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ACCREDITATION

Definition

It is the process by which an organization or an agency performs an external review and grants recognition to the program of study, or institution that needs certain pre-determined standards.

The review process and the standards to be met are devised and regulated by professional organizations.

The overall methodology and process, and the requisite modalities are depicted in the two models, on the following pages.

ACCREDITATION PROCESS

The accreditation process consists of two steps:

- Desktop review of the application
- Sight visit (of the care facility)

Desktop review

The applicant organization submits **evidence of compliance with accreditation standards**, which is reviewed by the accreditation reviewer (the desktop review).

In case the accreditation reviewer is in need of additional information, or substantiation, the applicant organization is so notified and the needed information is submitted.

Onsite Visit

Following that, an onsite visit is scheduled.

The accreditation review process, normally takes four to six months, depending on the type of accreditation and the number of standards that are to be met.

Reaccreditation

The applicant organization seeking reaccreditation submits a complete documentation, which for all practical purposes is the same as for the first time application. It is advisable that the application for reaccreditation should be submitted sufficiently ahead of the time of sight visit.

In cases where the **accreditation body does not grant accreditation**, or for that matter the reaccreditation, the accreditation **reviewer is supposed to identify** clearly the **deficiencies** or the **shortcomings** as they pertain to the **standards to be achieved**. Following that, the applicant organization is supposed to submit evidence of achievements, changes, improvements, or refinements so that the accreditation reviewer may consider those and give the final decision on accreditation.

Award of Accreditation Certificate

On critical review of all the information and based on the sight visit, the **review team** is to ensure that it is **satisfied** with regard to the **standards to be met**. Once the standards have been met, the award of accreditation certificate is issued by the designated agency.

Duration of Accreditation

Accreditation certificate is generally awarded for **two years**. However, the **accredited organizations** must **continue to remain in compliance with** the applicable **standards** throughout the accreditation cycle.

It is important to note that the **accreditation** status may be **rescinded** if an accredited **organization** is **unable to comply** with the agreed **standards**.

OVERVIEW OF ACCREDITATION SYSTEM

The process for accreditation has been discussed briefly, above. However, it is important to recognize that accreditation programs are developed by expert committees with representation from the following:

- **Employers**
- **Consumers**
- **Providers**
- **Regulators**
- **Experts in related fields**

Perspectives

Based on the general information that is available, the following perspectives need to be ensured:

- Healthcare provision standards
- Health network standards
- Health plan standards
- Health utilization management standards
- Employees compensation standards

SCOPE OF SERVICES

For accreditation review process, the following are covered:

Mission statement of the organization

This is viewed to ensure that the organization implements clearly defined plan designating the scope of services.

Personnel

- Overall staffing requirements to provide the services.
- Educational and licencial requirements.
- Administrative and clinical functions developed and followed within the organization.
- Mechanisms to ensure that the staff is optimally knowledgeable.

Operations/ Process

- Activities that the organization undertakes to ensure high quality services.
- Organization's core business processes and procedures.
- Updating of procedures and their consistent implementation.

Quality Improvement

- Organization's quality improvement program (Continuous Quality Improvement/ Total Quality Management).
- Coordination within the entire organization to ensure TQM/ CQI).

Delegation of Responsibilities

The overall pattern of delegation of responsibilities within the organization and the needed mechanisms to monitor the achievements or outcomes.

Confidentiality

Specification of confidentiality requirements and the mechanisms to achieve those.

Grievances and Complaints

Institutionalized mechanisms to ensure that grievances and complaints of the following are received, registered and resolved:

- Patients
- Employers
- Employees

The policies and procedures regarding grievances and complaints must be clearly stated and followed.

STANDARDS

The following nine standards are considered extremely important. For each of these operational meanings, or interpretation has been provided. For additional information, or substantiation the Chairman, Accreditation Committee may be communicated.

