STANDARDS FOR DAY SURGERY CENTERS

Health Policies and Standards Department

Health Regulation Sector (2019)
INTRODUCTION

Health Regulation Sector (HRS) is an integral part of Dubai Health Authority (DHA) and has been established to regulate, license and monitor health facilities and healthcare professionals in the Emirate of Dubai. The Standard was developed to improve the quality and safety of Day Surgical Centre Services (DSCS) under DHA jurisdiction. The Standard for Day Surgical Centre aims to fulfil the following overarching DHA Strategic objectives set out in the Dubai Health Strategy (2016–2021).

Objective #1: Position Dubai as a global medical destination by introducing a value-based, comprehensive, integrated and high-quality service delivery system.

Objective #2: Direct resources to ensure happy, healthy and safe environment for Dubai population.

Objective #3: Promote public and private collaboration in healthcare.

Objective #4: Foster innovation across the continuum of care.

ACKNOWLEDGMENT

The Health Policy and Standards Department (HPSD) developed this document in collaboration with Subject Matter Experts. HPSD would like to acknowledge and thank the subject matter experts for their contribution and dedication toward improving the quality and safety of healthcare services.

Health Regulation Sector

Dubai Health Authority
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EXECUTIVE SUMMARY

The purpose of this document is to assure provision of the highest levels of safety and quality Day Surgical Centres Services (DSCS) at all times. The standards have been developed to align with the evolving healthcare needs and international best practice. The standards include various aspects required to provide effective, efficient, safe and high quality Day Surgical Services. It includes the health facility and healthcare professional requirements, staffing requirements, permitted sedation levels, permitted patient acuity, emergency management and transfer of patients, sedation and procedure requirements. Various aspects of patient care and safety including set up, pre-assessment, diagnostics, informed consent, equipment use and maintenance, medication management, records management, infection control, quality control, reporting of key performance data and patient rights and responsibilities are also included.

A Day Surgical Standalone Centre is a freestanding surgical centre that provides low complexity surgical and diagnostic procedures and services for healthy patients or patients with mild diseases only without substantive functional limitations who do not require hospitalization or overnight stay beyond midnight (12.00 a.m.). A Day Surgical Standalone Centre may include several surgical units to accommodate different procedures by the respective surgical team. Day Surgical Centres are Consultant or Specialist Led services supported by a surgical team who are trained, competent, experienced and privileged by the Medical Director to perform specified surgical procedures within the confinements of permitted licensure, specialisation (and procedure), patient acuity and sedation levels.
DEFINITIONS

**Adverse Event**: is an unanticipated, unintended, undesirable or potentially dangerous occurrence/injury in a Healthcare organization.

**Analgesia**: means the reduction or elimination of pain. It is usually induced by drugs that act locally (by interfering with nerve conduction) or generally (by depressing pain perception in the central nervous system).

**Consultant/Specialist Led Service**: is a service where a consultant or specialist physician or dentist retains overall clinical responsibility for the service, care professional team or treatment. The consultant or specialist is not necessarily be physically present for each healthcare activity but takes clinical responsibility for the overall patient care and is the lead for the surgical procedure.

**Cooling off period**: is the point from when a patient has a pre-op assessment to the point of surgery.

**Day Surgery Centre**: is an independent Health Facility, which provides Day Surgical Services and is not located within or adjoining a hospital. It has an operating theatre and provides low complexity surgical and diagnostic procedures and services for healthy patients or patients with mild diseases only without substantive functional limitations who do not require hospitalization or overnight stay beyond midnight (12am). A Day Surgical Centre may include several surgical units to accommodate different procedures by the respective surgical teams. Day Surgical Centres are Consultant or Specialist led services supported by a surgical team who are trained, competent, experienced and privileged by the Medical Director to perform specified surgical procedures within the confinements of the permitted licensure, specialisation, patient acuity and sedation levels.
Dissociative Drugs: is an alter perception of pain and sight and elicit feelings of detachment/dissociation from the environment and self.

Healthcare professional: shall mean a natural person who is authorized and licensed by the Dubai Health Authority (DHA), to practice any of healthcare professions as per the unified prequalification's requirements for the United Arab Emirates.

Informed Consent: refers to an agreement and permission accompanied by full information on the nature, risks and alternatives of a surgical or interventional procedure. Informed consent for surgical procedures under anesthesia is a two-step process i.e. consent at the point of pre-op assessment and consent on the day of the procedure. At both points, consent is taken in a written form.

Never Events: are defined as Serious Incidents/Preventable Adverse Events that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at Dubai or Federal level have not been implemented by the healthcare provider.

Operating Room (OR): is defined as a room in the surgical suite that meets the requirements of a restricted area and is designated and equipped for performing surgical operations or other invasive procedures that require an aseptic field. Different form of anesthesia may be administered in an OR as long as appropriate anesthesia gas administration devices and exhaust systems are provided. A hybrid operating room is an operating room that has permanently installed equipment to enable diagnostic imaging before, during, and after surgical procedures (use of portable imaging technology does not make an OR a hybrid operating room).

Patient: is any individual who receives medical attention, care, treatment or therapy by a DHA licensed healthcare professional in a DHA licensed health facility.
**Procedures**: are surgical interventions, which require Informed Consent from the patients or next of kin/ legal guardian, as per UAE Federal Laws.

**Procedure Room**: is a room for the performance of medical procedures that do not require an aseptic field but may require use of sterile instruments or supplies. Procedure rooms are considered unrestricted areas. Local anesthesia and minimal and moderate sedation may be administered in a procedure room, but anesthetic agents used in procedure rooms do not require special ventilation or scavenging equipment.

**Recovery Area**: means a room/area dedicated to providing medical services to patients recovering from Surgery or Sedation/Anesthesia.

**Restricted Area**: is a surgical suite is a designated space that can only be accessed through a semi-restricted area in order to achieve a high level of asepsis control. Traffic in the restricted area is limited to authorized personnel and patients, and personnel are required to wear surgical attire and cover head and facial hair. Masks are required where open sterile supplies or scrubbed persons may be located.

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

**Safety**: means the condition of being protected against physical, psychological, or other types or consequences of failure, error, or harm, which could be considered non-desirable. This can take the form of being protected from the event or from exposure to something that causes health losses, for example, the use of a drug, or a procedure, or risk in the care environment.
Sedation: The administration of a sedative agent or drug to induce a state of calm, restfulness, or drowsiness. The sedative agent or drug depresses activity of the central nervous system, reduces anxiety, and induces sleep. There are four levels of sedation however, given that sedation is a continuum, it is not always possible to predict how an individual patient will respond and the patient may progress to a level of sedation that is beyond the scope of practice of staff without specific anaesthesia training:

a. **Minimal Sedation (Anxiolysis)** is a drug-induced state to reduce patient anxiety during in which the patient responds normally to verbal commands (technically awake). In this stage, the following shall be present:
   - Normal respirations
   - Normal eye movements
   - Intact protective reflexes
   - Amnesia may or may not be present

Refer to CLASS A CENTRE (Appendix 1).

b. **Moderate Sedation/Analgesia (Conscious Sedation)** is a drug-induced depression of consciousness during which the patient tolerates unpleasant therapeutic or diagnostic procedure, responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation while maintaining cardio-respiratory function. This commonly involves intravenous administration of drugs with anxiolytic, hypnotic, analgesic, and amnesic properties either alone or as a supplement to a local or regional anesthetic. Moderate sedation is a medically controlled state of drug induced depressed consciousness that:
• Allows protective reflexes to be maintained

• Retains the patient's ability to maintain a patent airway independently and continuously;

• Permits appropriate response by the patient to physical stimulation or verbal command, for example, "open your eyes."

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

Refer to CLASS B CENTRE (Appendix 1).

c. **Deep Sedation/Analgesia** is a drug-induced depression of consciousness or unconsciousness during which patients cannot be easily aroused and respond purposefully following repeated or painful stimulation or verbal command. The ability to independently maintain ventilatory function may be impaired thus; patients may require assistance in maintaining a patent airway and spontaneous ventilation. Cardiovascular function is usually maintained.

Refer to CLASS CM CENTRE (Appendix 1).

d. **General Anesthesia** is a controlled state of drug-induced unconsciousness state accompanied by a loss of protective reflexes, including loss of the ability to maintain a patent airway independently or to respond purposefully to physical stimulation or verbal command. Cardiovascular function may be impaired and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function.

Refer to CLASS C CENTRE (Appendix 1).

**Semi-restricted Area:** comprises the peripheral support areas surrounding the restricted area of a surgical suite. These support areas include facilities such as storage areas for clean and sterile supplies,
sterile processing rooms, work areas for storage and processing of instruments, scrub sink areas, corridors leading to the restricted area, and pump rooms.

**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.

**Spinal Anesthesia:** is a single injection with a thin needle that puts the local anesthetic close to the nerves, within the Cerebrospinal Fluid (CSF) that surrounds the spinal cord.

**Topical Anesthesia:** means the application of an anesthetic agent directly or by spray to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.
# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
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<td>ALS</td>
<td>Advanced Life Support</td>
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<tr>
<td>ARD</td>
<td>Antibiotic Removal Device</td>
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<tr>
<td>ART</td>
<td>Assisted Reproductive Techniques</td>
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<tr>
<td>ASA</td>
<td>American Society of Anaesthesiologists</td>
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<tr>
<td>BLS</td>
<td>Basic Life Support</td>
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<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<td>CAD</td>
<td>Coronary Artery Disease</td>
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<tr>
<td>CDC</td>
<td>Centre for Disease Control and Prevention</td>
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<td>CHF</td>
<td>Congestive Heart Failure</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>DAMA</td>
<td>Discharge Against Medical Advice</td>
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<td>DHA</td>
<td>Dubai Health Authority</td>
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<td>DIC</td>
<td>Disseminated Intravascular Coagulation</td>
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<td>DM</td>
<td>Diabetes Mellitus</td>
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<td>DSC</td>
<td>Day Surgical Centre</td>
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<td>DSS</td>
<td>Day Surgical Services</td>
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<td>DVT</td>
<td>Deep Vein Thromboembolism</td>
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<td>ESRD</td>
<td>End Stage Renal Disease</td>
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<td>Acronym</td>
<td>Description</td>
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<td>GIFT</td>
<td>Gamete Intra-fallopian Transfer</td>
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<td>HFG</td>
<td>Health Facility Design Guidelines</td>
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<td>HRS</td>
<td>Health Regulation Sector</td>
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<td>HT</td>
<td>Hypertension</td>
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<td>ICSI</td>
<td>Intracytoplasmic Sperm Injection</td>
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<td>IPU</td>
<td>Inpatient Unit</td>
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<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<td>IUI</td>
<td>Intra Uterine Insemination</td>
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<td>IV</td>
<td>Intravenous</td>
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<td>IVF</td>
<td>In vitro Fertilization</td>
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<td>MI</td>
<td>Myocardial Infarction</td>
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<td>MOHAP</td>
<td>Ministry of Health and Prevention</td>
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<td>MSDS</td>
<td>Material Safety Data Sheets (MSDS)</td>
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<td>PALS</td>
<td>Pediatrics Advanced Life Support</td>
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<td>PCA</td>
<td>Post Conceptional Age</td>
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<td>PPE</td>
<td>Personal Protective Equipment</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>TIA</td>
<td>Transient Ischemic Attack</td>
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<tr>
<td>VTE</td>
<td>Venous Thromboembolism</td>
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<td>ZIFT</td>
<td>Zygote Intra-fallopian Transfer</td>
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1. BACKGROUND

Developments in medical technology have resulted in a rise in the use of ambulatory surgery. The use of fast- and short-acting anesthetics, analgesics, and muscle relaxants, and improved monitoring techniques, have reduced anesthetic complications during recovery. Additionally, improvements in surgical techniques have enabled physicians to provide more invasive and complex medical procedures in an ambulatory care setting specifically Day Surgical Centres (DSC). A DSC is where admission, preparation and simple to moderate operative or endoscopic procedures are performed; within the same day and recovery/discharge is completed with patients who do not require hospitalization or overnight stay beyond 12.00 a.m. DSC is a Unit with one or more Operating Rooms (or Procedure Rooms) with the provision to deliver anaesthesia and accommodation for the immediate post-operative recovery of patients. The international expansion of day surgery units over the past decade has led to several publications highlighting the benefits of day surgery in respect to cost, safety, organisation, and easy access to a range of surgical procedures. The benefits also extend to shortened hospital stays and earlier mobilisation also reduce the risk of hospital-acquired infections and Venous Thromboembolism (VTE). It is estimated that each surgical case performed in a Day Surgery setting saves between 1 and 3 bed-days as Inpatient Unit (IPU) beds will not be occupied by the patient. These savings preserve valuable IPU beds for major inpatient surgery. There are various models of care for Day Surgical Centres which are dependant on service planning and patient flow.

For successful and safe ambulatory surgery and anesthesia, the surgeon and anaesthetist should consider various factors such as, appropriate patient selection, pre-operative assessment (including
the patients past history and family history), surgical and anesthetic methods and postoperative management to reduce postoperative complications, postoperative pain. A multi-modal and prophylactic approach to prevent postoperative complications should be considered in order to allow early and safe discharge and return to activities of daily living. Finally, it is important to maintain ongoing communication and cooperation between the patient and their carer, allied health professionals, physician and anaesthetist.

2. PURPOSE

2.1. To assure provision of the highest levels of safety and quality within DHA Licensed Stand-Alone Day Surgical Centres.

3. SCOPE

3.1. Stand-Alone Day Surgical Centres licensed by DHA.

4. APPLICABILITY

4.1. DHA licensed Healthcare Professionals and Health Facilities operating as Stand-Alone Day Surgical Centre (DSC).

5. STANDARD ONE: REGISTRATION AND LICENSURE PROCEDURES

5.1. All health facilities providing Day Surgical Services (DSS) shall adhere to Federal and Local Laws and Regulations.

5.2. A health facility seeking to provide Day Surgical Services shall comply with the DHA registration, licensure and administrative procedures available on the DHA website: https://www.dha.gov.ae
5.3. A licensed DSC opting to provide DSS shall apply to the Health Regulation Sector (HRS) to obtain permission to provide the required service(s).

5.4. All Day Surgical Centres (DSC) are mandated to be accredited in accordance to the required timeframe set out by DHA Circular (18 months).

5.4.1. Accreditation shall include the following International Society for Quality in Healthcare (ISQua) entities such as:

a. Accreditation Canada International (ACI).

b. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).


d. Joint Commission International (JCI) Ambulatory Care.

