Sultanate of Oman

Ministry of Health

Directorate General of Private Health Establishments

Operational and Process Standards for Private Health Providers

2016

DGPHE/HES/1.0

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Operational and Process Standards for Private Healthcare Providers

This is the first set of Operational and Process Standards, against which providers will be audited in the year 2016. In successive years these Standards will be extended and added to, to ensure the Annual Audit process applied by the Directorate of Private Health Establishments mirrors the Accreditation requirements of major International accreditation bodies (Joint Commission International etc.)

The first set of standards aims to establish foundation Patient Safety and Organizational Management requirements which are fundamental to ensuring safe patient care within the private health provider organizations in the Sultanate of Oman. The Patient Safety Standards address the highest operational risks associated with patient care.

Smaller institutions such as Polyclinics and Medical Centers may not have enough resources to establish all the infrastructural tools, such as committee structure, however they must put suitable arrangements in place to meet the intent of the Standard.

For all Standards and requirements, institutions must have a system for checking that those are being met, and documentary proof of this must be maintained in the institution for Inspection purposes.

Institutions must produce their own Policies and Procedures, with reference to the authorities and research cited in the document e.g. GCC policy on Infection Control, MOH Policy on Medical Records, etc.

Patient Safety Standards

1. Each Institution must have a written policy to ensure correct identification of patients. This must include two methods of identification, not including room number or location. For instance Patient number, wristband, invoice etc.
2. All patients must be formally identified before any treatment, procedure or medication administration.
3. Each institution must have a written Communication policy to govern communication of Patient information including verbal and telephonic communication. Verbal orders should be avoided if at all possible, and if there is a resident doctor in the institution and if it is possible, treating doctor should utilize their services, rather than communicate directly with nurse.
4. There must be a written process for communication of critical results including parameters for urgent communication.
5. There must be a clear process for handover communication, involving standard tools and methods.
6. There must be a written Policy covering High Alert medications, including a written list of these medications. The list will include medications that are regularly involved in errors, such as insulin, heparin, concentrated electrolytes or chemotherapeutics, medications whose names, packaging, or clinical use look alike and /or sound alike. The institution must have a list of all

medications in use which pose a significant risk to patients. The written Policy must include the strategies employed to ensure the safety of high alert medications.

7. There must be a written policy covering correct site, correct procedure and correct patient surgery. The process is standardized for all surgical users and includes at least marking of surgical site, perioperative patient identification and “time out”: informed consent confirmed, independent verification of patient identity and all relevant documentation and technologies are present and functional.
8. There is a checklist or other process document maintained within the patient record to confirm “time out” etc. As a minimum standard WHO Surgical Safety Checklist, must be used.
9. The institution has a written Infection Control policy covering all areas of the organization and all staff including at least:
    - Identification of a suitably qualified and experienced individual who oversees infection prevention and control activities
    - Infection control activities are present in the orientation and practice of all employees and contractors
    - The provision of adequate resources for all infection control activities is maintained at all times
    - Hand hygiene is given prominence
    - Safe clinical waste disposal
    - Food hygiene
    - Engineering and mechanical controls
    - Family and other care givers are given Infection Control instruction
    - There must be an Infection Control Committee which represents all staff in the institution and receives and reviews all Infection Control data.
10. A policy exists to reduce patient harm from falls. This will include at least a risk assessment requirement for each inpatient, moving and handling training for all staff and assessment of risks present in the building.
11. Patients must be protected for all forms of abuse. This includes physical harm, avoidable emotional distress and financial abuse and so on. The institution must have Policies and Procedures to protect patients from all of these which will include:
    - How access to patient areas in controlled and physical surveillance
    - Training for staff on how to recognize distress and intervene appropriately
    - How patients can complain if they are unhappy with their treatment or care
    - Clear explanation of all charges and alternatives prior to service provision etc.

Management Standards

12. There is a written organizational structure for the institution, clearly outlining key responsibility levels. This is freely available to staff and patients.
13. There is a written document specifying the scope of the institution's services: “who does what and where”.
14. Each care provider has an individual scope of practice authorized by the Management of the Institution. This will include procedures and services they are authorized to provide and parameters for further referral.
15. A Medical record with unique patient number must be held for all patients treated. The preference of the MOH is for an electronic record. A process exists for Auditing completeness of Medical Records at least once every three months this will include:
    - Legibility
    - Patient identity check, use of unique patient number and that all personal information is complete (date of birth, sex, contact details etc.)
    - Full medical history and relevant physical measurements
    - Presenting complaint and full symptoms
    - Provisional diagnosis and reasons for tests or procedures ordered
    - Completion of Notifications to MOH of required forms, e.g. Infectious Diseases etc.
    - If sick leave or attendants leave forms have been issued is it justified by care management
    - Care management plan
    - Reason for referral/follow up
    - Clear record of instructions given to patient
    - Verification of use of only approved abbreviations
    - Discharge summary for all inpatients and complex outpatients.
16. Governance structures are clearly laid out in bylaws, policies and procedures or similar documents.
17. There is clear management and supervision of all clinical and non- clinical departments and all patient support programmes are clearly multi- disciplinary and patient focused. For instance Housekeeping and Engineering support departments liaise continuously with nursing and care givers to ensure patient requirements are main emphasis. A committee structure exists to demonstrate this and each department is represented on this. If the size of the institution supports it, and whenever there is Inpatient care provided there must be at least a:
    - Senior Management Committee
    - Infection Control Committee
    - Theatre Users Committee (if appropriate)
    - Human Resources Committee or Staff Committee
    - Patient Safety/Risk/Quality Committee. All committees must receive and review appropriate data and develop improvement plans to address the issues.
    - Critical Care/CPR/Code Blue Committee