- **Organizational structure**
(must be functional)
- **Processes**
(must be streamlined and outcome oriented)
- **Integrity of data**
(the data must be reliable, valid, from the right source, and in the right format)
- **Confidentiality**
(confidentiality requirements must be specified and followed clearly)
- **Personnel**
(the number of personnel needed, along with qualifications and experience must be specified; and their continuing medical education/ continuing professional development must be ensured)
- **Communications**
(means and mechanisms to ensure harmonious vertical and horizontal communication should be instituted and remain functional)
- **Quality improvement**
(the emphasis should be on Total Quality Management and Continuous Quality Improvement)
- **Subcontracting**
(any services that are to be subcontracted must be specified clearly and should be provided in conforming to the requisite standards)
- **Onsite review**
(the review process must be aimed at identifying and resolving shortcomings)

While the above enumerated standards account for the complete process, the following three broad categories and, underneath each, specific standards need to be established and assured.

Patient-Focused Standards

- Patient rights and organization ethics
- Assessment of patients
- Care of patients
- Education of patients and families
- Continuity of care

Organization

- Improving organization performance
- Leadership
- Management of the environment of care
- Management of human resources
- Management of information
- Surveillance prevention, and control of infection

Structures

- Governance
- Management
- Medical Staff
- Nurses

Additional detailed item under each are available in the literature and need to be examined critically for devising standards

ACCREDITATION STATUS

The levels of accreditation decision can fall in one of these categories.

- **Excellent**

This is the highest accreditation status and it is granted only to those care plans/facilities that demonstrate level of service and clinical quality that meets or exceeds the requirement set by National Committee for Quality Assurance (NCQA). The major aspect for excellence relates to consumer protection and quality improvement.

- **Commendable**

This designation is equivalent to NCQA's former full accreditation's designation. This level is awarded to care plans/ facilities that demonstrate the level of service and clinical quality that meets the NCQA requirements.

- **Accredited**

It is accredited to those care plans/facilities that meet most of the NCQA's basic requirement for consumer protection and quality improvement. This status is generally granted for one year.

- **Provisional**

It indicates that a health care plan's/facility's service and clinical quality meet some, but not all of NCQA's basic requirements for consumer protection and quality improvement.

- **Denied**

It is an indication that the health care plan/facility did not meet NCQA's requirements during its review.

- **Suspended**

It relates to a situation where circumstances have reasons to cause NCQA to withdraw accreditation. This status stays still such time that NCQA conducts a thorough investigation, and the care plan/facility completes the corrective actions recommended by the reviewers.

- **Under Review**

It represents a situation in which an initial accreditation determination has been made, but is under review at the request of the care plan/facility.

- **NCQA Discretionary Review**

It denotes those care plans/facilities which have been chosen by the NCQA to review in order to assess the appropriateness of an existing accreditation decision.

GENERAL ACCREDITATION STANDARDS

Specific administrative and medical aspects of the Criteria for Accreditation are specified in later sections. This section details some other pertinent requirements which, if not properly ensured, are highly likely to affect the functionality of care facilities adversely and, therefore, the quality and utility.

1. Access

A health care provision facility is supposed to be designed and located at a geographical location for which the infrastructure related to transportation is optimally available. This is needed for administrators, care providers and the patients. While all hospitals in Kuwait have excellent access from roads, the access within the facilities also needs to be ensured. In this respect the following are needed:

- The physical access to each of the following should be available without any hindrance, obstacle, or restriction.
 - Main Door of the hospital
 - Main Door to the OPD
 - Parking facilities
 - Emergency Rooms

Note: In a number of hospitals, cars are parked in such a way that if a Fire Engine were to need access to the main gate of the hospital, it will be hindered seriously. This is because cars are parked on either side of the access road when, in fact, no vehicles should be parked there.

2. Parking

- The Car Parking for the 'Handicapped Persons' should be available nearest to the OPD, should be clearly marked (in Arabic and English) and no vehicles belonging to a normal, functional person should be parked there under any circumstances.
- The Porch in front of the Main Door of Entry should be used only to drop and pick-up patients, and that should not take more than a few minutes.

- Parking spaces for administrators, heads of departments (medical as well as others) should be clearly marked and no unauthorized use of those should be made.

3. **Signs**

- Signs for various facilities (e.g., Director's Office, Main Reception, Medical Records Department, Public Relation Office, X-Rays, Laboratories, Pharmacy(ies), Out Patient Department, Emergency Rooms, etc.) should be clearly marked outside the health care facility building, in Arabic and English.
- Within the building, all Medical Departments, Allied Health Departments, Support Services should be clearly marked in Arabic and English.

