nurse</td>
</tr>
<tr>
<td>1</td>
<td>Pediatrics ward</td>
<td>1:3 per shift (+ or-) 1-2 Nurses to be added to the total number.</td>
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<td>Neuro/Surgery ward</td>
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<tr>
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<td>Burns ward</td>
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<tr>
<td>6</td>
<td>Private ward</td>
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<tr>
<td>7</td>
<td>Geriatric ward</td>
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<td>Charge Nurse</td>
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<td>Renal Unit</td>
<td>1:2 per shift (+ or -) 1-2 Nurses to be added to the total number.</td>
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<tr>
<td>3</td>
<td>S.B.C.U / NICU</td>
<td>One to one</td>
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<tr>
<td>4</td>
<td>I.C.U</td>
<td>1 + (2-4 nurses to be added to the total number)</td>
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1. **Labor Suite**  
   Please refer to Maternity Standards for more details

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<td>Registered Nurse to patient ratio per shift</td>
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<td>First stage</td>
<td>1 RN, RM 2 + Leave Relief &amp; Duty Offs</td>
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<td>Delivery Room</td>
<td>1 RN, RM</td>
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2. **Staff guideline for A/E Department and operating Theatres**

The under listed factors should be considered:

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<th>Registered Nurse to patient ratio per shift</th>
<th>Charge Nurse</th>
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<td><strong>For A/E Dept.: layout</strong></td>
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<tr>
<td>1</td>
<td>No. of receiving rooms</td>
<td>1 +1 Triage Nurse additional</td>
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<td>2</td>
<td>No. of Treatment rooms (major and minor)</td>
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<td>No. of observation rooms</td>
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<td>No. of preparation/supply rooms</td>
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<td>Examination rooms in active use</td>
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<td>Average shift census/year</td>
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<td>7</td>
<td>Allowance for leave, public holidays, days off and maternity leave</td>
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3. **Operating Theatres**

3.1. Based on the hospital activities, number of surgical beds and physical layout of the operating theatres. Generally not less that three RN per theatre, the following factors are to be considered

3.2. The reception area

3.3. Number of operating rooms and recovery rooms functioning each day

3.4. Allowances for leave, public holidays, days off and maternity leave

3.5. Nature of surgery

3.6. Number of operations performed per shift per day.

4. **Recovery Room**: at least one RN in each shift
Appendix 7: Matrix for Staffing Decision Making

<table>
<thead>
<tr>
<th>Items</th>
<th>Elements</th>
</tr>
</thead>
</table>
| Patients             | • Patient characteristics  
                       | • Number of patients for whom care is being provided                     |
| Intensity of unit and care | • Individual patient intensity  
                         | • Unit–wide intensity (heterogeneity of settings)  
                         | • Variability of care  
                         | • Admissions, discharges, and transfers  
                         | • Volume                                                                    |
| Context              | • Architecture (geographic dispersion of patients, size and layout of individual patient rooms, arrangement of entire patient care unit(s)  
                         | • Technology (beepers, cell phones, computers)  
                         | • Same unit or cluster of patients                                             |
| Expertise            | • Learning curve for individuals and groups of nurses  
                       | • Staff consistency, continuity, and cohesion  
                       | • Cross-training  
                       | • Involvement in quality improvement activities  
                       | • Professional expectations  
                       | • Preparation and experience                                                  |
## Appendix 8: 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(^{nd}) dose given 1 month after 1(^{st}) dose 3(^{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(^{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

Cabinet Decision number (33) of 2009 promulgating the bylaw of the medical liability law.


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EQuIP 4 guide of the Australian Council on Healthcare Standard – ACHS

Guidelines for Design and Construction of Health Care Facilities Issued by the Facility Guidelines Institute (FGI)

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The National Hospital Standards of the Central Board of Accreditation for Health Institutions (CBAHI), Kingdom of Saudi Arabia.


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UAE Cabinet Decision number 28 of 2008 regarding Blood Transfusion Regulation.