5.5. The DSC shall have in place internal policies and procedures including but not limited to:

5.5.1. Service Description and Scope of Services.

5.5.2. Patient acceptance/referral criteria.

5.5.3. Lab and diagnostic services and turn-around timeframes for reporting non-critical and critical results.

5.5.4. Patient assessment and admission criteria.

5.5.5. Patient education, communication and informed consent.

5.5.6. Staffing plan, staff management and clinical and privileging.

5.5.7. Patient health record, confidentiality and privacy.

5.5.8. Infection control measures and hazardous waste management.
5.5.9. Incident reporting.

5.5.10. Falls management.

5.5.11. Medication management and pharmacy services.

5.5.12. Reprocessing of reusable equipment, safe use of chemicals used for cleaning and disinfecting and infection control.

5.5.13. Medical and hazard waste management as per Dubai Municipality (DM) requirements.
   a. There should be an allocated medical waste storage and collection area that is well ventilated and secured from public and patient access.
   b. The medical waste storage and collection area shall be adequately labelled with a hazard sign to prevent any unexpected entry from patients or the public.

5.5.14. Monitoring Medical, Electrical and Mechanical equipment, visual inspections for apparent defects and maintenance by competent entity with valid testing certificates.

5.5.15. Laundry and housekeeping services.

5.5.16. Patient belongings.

5.5.17. Clinical Audit.

5.5.18. Pharmacy Services.


5.5.20. Violence against Staff/Zero Tolerance.

5.6. The health facility should ensure it has in place adequate lighting and utilities, including temperature controls, water taps, medical gases, sinks and drains, lighting, electrical outlets and communications.
5.7. The health facility shall maintain documented evidence of treatment protocols and care pathway for surgical procedures to include, but not be limited to the following:

5.7.1. Referral criteria.
5.7.2. Consultation.
5.7.3. Clinical laboratory services and diagnostics.
5.7.4. Pre-op assessment and patient acuity classification.
5.7.5. Staffing requirements.
5.7.6. Informed Consent.
5.7.7. Surgical Safety Checklist for Surgical Procedures.
5.7.8. Patient Monitoring, Recovery and Discharge.
5.7.9. Emergency procedures and transfer of critical/complicated cases when required.
5.7.10. Patient discharge and follow up.
5.7.11. Patient complaints.

6. **STANDARD TWO: HEALTH FACILITY REQUIREMENTS**

6.1. Day Surgical Centres shall be granted a license based on the Health Facility Classification and their permitted Anesthesia and Sedation Levels (Appendix 1-2).

6.2. Day Surgical Centre Shall Only provide Surgical and Diagnostic procedures for ASA PS Classification I and II Patients (Appendix 1-3).

6.3. If the surgical procedure requires higher-level sedation, which does not align with the existing day surgical category, then the provider is not allowed to perform the procedure.
6.3.1. Surgical procedures are limited to those where there is only a small risk of surgical and anaesthetic complications and hospitalization.

6.3.2. The surgical setup shall be capable of providing the required level of sedation/anaesthesia and emergency response.

6.3.3. The following exclusions must be considered during patient consultations and pre-op assessments:

a. Emergency/unprepared patients.

b. Inpatients.

c. Uncooperative patients.

d. Patients with history of sleep apnoea.

e. Patients with history of drug or alcohol abuse.

f. Patients with airway difficulties.

g. Patients with severe allergies.

h. Patients with at risk of blood loss, excessive bleeding and may require blood transfusion.

i. Patients that require cardiac catheterization or Interventional Cardiology

j. Patients with metabolic disorders (PSA 3 and above).

k. High-risk patients (ASA III-VI) in accordance to the American Society of Anaesthesiologist (ASA) Classifications.

6.4. Day Surgical Services shall be Consultant or Specialist Led services.
6.5. The Health Facility shall comply with DHA Health Facility Design Guidelines (HFG) and staffing requirements for DSC.

6.6. The Health Facility shall ensure access to non-treatment and treatment areas are safe for all patient groups.

6.6.1. A comfortable treatment environment should be provided in the health facility and assure patient privacy and confidentiality.

6.7. HRS must be informed and approve changes to existing or new services or staffing levels.

6.8. The health facility shall install and operate equipment required for provision of proposed services in accordance to the manufacturer’s specifications.

6.9. The health facility shall always have in place appropriate equipment and trained healthcare professionals to perform necessary diagnostics, patient assessments, surgery, resuscitation, stabilisation and transfer of critical and emergency cases to a nearby Hospital.

6.9.1. Class CM and C Day Surgical Centres will have sufficient medical equipment (ventilator, portable ventilator, EMS call system, pulse oximeter, anesthesia machine with vital sign monitor (ECG), and hemodynamic monitoring equipment) with annual certification of equipment by qualified maintenance company.

a. A back up anesthesia machine is only required for Class C Day Surgical Centres.

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

6.9.3. Assure medical equipment and devices are in place for emergency scenarios.
6.9.4. All DSC shall have access to diagnostics and laboratory services as per patient needs to include urinalysis, complete blood count, bio-chemistry and necessary emergency laboratory tests as determined by the medical team.

a. Class A and B DSC categories may outsource laboratory and diagnostics services.

   **Laboratory Services**

   i. Arterial Blood Gas (ABG)

   ii. Point of Care Testing (glucose, Prothrombin time/International normalized ratio (PT/INR), Dipstick urinalysis and hCG.

   iii. Remaining lab services as per patient need may be contracted with an external lab provider.

b. CM and C DSC categories must provide basic onsite radiology services and lab services.

   i. Radiology (or portable x-ray) to provide plain x-rays and chest x-rays.

      • Physicians and Nurses shall have training to provide plain x-ray and chest x-rays.

   ii. Remaining radiology services as per patient need may be contracted with an external radiology provider.

6.9.5. All laboratory equipment shall be calibrated and maintained as per DHA Policy for Clinical Laboratory.

6.9.6. All DSC must have in place a written agreement for patient referral and emergency transfer to a nearby Hospital setting. The transfer agreement shall detail the transfer
plan/protocol of patients and meet Dubai transfer timeframes for emergency patients.

a. The Health Facility shall put in place an annual simulation scenarios with all members of the surgical teams to manage patient recovery and transfer.

b. Simulation outcome and improvement plans shall be documented.

6.9.7. All DSC shall have in place a Business Continuity Plan to ensure the core functions of the centre are met.

7. **STANDARD THREE: STAFFING AND HUMAN RESOURCE REQUIREMENTS**

Staffing requirements to provide day surgical and diagnostic services shall be based on what is required to create a safe environment for the patient and to ensure the safe performance of services by healthcare professionals. Both patient and procedural factors shall be considered in determining staffing requirements.

7.1. To provide DSC procedures and diagnostic services, all healthcare professionals in the health facility shall hold an active DHA professional license and work within their scope of practice and granted privileges.

7.2. All physicians must have an up to date medical malpractice insurance.

7.3. The Privileging Committee and/or Medical Director of the DSC shall take responsibility to privilege staff as per the DHA Policy for Clinical Privileging Policy.

7.4. For Endoscopic Standards refer to the DHA Standards for Endoscopy Services and Appendix 3.
7.5. Appropriate and sufficient number of healthcare professionals are always required to be on duty to diagnose, plan, supervise and evaluate patient care. The number of licensed healthcare professionals assigned to each health service in the DSC shall be determined by DSC management and be consistent with DSC services, bed capacity and type of care provided. DSC will adhere to the following:

7.5.1. At least one full time licensed specialist or consultant surgeon present in the Day Surgical Centre.
   a. The Specialist or Consultant surgeon is responsible to ensure the availability of surgical team before and during the procedure.
   b. The surgeon and anaesthesiologist must be present until patient discharge or transfer to hospital setting.

7.5.2. There must be at least one full time Anaesthetist present in DSC Class CM and C Day Surgical Centre to attend each surgical procedure.

7.5.3. There must be at least one full time licensed physician with role of the Medical Director.

7.5.4. Minimum nursing requirements should consider the following:
   a. The reception area(s).
   b. The number of operating theatres and recovery rooms.
   c. Nature of surgery and number of surgical or endoscopic procedures performed per day and shifts.
   d. Allowances for annual and sick leave, public holidays etc.
e. The DSC shall have sufficient number of staff as per the health facility licensure requirements set out DHA Health Facility Licensing Policy. Additional staff must be in place as per specialisation, service descriptions, scope and patient volume.

f. Adequate Registered Nurses (RNs), Assistant Nurses (ANs) and/or Operation Theatre Technicians should be present to assist with the technical aspects of the surgical or endoscopic procedures.

g. For DSC that provide full Laboratory Services, one full time or part time DHA licensed pathologist shall be available to supervise and manage the clinical laboratory services in the DSC and laboratory technicians.

i. At least one laboratory technician shall be available in each shift and shall only be responsible for basic laboratory services.

h. For DSC that provide full Radiology Services, one full time or part time specialist/consultant radiologist shall be available to supervise and manage the radiology services in the DSC.

ii. At least one radiography technician shall be available in each shift and shall only be responsible for basic radiography services.

i. The health facility shall employ a biomedical engineer or maintain a service contract with a certified maintenance company to ensure safety, reliability, validity and efficiency of medical devices and mechanical equipment.

j. DSC Class C should employ a pharmacist as per the scope of pharmacy services. In the absence of a pharmacist, the anaesthetists shall be responsible for managing
Standards for Day Surgery Centres

anesthesia, narcotic and controlled medications, emergency medicine, any other medication and record keeping in the DSC.

i. DHA licensing department must be informed where staffing levels fall below or exceed the requirements for licensure or services provision.

ii. In charge, approvals for pharmacy must be obtained from DHA Drug Control Section.

7.6. Staffing levels, required competencies, medical equipment, sedation and surgical environment should never be compromised. If either of these factors come into play:

7.6.1. Patients should be offered an alternative surgical date or referred to another health facility.

7.7. Human resources management shall ensure patient safety, healthcare quality, competent workforce and satisfy the working environment for employees. Human resources management includes:

7.7.1. Planning and Recruitment.

7.7.2. Continuing performance development.

7.7.3. Employee support systems.

7.7.4. Effective workplace relations.

7.8. Human resource practices should be supported by policies and procedures with supporting systems to influence employee’s behaviours, attitudes and performance for efficient, safe and high-quality care.
7.9. The recruitment selection and appointment system shall ensure the skill mix and competence of staff meet the DSC needs.

7.9.1. The DSC is responsible to put in place a written staffing plan to address high patient volumes, staff sickness or staff resignations.

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

7.11. A written policy on staff training along with the type and frequency of core competency assessment should be documented and monitored on an annual basis.

7.12. A development system shall be in place to ensure the core skills and competencies of staff are always met

7.12.1. Continuing Professional Development (CPD) activities and evidence of hands on learning shall be documented.

7.13. A structured and uniform system shall be maintained to assure adequate staffing levels, staff orientation, staff training needs, professional retention and staff performance evaluation.

8. **STANDARD FOUR: PRE-OP ASSESSMENT, PATIENT CARE AND ANESTHESIA**

8.1. All Day Surgical Centres must have in place a written Surgical Care Pathway (*Appendix 4*).

8.2. All patients who have been referred for surgery must have had a physician consultation with appropriate lab and diagnostics testing and a follow up appointment with the physician to discuss surgical and non-surgical options.
8.3. A comprehensive pre-op patient assessment process and testing shall be achieved with the support of a multi-disciplinary team (as applicable) and be based on the clinical and priority needs of each individual patient.

8.3.1. For DSC Class B, CM and C, pre-op assessment should include CBC, Blood Pressure, Blood Glucose, Coagulation Profile, BMI and rule out the exclusions (see section 6.2.3.).

a. Pre-op assessments shall be conducted on the same site of DSC surgery.

b. The patient shall sign an initial consent at pre-assessment point to proceed for elective surgery.

c. Patients or their next of kin/legal guardian shall be given written information/instructions on the surgery and surgical preparation and copy of the first signed informed consent form.

d. Patients shall be given sufficient time to make an informed decision prior to the surgical procedure (cooling off period).

8.3.2. The timeframe from pre-op assessment to surgery shall be conducted within 4- weeks. Patients exceeding the 4-week window should be re-assessed.

8.4. On the day of surgery, the patient must sign the second informed consent form that elaborates risks, benefits and alternatives prior to commencement of the procedure. The physician shall be available to answer any further questions in a non-technical way. The minimum requirements for informed consent are set out in Appendix 5.
8.4.1. The second informed consent form shall be signed prior to surgery and a copy must be issued to the patient or their next of kin/legal guardian.

8.5. Before commencing the procedure, the patient, staff physician performing the procedure should verify the correct patient and procedure to be performed and identify any potential risks following pre-op assessment.

8.5.1. A Physician, Anaesthetists and RN must be document, complete and verify the Surgical Safety Checklist (Appendix 6).

8.5.2. All surgeries under Day Surgical Centre category B, CM and C must always be overseen by a DHA licensed surgeon, anaesthetist and nurse.

8.5.3. The surgical team shall be competent to stabilize critically ill patients and transfer them to a higher level of care if the health facility is unable to manage the patient onsite.

8.6. Minimally invasive procedures shall follow Procedural Sedation and Analgesia (PSA), which is a continuum of depressed level of state of consciousness ranging from minimal sedation to general anesthesia.

8.7. The DHA Licensed anaesthetist shall be certified, trained and competent in:

8.7.1. Understanding the continuum of sedation and apply methods and levels of sedation, conscious sedation and associated risks of moderate/deeper sedation training and required competencies (Appendix 7-8).

8.7.2. Being able to conduct a physical assessment to assess the fitness and appropriateness of the patient for PSA.
8.7.3. Reviewing the patient’s condition and vital signs prior, during and after a procedure and during recovery to assess any change in the condition of the patient that may affect the administration or management of PSA until discharge from recovery area.

a. Vital signs include level of consciousness, ventilatory and oxygenation status, hemodynamic variables, temperature, pain and anxiety levels.

8.7.4. Recognising the important principle of minimum intervention, where the simplest and safest technique, which is likely to be effective, is used to achieve the clinical goal.

8.7.5. Being able to maintain effective communication and clear explanation at every stage of patient management to reassure the patient.

8.7.6. Understanding that loss of verbal responsiveness/deep sedation requires the same level of skills and care as for general anaesthesia.

8.7.7. Understanding the fundamentals, actions and interactions of the sedative and analgesic and multiple drugs being administered, their synergistic effects; how to use reversal agents; and necessary adjustments to accommodate different patient needs.

8.7.8. Putting in place a pain signalling and stimulus system prior to the initiation of sedation and understand the timeframe for the sedation effect to take place.