4. **Fire and Related Requirements**

Fire extinguishers must be clearly marked and placed at the most appropriate spots and instructions on how to use the fire extinguisher (in Arabic and English) should be placed prominently.

5. **Smoking**

Under no circumstances should the hospital staff smoke within the hospital premises. Administrative staff, in particular, should be the pace setters.

6. **Language Facilitation**

The General Reception of each hospital and the Public Relations Department must have, at all times, at least one person who can converse in English.

7. **Workers Rest Area**

Various Porters, Cleaners and other workers should rest and sit in designated areas only. People sitting in corridors and dozing off do not present a compatible sight with the expected environment of a care provision facility.

8. **Noise**

All hospital staff need to be provided an orientation to converse with each other with a volume of voice which does not generate noise. Calling people with loud voices across the corridors needs to be checked and controlled.

9. **Courtesy**

All administrative staff should be well groomed to be courteous to all patients and their attendants, irrespective of race, religion, language, or other background characteristics.

10. **Telephones**

All telephones should be functional and attended promptly.

Note: It is not uncommon to find that at time telephones ring and the person who is supposed to attend to the incoming call fails to attend. This needs to be checked and rectified.

11. **Telephone Directory**

All Medical, Allied Health and Administrative staff must have the most commonly used telephone numbers available and visibly displayed. Similarly, the telephone numbers of various departments of all hospitals to which the physicians/surgeons may need to refer patients, should be readily available with the Secretaries of departments and Medical Records department.

Note: During our visits we observed that at times a departments' Secretary was not be able to find the telephone number of another department.

12. **Visiting Hours**

- Visiting hours must be enforced strictly. Particular attention needs to be paid to the following:
 - Children should not be allowed in hospitals on days when they are not supposed to visit patients.
 - A patient should not have more than the maximum number of visitors allowed at any given time.

- ICU/CCU should not be considered as a place to which relatives and friends of patients can just walk in at leisure. Standard requirements must be implemented and ensured.

13. Unnecessary Traffic within a Hospital

The accompanying persons with patients, in general, and children in particular, should not be allowed to wander off into hospital areas where they are not supposed to go (e.g., if the patient, and therefore the accompanying person, is to visit Radiology department, or Medical Laboratory, as per the advice of the OPD physician/surgeon, they should go to the facility directly).

14. Waiting Areas

All hospitals have a general idea of the number of patients and therefore the accompanying persons expected on any given day. The hospital administration, in view of the quantum, should ensure sufficient waiting space in the OPD for males and females.

15. Service Numbering System

It is not uncommon to find that a number of patients wait immediately outside the Surgeons'/Physicians' offices and they usually stand and wait. Each hospital should develop and implement a "Service Numbering System" so that only the patient to be served should be called and, therefore, come to a physician's office when he/she is to be seen/served.

16. Appointments and Walk-ins

Each department should ensure that only adequate number of patients are given appointments on a given day. Some margin will always need to be built into the OPD appointments for walk-in patients. The intent is to ensure that OPDs are appropriately organized and managed.

17. OPD Offices

Under no circumstances should the doors of OPD doctors' offices be locked from inside, at any time. This practice is non-compatible with health care provision practices. If the "Service Numbering System" (please refer to item 15) is implemented, the perceived need for locking from inside will become irrelevant and unnecessary.

18. **Scrubbing**

Physicians, Surgeons, and Para-medics who assist, must follow the requisite scrubbing/cleaning practices. Further, under no circumstances should anyone of them indulge in smoking while examining or caring for a patient.

19. **Emergency Rooms (ERs)**

Patients in ERs are to be seen on a “first come-first served” basis. However, the severity of medical condition should always be considered in the provision of ER and this is to be managed by the nurse.

20. **Protocols**

Major protocols in terms of DO’S & DON’TS must be adapted, and where needed should be developed, and posted prominently in OPDs, ERs, ORs, ICUs and CCUs. More importantly, these should be referred to, comprehended, used and followed by all concerned.

21. **Others**

Under no circumstances should trolleys, stretchers, beds or any other piece of furniture be placed in the corridors.

