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المديرية العامة لمستشفى خولة
Directorate General of Khoula Hospital

Quality Management & Patient Safety Directorate

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Content

Acronyms

DGKH	Directorate General of Khoula Hospital
MoH	Ministry of Health
DG	Director General
PSFHI	Patient Safety Friendly Hospital Initiative
OHAS	Oman Healthcare Accreditation System
PMTC	Primary Medical Technical Committee
M&M	Mortality & Morbidity
QM&PSD	Quality Management and Patient Safety Directorate
QSED	Quality Service Evaluation Department
KPIs	Key Performance Indicators
RCA	Root Cause Analysis
FMEA	Failure Mode and Effects Analysis
CGC	Clinical Governance Committee
HR	Human Resources
BLS	Basic Life Support
ACLS	Advanced Cardio-vascular Life Support
NRP	Neonatal Resuscitation Program
IPC	Infection Prevention & Control
LASA	Look Alike- Sound Alike
SSI	Surgical Site Infection
ICU	Intensive Care Unit
HCWs	Health Care Workers
VTE	Venous Thromboembolism
CSSD	Central Sterile Services Department
ToR	Term of Reference
SOPs	Standard Operating Procedures

1.Definitions

1.1 Corporate Governance: Structures and processes for directing, managing and controlling hospital operations and procedures.

1.2 Clinical Governance: A systematic approach to maintaining and improving the quality of patient care within a health system through clear accountability, leadership, measurement, and improvement.

1.3 Leadership System: The network of roles and committees overseeing strategy, clinical performance and risk.

1.4 Incident: Any event or circumstance that could have or did lead to unintended harm.

1.5 Risk: The effect of uncertainty on objectives, measured by consequence × likelihood.

1.6 Credentialing/Privileging: Verification of qualifications and authorization of specific clinical activities.

Guideline for Leadership and Clinical Governance

Chapter One

2.Introduction

Effective leadership and robust clinical governance are essential foundations for delivering safe, high-quality, and patient-centered healthcare. This Guideline of DGKH outlines the framework through which the organization ensures accountability, transparency, and continuous improvement across all clinical and non-clinical services. It defines the structures, roles, and processes that guide decision-making, support clinical excellence, and foster a culture of safety throughout the hospital

This Guideline establishes a structured and transparent framework for leadership and clinical governance at the Directorate General of Khoula Hospital.

3.Purpose

The purposes of this guideline are to:

3.1 Establish a structured and comprehensive leadership and clinical governance system that ensures the delivery of safe, effective, patient-centered, timely, efficient, and equitable care.

3.2 Ensure compliance with national and international standards of care and embed a culture of transparency, continuous quality improvement, and risk management across the Directorate.

3.3 Oversee measurable clinical outcomes and operational performance.

4.Scope

This guideline applies to:

4.1 Director General.

4.2 Assistant Directors General.

4.3 Directors at the Directorate General.

4.4 Heads of Departments.

4.5 Medical, nursing, allied health leaders.

4.6 Quality Management & Patient Safety Directorate.

4.7 All clinical and non-clinical Directorates and Departments.

4.8 All committees and task forces.

4.9 All employees and contracted service providers.

Chapter Two

5.Structure

It is the guideline of DGKH which operates an integrated corporate and clinical governance framework that defines authority, responsibilities, and accountability at all levels incorporating:

- Clear delegation and supervision lines of accountability through an approved organizational structure.
- Commitment to patient safety through standardized risk, incident, audit, and improvement processes.
- Integration of governance functions (leadership, quality, risk assessments, ethics, KPIs and audits).
- Patient and family partnership in design, delivery, and evaluation.
- Workforce competency, credentialing, and professional conduct controls.
- Evidence-based decision-making, continuous monitoring of clinical outcomes, research ethics, regulatory compliance, and continuous learning.
- Transparent disclosure of adverse events.
- Empowerment of staff to report safety concerns and adoption of just culture principles.

5.1 Leadership and Governance Principles:

a.Clear leadership roles and responsibilities.

b. Establishment of a clear organizational governance structure for decision-making and oversight.

c. Leadership commitment to patient safety and quality of care is a strategic priority.

d. Formation of a clinical governance and patient safety committee at hospital level.

e. Appointment of a patient safety officer with defined authority and responsibilities.

f. Development of multidisciplinary committees to oversee patient safety programs, clinical quality audits, and legislative regulations and health documents implementation.

g. Senior leadership conducts regular patient safety walk-rounds and monitors performance indicators.

h. The patient experience department oversees and evaluates overall patient experience and promotes patient-centered care.

i. Promotion of transparency and non-punitive reporting of adverse events and near misses.

j. Annual celebration of World Patient Safety Day and Hand Hygiene Day to strengthen organizational culture.