8.7.9. Titrating to patient needs in a small, incremental doses and be able to identify the sum of the incremental doses has reached the maximum dose.

8.7.10. Providing simple and advanced sedation and be competent to manage failed sedation.

8.7.11. Determine stock levels and reversible agents required for managing sedation-related side effects in a timely manner.
8.7.12. Ensuring patient safety is always paramount taking into account the number of procedures conducted in a single sitting, duration of surgery, patient manipulation and anticipated complications.

8.7.13. Safely delivering pharmacological sedation to appropriate patients and recognise the limits of their competency and experience.

8.7.14. Discharging the patient, including but is not limited to the following checks:
   a. The patient returned to their baseline level of consciousness.
   b. Vital signs are stable and within acceptable limits.
   c. Sufficient time has elapsed following administration of reversal agents (if applicable) to ensure that patients does not become re-sedated.
   d. All assessments for recovery, discharge and home release have been met and completed (Appendix 9-10).
   e. There is a responsible adult to accompany the patient home.

8.7.15. Being able to discuss where and when deeper levels of sedation or anaesthesia may be indicated.

8.7.16. Detecting and rescuing patients from sedation-related adverse responses including anaphylaxis and cardiorespiratory failure.

8.7.17. Declaring an emergency and directing the surgical team on emergency procedures and protocol and where necessary lead on the emergency patient transfer.
9. **STANDARD FIVE: PATIENT SAFETY**

9.1. There is an array of Patient Safety considerations that are paramount and shall be considered and documented in the patient record.

9.1.1. Patient identity (including history and family history).

9.1.2. Evidence of consultation, physical examinations and confirmatory lab or diagnostics (patient selection).

9.1.3. Procedure to be undertaken and location with clear markings.

9.1.4. No emerging issues since the last pre-op assessment.

9.1.5. Informed Consent for the procedure.

9.1.6. Verification of Nothing by Mouth Status.

9.1.7. Mitigating circumstances/exclusions not to perform the surgery (6.2.3. and Appendix 3).

9.1.8. Adequate staff levels for the procedure.

9.1.9. Emergency training and preparedness of staff.

9.1.10. Up to date medical records.

9.1.11. Pre-anesthesia assessment and patient acuity (Class I or II).


9.1.13. Confirmation of functioning equipment and back-up plan.


9.1.15. A list of look-alike, sound-alike medication.

9.1.16. Medical devices are fully functional.
9.1.17. Control of concentrated electrolyte solutions.

9.1.18. Assuring medication accuracy and safe dosing.

9.1.19. Avoiding catheter and tubing misconnections.

9.1.20. Prophylaxis.


9.1.23. Fully stocked crash cart and emergency medications and per DSC Classification (Appendix 11-12)
   a. A crash cart must always be available in the operating theatre, recovery, and critical care area.

9.1.24. Stopping the procedure in the event the patient condition deteriorates.

9.1.25. Patient recovery plan.


9.1.27. International Patient Safety Goals.

9.1.28. Communication of staff and during patient hand-over.

9.1.29. Patient post-op instructions, discharge and follow up.

9.1.30. Patient transfer to referral or alternative health facility.

9.1.31. Restricted and semi-restricted areas.

9.1.32. Regular clinical audit and improvement plan.

9.2. The treating surgeon shall be available at the DSC facility until the patient is discharged safely.
9.3. Visiting surgeons must always ensure their patients are handed over to a competent physician(s) to oversee patient follow up and patient care during their absence.

10. STANDARD SIX: PATIENT MONITORING AND DISCHARGE

10.1. All patient diagnostic or surgical procedures shall be constantly monitored in accordance to the surgical procedure, patient safety and risk factors. Monitoring should be performed before the procedure, after administration of sedatives, at regular intervals during the procedure, during initial recovery and just before discharge.

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

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

10.4. The surgical procedures in DSC are limited to those in which there is only a small risk of surgical and anaesthetic complications, and hospitalization as result of these complications is unlikely (Appendix 1-3).

10.5. When moderate sedation is targeted, the healthcare professional is assigned responsibility for patient monitoring and may perform brief interruptible tasks. Monitoring includes electronic
assessment of blood pressure, respiratory rate, heart rate and pulse oximetry combined with visual monitoring of the patient's level of consciousness and discomfort.

10.6. Procedures that require, the use of deep sedation/analgesia, general anesthesia, or major conduction blockade (e.g. liposuction) may be serious or life threatening (Appendix 1-3).

10.6.1. Major regional blocks include but are not limited to, spinal, epidural or caudal injection of any drug, which has analgesic, anesthetic or sedative effects.

10.6.2. When deep sedation or general anesthesia is targeted, the healthcare professional responsible for patient monitoring must be dedicated solely to that task and may not perform any other function during the procedure.

10.7. The DSC shall put in place procedures to rescue patients who are sedated deeper than intended.

10.8. Documentation of the clinical assessments and monitoring data during sedation and recovery and discharge is required to include:

10.8.1. Time, date, physician name, patient condition and action taken.

10.8.2. Food consumption appropriate for the patient and consistent with patient’s condition and clinical care shall be provided.

10.8.3. Ability to pass urine following surgery.

10.8.4. Patient level on consciousness and ability to put on clothing without assistance.

10.9. The incidence of falls and fall injuries shall be minimized through a fall management program and prevention strategies according to patient risk factors. A written policy shall be in place for falls management. Patients shall be assessed for risk of falls:

10.9.1. Upon admission.
10.9.2. Once a change of health status has been identified.

10.9.3. After a fall.

10.9.4. Upon Discharge.

10.10. A discharge plan shall start from the point of patient admission and include various personnel, information and resources. Considerations for discharge preparation shall include but not be limited to:

10.10.1. Risk assessment and process for discharge.

10.10.2. Medication needed from pharmacy.

10.10.3. Physician written authorisation for discharge.

10.10.4. Documentation of the procedure for the patient and treating physician.

10.10.5. The pickup person and aftercare support within the first 24-hours.

10.10.6. No driving policy and travel distance to home.

10.10.7. Environmental conditions, such as stairs, access to toilet or bedroom.

10.10.8. The carer’s/authorized persons contact details and their awareness of possible issues and requirements following discharge.

10.10.9. Contact numbers after discharge, such as the doctor or emergency contact.

a. Follow up phone call and follow up appointments.

10.10.10. Treating physician shall respect patients’ choices if they decide to Discharge Against Medical Advice (DAMA). DAMA patients must sign a form before leaving the facility and be witnessed by the treating physician and a nurse.
11. STANDARD SEVEN: MEDICATION MANAGEMENT AND PHARMACY

11.1. Medications shall be managed to ensure safe and effective practice. The DSC shall maintain a policy and procedures on medication management, medication storage and monitoring of medication inventory and expiration dates consistent with applicable federal and local legislation and regulations. Considerations for DSC include:

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

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

11.1.3. Special arrangements shall be in place for post-discharge medications with clear written instructions, for example suitable analgesia should be provided for the minimum required period after discharge.

11.2. DSC shall facilitate access to discharge medication where it is not provided by the facility.

11.3. DSC shall put in place a policy on proper storage and handling of anaesthesia agents and ensure this abides by the Ministry of Health and Prevention (MOHAP) regulation on storage, handling and records maintaining of narcotic and controlled medications.

11.3.1. A daily medication log shall be maintained.

11.3.2. All narcotic and controlled medication must be stored and kept in a safe and secure place with a double locked or a lock with the provision of a code locking mechanism as per Federal and local regulations.
11.3.3. Disposal of controlled drugs shall be locked in a cabinet, restricted to specified staff and be compliant with federal laws and local regulations.
   
a. Up to date and accurate records must be kept on the receipt and disposition of all controlled substances.

11.3.4. A log of narcotics and controlled medication and wasted vials used must be documented and maintained.

11.4. A qualified and licensed healthcare professional (physician/pharmacist/RN) shall oversee medication usage.

11.5. Medication shall be securely stored under environmental conditions consistent with the manufacturer's specifications.

11.5.1. DSC shall put in place a policy to promote safe and secure storage and use high concentrated electrolytes and high alert medications.
   
a. Use pre-prepared bags for high concentrated electrolytes if available, or the competent anaesthetist shall be responsible to prepare and dilute the required medications.

11.5.2. The use of single-dose vials for all sedative and analgesic medications is strongly recommended.

11.5.3. Healthcare professionals should have access to published guidelines for medication Management.

11.6. Medication should only be given only under the order of the supervising physician.
11.7. A written policy shall be in place for the identification, documentation and review of adverse drug reactions.

11.7.1. Reversal agents for opioids and benzodiazepines shall be readily available as per the DSC facility classification.

11.8. Pharmacy services shall be provided in the DSC to meet the needs of patient directly or through written agreement with an external pharmacy provider licensed by DHA. The experienced Pharmacist shall:

11.8.1. Assure proper storage, control, handling, compounding and dispensing of drugs, devices and biological materials shall be according to the applicable Ministry of Health and Prevention (MOHAP) Laws and regulations.

11.8.2. Ensure provisions are made for storage and preparation of medications administered to patients.

11.8.3. Ensure drugs, devices and biologicals must be stored in locked areas according to the manufacturer’s instructions for temperature, light, humidity or other storage instructions.

a. A specific refrigerator for pharmaceuticals storage and control shall be available.

11.8.4. Emergency drugs, devices and biologicals as determined by the healthcare professional staff must be available for use at designated locations when an emergency occurs.

11.8.5. The supply of drugs, devices and biologicals and controlled substances must be protected and restricted for use for legally authorized purposes only.
11.8.6. The supply of drugs and devices must be checked on a regular basis to ensure expired, mislabelled, unlabelled or unusable products are not available for patient use and are disposed accordingly.

12. **STANDARD EIGHT: CRITICAL CARE SERVICES AND EMERGENCY MANAGEMENT**

Provision of critical care services and emergency management is paramount to ensuring early detection and prevention of patient deterioration. DSC shall ensure:

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

12.2. There is one competent Registered Nurse (RN) during surgery with suitable training and experience in critical care on duty to provide the critical care services if required and evidence of the competency and training shall include the following:

   12.2.1. Recognizing arrhythmias.
   12.2.2. Assisting physician in placing central lines or arterial lines.
   12.2.3. Obtaining blood gases ABG’s.
   12.2.4. Central Venous Pressure (CVP) line.
   12.2.5. Infection control principles.
   12.2.6. Glasgow Coma Scale (GSC).
   12.2.7. Training in using defibrillator and care of patients on ventilators.
12.3. The DSC shall ensure periodic training and education for staff in the use of equipment for emergency management. Training and assessment of competency shall be documented as per the requirements of the training provider.

12.4. DSC Class B, CM and C must have a room for post-operative recovery of critical care patients and emergency transfer. Critical care services equipment and supplies must be immediately available in the DSC for immediate and safe provision of care and treatment required.

12.4.1. Critical care room will include medical gases outlets (O2, Air, Suction), enough numbers of electrical outlets, examination lights. Supply of medical gases shall be available and centralized medical gas system shall be according to HTM 2022 or its equivalent internationally accepted standard.

12.4.2. Pharmaceutical agents, oxygen, oral suction, laryngoscope, ambu-bag shall be readily available in the health facility.

12.4.3. Equipment shall include Ventilators, Tracheostomy set, Defibrillator machine, Pulse Oximetry and vital signs monitor, Infusion pumps, blood gas analyser with capability for electrolytes measuring and emergency crash cart that includes all emergency supplies and medications.

12.5. At minimum DSC shall have, a clear protocol and provision for basic emergency management for illness and/or injuries occurred for patient, healthcare professionals, employees or visitors, which needs immediate emergency care and assistance prior to transport to another health facility.
12.6. Emergency services must be provided by qualified and licensed physician(s) who are authorized by their scope of practice to provide emergency services and received privileges from the facility to perform specific emergency procedures.

12.7. All Physicians, Anaesthetists, Technicians and Nurses engaged in surgery shall maintain up to date hands on/practical Advanced Life Support (ALS) or Advanced Cardiac Life Support (ACLS) or Paediatrics Advanced Life Support (PALS) Certification as per the scope of services provided.

12.8. If the DSC manages paediatric cases, DSC must ensure anaesthetist are trained in managing paediatric cases.

12.8.1. All RN who provide patient care are required to maintain a valid Basic Life Support (BLS) certification.

12.9. RN providing emergency services in the DSC shall be trained and competent to provide the emergency care, as needed:

12.9.1. Patient Triage.

12.9.2. Operating a Cardiac Monitor.

12.9.3. ECG Recording and Interpretation.

12.9.4. Pulse Oximetry.

12.9.5. Oxygen Administration.


12.9.7. Intravenous cannulation.

12.9.8. Medication administration.

12.9.9. Emergency services will be available during the operational hours of the DSC.
12.10. Emergency drugs (Appendix 11-12), devices, equipment and supplies must be available for immediate use for treating life-threatening conditions.

12.10.1. Defibrillator.

12.10.2. Emergency Cart with Emergency medicines.

12.10.3. Resuscitation Kit, Cardiac board and Oral airways.

12.10.4. Laryngoscope with blades.

12.10.5. Diagnostic set.

12.10.6. X-ray viewer.

12.10.7. Patient trolley with IV stand.


12.10.9. Refrigerator for medication.

12.10.10. Floor Lamp (Operating light mobile).

12.10.11. Sets of instruments, which shall include suturing set, dressing set, foreign body removal set or minor set and cut down set.

12.10.12. Disposable supplies which shall include suction tubes (all sizes), tracheostomy tube (all sizes), intravenous cannula (different sizes), IV sets, syringes (different sizes), dressings (gauze, softratulle, etc.), crepe bandages (all sizes), splints (Thomas splints, cervical collars, finger splints).

12.10.13. All types of fluids (e.g. D5W, D10W, Lactated Ringers, Normosol R, Normosol M, Haemaccel, etc.) and Glucometer.
12.10.14. Sufficient electrical outlets to satisfy monitoring equipment requirements, including clearly labelled outlets connected to an emergency power supply.

12.10.15. Reliable source of Oxygen.

12.10.16. Portable vital signs monitor (ECG, Pulse-Oximetry, Temperature, NIBP, EtCO2).

12.10.17. Portable transport ventilator with different ventilation mode (IPPV, SIMV, spontaneous, PS).


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

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

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

12.14. Well-equipped ambulance services shall be ready and nearby for with licensed, trained and qualified Emergency Medical Technicians (EMT) for patient transportation if required, this service can be outsourced with a written contract with an emergency services provider licensed in Dubai.