HEALTH INFORMATION ADMINISTRATION ACCREDITATION STANDARDS

Management of Information/Patient-specific Data Medical Record Services

A medical record must be maintained for every individual evaluated or treated in the hospital. In this regard, the following are important.

Only authorized individuals make entries in medical records.

Every medical record entry is dated, its author identified, and when necessary, authenticated.

The medical record contains sufficient information to **identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care** among healthcare providers.

The Content

To facilitate consistency and continuity in patient care, the medical record contains very specific data and information, including:

- a. the patient's name, address, date of birth, and the name of any legally authorized representative;
- b. the legal status of patients receiving mental health services;
- c. emergency care provided to the patient prior to arrival, if any;
- d. the record and findings of the patient's assessments;
- e. conclusions or impressions drawn from the medical history and physical examination;
- f. the diagnosis or diagnostic impression;
- g. the reasons for admission or treatment;
- h. the goals of treatment and the treatment plan;
- i. diagnostic and therapeutic orders, if any;

- j. guidance of informed consent, when required by hospital policy;
- k. all diagnostic and therapeutic procedures and test results;
- l. all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- m. progress notes made by the medical staff;
- n. all reassessments and any revisions of the treatment plan (physical medicine (mental));
- o. clinical observations;
- p. the patient's response to care;
- q. consultation reports;
- r. every medication ordered or prescribed for an inpatient;
- s. every medication dispensed to an ambulatory patient or an inpatient on discharge;
- t. every dose of medication administered and any adverse drug reaction;
- u. all relevant diagnosis established during the course of care;
- v. conclusions at termination of hospitalization;
- w. discharge instructions to the patient and family; and
- x. clinical resumes and discharge summaries, or a final progress note or transfer summary.

A concise clinical resume included in the medical record at discharge provides important information to other care-givers and facilitates continuity of care. For patients discharged to ambulatory (outpatient) care, the clinical resume summarizes previous levels of care.

The discharge summary contains the following information:

- the reason for hospitalization;
- significant findings;

- procedures performed and treatment rendered;
- the patient's condition at discharge; and
- instructions to the patient and family

For normal newborns with uncomplicated deliveries, or for patients hospitalized for less than 48 hours with only minor problems, a progress note may substitute for the clinical resume.

The medical staff defines what problems and interventions may be considered minor. The progress note may be handwritten. It documents the patient's condition at discharge, discharge instructions, and follow-up care required.

All records must document the following appropriately:

- Admitting diagnosis
- Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
- Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.
- Properly executed informed consent forms for procedures and treatments specified by the medical staff.
- All practitioners' orders, nursing notes reports of treatment, medication records, radiology, and laboratory reports, vital signs, and other information necessary to monitor the patient's condition.
- Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.
- Final diagnosis with completion of medical records within 30 days following discharge.

All medical records begin with a **“statistical summary sheet”**, which is sometimes also known as the **“face” or “top” sheet**. This summary sheet contains essential identifying and demographic data about the patient. It includes the patient medical record number and may include a different billing number. Essential to this sheets, upon completion of the care/service, is the:

- a. admitting date and diagnosis;

- b. final principal and secondary diagnoses, including complications and somatic dysfunctions; and
- c. operative and invasive procedures.

NOTE: The use of abbreviations on the face sheet is not acceptable.

When a patient is transferred within the same organization from one level of care to another, and the caregivers change, a transfer summary may be substituted for the clinical resume. A transfer summary briefly describes the patient's condition at time of transfer, and the reason for the transfer. When the caregivers remain the same, a progress note may suffice.

History and Physical Exam Reports

The following are important considerations:

A patient admitted for inpatient care has a medical history and an appropriate physical examination performed by qualified a physician.

Qualified oral and maxillofacial surgeons may perform the medical history and physical examinations, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), if applicable.

The medical staff determines those non-inpatient services (for example, ambulatory surgery), if any, for which a patient must have a medical history taken and appropriate physical examination performed by a qualified physician who has such privileges.

The patient' history and physical examination, nursing assessment, and other screening assessments are completed within 24 hours of admission as an inpatient.

If a history and physical examination have been performed within 30 days before admission, a durable, legible copy of this report may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission.