5.2 Clinical Governance Framework:

a. Clinical effectiveness & evidence-based practice.

b. Risk management & patient safety.

c. Workforce & professional standards.

d. Information management.

e. Quality improvement & audit.

f. Patient & public involvement.

g. Infection prevention & control.

h. Training and professional development.

5.3 Clinical Governance Programs:

a. Implementation of a structured patient safety program with KPIs.

b. Establishment of departmental Morbidity & Mortality (M&M).

c. Regular Morbidity & Mortality (M&M) meetings are conducted bimonthly.

d. Quarterly clinical audits and risk assessments with documented follow-up actions.

e. Publication of quarterly safety reports to leadership and relevant stakeholders.

f. Medical Ethics Committee oversight.

5.4 Organogram & Diagram:

Refer to appendix 1 for approved DGKH organizational structure and clinical governance diagram.

5.5 Clinical Governance Leadership Structure & Accountability: (Refer to appendix 2)

5.6 Core Governance Committees: (Refer to appendix 3)

5.7 Core Governance Processes:

a.Risk Management:

i.Risk Identification:

- Proactive (leadership walk rounds, quality, departmental, service and hospital audits)
- Reactive (incidents/complaints).

ii. Risk Register:

- Risk register should be maintained at hospital level

iii. Escalation:

- Red or high risks should be escalated to Clinical Governance Committee (CGC) within 48 hours.
- Extreme or critical risks should be escalated to DG within 24 hours.

iv. Review:

- Monthly department reviews.
- CGC review each meeting.
- Closure upon verified control effectiveness.

b. Incident, Complaint & Claim Management:

i.Reporting: 24/7 via electronic portal (AMAN system).

ii. Severity: harm level (no harm /minor/moderate/severe/catastrophic), specialty, and safety domain to be identified.

iii. Primary Medical Technical Committee: investigates complaints and communicates quality-improvement recommendations to QMPSD.

iv. Investigation:

- No/minor harm: Concise review within 5 working days.
- Moderate/severe/catastrophic: RCA within 30 calendar days; immediate containment actions must be documented.

v. Family Communication: Initial disclosure within 24 hours for moderate or harm; documented in alignment with the national policy for Medical Disclosure.

vi. Learning: Safety alerts, debriefs, RCA, audits of implementation.

vii. Complaints: Acknowledgement within two working days to PMTC and Patient experience; response within 20 working days; trend analysis conducted quarterly.

c. Morbidity & Mortality (M&M) Review:

- Standardized case selection criteria; structured presentation template, and actions logged.
- Governance-level themes reported to CGC; serious-case learnings fed to guideline.
- Bi-monthly hospital and departmental committees meeting should be maintained.

d. Clinical Audit & Guidelines:

i. An annual audit plan is led by Quality Service Evaluation Department (QSED). It covers high-risk pathways, clinical services, outlier KPIs, previous incidents, and policy adherence.

ii. Method: Define standards, select samples, and establish criteria, Utilize data tools, conduct re-audits.

iii. Guideline lifecycle:

- Development of a document
- Reviewing of a document
- Approval of a document
- Dissemination of a document
- Periodic review every three years, or earlier if evidence changes, a major incident occurs, or regulations are updated.

e. Credentialing & Privileging:

- All verification of qualifications, licenses, and experience align with MOH medical law and promotion standards.
- Procedure-specific privileges with volume and competency thresholds are defined by the HoD and direct supervisors.
- Periodic re-credentialing and staffing reviews are conducted every 1–2 years; proctoring or mentoring for new or high-risk privileges is based on service needs as highlighted by the HoD.

f. Workforce Capability, Education & Competency:

- Mandatory training matrix (BLS/ACLS/PALS/NRP, IPC, medication safety, radiation safety, safeguarding, documentation, patient safety orientation, new staff orientation, national policies etc.).
- Annual competency validation is required for high-risk tasks (e.g., mass-casualty trauma, blood administration, and trauma management).

g. Medication & Therapeutics:

- Formulary oversight, high-alert medication controls, LASA medications, medication incident review, pharmacy & therapeutics reporting.
- Approval of requests for new medications.

h. Infection Prevention & Control:

- Surveillance, trending, and mitigation of healthcare-associated infections; outbreak management; audits of hand hygiene, environmental cleaning, and antibiotic prophylaxis; antimicrobial stewardship; and isolation practices.

i. Operational Theatre Governance:

- Oversees efficient utilization and distribution of operating theatres across the Directorate.
- Monitors surgical waiting lists.
- Ensures procedure/surgical safety: WHO checklist compliance ≥95%; peri-op indicators (SSI, returns to theatre, unplanned ICU).
- Maintain implant & device traceability.
- Ensure operational governance through policies.
- Interventional radiology safety.

j. Information Governance & Digital Safety:

- Patient data protection and access control, clinical documentation standards, downtime procedures, clinical decision support governance, data quality assurance.
- Availability of digital system for safe patient care and effective digital infrastructure version control for digital documentation.
- Downtime safe management.

k. Patient Satisfaction & Family Engagement:

- The Patient Experience Department oversees the overall patient experience, monitors patient surveys (inpatients and outpatients), supports co-produced improvement projects, ensures accessibility, and conducts complaint analysis.

l. Research & Ethics:

- Ethical approval prior to patient involvement; safety monitoring; conflicts of interest declarations; alignment with national research governance, mentoring and building up culture of research activity.

m. Safeguarding & Vulnerable Groups:

- Child protection, maternity & neonatal, white code for staff wellness, mental health, disability; clear referral pathways and mandatory reporting timelines.

n. Creating Culture of Safety:

- Promote culture of transparency and ownership.
- Conduct biannual hospital operational planning and achievement reviews with active involvement of all HCWs.
- Promote transparency and non-punitive reporting of adverse events and near misses (AMAN system).
- Conduct quarterly reports on summary of reported incidents, lessons learned and action plan and disseminate the findings through lectures, hospital official email (Barwa system) and screen saver throughout the Directorate.
- Celebrate World Patient Safety Day and Hand Hygiene Day annually to strengthen organizational culture.
- Attend departmental mortality and morbidity meetings and actively participate in discussion, recommendations, and follow-up actions. Conduct regular PMTC meetings with reflective learning and quality-improvement actions.
- Conduct regular training workshops and individual department's sessions for HCW.

o. Key Processes Ensuring Patient Safety:

- Incident reporting within 48 hours; RCA initiated within 7 days and completed within 30 calendar days.
- Sentinel events are reported immediately to the Director General and Director of Quality Management and Patient Safety.

- Credentialing & Clinical Privileging as per MOH as well as DGKH rules and regulations.
- Clinical Audit & Quality Improvement — annual plan aligned to risks.
- Policy& Procedure and Guideline review every three years or earlier if needed.
- Monitoring of Hospital Key Performance Indicators and individualized clinical outcome based on KPI.

p. Data, Reporting & Escalation:

- Monthly and weekly CGC dashboard.
- Sentinel and Red flag events escalated within 24 h.

q. Education & Training:

- Mandatory training for all clinical staff.
- Annual training compliance target ≥ 80%.
- Competency assessments for high-risk roles e.g. ACLS, NRP, Fire Safety, Disaster and evacuation drills.
- Annual training plan based on need assessment.

r. Continuous Improvement and sustainability:

- Data-driven monitoring of patient safety indicators.
- Benchmarking against national and international standards.
- Development of quality improvement plans based on root-cause analyses and trend reviews.
- Centralized system for document control, approval, review, and updates.
- Incident command structure, mass casualty & disease outbreak plans, drills, after-action reviews, critical supplier risk, and redundancy for vital equipment.

s. Performance Assurance Framework (refer to appendix 4)

- Hospital and Departmental KPIs.
- Standardized mortality statistics, unplanned readmissions less than or equal 7/30 days, serious incidents per 1,000 episodes, hand hygiene compliance, device-associated infection rates, surgical site infections, medication reconciliation within 24 h, VTE risk assessment coverage, surgical checklist compliance, staff safety training completion, documentation completeness, discharge summary within 48h.
- Assurance Rounds: Executive/CGC safety walk rounds (monthly rotating areas).