13. **STANDARD NINE: SUPPORT SERVICES**

13.1. **Allied Health Services**

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

   13.1.2. Allied health services shall be provided by competent and licensed healthcare professionals. The management shall support the Allied healthcare professional's education and training, such training shall ensure competency in specific areas e.g. lifting and manual handling, infection control, fire and Cardiopulmonary Resuscitation training.

13.2. **Nutrition Services**

   13.2.1. Nutrition services shall be provided as necessary by the DSC either on the premises or through a written agreement with an external provider. If provided internally, proper hygienic conditions shall be maintained in the DSC kitchen during preparing, storing and serving food.

13.3. **Laundry**

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

13.4. **Sanitary Services**
13.4.1. Clean and hygienic water supply shall be provided in the DSC Water tanks shall be maintained, clean and well closed.

13.4.2. Clean bathrooms for outpatients shall be provided (separate for male and female). Each bathroom shall have at least one washbasin and commode with soap and hand towel. All staff and patients' toilets shall be kept clean.

13.4.3. All DSC drainage and sewage shall be connected to general sewerage and comply with the drainage and sanitation requirements of Dubai Municipality regulations.

13.5. External Services

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

13.5.2. While a contracted service agreement is important for both the health facility and service provider to ensure quality maintenance of the services, the fundamental responsibility for quality still rests with the contracting health facility. The health facility shall precisely outline in its service agreement/contract, the type and standard of the services expected and evidence compliance with relevant regulatory bodies such as Dubai Municipality (DM).

13.6. Care for Deceased Patients
13.6.1. A policy for mortuary management shall be available in the health facility and assure respect and dignity.

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

13.6.3. All deceased patients shall be considered infectious. Strict infection control measures shall be adopted. The body shall be cleaned and wrapped according to the requirements of the mortuary service.

13.6.4. Patient’s family rights shall be respected and considered; requests for relatives/friends to view the deceased shall be arranged by the DSC staff or at the mortuary.

13.6.5. Deceased registration and notification shall be reported to DHA and MOHAP and maintained by the DSC.

14. **STANDARD TEN: MEDICAL RECORD AND HEALTH INFORMATION MANAGEMENT**

14.1. DSC shall ensure all patients have in place a medical file that is protected, secured, accurate and up to date. As a minimum, the file shall entail the following:

14.1.1. Patients full contact details.

14.1.2. Emergency contact person (next of kin).

14.1.3. Patient health status.


14.1.5. Any allergies or contract indications.

14.1.7. Lab and diagnostic information.


14.1.9. Information on consent.

14.1.10. Date, time and observations for all consultations.

14.2. Up to date operating theatre records shall be maintained including but not be limited to:

14.2.1. Name, date of birth and identification number of the patient.

14.2.2. Date, inclusive of time of the surgical procedure.

14.2.3. Surgical procedure(s) performed, time in and time out.

14.2.4. Name(s) of Physicians, Nurses and Technicians.

14.2.5. Name of nursing personnel (scrub and circulating).

14.2.6. Type of anesthesia administered, dose, time, date and professional.

14.2.7. Name and title of person managing anesthesia.

14.2.8. Requirements for testing and disposal of surgical specimens.

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

14.2.10. Procedures for handling infectious cases.

14.3. Maintain post-op quality data to inform a quality management and patient safety including but not be limited to:

14.3.1. Recovery timeframe.

14.3.2. Wound healing time.

14.3.3. Complication rate.
14.3.4. Incidence of pain, nausea and vomiting.

14.3.5. Incidence of treatment related side effects.

14.3.6. Incidence of changes to patient mobility arising directly from the procedure.

14.3.7. Patient satisfaction rate.

15. **STANDARD ELEVEN: ADMINISTRATIVE REPORTING**

Unanticipated, undesirable or potentially dangerous occurrence of events such as never events, adverse events and sentinel events in a healthcare organization might occur. DSC shall develop a written policy for incident reporting to DHA when such events occur. This includes but is not limited to the following:

15.1. 0-48 hours

15.1.1. Any incident prior to or following surgery or administration of anesthesia that results in patient death, loss of function or limb.

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

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

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

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

15.1.6. Loss of patient data or patient files.

15.1.7. Full or partial evacuation of the DSC for any reason.
15.1.8. Major incident in the DSC premises (fire, flood, electrical outage, outbreak of disease etc.)

15.2. Means for reporting adverse events, never events and sentinel events, and major incidences shall include a written official letter to HRS Clinical Audit and Control Department at DHA either by courier, in person and verified by email and follow up phone call unless specified by DHA otherwise. DSC management team shall prepare a written evaluation of its response following investigation, root cause analysis and action plan.

15.3. The response shall be submitted to HRS Clinical Audit and Control Department at DHA by courier, in person and verified email and follow up phone call within 45 calendar days from the date of the event.

15.4. Key Performance Indicators shall be captured by the DSC and reported to HRS within the 2nd week of each quarter through the online QEYAS Portal. Submission reflect outcomes achieved in the previous quarter. Data submission includes but is not limited to the following:

15.4.1. Patient waiting time for elective surgery

15.4.2. Number of diagnostic procedures Performed

15.4.3. Number of informed consent

15.4.4. Number of pre-assessments

15.4.5. Number of surgical procedures performed

15.4.6. Number of Surgical procedures performed by sedation classification

15.4.7. Number of Surgical procedures performed by Permitted Patient Acuity

15.4.8. Number of surgical cancellations
15.4.9. Number of surgical complications
15.4.10. Number of Surgical Site Infections
15.4.11. Number of 30-day re-operated
15.4.12. Number of Sentinel Events
15.4.13. Number of hospital emergency transfers
15.4.14. No. of Falls
15.4.15. Number of deaths within 30 days
15.4.16. Patient Satisfaction %
15.4.17. Staff Satisfaction %

16. **STANDARD TWELVE:** FACILITY MANAGEMENT

16.1. Medical Equipment and Supplies

Accurate and safe clinical equipment is an essential requirement in the provision of health services. Medical equipment shall be installed and operated in accordance with manufacturer specifications. The DSC shall maintain effective Preventive Maintenance (PM) as per the manufacturer recommendations (at least 95% of medical equipment shall receive PM), the PM shall include the following:

16.1.1. Electrical safety testing for patient related equipment.

16.1.2. Each piece of equipment has a checklist for its maintenance schedule, failure incidence and repairs done.
16.1.3. Make use and maintain Statistical data of Preventative Maintenance (PM) for upgrading/replacing equipment.

16.1.4. The DSC shall maintain copy of operator and safety manuals of all medical equipment and inventory list with equipment location.
   a. DSC healthcare professionals (physicians, nurses, and allied health) shall be trained to operate the medical equipment assigned to them and the hazards attached to it.
   b. Training shall be documented and kept up to date.

16.1.5. Maintain written policy for tagging medical equipment which should include:
   a. PM with testing date and due date.
   b. Inventory number.
   c. Safety checks.
   d. Installation.
   e. Removal.
   f. Reporting incidents, hazards and corrective actions.

16.2. Safety and Quality Management Systems

16.2.1. DSC shall ensure that the healthcare environment is safe, functional, supportive and effective for patients, family and staff members.

16.2.2. The DSC leadership shall plan and budget for all necessary support and resources for safety.
16.2.3. The DSC shall designate a safety officer person(s) with skills and experience responsible for the operation and implementation of the safety program.

16.2.4. The safety management system is supported by a policy and shall comply with the related federal and local regulation in UAE, the safety officer shall undertake appropriate training relevant to jurisdictional requirements.

16.2.5. The safety management system shall include fire safety, hazardous waste, emergencies, security.

16.2.6. External service providers shall be supplied with relevant information and comply with the DSC health and safety requirements.

16.2.7. Orientation on the safety measures shall be included in the induction program of new staff.

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

16.2.8. DSC shall abide with the prevention and safety measures required by Dubai Civil Defence.

16.2.9. DSC management shall ensure the compliance with Federal Authority Nuclear Regulation-FANR rules and regulations regarding the use of ionizing radiation and radioactive materials in DSC.

16.3. Fire Safety
16.3.1. Fire is a potential risk for all healthcare organizations and is critical where immobile patients are in locations that are difficult to evacuate. To respond to fire risk the DSC shall:

a. Establish a fire safety plan for early detection, confining, extinguishment, Rescue and alerting the Dubai Civil Defence.

b. Establish a No Smoking policy.

c. Assess the fire risks to the facility.

d. Understand and manage risks associated with the facility's location and physical structures.

e. Maintain and test fire protection and emergency communication systems

f. Train staff to respond to a fire event in the building.

g. Monitor whether adequate numbers of suitably trained staff are posted across all shifts to respond appropriately to a fire event.

h. Rehearse emergency scenarios to assess preparedness.


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

16.4.2. There should be adequate space and ventilation for safe handling of dangerous materials and hazardous substances.
16.4.3. Each DSC shall have a current list of hazardous substances and dangerous materials used in their area, the list covers:

a. Purpose of use.

b. The responsible person.

c. Permitted Quantity.

16.4.4. All substances shall be clearly labelled; this includes corrosives, acids, toxic material, hazardous gases and anesthetic gases.

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

16.4.6. Employees dealing with hazardous substances shall have protective clothes or equipment as required.

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

16.5. Waste and Environmental Management

16.5.1. Waste and environmental management shall support safe practice and a safe environment. The DSC shall develop and implement a waste and environmental management policy. The policy shall include segregation and disposal of DSC clinical waste in a responsible manner in accordance with federal and local regulations in the UAE.
16.5.2. The waste management policy shall cover handling, storing, transporting, and disposing all kinds of waste:

a. Anatomical e.g. blood and organs (red).

b. Clinical/infectious waste (orange).

c. Clinical/highly infectious, pathological waste and sharps (yellow).

d. Medicine unused drugs (blue).

e. Cytotoxic, Cytostatic, Chemotherapeutic, hemotherapy medicines waste (Purple).

f. Dental (white).

g. Offensive but not hazardous (yellow and black).

h. Radioactive waste (lead box).

i. Chemical or pharmaceutical (brown).

j. Domestic waste (black).

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

16.5.4. Contracting with a specialized company to transport and destroy medical waste materials shall be according to the conditions issued by Dubai Municipality.

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

16.5.6. Cleanliness throughout the DSC shall be maintained by trained staff.

16.6. Emergency and Disaster Management

16.6.1. The DSC shall develop a plan and policies for dealing with and managing emergencies and internal disasters, which shall include:
a. Duties and responsibilities of healthcare professionals and employees in the DSC.

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

c. The triage areas, their locations, and triage action cards.

d. Names of all staff called, including their contact.

16.6.2. The DSC shall conduct Emergency practice/drill exercises including fire and evacuation with the aim to test the following:

a. The timely response of staff to the emergency call.

b. The efficiency of the communication system, e.g. bleeps, mobile phone and overhead paging system.

c. If all staff can perform their expected roles.

d. The time taken to evacuate patients and beds.

16.6.3. There are evacuation maps posted in the DSC indicating locations of:

a. You are here.

b. Fire extinguishers.

c. Fire hose reel/cabinets.

d. Escape routes.

e. Assembly points.

f. Fire exits.

g. Call points break glass / pull station.
16.6.4. External service providers shall comply with the DSC requirements for the prevention of emergencies.

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

16.7. Security Management

16.7.1. Security management shall support safe practice and a safe environment.

16.7.2. The facility management may assign specific personnel to take care of security in the DSC or may ensure security by installing CCTV camera or other means of surveillance.

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

16.7.4. There is a security policy, which includes identification of all the following by badge:

   a. The DSC staff.

   b. Temporary employees.

   c. Trainees.

   d. Contractor staff.

16.7.5. There are written policies on the following that includes but not limited to:

   a. Lost and found items.

   b. Safe keeping of patient belongings.

   c. How to contact the local police, in case of need.

16.7.6. Major security risks shall be identified in the DSC.
16.7.7. Restricting access to sensitive areas by Security Personnel/Security System such as operating area, no filming in operating theatre as per DHA Circular.

16.7.8. External service providers are supplied with relevant information and comply with the DSC security controls.

17. **STANDARD THIRTEEN: INFECTION PREVENTION AND CONTROL**

17.1. There shall be in place an infection prevention control Policy and lead to oversee the DSC infection prevention and control program and monitoring shall be implemented to prevent transmission of pathogens across the DSC.

17.1.1. The lead shall report to the Medical Director or management committee.

17.2. Written policies and procedures regarding infection control management, prevention and surveillance shall be in place and documented as part of the DSC policies and procedures.

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

17.3.1. The basic measures for infection control/hand hygiene/hand washing.

17.3.2. The procedures for minimizing risk/cleaning/disinfection/sterilization.

17.3.3. Use of standard precautions and additional precautions in certain cases.

17.3.4. Restriction of jewellery, nail polish, false nails and clothing in surgical theatre.

17.3.5. Healthcare professional vaccination and immunisations (Appendix 13).
17.3.6. Monitoring/investigation of demonstrated or suspected spread of infection within the DSC.

17.3.7. Environmental cleaning, single-use items and reprocessing of sterile instruments.

17.3.8. Recommended cleaning, disinfectants and sterilisation in healthcare setting for surgical and non-surgical areas as per Centre for Disease Prevention and Control recommendations

(https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html)

a. Sterilisation may be outsourced and is subject to DHA approval.

17.3.9. There should be a sterilizing area, which can be located near Operating Theatre area with adequate high-speed autoclave machine. Operation instruments and trolleys may be arranged at this area.

17.3.10. Post-exposure prophylaxis protocols.

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

17.4. An active infection prevention surveillance program and ongoing educational and competency evaluation of staff regarding activities within the pre-procedure, intra-procedure and post-procedure phases are necessary for overall safety of patients and healthcare professionals.

17.5. To prevent pathogens transmission resulting from improper use or reuse of syringes, multiple dose drug vials and IV equipment the following shall be adhered to:
17.5.1. Preparing medications for multiple patients shall be done in an area away from direct patient care or procedure rooms.

17.5.2. All medications shall be appropriately labelled by the nurse, including those used for sedation, unless the medication is for immediate use (prepared and administered immediately without leaving the provider’s hand).

17.5.3. Medications either marked on the container or noted in the package insert as “single patient use” shall be used for a single patient only and any remaining drug should be discarded.

17.5.4. New fluid administration sets (e.g., IV tubing) units shall be used for each patient.

17.5.5. Use of a single-dose vial is preferred over multiple dose vials, particularly when medications are administered to multiple patients.