Before surgery, the patient's physical examination and medical history, any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record.

A physical examination and medical history (are to) be done no more than 7 days before or 48 hours after an admission for each patient by a doctor of medicine or osteopathy or, for patient admitted only for oromaxillofacial surgery, by an oromaxillofacial surgeon who has been granted such privileges by the medical staff in accordance with state law(s).

A complete physical examination shall be performed no more than 7 days before or with 24 hours after admission, and shall be on the chart within 48 hours after admission.

Although the history and physical examination may incorporate the findings from other sources, the attending/primary physician is responsible for the content.

A musculoskeletal examination is required as an integral part of the physical examination performed by orthopedic physicians on their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this exam is contraindicated.

Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

Plan of Care

Care, treatment, and rehabilitation are planned to ensure that they are appropriate to the patient's needs and severity of disease, condition, impairment, or disability.

Settings and services required to meet patient care goals are identified, planned, and provided, if appropriate.

When care is not planned to meet all identified needs, this is documented in the medical record.

Plans of care are developed and documented in the patient's medical record before the operative or other procedure is performed.

Each patient will have a comprehensive, integrated multi-disciplinary plan of care which is developed from the initial patient assessment. This care plan will include, at a minimum, physician and nursing components.

The plan of care is based upon the list of patient problem, needs, and diagnoses.

The plan of care is initiated within the time frames established by the facility and updated whenever there are significant changes in the list of patient problems, needs and diagnosis.

Orders

All records must document all practitioners' orders.

All orders for drugs and biologicals must be in writing, and signed by the practitioner or practitioners responsible for the care of the patient.

Consultation Reports

Except in emergencies, consultations are required on critically ill patients, patients who are poor surgical risks, and those whose diagnoses are difficult or obscure.

Progress Notes

All records must document, as appropriate, findings by clinical and other staff involved in the care of patients.

Reassessments, also known as progress notes, are entered into the clinical record by each discipline providing care to the patient, at the time of observation and at frequencies established within discipline-specific standard(s) of practice.

Progress notes are dated, timed, and signed by the author.

LAB

Informed consent for blood transfusion.

Nursing Documentation

An R.N. assesses each patient who requires nursing care. There is a nursing policy and procedure on the nursing process that is current.

The R.N. assessment results in a listing of patient problems, needs, or nursing diagnosis(es).

The R.N. assessment results in a written plan of care for each patient. The plan addresses physical, emotional, social needs, and education needs of the patient and family.

Radiologic Services

Each request for imaging services shall contain the reason(s) for the examination.

Signed laboratory and X-ray reports of all examinations performed shall be made a part of the patient's hospital record.

All laboratory and X-ray reports of diagnostic studies and therapy performed outside the hospital pertinent to the case and treatment of the patient shall be made part of his/her hospital record.

The radiologist or other practitioner who performs radiology services must sign reports of his/her interpretations.

The official, signed radiologist's report, with signature, must be placed in the patient's chart to remain through the life of the chart.

The hospital must maintain the following for at least five years.

- (i) Copies of reports and printouts.
- (ii) Films, scans, and other image records as appropriate

Dietetic Services

Authorized individuals prescribe or order food and nutritional products in a timely manner.

Operative Reports

The medical record thoroughly documents operative or other procedures and the use of anesthesia.

A preoperative diagnosis is recorded before surgery by the licensed independent practitioner responsible for the patient.

Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis.

The completed operative report is authenticated by the surgeon and filed in the medical record, as soon as possible, after surgery.

When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.

Postoperative documentation records the patient's vital signs and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications; and management of such events.

Post operative documentation records the patient's discharge from the postanesthesia care area by the responsible licensed practitioner or according to discharge criteria.

Compliance with discharge criteria is fully documented in the patient's medical record.

Postoperative documentation records the name of the licensed practitioner responsible for discharge.

There must be a complete history and physical workup in the chart of every patient prior to surgery, except in emergencies. If this has been dictated, but not yet recorded in the patient's chart, there must be a statement to the effect and an admission note in the chart by the practitioner who admitted the patient.

The preoperative assessment of the surgeon is documented. Check the progress note of the surgeon for the history and physical.