18. Staff safety and well- being are ensured by Managers. This will include:
    - Provision of adequate Personal Protective Equipment (PPE) - aprons, gloves, goggles etc.
    - Adherence to MOH uniform policy
    - A staff health programme including vaccination, inoculation, review of absence data and any trends etc.
    - Staff Injury policy
    - Staff Rights Policy, including protection of staff abuse/bullying, guaranteeing their statutory human rights.
19. Senior leaders ensure all staff and contractors are appropriately qualified and licensed (if necessary) to carry out their duties and understand their role in ensuring patient safety.
20. The Leadership receives and review data on key patient safety issues as appropriate to their operation, for instance a hospital will require more data collection than an Ambulatory Care facility and acts on this. This should include at least:
    - Care and referral waiting list/extended length of stay
    - Infection rates
    - Returns to theatre
    - Returns to intensive care
    - Unexpected readmission within 28 days of discharge
    - Patients leaving against medical advice
    - Pressure sores
    - Unexpected deaths
    - C-section rate
    - Medication usage.
21. There is a documented Quality Improvement and Patient Safety programme, including but not limited to review all of Patient Safety measures by suitably qualified individual or group. This will include at least:
    - System for gathering and review of all patient safety data and information
    - Annual review and updating of plan
    - Trending of data over time and benchmarking process if possible
    - The method employed by the organization for investigating complaints, incidents and near misses.
22. There is a Fire Safety Programme which includes at least requirements for:
    - Staff training
    - Identification of specific risks in relation to premises
    - Measures to reduce risk- fire exits, firefighting equipment, smoking policy, kitchen and laundry safety etc.
    - How fire and fire regulations will be communicated to staff and patients
    - Evacuation plan with clear identification of fire alert procedures and means of escape.
23. There is a written plan for dealing with all major internal disasters such as:
    - Loss of utilities- electricity, water, gas
    - Building damage- loss of patient area, loss of kitchen, or laundry etc.

    this clearly sets out how patients will be protected from any risks, and how services will be maintained.

24. There is an Incident/Exception/Significant event reporting system covering at least:
    - Any breach of policy or unexpected occurrence which did or could have resulted in patient harm
    - Any activation of any special process e.g. fire alert, security breach, Code Blue etc.

    There is clear evidence that these occurrences are reported to Senior Leaders and appropriate investigation and review of adequacy of response/ Corrective action (if appropriate) has been taken.
25. All significant business interruption or patient safety related events must be notified to DGPHE within 2 working days. This would include for instance:
    - Fire
    - Closure of any service
    - Security incidents
    - Unexpected patient deaths
    - Change of senior managers
    - Staff injuries- including needle stick

26. There is evidence of Management Review Meetings at least twice per year which cover:
    - Effectiveness of Quality Management System
    - Exposure of irregularities or defects in system
    - Identification of opportunities for improvement
    - Review of key complaints and corrective actions
    - Evaluation of Key Performance Indicators and trend analysis
    - Review of Incident Reports and corrective action
    - Effectiveness and accuracy of assessment systems
    - Changes required to practice, technology etc.
    - Review of any audits carried out by outside organisations e.g. DGPHE
    - Review of available resources and suitability to meet scope of practice
    - Review of Scope of Practice
    - Confirmation of all statistical returns required by the MOH have been submitted.

Appendix 1 List of Minimum Policy and Evidence Documentation

Institutions may have more than one document covering these key areas

1. Patient Identification policy
2. Communication policy, including instructions on verbal orders, critical results and handover processes.
3. Policy on High Alert medications
4. Correct Site, Correct Procedure, Correct Patient policy.
5. "Time Out" Policy in Theatres and record documentation.
6. Infection Control Policy
7. Policy to reduce patient harm from falls and risk assessment documentation
8. Patient protection from all forms of abuse Policy
9. Organisational structure showing named individuals with responsibility for all patient safety areas
10. Institution's scope of Services offered
11. Policy on individual departmental and individual clinician's scope of practice
12. Medical Record policy and audit documentation evidence
13. Governance Policy and evidence of practice review
14. Committee Structure and minutes for last year
15. Organisation Health and Safety policy
16. Contracts with any outside provider, e.g. laundry, housekeeping, catering, waste disposal, etc.
17. Policy on key performance indicators and evidence that leaders are reviewing services and outcomes, e.g. length of stay, infection rates, returns to theatre, returns to ICU?HDU, readmissions, unexpected deaths or extended length of stay, LAMA's, pressure sores, medication usage, etc.
18. Policy on Quality Improvement and Patient safety programme and evidence of effective implementation
19. Fire safety policy and evidence of "testing"
20. Internal Disaster policy, and evidence of "testing".
21. Incident reporting Policy and evidence of follow-up by leaders.
22. Evidence that any notifiable occurrences to DGPHE have been made
23. Evidence of Management review meetings, issues discussed, and any corrective/improvement actions taken.