17.5.6. If a multiple-dose vial is used for more than one patient, they should remain in a centralized medication area and not enter the patient procedure room. They should be dated when opened and discarded according to protocols, in compliance with nationally MOHAP accepted guidelines and those published by the Centers for Disease Control and Prevention (CDC).

17.5.7. Re-use of a syringe to enter a medication vial or solution, even with a new needle shall not be permitted.

17.5.8. The same syringe shall not be used to administer medications to multiple patients regardless of whether the needle is changed, or an intervening length of IV tubing is used.
17.5.9. Used syringes and needles shall be disposed of at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof.

17.5.10. If tubes of lubricant are used for more than one examination, appropriate infection control habits should be observed and any tube that has potentially been contaminated should be discarded.

17.5.11. Aseptic technique (i.e., cleansing the access diaphragms of medication vials with 70% alcohol before inserting a device in the vial) should be used to prepare and administer injections. Single-dose vials, ampules, bags, or bottles of IV solution should be used for a single patient only.

17.6. A clearly defined policy for the management of sharps and sharps-related injuries, including the reporting of blood and body fluid exposures shall be developed.

17.7. Hand hygiene shall be performed before patient contact (even if gloves are to be worn), after patient contact and before exiting the patient care area, after contact with blood, body fluids or contaminated surfaces, before performing invasive procedures and after glove removal.

17.8. Convenient access to hand-washing stations shall be available in all consultation, treatment, patient care, sterilisation, dirty utility and housing keeping areas.

17.9. Use of soap and water is required when hands are visibly soiled.

17.10. Environmental cleaning of surfaces with a disinfectant is mandatory and shall follow manufacturer recommendations, especially for surfaces that are most likely to become contaminated with pathogens, such as those near the patient (e.g. side rails) and other frequently touched surfaces.
17.10.1. The DSC shall maintain material safety data sheets (MSDS) for all chemicals used for cleaning and disinfection. These sheets shall detail the safe and proper use and emergency protocol for a chemical. Material safety data sheets should be used for training staff on each chemical’s safe use.

17.11. There must be appropriate measures for cleaning and decontamination of spills of blood or other potentially infectious material. The health facility should:

17.11.1. Follow the CDC directions for surface disinfection of patient care items.

   a. Appropriate contact time of disinfectant to achieve germicidal kill shall be followed.

   b. Alcohol should not be used to clean environmental surfaces.

   c. Properly clean and disinfect surfaces that are frequently touched like endoscopy keyboards, video monitors, consoles or dirty equipment in the endoscopic procedure area at the beginning of the day, between cases and during terminal cleansing.

   d. Endoscopy equipment shall be dried and stored in an endoscopy storage cabinet.

17.12. The use of Personal Protective Equipment is dictated by patient traffic patterns, location of care and the potential of direct contact with patients and their bodily fluids during specific activities.

17.13. Healthcare professionals shall remove and appropriately, discard used PPE before leaving the procedure room.
17.14. Contaminated clothing shall be placed in a bag and identified as potential biohazardous. The bag with the contaminated clothing should be sent to a laundry capable of cleaning and disinfecting them.

17.15. Healthcare professionals engaged in endoscopic procedures with potential splash/contamination shall wear gloves, face/eye shields/impervious gowns.

17.16. Final rinse water of the endoscope washer disinfecter and rinse sample cultures for endoscopic channels and water bottle shall be tested on a monthly basis.

17.17. Single-use devices as determined by the manufacturer label or packaging insert should not be reprocessed.

17.18. The reprocessing protocol of reusable medical equipment such as endoscopes and endoscopic accessories must be strictly followed.

18. **STANDARD FOURTEEN: PATIENT RIGHTS AND RESPONSIBILITIES**

18.1. DSC must put in place a written policy that adheres to DHA requirements for patient rights and responsibilities. Information on patients’ rights and responsibilities shall be communicated and displayed in at least two languages (Arabic and English), at the entrance, reception and waiting area(s) of the premise and website. Requirements for patient rights and responsibilities include but are not limited to the following:

18.1.1. Patients have the right to full disclosure of healthcare service costs. Cost information can be displayed in the form of price leaflet/brochure/online or any other feasible manner.
18.1.2. Patients have the right to request information about a physician’s scope of practice, credentials and license.

18.1.3. Patients have the right to be provided information concerning their diagnosis, evaluation, treatment options, and prognosis.

18.1.4. Patients have a right to obtain comprehensive medical report based on their personal medical records along with copies of all investigation reports.

18.1.5. Patients have the right to participate in decisions involving their care.

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

18.1.7. Patients have the right to seek a second opinion.

18.1.8. Patients have the right to make a complaint and to receive a written response.

a. Timescales for managing complaints shall be provided in writing to the patient.

b. Complaints made by a patient or by patient’s family shall be investigated, documented including the resolution of the complaint.

18.1.9. The DSC shall ensure patients are made aware and understand their rights as well as their responsibilities regarding the procedures/surgery, including but not limited to provision of patient or next of kin/legal guardian identification, fasting times, medications, financing, notification where change in their medical condition has taken place and adherence to physician and staff instructions.
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   (accessed 19/05/19).
## APPENDICES

### APPENDIX 1: DSC CLASSIFICATION (ANESTHESIA, SEDATION AND PATIENT SAFETY)

<table>
<thead>
<tr>
<th>Health Facility CLASS A</th>
<th>Health Facility CLASS B</th>
<th>Health Facility CLASS CM</th>
<th>Health Facility CLASS C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Sedation</td>
<td>Moderate Sedation/Analgesia (Conscious Sedation)</td>
<td>Deep Sedation/Analgesia</td>
<td>General Anesthesia</td>
</tr>
<tr>
<td>(Anxiolyis)</td>
<td>is a drug-induced depression of consciousness during which the patient tolerates unpleasant therapeutic or diagnostic procedure, responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation while maintaining cardio-respiratory function. This commonly involves intravenous administration of drugs with anxiolytic, hypnotic, analgesic, and amnesic properties either alone or as a supplement to a local or regional anesthetic. Moderate sedation is a medically controlled state of depressed consciousness that:</td>
<td>is a drug-induced depression of consciousness or unconsciousness during which patients cannot be easily aroused and respond purposefully following repeated or painful stimulation or verbal command. The ability to independently maintain ventilatory function may be impaired thus, patients may require assistance in maintaining a patent airway and spontaneous ventilation. Cardiovascular function is usually maintained.</td>
<td>is a controlled state of drug-induced unconsciousness state accompanied by a loss of protective reflexes, including loss of the ability to maintain a patent airway independently or to respond purposefully to physical stimulation or verbal command. Cardiovascular function may be impaired and Positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function.</td>
</tr>
<tr>
<td>is a drug-induced state to reduce patient anxiety during which the patient responds normally to verbal commands (technically awake). In this stage, the following should be present:</td>
<td>• Allows protective reflexes to be maintained</td>
<td>i. Topical anesthesia, oral sedative and local Anesthesia</td>
<td>i. Topical anesthesia, oral sedative and local Anesthesia</td>
</tr>
<tr>
<td>in which the patient responds normally to verbal commands (technically awake). In this stage, the following should be present:</td>
<td>• Retains the patient’s ability to maintain a patent airway independently and continuously;</td>
<td>ii. Regional Anesthesia</td>
<td>ii. Regional Anesthesia</td>
</tr>
<tr>
<td>• Normal respirations</td>
<td>• Permits appropriate response by the patient to physical stimulation or verbal command, for example, &quot;open your eyes.&quot;</td>
<td>iii. Dissociative Drugs (including Propofol)</td>
<td>iii. Dissociative Drugs (including Propofol)</td>
</tr>
<tr>
<td>• Normal eye movements</td>
<td>• The drugs, doses, and techniques used are not intended to produce a loss of consciousness.</td>
<td>iv. Spinal Anesthesia</td>
<td>iv. Epidural Anesthesia</td>
</tr>
<tr>
<td>• Intact protective reflexes</td>
<td>i. Topical anesthesia, oral sedative and local Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Amnesia may or may not be present</td>
<td>ii. Regional Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Topical anesthesia, oral sedative and local Anesthesia</td>
<td>iii. Dissociative Drugs (excluding Propofol)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note 1: Regional Anesthesia involves the injection of local anesthetic in the vicinity of major nerve bundles supplying body areas, such as the thigh, ankle, forearm, hand or shoulder, etc. so the patient cannot feel pain in that area. It is an umbrella term used to describe nerve blocks, epidural blocks (pain relief and having a baby) and spinal blocks.</td>
<td>Note 1: The use of Endotracheal Intubation Anesthesia, Laryngeal Mask Airway Anesthesia, and/or Inhalation General Anesthesia (including Nitrous Oxide) is prohibited in a Class CM Centre.</td>
<td>Note 2: Epidural Anesthesia is a fine plastic tube (an epidural catheter) that is threaded through a needle and the tube is left in the epidural space in the back. Local anesthetic is injected down the tube to cause numbness, which varies in extent according to the amount of local anesthetic injected.</td>
<td>Note 1: Major regional blocks including, but not limited to, spinal, epidural or caudal injection of any drug, which has analgesic, anesthetic or sedative effects are in the same category as general anesthesia.</td>
</tr>
<tr>
<td>Note 2: The use of Propofol, Spinal Anesthesia, Epidural Anesthesia, Endotracheal Intubation Anesthesia, Laryngeal Mask Airway Anesthesia, and/or Inhalation General Anesthesia (including Nitrous Oxide) is prohibited in a Class B Centre.</td>
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</tbody>
</table>

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### Standards for Day Surgery Centres

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Ref. No. HRS/HPSD/DSC/1/2019
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Health Facility CLASS A Minimal Sedation (Anxiolysis)</th>
<th>Health Facility CLASS B Moderate Sedation/Analgesia (Conscious Sedation)</th>
<th>Health Facility CLASS CM Deep Sedation/Analgesia</th>
<th>Health Facility CLASS C General Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness</td>
<td>Normal response to Verbal Stimulation</td>
<td>Purposeful response to verbal and tactile simulation</td>
<td>Purposeful response following repeated or painful simulation</td>
<td>Unarousable even with painful stimulus</td>
</tr>
<tr>
<td>Airway</td>
<td>Unaffected</td>
<td>No intervention required</td>
<td>Intervention may be required</td>
<td>Intervention often required</td>
</tr>
<tr>
<td>Spontaneous Ventilation</td>
<td>Unaffected</td>
<td>Adequate</td>
<td>May be adequate</td>
<td>Frequency inadequate</td>
</tr>
<tr>
<td>Cardiovascular Function</td>
<td>Unaffected</td>
<td>Usually maintained</td>
<td>Usually maintained</td>
<td>May be impaired</td>
</tr>
<tr>
<td>ASA PS Classification</td>
<td>ASA I (A normal healthy patient i.e. Healthy, non-smoking, no or minimal alcohol use)</td>
<td>ASA I (A normal healthy patient i.e. Healthy, non-smoking, no or minimal alcohol use)</td>
<td>ASA I (A normal healthy patient i.e. Healthy, non-smoking, no or minimal alcohol use)</td>
<td>ASA I (A normal healthy patient i.e. Healthy, non-smoking, no or minimal alcohol use)</td>
</tr>
<tr>
<td></td>
<td>ASA II (Mild diseases only without substantive functional limitations. Examples include but not limited to current smoker, social alcohol drinker, pregnancy, obesity (30 &lt; BMI &lt; 40), well-controlled DM/HTN, mild lung disease)</td>
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</tr>
</tbody>
</table>
### ASA PS Classification

<table>
<thead>
<tr>
<th>ASA PS Classification</th>
<th>Definition</th>
<th>Examples, Include but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA I</td>
<td>A normal healthy patient, without organic, physiologic, or psychiatric disturbance</td>
<td>Healthy patient with good exercise tolerance, non-smoking, no or minimal alcohol use</td>
</tr>
<tr>
<td>ASA II</td>
<td>A patient with mild systemic disease</td>
<td>Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 &lt; BMI &lt; 40), well-controlled DM/HTN, mild lung disease, anaemia, pregnancy</td>
</tr>
<tr>
<td>ASA III</td>
<td>A patient with severe systemic disease</td>
<td>Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, CHF, Stable Angina, old MI, COPD, Bronchospastic disease with intermittent symptoms, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, chronic renal failure, premature infant PCA &lt; 60 weeks, history (&gt;3 months) of MI, CVA, TIA, or CAD/stents.</td>
</tr>
<tr>
<td>ASA IV</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Examples include (but not limited to): recent (&lt; 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis, unstable angina, Symptomatic COPD, Symptomatic CHF, Hepatorenal failure</td>
</tr>
<tr>
<td>ASA V</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction, sepsis syndrome with hemodynamic instability, Hypothermia, Poorly controlled Coagulopathy</td>
</tr>
<tr>
<td>ASA VI</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>This modifier is added to any of the above classes to signify a procedure that is being performed as an emergency and may be associated with a sub optimal opportunity for risk modification</td>
<td></td>
</tr>
</tbody>
</table>

**Note 1:** The American Society of Anaesthetists’ Physical Class System was designed to describe the patient’s current health status. As such, it is one of the most important factors used to assess the overall perioperative risk.