An informed consent for surgery shall be part of the patient's chart before surgery is performed. It must be dated, timed, and signed by the patient and the physician informant.

An operative report describing the following must be written, or dictated immediately following surgery and signed by the surgeon:

- reason for procedure
- gross findings
- (techniques) operative procedure
- tissues removed or altered

Anesthesia Records

A preanesthesia assessment is performed for each patient before anesthesia induction.

A preanesthesia evaluation is performed within 48 hours prior to surgery by an individual qualified to administer anesthesia.

An intraoperative anesthesia record is provided.

With respect to inpatients (if day care surgery would be included) a postanesthesia follow-up report is written within 48 hours after surgery by the individual who administers the anesthesia.

A preanesthesia evaluation is documented by an individual qualified to administer anesthesia and is performed within 48 hours prior to the anesthesia event of surgery.

A preanesthesia evaluation summarizes the present physical and emotional status, anesthesia and medical histories, and a risk assessment of the patient. It results in a documented anesthesia plan.

There is an anesthesia event record. This record accurately reflects critical techniques, management and patient responses including condition at the end of the anesthetic.

There is a postanesthesia reassessment.

Physical Medicine and Rehabilitation

Rehabilitation services must be furnished in accordance with a written plan of treatment. Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services, and the orders must be incorporated in the patient's record.

Mental Health

Written order prior to use of restrains or seclusion with clinical justification.

Documentation of order for episodes of restraint monitoring of patients in restraints.

Electroconvulsive therapy, psychosurgery, behavior modification procedures that use painful stimuli, and the use of experimental or unusual drugs require the written informed consent of the patient or appropriate legally responsible person before procedure can be carried out.

Nuclear Medicine

The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures.

The hospital must maintain copies of nuclear medicine reports according to Kuwaiti laws.

The practitioner approved by the medical staff to interpret diagnostic procedures must sign and date the interpretation of these tests.

The official interpretive report, with signature, must be placed in the patient's chart to remain through the life of the chart.

Autopsy Reports, if done in the hospital, should contain the following:

The medical staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The mechanism for documenting permission to perform an autopsy must be defined. There must be a system for notifying the medical staff, and specifically the attending practitioner, when an autopsy is being performed.

An autopsy permit shall be obtained from the legally responsible person of the deceased before performance of an autopsy. Documentation of the hospital's request for permission and the response to that request should be documented in the progress notes.

When an autopsy is performed, the preliminary impression of the cause of death should be added to the medical record within 3 days.

The final autopsy report (including toxicology reports when pertinent) should be completed and on the patient's chart within 60 days unless there are valid delays due to forensic considerations.

If the final diagnosis is not in accord with the autopsy report, disagreement or a correction of the final diagnosis shall be added to the progress report.

Emergency Services

There is a record for each patient presented for emergency services. Specific issues to be addressed include:

- a. onset and duration of entry complaint;

- b. time and method of arrival;
- c. triage status upon arrival;
- d. treatment attempted prior to arrival;
- e. assessment(s), problem list(s), plan(s);
- f. testing results, and treatment rendered;
- g. patient responses to treatment;
- h. further care needs, with plan for same;
- i. time and condition on discharge; and
- j. instructions given to patients.

When emergency, urgent, or immediate care is provided, the time and means of arrival are also documented in the medical record.

The medical record notes when a patient receiving emergency, urgent, or immediate care left against medical advice.

The medical record of a patient receiving emergency, urgent, or immediate care notes the conclusions at termination of treatment, including final disposition, condition at discharge, and instructions for follow-up care.

When authorized by the patient or a legally authorized representative, a copy of the emergency services provided is available to the practitioner or medical organization providing follow-up care.

Ambulatory Care Services

For patients receiving continuing ambulatory care services, the medical record contains a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications.

The list is initiated for each patient by the third visit and maintained thereafter.

Medical Record Completion

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

The author of each entry must be identified and must authenticate his/her entry.

Authentication may include signature, written initials, or computer entry.

Entries may be confirmed by written signatures or initials, by rubber-stamp, or computer “signatures” (or sequence of keys). Any practitioner who uses a rubber-stamp or computer signature to authenticate entries, signs a statement that he/she alone will use it. A stamp or computer signature authorized for one person is not used by anyone else.