- Internal and external monitoring when feasible e.g. CSSD and infection control.
- Disaster readiness reviews and mock tracers (semi-annual).

t. Escalation & Decision-Making:

- Immediate Escalation Triggers: Sentinel events, cluster outbreaks, IT/downtime affecting patient safety, building/utility failure and security threats.
- Escalation Timeframes: immediate notification to the administrator-on-call; DG within two hours for sentinel events; CGC at the next sitting with a preliminary report within 72 hours. Sentinel events and red flag events escalated within 24 hours.

u. Documentation & Records Management:

- Standard templates (meeting minutes, TOR, RCA, audit reports, SOPs).
- Controlled documents as per National Guideline for Document Development

v. Training & Communication:

- Onboarding module for all new staff; annual refreshers; policy summary posters; intranet site with quick links; hospital screen saver messages; and a quarterly safety newsletter.

w. Monitoring, Evaluation & Document Review:

- Regular audit should be performed to ensure compliance; results are reported to CGC, and improvement actions are tracked.
- Document reviews every Three years or after a major incident or regulatory change.
- Monthly and weekly CGC dashboards monitor governance performance indicators.

Chapter Three

6.Responsibilities

6.1 Director General Shall:

6.1.1 Adhere to this guideline.

6.2 Assistant DG for paramedical affairs/ Assistant DG for Medical Affairs/ Assistant DG of Admin & Finance Shall:

6.2.1 Adhere to this guideline.

6.3 Directors/HoDs Shall:

6.3.1 Adhere to this guideline

6.4 Clinical Committees Shall:

6.4.1 Adhere to this guideline

6.5 Quality management and Patient Safety Directorate Shall:

6.5.1 Adhere to this guideline.

6.5.2 All Health Care Workers Shall:

6.5.3 Adhere to this guideline.

Chapter Four

7.Document History and Version Control Table

Version	Description	Name of authors	Review Date
1	Initial Release	Dr. Salima AL Aisari	2029
2	Second Version		

8.Attached Documents

8.1 Oman Healthcare Accreditation System (OHAS) Standards.

8.2 MOH Medical Law and Promotion Standards.

8.3 Patient Safety Friendly Hospital Initiative (PSFHI) Framework.

8.4 National Incident Reporting Policy.

8.5 National Open Disclosure Policy.

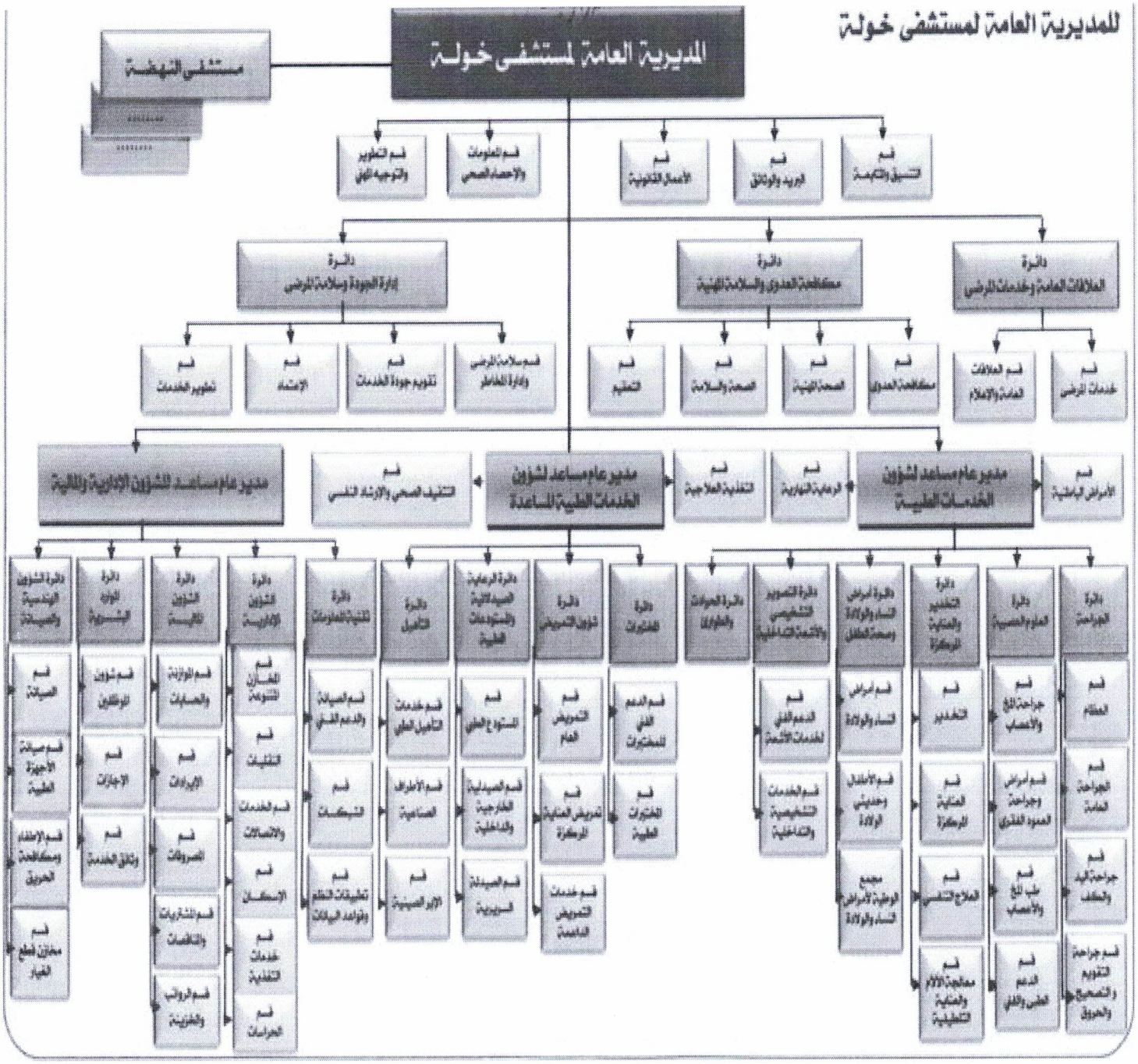
8.6 DGKH Organizational Structure.