**Note 2:** Level III-VI patients are not permitted in DSC setting.
## APPENDIX 2: DSC CLASSIFICATION AND PERMITTED MEDICATIONS

<table>
<thead>
<tr>
<th>No.</th>
<th>Health Facility Class/Type (A, B, CM or C)</th>
<th>Method of Delivery</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A</td>
<td>Topical Anesthesia</td>
<td>Benzocaine, lidocaine, lignocaine, prilocaine</td>
</tr>
</tbody>
</table>
|     | A                                       | Oral sedative     | Alprazolam (Xanax)  
|     |                                         |                   | Clonazepam (Rivotril)  
|     |                                         |                   | Diazepam (Valium)  
|     |                                         |                   | Midazolam (Dormicum)  
|     |                                         |                   | Lorazepam (Ativan)  
|     |                                         |                   | Chlordiazepoxide (Librium)*   
|     |                                         |                   | Chloral Hydrate* (non-registered medication)  
|     | B                                       | Oral sedative     | See Health Facility Class/Type A |
|     | B                                       | Local Anesthesia  | See Health Facility Class/Type A |
|     | B                                       | Regional Anesthesia | Procaine* (non-registered medication) |
### Dissociative Drugs (excluding Propofol)

- Ketamine
- PCP (Phencyclidine)* (non-registered medication)
- DXM (Dextromethorphan)* (non-registered medication)

### 3. Topical Anesthesia

- See Health Facility Class/Type A

### Oral Sedative

- See Health Facility Class/Type A

### Local Anesthesia

- See Health Facility Class/Type A

### Regional Anesthesia

- See Health Facility Class/Type B
<table>
<thead>
<tr>
<th><strong>CM</strong></th>
<th>Dissociative Drugs (including Propofol)</th>
<th>See Health Facility Class/Type B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CM</strong></td>
<td>Spinal Anesthesia</td>
<td>Bupivacaine (Marcaine)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ropivacaine (Naropin)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lidocaine</td>
</tr>
<tr>
<td><strong>CM</strong></td>
<td>Epidural Anesthesia</td>
<td>Bupivacaine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lidocaine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fentanyl</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Topical Anesthesia</td>
<td>See Health Facility Class/Type A</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Oral sedative</td>
<td>See Health Facility Class/Type A</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Local Anesthesia</td>
<td>See Health Facility Class/Type A</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Regional Anesthesia</td>
<td>See Health Facility Class/Type B</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Dissociative Drugs (including Propofol)</td>
<td>See Health Facility Class/Type B</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Spinal Anesthesia (including Propofol)</td>
<td>See Health Facility Class/Type C</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>Epidural Anesthesia</td>
<td>See Health Facility Class/Type C</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>General Anesthesia (with or without Endotracheal Intubation or Laryngeal Mask Airway Anesthesia)</td>
<td>Thioental* (non-registered medication)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inj Midazolam Dormicum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inj Diazepam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sevoflurane,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Isoflurane</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Halothane</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nitrous Oxide* - (non-registered medication)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Propofol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ketamine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dexmedetomidine (Precedex)</td>
</tr>
<tr>
<td></td>
<td>Morphine Sulfate Injection</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pethidine Hydrochloride</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fentanyl</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alfentanil</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remifentanil (ultiva)</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 3: LIST OF PERMITTED PROCEDURES BY DAY SURGICAL CENTRE CLASSIFICATION

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Assisted Reproductive Techniques (ART)</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Intra Uterine Insemination (IUI)</td>
<td>C</td>
</tr>
<tr>
<td>2.</td>
<td>In vitro Fertilization (IVF)</td>
<td>C</td>
</tr>
<tr>
<td>3.</td>
<td>Intracytoplasmic Sperm Injection (ICSI)</td>
<td>C</td>
</tr>
<tr>
<td>4.</td>
<td>Gamete Intra-fallopian Transfer (GIFT)</td>
<td>C</td>
</tr>
<tr>
<td>5.</td>
<td>Zygote Intra-fallopian Transfer (ZIFT)</td>
<td>C</td>
</tr>
</tbody>
</table>

**Note:** The above procedures can only be performed in a fertility centre.

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Endoscopic procedures</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Colonoscopy</td>
<td>B</td>
</tr>
<tr>
<td>2.</td>
<td>Gastroscopy</td>
<td>B</td>
</tr>
<tr>
<td>3.</td>
<td>Laryngoscopy</td>
<td>B</td>
</tr>
<tr>
<td>4.</td>
<td>Bronchoscopy</td>
<td>CM</td>
</tr>
<tr>
<td>5.</td>
<td>Cystoscopy</td>
<td>CM</td>
</tr>
<tr>
<td>6.</td>
<td>Esophagoscopy</td>
<td>CM</td>
</tr>
<tr>
<td>7.</td>
<td>Sigmoidoscopy</td>
<td>CM</td>
</tr>
<tr>
<td>8.</td>
<td>Arthroscopy</td>
<td>C</td>
</tr>
</tbody>
</table>

**Note:** Thoracoscopy and laparoscopy can only be performed in a hospital setting.

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>General Surgery</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Ganglions</td>
<td>A</td>
</tr>
<tr>
<td>2.</td>
<td>In-grown toe-nail</td>
<td>A</td>
</tr>
<tr>
<td>No.</td>
<td>Speciality/Procedure Names</td>
<td>Minimum Health Facility Classification/Type (A, B, CM or C)</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>3</td>
<td>Excision of skin and subcutaneous benign mass</td>
<td>A</td>
</tr>
<tr>
<td>4</td>
<td>Drainage of Abscesses</td>
<td>A</td>
</tr>
<tr>
<td>5</td>
<td>Temporal artery biopsy</td>
<td>B</td>
</tr>
<tr>
<td>6</td>
<td>Anal procedures - dilatation/fissure/bandin/low anal fistula</td>
<td>CM</td>
</tr>
<tr>
<td>7</td>
<td>Breast lump excision (benign)</td>
<td>CM</td>
</tr>
<tr>
<td>8</td>
<td>Excision varicocele</td>
<td>CM</td>
</tr>
<tr>
<td>9</td>
<td>Testicular fixation and Orchidopexy</td>
<td>CM</td>
</tr>
<tr>
<td>10</td>
<td>Varicose vein surgery</td>
<td>CM</td>
</tr>
<tr>
<td>11</td>
<td>Hernia repair – inguinal/epigastric/femoral/incisional/umbilical</td>
<td>C</td>
</tr>
<tr>
<td>12</td>
<td>Hemorrhoids (2nd 3rd Degree) and Incision and Excision of superficial Thrombosed Hemorrhoid</td>
<td>C</td>
</tr>
</tbody>
</table>

**Note:** Appendectomy, abdominoplasty, Pilonidal Sinus, bariatriac and laparoscopic can only be performed in a hospital setting.

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Neurosurgery/anesthesia/pain management</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Epidural Steroid Injections/Block</td>
<td>B</td>
</tr>
<tr>
<td>2.</td>
<td>Selective Nerve Root injections</td>
<td>B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Obstetric/Gynecology</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Bladder distension</td>
<td>A</td>
</tr>
<tr>
<td>2.</td>
<td>Endometrial biopsy</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>Colposcopic procedures</td>
<td>A</td>
</tr>
<tr>
<td>4.</td>
<td>Urethral dilatation</td>
<td>B</td>
</tr>
</tbody>
</table>
5. Cervical biopsies | B
6. Vaginoplasties, vulva repair and perineal repair | CM
7. Cautery to cervix | C
8. Dilatation and curettage | C
9. Endometrial ablation | C
10. Tension free vaginal tape | C
11. Excision urethral caruncle | C
12. Fenton’s procedure | C
13. Labial procedures/Bartholin’s | C
14. Polypectomy | C

Note: Hysterectomy and laparoscopic surgery can only be performed in a hospital setting.

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A,B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Apicoetomy</td>
<td>A</td>
</tr>
<tr>
<td>2.</td>
<td>Biopsy of oral lesions/swellings</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>Gum surgery</td>
<td>A</td>
</tr>
<tr>
<td>4.</td>
<td>Excision of oral cysts</td>
<td>A</td>
</tr>
<tr>
<td>5.</td>
<td>Exposure and bonding of impacted incisors</td>
<td>A</td>
</tr>
<tr>
<td>6.</td>
<td>Exposure of impacted canines</td>
<td>A</td>
</tr>
<tr>
<td>7.</td>
<td>Removal of impacted canines</td>
<td>A</td>
</tr>
</tbody>
</table>

Note: Maxillofacial procedures can only be performed in a hospital setting.

<table>
<thead>
<tr>
<th>Orthopaedic Surgery</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
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<td>2.</td>
</tr>
<tr>
<td>No.</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
</tr>
<tr>
<td>6.</td>
</tr>
<tr>
<td>7.</td>
</tr>
<tr>
<td>8.</td>
</tr>
</tbody>
</table>

*Note: Intramedullary nailing and plating of long bones can only be performed in a hospital setting*
<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Excision lymph nodes</td>
<td>C</td>
</tr>
<tr>
<td>10.</td>
<td>Functional Endoscopic Sinus (FESS) Surgeries</td>
<td>C</td>
</tr>
<tr>
<td>11.</td>
<td>Uvuloplasty</td>
<td>C</td>
</tr>
<tr>
<td>12.</td>
<td>Myringotomy</td>
<td>C</td>
</tr>
<tr>
<td>13.</td>
<td>Grommet insertion, tympanoplasty and simple mastoidectomy</td>
<td>C</td>
</tr>
<tr>
<td>14.</td>
<td>Antrostomy</td>
<td>C</td>
</tr>
<tr>
<td>15.</td>
<td>Tympanoplasty</td>
<td>C</td>
</tr>
<tr>
<td>16.</td>
<td>Uvulectomy</td>
<td>C</td>
</tr>
<tr>
<td>17.</td>
<td>Removal submandibular calculus</td>
<td>C</td>
</tr>
</tbody>
</table>

**Note:** Rhinoplasty and tonsillectomy can only be performed in a hospital setting.

---

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Cataract extraction</td>
<td>A</td>
</tr>
<tr>
<td>2.</td>
<td>BCC Excision and skin graft</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>Sling Procedure</td>
<td>A</td>
</tr>
<tr>
<td>4.</td>
<td>Chalazion</td>
<td>A</td>
</tr>
<tr>
<td>5.</td>
<td>Conjunctiva Biopsy</td>
<td>A</td>
</tr>
<tr>
<td>6.</td>
<td>Conjunctival Suture Removal</td>
<td>A</td>
</tr>
<tr>
<td>7.</td>
<td>Cryotherapy</td>
<td>A</td>
</tr>
<tr>
<td>8.</td>
<td>Ectropian and Entropian</td>
<td>A</td>
</tr>
<tr>
<td>9.</td>
<td>Electrolysis</td>
<td>A</td>
</tr>
<tr>
<td>10.</td>
<td>Epilation of lashes</td>
<td>A</td>
</tr>
<tr>
<td>11.</td>
<td>Gold Weight Insertion</td>
<td>A</td>
</tr>
<tr>
<td>12.</td>
<td>Hughes Flap and Release</td>
<td>A</td>
</tr>
<tr>
<td>13.</td>
<td>Intraocular lens implantation</td>
<td>A</td>
</tr>
<tr>
<td>No.</td>
<td>Speciality/Procedure Names</td>
<td>Minimum Health Facility Classification/Type (A, B, CM or C)</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>14</td>
<td>LASIK and LASEK</td>
<td>A</td>
</tr>
<tr>
<td>15</td>
<td>Peripheral Indectomy</td>
<td>A</td>
</tr>
<tr>
<td>16</td>
<td>Pterygium</td>
<td>A</td>
</tr>
<tr>
<td>17</td>
<td>Ptosis</td>
<td>A</td>
</tr>
<tr>
<td>18</td>
<td>Punctal Plug Insertion</td>
<td>A</td>
</tr>
<tr>
<td>19</td>
<td>Second Stage Reconstructions</td>
<td>A</td>
</tr>
<tr>
<td>20</td>
<td>Syringe and Probe</td>
<td>A</td>
</tr>
<tr>
<td>21</td>
<td>Tarsorrhaphy</td>
<td>A</td>
</tr>
<tr>
<td>22</td>
<td>Temporal Artery Biopsy</td>
<td>A</td>
</tr>
<tr>
<td>23</td>
<td>Three Snip Procedure</td>
<td>A</td>
</tr>
<tr>
<td>24</td>
<td>Trabeculectomy (glaucoma)</td>
<td>A</td>
</tr>
<tr>
<td>25</td>
<td>Vitrectomy</td>
<td>A</td>
</tr>
<tr>
<td>26</td>
<td>Keratoplasty, Keratomileusis, Keratoprosthesis</td>
<td>A</td>
</tr>
</tbody>
</table>

Note: Keratoplasty, Keratomileusis, Keratoprosthesis is subject to DHA written approval.

**Plastic Surgery**

<table>
<thead>
<tr>
<th>No.</th>
<th>Speciality/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A, B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Excision of skin tag</td>
<td>A</td>
</tr>
<tr>
<td>2</td>
<td>Minor Scalp Surgery (lipoma, cyst, cut wounds)</td>
<td>A</td>
</tr>
<tr>
<td>3</td>
<td>Face, neck and eye brow lift</td>
<td>CM</td>
</tr>
<tr>
<td>4</td>
<td>Blepharoplasty</td>
<td>CM</td>
</tr>
<tr>
<td>5</td>
<td>Belly button surgery (or umbilicoplasty/navel surgery)</td>
<td>C</td>
</tr>
<tr>
<td>6</td>
<td>Breast implants</td>
<td>C</td>
</tr>
<tr>
<td>7</td>
<td>Calf, Cheek and Chin Surgery/implants</td>
<td>C</td>
</tr>
<tr>
<td>8</td>
<td>Ear surgery (otoplasty/pinnaplasty)</td>
<td>C</td>
</tr>
<tr>
<td>9</td>
<td>Liposuction (or lipoplasty/liposculpture) and fat transfer</td>
<td>C</td>
</tr>
</tbody>
</table>

Note: Lip implants, breast surgery/reconstruction and abdominoplasty can only be performed in a hospital setting.
<table>
<thead>
<tr>
<th>No.</th>
<th>Specialty/Procedure Names</th>
<th>Minimum Health Facility Classification/Type (A,B, CM or C)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Urology</strong></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Biopsies</td>
<td>A</td>
</tr>
<tr>
<td>2.</td>
<td>Suprapubic catheter</td>
<td>A</td>
</tr>
<tr>
<td>3.</td>
<td>Circumcision</td>
<td>B</td>
</tr>
<tr>
<td>4.</td>
<td>Urethral dilatation</td>
<td>B</td>
</tr>
<tr>
<td>5.</td>
<td>Locate/remove JJ stent</td>
<td>CM</td>
</tr>
<tr>
<td>6.</td>
<td>Epididymal cyst excision</td>
<td>CM</td>
</tr>
<tr>
<td>7.</td>
<td>Cysto-diathermy bladder</td>
<td>C</td>
</tr>
<tr>
<td>8.</td>
<td>Excision hydrocele</td>
<td>C</td>
</tr>
<tr>
<td>9.</td>
<td>Lithoclast</td>
<td>C</td>
</tr>
<tr>
<td>10.</td>
<td>Bladder neck incision</td>
<td>C</td>
</tr>
<tr>
<td>11.</td>
<td>Prostate - Plasma kinetic vaporisation/biopsy</td>
<td>C</td>
</tr>
<tr>
<td>12.</td>
<td>Orchidopexy, Testicular and penile prosthesis</td>
<td>C</td>
</tr>
</tbody>
</table>
APPENDIX 4: DAY SURGICAL CENTRE CARE PATHWAY

Note:
* Pre-op information provided
** Post Op information and analgesics and instructions
APPENDIX 5: MINIMUM REQUIREMENTS FOR INFORMED CONSENT FORM

<table>
<thead>
<tr>
<th>Informed Consent Form for Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Healthcare Professional:</td>
</tr>
<tr>
<td>Name of Health Facility:</td>
</tr>
<tr>
<td>Name of Patient: File No:</td>
</tr>
</tbody>
</table>

This Informed Consent Form has two parts:
- Information Sheet (to share information about the treatment with you)
- Certificate of Consent (for signatures if you agree to go ahead with the treatment)

You will be given a copy of the full Informed Consent Form

PART I: Information Sheet

Introduction:
I, Dr. ___________________________ with license No:___________ should be performing the ________________ treatment/ procedure on Miss/Mrs./Mr.__________________ aged _________years, on date _______________.