All records must have documented completion of medical records within 30 days following discharge, including history and physical, operative report, and final diagnosis.

A system shall be used to ensure the integrity of the authentication and protect the security of all record entries.

Health Record Management

The Ministry of Health determines how long medical record information is retained, based on law and regulation and the information used for patient care, legal, research, and educational purposes.

Medical records must be retained in their original or legally reproduced form for a period of five years.

Medical Record Management

Medical record data and information are managed in a timely manner.

A medical record is considered delinquent when it has not been completed within a specific time following the patient’s discharge. This time period is spelled out in the medical staff’s rules and regulations and cannot exceed 30 days.

The hospital can quickly assemble and have access to all relevant information from components of a patient’s record, when the patient is admitted or is seen for ambulatory or emergency care.

Staffing

The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

The Medical Record staff in each general hospital should be as under:

- **Director**

The person should have a baccalaureate degree (a graduate of Faculty of Allied Health Sciences and Nursing).

- **Assistant Director**

Each general hospital, in order to provide optimal services, should have two Assistant Directors and each of these should have a baccalaureate degree (a graduate of Faculty of Allied Health Sciences and Nursing).

- **Supervisor**

Each general hospital will need a minimum of four supervisors. Of those, the supervisor in charge for Statistics Section should be a graduate of the Faculty of Allied Health Sciences and Nursing. However, the other three supervisors should be graduates of the College of Health Sciences (Associate Degree/Diploma).

- **Clerk**

Each hospital should have 45 to 50 clerks to provide effective services to each of three shifts (24 hour service). The clerks must be high school graduates and must have training in Admission, Discharge, and Transfer. Besides, each clerk should have the basic English comprehension to provide the needed services.

Information Management Planning

The hospital plans and designs information-management processes to meet internal and external information needs.

Internal and external information-management processes are appropriate for the hospital's size and the complexity of its services.

The hospital bases management, staffing, and material resource allocation for information management on the scope and complexity of services provided.

Appropriate clinical and administrative staff participate in assessing the hospital's information needs, and in selecting, integrating, and using information-management technology.

Confidentiality, security, and integrity of data and information are maintained.

The hospital determines appropriate levels of security and confidentiality for data and information based on the laws of the State of Kuwait.

Collection, storage, and retrieval systems are designed to allow timely and easy use of data and information without compromising their security and confidentiality.

Records and information are protected against loss, destruction, tampering, and unauthorized access or use.

Uniform data definitions and methods to capture data are used whenever possible.

Minimum data sets, data definitions, codes, classifications, abbreviations and terminology are standardized whenever possible.

The hospital collects data in a timely, economical, and efficient manner and with the degree of accuracy, completeness, and discrimination necessary for their intended use.

Medical records are reviewed on an ongoing basis for completeness and timeliness of information, and action is taken to improve the quality and timeliness of documentation that impacts patient care.

A representative sample of records is included in the review process.

Decision makers and other appropriate staff members are educated and trained in the principles of information management.

Transmission of data and information is timely and accurate.

The format and methods for disseminating data and information are standardized, whenever possible.

Adequate integration and interpretation capabilities are provided.

Confidentiality and Release of Information

The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records must be released only to authorized individuals, and the facility must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with laws, court orders, or subpoenas.

Records that are legally pending must be kept in a secure file to prevent alteration by physicians or other health care providers.

MEDICAL LABORATORY ACCREDITATION STANDARDS

The fundamental accreditation requirements and therefore criteria related to Medical Laboratory Services are presented below, under specific subjects.

A. Management and Staffing

1. The laboratory has appropriately qualified senior managerial staff e.g. Laboratory Director and Chief Technologist.
2. The laboratory is divided into appropriate units relevant to the nature of the work undertaken.
3. Each unit is directed by an appropriately qualified senior staff member, normally a consultant in the specialty.
4. There are adequate staff with appropriate qualifications and grades, to undertake the work of the laboratory.
5. The management structure of the laboratory is understood by the staff.
6. Staff job descriptions are available.
7. A senior member of the technical staff in each unit is designated, responsible for:
 - a. in service training and continuing education.
 - b. safety.
 - c. quality assurance.
 - d. orders and inventories
8. Adequate arrangements are available to cover absences and leave of senior staff.