8.7 National Clinical Risk Management Guideline.

8.8 Infection Prevention and Control Policy.

9. Annexes:

9.1 Appendix (1): DGKH Organizational Structure and Clinical Governance Diagram



9.2 Appendix (2): Clinical Governance Leadership Structure & Accountability

Designation	Key Role & Responsibility	Reports to
Director General	• Overall accountable leader ensuring strategic direction and resource allocation. • Endorses governance structure, ensures accountability, and resource support. • Approving clinical governance strategy & policy • Ensure operational and resource alignment • Final approval of high-risk recommendations (M&M, safety, Sentinel incident reviews) • Represent hospital leadership nationally/internationally	Undersecretary of Medical affairs / MOH
Deputy DG – Clinical Services (Chair of Clinical Governance Board)	• Clinical governance owner leading clinical standards and overseeing clinical divisions. • Clinical performance, safety, service improvement • Implement governance systems within respective domains. • Lead Clinical Governance committee & sign off improvement plans • Oversee implementation of clinical policies & care standards • Ensure HoDs implement governance KPIs • Leads mortality/morbidity decision actions	Director General
Deputy DG – Administrative & Financial Affairs	• Resource governance, risk financing, operational sustainability • Allocate budget to support governance actions • Ensure staff planning, resource adequacy • Sign-off infrastructure & equipment approvals • Oversee financial and administrative risk reporting	Director General
Deputy DG for Paramedical Services	• Allied health performance, therapy outcomes, support efficiencies	Director General

	• Governance of labs, pharmacy, rehab services • Ensure non-physician clinical teams engage in CG • Monitor allied health KPIs	
Deputy DG for Administration & Finance	• Prioritize budget allocations across the Directorate. • Enforce policy document control, contracts, operational readiness • Ensure availability of contracts for improvement projects • Support governance legal needs • Manage communications & policy issuance	Director General
Director of Quality & Patient Safety Directorate	• Leads accreditation and quality improvement oversight of clinical quality, manages risk registers and reporting, audit, adverse event review and credentialing. • Lead CG policy deployment • Maintain improvement dashboards • Coordinates all governance committees, monitors compliance, and reports leadership.	Director General
Director – Nursing Affairs	• Nursing governance and standards, safe staffing, nursing incident review. • Workforce competency, direct patient care risk • Set nursing safety KPIs • Manage nursing training & competency • Enforce clinical documentation standards	Assistant DG for paramedical affairs
Director of Infection Control	• Lead the hospital-wide Infection Prevention and Control program. • Develop and implement the annual IPC strategic plan. • Ensure alignment with national and international regulations. • Provide expert advice during outbreaks and public health emergencies. • Oversee occupational health and safety related to infection risk. • Supervise staff immunization programs. • Have authority to enforce IPC policies across the hospital	Assistant DG for Medical Affairs
Directors of	• Shared Governance Duties	