Description of the Procedure and Process
Describe to the patient or customer, the procedure and what will happen on a step-by-step basis. The patient should be informed that procedure is newly introduced and the amount of supporting research and study available.

Side Effects
Potential patients should be told if there are any known or anticipated side effects and what will happen in the event of a side effect or an unexpected event.

Risks
Explain and describe any possible or anticipated risks. Describe the level of care that will be available in the event that harm does occur, who will provide it, and who will pay for it.

Complications
Inform and explain any possible complications that could be caused as a result of the treatment.

Discomforts
Explain and describe the type and source of any anticipated discomforts that are in addition to the side effects and risks discussed above.

Benefits
Mention only those activities that will be actual benefits of the treatment.

Confidentiality
Explain how the clinical team will maintain the confidentiality of data, especially with respect to the information about the patient including photography and videography.

**Right to Refuse treatment/procedure**

This is a reconfirmation that the patient has the right to refuse the treatment.

**Alternatives to clinical procedure or treatment**

It is important to explain and describe the established standard treatment or procedure for the patient’s condition.

**Financial Implications**

All procedures/treatments provided that are not covered by insurance or which may require the patient’s full payment or co-payment.

**PART II: Certificate of Consent**

This section can be written in the first person. It should include a few brief statements about the treatment and be followed by a statement similar to the one in bold below. The healthcare professional performing the treatment and the person going over the informed consent should sign the consent.

Example:

**Patient Consent statement**

*I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to undergo this treatment and understand that I have the right to withdraw from the procedure or treatment at any time without in any way affecting my medical care.*

Name of Patient: ____________________________________________________  
Signature of Patient:___________________________  Date:  ____________

**Witness statement**

*I have accurately read or witnessed the accurate reading of the consent form to the potential patient, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.*

Name of witness: ____________________________________________________  
Signature of witness: _________________________  Date:  ______________

**Healthcare Professional Declaration:**
I have adequately explained to the patient about the procedure along with risks, adverse effects and the standard alternatives that are available for the procedure. I have permitted time and opportunity for the patient to ask questions and all questions have been answered to my knowledge.

Name of healthcare professional: ________________________________

Signature of healthcare professional: __________________ Date: __________
APPENDIX 6: SURGICAL SAFETY CHECKLIST

Surgical Safety Checklist

Before induction of anaesthesia
(with at least nurse and anaesthetist)

- Has the patient confirmed his/her identity, site, procedure, and consent?
  - Yes
  - Not applicable

- Is the site marked?
  - Yes
  - Not applicable

- Is the anaesthesia machine and medication check complete?
  - Yes

- Is the pulse oximeter on the patient and functioning?
  - Yes

- Does the patient have a:
  - Known allergy?
    - No
    - Yes
  - Difficult airway or aspiration risk?
    - No
    - Yes, and equipment/assistance available
  - Risk of >500ml blood loss (7ml/kg in children)?
    - No
    - Yes, and two IVs/central access and fluids planned

Before skin incision
(with nurse, anaesthetist and surgeon)

- Confirm all team members have introduced themselves by name and role.
- Confirm the patient’s name, procedure, and where the incision will be made.
- Has antibiotic prophylaxis been given within the last 60 minutes?
  - Yes
  - Not applicable

Anticipated Critical Events

To Surgeon:
- What are the critical or non-routine steps?
- How long will the case take?
- What is the anticipated blood loss?

To Anaesthetist:
- Are there any patient-specific concerns?

To Nursing Team:
- Has sterility (including indicator results) been confirmed?
- Are there equipment issues or any concerns?

Is essential imaging displayed?
- Yes
- Not applicable

Before patient leaves operating room
(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- The name of the procedure
- Completion of instrument, sponge and needle counts
- Specimen labelling (read specimen labels aloud, including patient name)
- Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

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APPENDIX 7: CONSCIOUS SEDATION COMPETENCY AND DUTIES TRAINING OF PERSONNEL AND GENERAL CONSIDERATIONS

**Physician:**

1. Individuals responsible for patients receiving sedation/analgesia should understand the pharmacology of the agents that are administered, as well as the role of pharmacological antagonists for opioids and benzodiazepines.

2. Individuals monitoring patients receiving sedation/analgesia should be able to recognize the associated complications.

3. At least one individual capable of establishing a patent airway and positive pressure ventilation, as well as a means for summoning additional assistance, should be present whenever sedation/analgesia is administered.

4. It is recommended that an individual with advanced life-support skills be immediately available.

5. Hence, physician intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended.

   5.1. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue patients who enter a state of Deep Sedation/Analgesia.

   5.2. While those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of general anaesthesia.

**Nursing Staff:**

The following are the criteria for providing conscious sedation:

1. Qualified Nurses are responsible for monitoring and assisting treating physician for patients receiving sedation/analgesia.

2. Qualified Nurses caring for the patient receiving sedation/analgesia should have no other responsibilities that would leave the patient unattended or compromise continuous monitoring of the patient from the administration of medication through the recovery process.

3. Responsibility cannot be delegated to a Non-Staff Nurse.
4. Nurses should have experience in areas such as, surgery, critical care, emergency, orthopaedic, and Pediatric Nursing.

5. Should be trained in:

5.1. BLS.
5.2. Insertion of IV lines.
5.3. Assessment and monitoring patients under sedation.
5.4. Pain assessment and management.
5.5. Understand the pharmacology of the agents that are administered, as well as the role of pharmacological antagonists for opioids and benzodiazepines.

General Considerations:

1. The provision of sedation/analgesia (conscious sedation) is an interdependent role, requiring a physician's order prior to implementation.

2. Appropriate pre-procedure evaluation of patients' histories, physical findings and laboratory evaluation reduces the risk of adverse outcomes and leads to improved patient satisfaction.

3. The individuals providing such care should have proven competency prior to administering conscious sedation.

4. The individuals providing such care should be also knowledgeable about use of reversal agents.

5. The provider should also have current BLS knowledge.

6. Sedation/analgesia can be administered only in designated areas meeting all criteria in the protocol.

7. The appropriate choice of agents and techniques for sedation /analgesia is dependent on the experience and preference of the individual physicians, requirements or constraints imposed by the patient or procedure, and the likelihood of producing unintended loss of consciousness.

8. Excessive sedation/analgesia may result in cardiac or respiratory depression that must be rapidly recognized and appropriately managed to avoid the risk of hypoxic brain damage, cardiac arrest, or death.

9. Conversely, inadequate sedation/analgesia may result in undue patient discomfort or patient injury because of lack of cooperation or adverse physiologic response to stress.
APPENDIX 8: MODERATE SEDATION/ANALGESIA

**Locations Designated For Moderate Sedation/Analgesia**

Moderate Sedation should be administered only in designated areas that meeting all criteria in the protocol.

This area must have specific structures, which include:

1. Pre-determined exclusion criteria for patients who are not candidates for Moderate sedation
2. A written protocol to ensure continuous monitoring of patients throughout the procedure, as well as the recovery phase.
3. Instructions for medication administration to include drugs, drug routes, and amounts recommended for administration.
4. Written guidelines for managing potential complications or emergencies.
5. Availability of Oxygen:
   5.1. There should be a reliable source of oxygen adequate for the length of the procedure and a backup supply.
      5.1.1. Prior to administering any anesthetic, the physician should consider the capabilities, limitations and accessibility of both the primary and backup oxygen sources.
      5.1.2. Oxygen piped from a central source is strongly encouraged.
      5.1.3. The backup system should include the equivalent of at least a full E cylinder.
6. Availability of emergency equipment
   6.1. Appropriate emergency equipment for maintaining the patient's airway, Respiratory status and cardiac status will be readily available when sedation medications are given to the patient.
   6.2. Equipment should be suitable for the size and age of the patient.
   6.3. The following equipment is essential, but not limited to:
      6.3.1. Emergency cart with defibrillator (immediately accessible) Suction at bedside
      6.3.2. Oxygen and oxygen delivery devices (cannula, mask)
      6.3.3. Appropriate oral and nasal airways (pediatric and adult as appropriate)
      6.3.4. Continuous noninvasive BP monitoring device
      6.3.5. Cardiac monitor
6.3.6. Pulse oxymeter
6.3.7. Ambu bag
6.3.8. Intubation tray

7. Availability of emergency medication:
   7.1. Adequate anesthesia drugs and supplies for the intended care.
   7.2. Pharmacological antagonists (Naloxone and Flumazenil).
   7.3. IV supplies

**General Considerations for Moderate Sedation/Analgesia**

1. The provision of moderate sedation/analgesia is an interdependent role, requiring a physician's order prior to implementation.
2. Appropriate pre-procedure evaluation of patients' histories, physical findings and laboratory evaluation reduces the risk of adverse outcomes and leads to improved patient satisfaction.
3. The individuals providing such care shall have proven competency prior to administering conscious sedation.
4. The individuals providing such care should be also knowledgeable about use of reversal agents.
5. The provider must also have current BLS knowledge.
6. Sedation/analgesia can be administered only in designated areas meeting all criteria in the protocol.
7. The appropriate choice of agents and techniques for sedation/analgesia is dependent on the experience and preference of the individual physicians, requirements or constraints imposed by the patient or procedure, and the likelihood of producing unintended loss of consciousness.
8. Excessive sedation/analgesia may result in cardiac or respiratory depression and should be rapidly recognized and appropriately managed to avoid the risk of hypoxic brain damage, cardiac arrest, or death.
9. In order to avoid excessive levels of sedation, drugs should be titrated in increments rather than administered in larger doses according to predetermined notions of efficacy.
10. Continuous infusions (propofol) are superior to intermittent bolus dosing because they produce less fluctuation in drug concentration, thus reducing the number of episodes of inadequate or excessive sedation and contributing to prompter recovery.
11. Conversely, inadequate sedation/analgesia may result in undue patient discomfort or patient injury because of lack of cooperation or adverse physiologic response to stress.
12. The ideal sedation technique involves the administration of either individual drugs or combinations of analgesic, amnesic and hypnotic drugs.

13. The drug(s) selected should allow rapid and complete recovery with a minimal incidence of nausea and vomiting or residual cardio-respiratory depression.

14. Causes of Patient Agitation During Moderate Sedation/Analgesia:
   14.1. Increased patient agitation may be a result of pain or anxiety.
      14.1.1. Pain may be treated with systemic analgesics, regional techniques, or removal of the painful stimulus.
      14.1.2. Anxiety may be treated with reassurance and/or a Benzodiazepine.
   14.2. Life threatening factors
      14.2.1. Hypoxemia
      14.2.2. Hypoventilation
      14.2.3. Impending local Anaesthetics toxicity
      14.2.4. Cerebral hypo-perfusion
   14.3. Less ominous but often overlooked factors
      14.3.1. Distended bladder
      14.3.2. Hypothermia or hyperthermia
      14.3.3. Pruritus, Nausea
      14.3.4. Positional discomfort
      14.3.5. Uncomfortable oxygen masks or nasal Cannula
      14.3.6. Intravenous cannulation site infiltration
      14.3.7. Member of surgical team leaning on patient
      14.3.8. Prolonged pneumatic tourniquet inflation

15. Patient's Outcome after Sedation/Analgesia:
   Surgeries performed under Sedation/Analgesia may offer many advantages over procedures done under general or regional Anesthesia such as:
   15.1. Preservation of protective reflex
   15.2. Decreased post-operative pain
   15.3. Decreased post-operative nausea and vomiting
   15.4. Reduced cardiovascular and respiratory side effect
   15.5. Invoke less physiological disturbances, the factor which is more advantageous in older
and critically ill patient

15.6. Prevention of endotracheal intubation risks such as dental damage, sore throat or vocal cords injury etc.

15.7. Allow faster recovery, shorter stay in PACU and faster discharge from hospital

16. Quality Assurance for Moderate Sedation/Analgesia:

16.1. The fundamental concept underlying modern Moderate Sedation is that the care delivered to the patient should be of high quality.

16.2. All concerned staff should become involved in clinical audit activities as this yields benefits for all concerned. The audit activities include:

16.2.1. The satisfaction of the patient and the family.

16.2.2. Patient’s complaints: Peri-, intra- and post-operatively:
   a. Pain.
   b. Nausea and vomiting.
   c. Amnesia.
   d. Headache, dizziness,
   e. Fainting attacks or tiredness.
   f. Loss of appetite, etc.

17. Monitoring During the Moderate Sedation/Analgesia

17.1. Level of Consciousness:

17.1.1. It is important that a qualified staff continually evaluate the patient’s response to verbal stimulation in order to titrate the level of sedation and to allow the early detection of neurological or cardiopulmonary dysfunction.

17.1.2. The response of patients to commands during procedures performed with sedation/analgesia serves as a guide to their level of consciousness.

17.1.3. Spoken responses also provide an indication that the patients are breathing.

17.1.4. Patients, whose only response is reflex withdrawal from painful stimuli are likely to be deeply sedated, approaching a state of general anesthesia, and should be treated accordingly.

17.1.5. Monitoring of patient response to verbal commands should be routine, except in patients who are unable to respond appropriately (e.g., young children, mentally
impaired or uncooperative patients) or during procedures in which facial movement could be detrimental.

17.1.6. During procedures in which a verbal response is not possible (e.g., oral surgery, upper endoscopies), the ability to give a "thumbs up" or other indication of consciousness in response to verbal or tactile (light tap) stimulation suggests that the patient will be able to control his airway and take deep breaths if necessary.

17.2. Pulmonary Ventilation:
Monitoring of Respiratory function reduces the risk of adverse outcomes associated with sedation/analgesia. Ventilatory function should be continually monitored by:

17.2.1. Visual, Tactile and Auditory Assessment
   a. Rate, depth and pattern of breathing.
   b. Pallor, Shivering, Cyanosis.
   c. In circumstances where patients are physically separated from the caregiver, automated apnea monitoring (by detection of exhaled carbon dioxide or other modality) may decrease risks.

17.2.2. Auscultation: Heart and breath sounds (pre-cordial stethoscope)

17.3. Oxygenation:
The early detection of hypoxemia using Oximetry during sedation/analgesia decreases the likelihood of adverse outcomes, such as cardiac arrest and death.

17.3.1. All patients undergoing sedation/analgesia should be monitored by pulse Oximetry with appropriate alarms. If available, the variable pitch "beep," which gives a continuous audible indication of the oxygen saturation reading, may be helpful.

17.3.2. The nurse will inform the physician of change in patient condition or drop in SaO2 below 92%, or the other parameter.

17.3.3. If hypoxemia is anticipated or develops during sedation/analgesia, supplemental oxygen should be administered and titrate the oxygen.

17.3.4. Capnography (most effective in intubated patients but can be adapted (side-stream) in non-intubated patients.

17.4. Hemodynamic:
Sedative/analgesic agents may blunt the appropriate autonomic compensation for hypovolemia and procedure-related stresses. Early detection of changes in patients’ heart rate and blood pressure may enable physicians to detect problems and intervene in a timely fashion, reducing the risk of cardiovascular collapse.

17.4.1. Continuous Electrocardiograph monitoring should be used in patients with hypertension, significant cardiovascular disease as well as during procedures where dysrhythmias are anticipated.

17.4.2. Blood pressure should be determined before sedation/analgesia is initiated.

17.4.3. Palpation of the arterial pulse,

17.4.4. Peripheral perfusion based on temperature of extremities and capillary refill

17.4.5. Once sedation/analgesia is established, blood pressure should be measured at regular intervals during the procedure, as well as during the recovery period (at least every 5 minutes).

17.4.6. Routine blood pressure monitoring with the sedation of children often causes unnecessary stimulation of the patient resulting in awakening. For this reason, blood pressures are taken pre and post procedure and at intervals based on patient needs and clinician judgment.

17.5. Temperature: especially in:

17.5.1. Elderly patients.

17.5.2. Prolonged procedures.

17.5.3. Cold operating rooms.

17.6. Availability of a Staff Person Dedicated Solely to Patient Monitoring and Safety

17.6.1. The presence of a vigilant anaesthetist is the single most important monitor in the operating room.

17.6.2. Monitoring techniques and devices enhances the effectiveness of this vigilance.

17.6.3. A designated individual, other than the physician performing the procedure, should be present to monitor the patient throughout procedures performed with sedation/analgesia. This individual should not leave the procedure room while the procedure is being performed.
**APPENDIX 9: ALDRETH’S SCORING SYSTEM FOR RECOVERY & DISCHARGE FROM THE RECOVERY ROOM**

According to the evaluation and documentation the criteria for **Activity**, **Breathing**, **Circulation**, **Consciousness**, **SaO2**

<table>
<thead>
<tr>
<th>Discharge Criteria</th>
<th>Discharge Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
<td></td>
</tr>
<tr>
<td>Moving all four limbs spontaneously or on command</td>
<td>2</td>
</tr>
<tr>
<td>Moving two limbs spontaneously or on command</td>
<td>1</td>
</tr>
<tr>
<td>No movement of limbs neither spontaneously nor on command</td>
<td>0</td>
</tr>
<tr>
<td><strong>Breathing</strong></td>
<td></td>
</tr>
<tr>
<td>Able to breathe deeply, and coughing adequately</td>
<td>2</td>
</tr>
<tr>
<td>Dyspnea or shortness of breath</td>
<td>1</td>
</tr>
<tr>
<td>Apnea</td>
<td>0</td>
</tr>
<tr>
<td><strong>Circulation</strong></td>
<td></td>
</tr>
<tr>
<td>BP is ± 20% of the pre-operative initial value</td>
<td>2</td>
</tr>
<tr>
<td>BP is ± 20 to 50% of the pre-operative initial value</td>
<td>1</td>
</tr>
<tr>
<td>BP is &gt; ± 50% of the pre-operative initial value</td>
<td>0</td>
</tr>
<tr>
<td><strong>Consciousness</strong></td>
<td></td>
</tr>
<tr>
<td>Fully conscious</td>
<td>2</td>
</tr>
<tr>
<td>Responding to verbal commands</td>
<td>1</td>
</tr>
<tr>
<td>Not responding</td>
<td>0</td>
</tr>
<tr>
<td><strong>SaO2</strong></td>
<td></td>
</tr>
<tr>
<td>Able to maintain SaO2 &gt; 92% on room air</td>
<td>2</td>
</tr>
<tr>
<td>Needs oxygen therapy to maintain SaO2 &gt; 90</td>
<td>1</td>
</tr>
<tr>
<td>SaO2 &lt; 90% despite oxygen therapy</td>
<td>0</td>
</tr>
</tbody>
</table>

| Total Score                                              |                 |

1. All patients should be assessed and scored on admission, in individual intervals and before discharge from the recovery area.
2. Values should be documented in the anaesthesia chart.
3. The scoring includes five futures:
4. Activity, Breathing, Circulation, Consciousness and SaO2
5. Each feature will be scored with 0, 1 or 2 point, so that the maximum numbers of points will be 10 and the least is 0 point.
6. The patient should be discharged from the recovery area only if the total score ≥ nine or alternatively, at the pre-sedation baseline.
**APPENDIX 10: CRITERIA FOR HOME-READINESS**

Evaluation and documentation the criteria for Vital Signs, Ambulation, Nausea and Vomiting, Pain, Surgical Bleeding.

Post-Anaesthesia Recovery Score for Discharge Home (PARSDH)

<table>
<thead>
<tr>
<th>Discharge Criteria</th>
<th>Discharge Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vital Signs</strong></td>
<td></td>
</tr>
<tr>
<td>Vital signs + 20% of pre-operative value</td>
<td>2</td>
</tr>
<tr>
<td>Vital signs + 20 – 40% of pre-operative value</td>
<td>1</td>
</tr>
<tr>
<td>Vital signs + 40% of pre-operative value</td>
<td>0</td>
</tr>
<tr>
<td><strong>Ambulation</strong></td>
<td></td>
</tr>
<tr>
<td>Steady gait and no dizziness</td>
<td>2</td>
</tr>
<tr>
<td>With assistance</td>
<td>1</td>
</tr>
<tr>
<td>None / dizziness</td>
<td>0</td>
</tr>
<tr>
<td><strong>Nausea &amp; Vomiting</strong></td>
<td></td>
</tr>
<tr>
<td>No or minimal</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td></td>
</tr>
<tr>
<td>No or minimal</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td><strong>Surgical Bleeding</strong></td>
<td></td>
</tr>
<tr>
<td>No or minimal</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Score (Discharge Home)</strong></td>
<td></td>
</tr>
</tbody>
</table>
1. All patients those going to be discharged home should be assessed and scored on the “criteria to go home” after fulfilling the Aldrete’s recovery & discharge criteria.

2. Values should be documented in the sedation chart.

3. The scoring includes five futures Vital Signs, Ambulation, Nausea and Vomiting, Pain and Surgical Bleeding.

4. Each feature will be scored with 0, 1 or 2 point, so that the maximum numbers of points will be 10 and the least is 0 point.

5. The patient is ready for discharge home only if the totals score \( \geq 9 \).

6. Make sure that the patient have responsible escort for transport and at home.

7. Driving and operating machinery should not be attempted for 24 hour.
### APPENDIX 11: MINIMUM EMERGENCY MEDICATION (CLASS A, B and CM)

<table>
<thead>
<tr>
<th>No.</th>
<th>Drug Name</th>
<th>Quantity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Inj. Adrenaline 1:1000</td>
<td>5</td>
<td>Anaphylaxis or acute angio-oedema</td>
</tr>
<tr>
<td>2.</td>
<td>Inj. Atropine 600mcg</td>
<td>10</td>
<td>Bradycardia, Organophosphate and Carbamate overdose</td>
</tr>
<tr>
<td>3.</td>
<td>Adenosine 3mg /ml 2ml inj.</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>4.</td>
<td>Inj. Diazepam 10mg/2ml</td>
<td>2</td>
<td>Status epilepticus</td>
</tr>
<tr>
<td>5.</td>
<td>Rectal Diazepam</td>
<td>2</td>
<td>For children with Status epilepticus</td>
</tr>
<tr>
<td>6.</td>
<td>Inj. Amiodarone 50mg/Ml</td>
<td>2</td>
<td>Tachyarrhythmia, cardiac arrest</td>
</tr>
<tr>
<td>7.</td>
<td>Inj. Dextrose 50%, 50ml</td>
<td>2</td>
<td>Hypoglycaemia</td>
</tr>
<tr>
<td>8.</td>
<td>Inj. Furosemide 20mg/2ml</td>
<td>3</td>
<td>Relief of pulmonary oedema</td>
</tr>
<tr>
<td>9.</td>
<td>Inj. Hydrocortisone 100mg/2ml</td>
<td>3</td>
<td>Acute asthma attack and post anaphylaxis</td>
</tr>
<tr>
<td>10.</td>
<td>Inj. Dopamine 200mg/5ml</td>
<td>2</td>
<td>Hypovolaemic shock cardiogenic shock, CHF</td>
</tr>
<tr>
<td>11.</td>
<td>Inj. Dobutamine 250mg</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>12.</td>
<td>IV Fluids such as Ringer Lactate, Dextrose Water, Dextrose Saline, Normal Saline.</td>
<td>5 each</td>
<td>For hypovolemia</td>
</tr>
<tr>
<td>13.</td>
<td>Water for injection</td>
<td>1 Box</td>
<td>To mix hydrocortisone inj, etc.</td>
</tr>
<tr>
<td>14.</td>
<td>EpiPen Jr. (for child less than 30 kilograms)</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>15.</td>
<td>Epinephrine (Auto-Injectors)</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>16.</td>
<td>Normal Saline 10 ml</td>
<td>10</td>
<td>For flushing after Adenosine etc.</td>
</tr>
</tbody>
</table>
**APPENDIX 12: MINIMUM EMERGENCY MEDICATION (CLASS C)**

Include CLASS A, B and CM Drugs and the following:

<table>
<thead>
<tr>
<th>No.</th>
<th>Drug Name</th>
<th>Strength</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>XYLOCARD (LIDOCAINE) (BOLUS)</td>
<td>2%(100mg/5 ml)</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>2.</td>
<td>ROCURONIUM BROMIDE</td>
<td>50mg/5ml Vial</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>3.</td>
<td>1/5 Dextrose/ Saline 250ML Inj.</td>
<td>1/5 Strength</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>4.</td>
<td>1/5 Dextrose/ Saline 500ML Inj.</td>
<td>1/5 Strength</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>5.</td>
<td>Adenosine 2ML Inj.</td>
<td>3MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>6.</td>
<td>Adrenaline 1ML Inj.</td>
<td>1: 1000</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>7.</td>
<td>Amiodarone 3ML Inj.</td>
<td>50MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>8.</td>
<td>Atropine 1ML Inj.</td>
<td>0.6MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>9.</td>
<td>Calcium Chloride 10ML Inj.</td>
<td>10%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>10.</td>
<td>CISATRACURIUM</td>
<td>20mg/10ml (2mg/1ml)</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>11.</td>
<td>Compound Sodium Lactate FULL STRENGTH</td>
<td>Full Strength</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>12.</td>
<td>Dextrose 50% 50ML Inj.</td>
<td>0.5GM/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>13.</td>
<td>Dextrose 500ML Inj.</td>
<td>5%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>14.</td>
<td>DIAZEPAM (RECTAL SOLUTION)</td>
<td>5MG</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>15.</td>
<td>Diazepam 2ML Inj.</td>
<td>5MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>16.</td>
<td>DOBUTAMINE HYDROCHLORIDE</td>
<td>250 mg</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>17.</td>
<td>Dopamine 5ML Inj.</td>
<td>40MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>18.</td>
<td>FLUMAZENIL (ANEXATE)</td>
<td>0.5mg/5ml</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>19.</td>
<td>Frusemide 2ML Inj.</td>
<td>10MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>20.</td>
<td>Gelofusine 500ML Inj.</td>
<td>4%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>21.</td>
<td>K-Y Jelly</td>
<td>-</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>22.</td>
<td>Lignocaine 5ML Inj.</td>
<td>10MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>23.</td>
<td>Magnesium Sulfate 10ML Inj.</td>
<td>50%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>24.</td>
<td>MIDAZOLAM (DORMICUM)</td>
<td>15mg/3ml</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>No.</td>
<td>Drug Name</td>
<td>Concentration</td>
<td>Stock Information</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------</td>
<td>---------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>25</td>
<td>Naloxone HCI 1ML Inj.</td>
<td>0.4MG/ML</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>26</td>
<td>NORADRENALINE</td>
<td>4mg/4ml</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>27</td>
<td>PROPOFOL 1%</td>
<td>200mg (10mg/ml)</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>28</td>
<td>Sodium Bicarbonate 50ML Inj.</td>
<td>8.40%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>29</td>
<td>Sodium Chloride 10ML Inj</td>
<td>0.90%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>30</td>
<td>Sodium Chloride 1L Inj.</td>
<td>0.90%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>31</td>
<td>Sodium Chloride 500ML Inj.</td>
<td>0.90%</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>32</td>
<td>SUXAMETHONIUM (SUCCINYLCHODLINE)</td>
<td>100mg (50mg/ml)</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>33</td>
<td>VASOPRESSIN</td>
<td>20iu/ml</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
<tr>
<td>34</td>
<td>XYLOCAINE JELLY</td>
<td>0.02</td>
<td>Stock as per scope of services and patient need and volume</td>
</tr>
</tbody>
</table>
### APPENDIX 13: HEALTHCARE PROFESSIONAL VACCINATION AND IMMUNISATION REQUIREMENTS

<table>
<thead>
<tr>
<th>Mandatory Vaccination:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B:</strong></td>
</tr>
<tr>
<td>If previously unvaccinated, give 3 doses series of Hepatitis B vaccine to all non-immune employees upon hiring.</td>
</tr>
<tr>
<td>Hepatitis B Antibody will be checked after the vaccination is completed.</td>
</tr>
<tr>
<td>If the level is &lt; 10 international units, a second 3 doses series will be given. If the repeat Hepatitis B Antibody is still &lt;10 international units, then the employee will be labelled as non-responder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Varicella Vaccine:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check evidence of immunity to varicella.</td>
</tr>
<tr>
<td>Offer/provide Varicella vaccine to all non-immune employees.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommended vaccines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Influenza vaccine annually to all clinical healthcare workers, before the influenza season.</td>
</tr>
<tr>
<td>Recommend Pneumonia vaccination at age 65 (one-time vaccine).</td>
</tr>
<tr>
<td>Recommend Tetanus booster (once every 10 years).</td>
</tr>
</tbody>
</table>