Labs, Pharmacy, Rehabilitation, Imaging	• Ensure safe & evidence-based diagnostic/therapeutic workflows • Report quality indicators to CG Board • Lead specialty-based risk reduction • Follow MOH competency-based staff planning	
Director of Financial Affairs	• Financial risk management for critical care, safety investments • Contracts management and approval • Finance-driven governance KPIs	Assistant DG of Admin & Finance
Director of Human Resources	• Leadership succession, competency planning • Develop staff governance employment process • Embed governance duties into job planning	
Director of Information Technology	• Digital governance, data safety, and incident tracking. • Oversees digital services across the Directorate. • Implements clinical governance dashboards. • Supports digital incident and complaints tracking.	Assistant DG for paramedical affairs
Director of Engineering & Maintenance	• Facility safety and related risk management • Facility and Equipment maintenance • Provide supportive services to clinical governance. • Infrastructure risk management	Assistant DG for paramedical affairs
Director of Public Relations and patient Services	• Leads and oversees public relations and patient services. • Ensures efficient operation of patient reception and guidance services. • Supports proper management of patient inquiries and service facilities. • Supports vulnerable groups. • Coordinates external communication. • Participates in events management.	

Department Heads	• Implement pathways and governance at service level. • Ensure competencies, maintain departmental risk registers, audits, and departmental M&M committees. • Ensure guideline adherence and staff training. • Implement evidence-based practice and report KPIs monthly. • Ensure implementation of departmental policies, SOPs, and performance indicators aligned with hospital governance.	Assistant DG for medical affairs
Disaster management officer	• Leads the Hospital wide environmental and Disaster Risk Governance Framework • Ensure Identification, assessment and mitigation of location specific environmental risks • Maintains enterprise risk registry and manages enterprise disasters. • Align disaster preparedness with national civil defense regulations.	Assistant DG for medical affairs
Clinical Committees	All governance committees shall integrate with the hospital strategic goals and the patient safety framework.	QMPS

9.3 Appendix (3):Core Governance Committees

The following committees form the backbone of the clinical governance architecture at DGKH:

Committee	Core Functions
Surgical & Medical Governance Committee (Chaired by DG or Delegate)	• Reviews clinical outcomes and mortality/morbidity trends • Oversees policy approval • Reviews high-risk incidents and sentinel events
Quality & Patient Safety Committee	• KPI review and risk register oversight • Accreditation readiness monitoring • RCA oversight and clinical auditing
Disclosure Committee	• Reviews sentinel events • Oversees patient and family disclosure • Ensures documentation and transparency
Mortality & Morbidity Committee	• Structured case reviews with system-based analysis • Learning dissemination • Bi-monthly hospital and departmental meetings
OT & Surgical Oversight Committee	• Electronic waiting list review • Surgical KPIs, cancellation and defaulter rates • Complication tracking, implant and device traceability
Emergency Department Operational Committee	• ED KPIs: door-to-doctor time, length of stay, left-without-being-seen rate • Escalation triggers and capacity planning

9.4 Appendix (4): Performance Assurance Framework

The following key performance indicators are mentioned across the Directorate

Indicator	Frequency	Threshold / Target
Standardized Mortality Ratio	Monthly	Trending down; benchmark national average
Unplanned Readmissions (7- and 30-day)	Monthly	≤ national benchmark
Serious Incidents per 1,000 Episodes	Monthly	Continuous reduction
Hand Hygiene Compliance	Monthly	≥ 90%
Device-Associated Infection Rates (CLABSI, CAUTI)	Monthly	Zero tolerance target
Surgical Site Infection Rate	Monthly	≤ 2% (elective surgery)
WHO Surgical Safety Checklist Compliance	Monthly	≥ 95%
Medication Reconciliation within 24 Hours	Monthly	≥ 95%
VTE Risk Assessment Coverage	Monthly	≥ 95% of inpatients
Staff Safety Training Completion	Quarterly	≥ 80%
Discharge Summary within 48 Hours	Monthly	≥ 90%
Documentation Completeness	Monthly	≥ 95%