B. Staff Training and Continuing Education

1. Staff are adequately qualified or trained to perform the procedures in the unit to which they are assigned.

2. In service training of staff is documented.
3. Continuing education of staff is documented.
4. Staff assigned out of hours duties (afternoons and nights) are adequately trained to perform out of hours procedures without supervision.
5. Adequate back-up from senior staff is available to afternoon and night duty staff, if required.
6. Facilities for staff training and continuing education are available, including:
 - a. textbooks and manuals
 - b. journals
 - c. a room for lectures and seminars
 - d. an internet connection.

C. Staff Facilities

1. There are lockers for the storage of outdoor clothing and other possessions.
2. There are adequate toilet facilities for staff.
3. There is suitable overnight accommodation for staff on night duty, if required.
4. There are staff facilities that are accessible, but separate from the laboratory which include:
 - a. adequate space for the number of staff.
 - b. suitable furnishings.
 - c. basic catering facilities.
 - d. space for storage of laboratory coats during staff break times.

D. General Facilities

1. There is adequate bench space for the number of staff.
2. There is adequate space for the safe use of equipment.
3. There is adequate circulation space.
4. There are adequate handwashing facilities.
5. There is adequate storage space.

E. Lighting, Heating, Air Conditioning and Ventilation

1. There is adequate lighting for test interpretation and for reading and writing.
2. There is adequate air conditioning and heating to maintain a comfortable ambient temperature suitable for staff comfort and satisfactory functioning of equipment.
3. There are an adequate number of power sockets. suitably placed.
4. Ducting for piped gas is safe and properly maintained.
5. Cylinder cases are safely stored and suitably supported.
6. Sink and floor drains are functioning satisfactorily, and piping is maintained. Piping is suitable for corrosives and organic solvents if these are flushed down sinks.

F. Equipment

1. There is a document for each piece of equipment including:
 - a. date of installation
 - b. warranty period
 - c. responsibility for maintenance (e.g., manufacturer, agent, laboratory)

- d. type of maintenance required (e.g., cleaning, defrosting, routine preventive, emergency and time intervals e.g., daily, weekly etc.)
 - e. maintenance contracts, including start and end dates and details (e.g., preventive, emergency only)
2. Each unit has a file containing the maintenance documentation for the instruments in use in that unit.
3. There are documented procedures for the safe operation of all pieces of equipment (see also safety)
4. There are documented procedures for cleaning and decontamination of equipment in the event of spillages of reagents or samples (see also safety).
5. There are materials available for routine cleaning, and for decontamination of equipment in the event of spillage (see also safety).

G. Laboratory Safety

1. There is a laboratory safety manual.
2. The safety manual contains information regarding:
 - a. electrical hazards
 - b. chemical hazards
 - c. compressed and piped gas hazards
 - d. equipment hazards
 - e. microbiological hazards
3. Copies of the safety manual are available to staff.
4. Staff are familiar with, and follow the requirements of the safety manual.
5. Appropriate signs are displayed to indicate the presence of hazards.
6. Fire exits are clearly marked and not blocked or sealed.

7. Suitable fire fighting equipment is available and the equipment is regularly checked.
8. Staff are familiar with the correct use of fire fighting equipment.
9. There are suitable facilities for the storage of inflammable and corrosive substances.
10. Chemical safety hoods are correctly installed and regularly maintained and serviced.
11. Microbiological safety cabinets are correctly installed and regularly maintained tested and serviced.
12. There are instructions for disposal of toxic, inflammable and corrosive chemicals.
13. There are materials available for dealing with spills of toxic, inflammable and corrosive chemicals.
14. There are suitable containers for the disposal of needles, glass slides, cover slips, capillary tubes and other sharps.
15. Infectious and potentially infectious waste (e.g., patient samples) is placed in suitable disposal bags supported to prevent leakage or spillage. Sharp objects are not placed in the bags. The bags are transported in leak proof containers to the site of incineration.
16. There are disinfectants and other materials available for dealing with biohazardous spills.
17. Laboratory accidents are documented, reported to concerned authorities and monitored.

H. Laboratory Records

1. There are satisfactory record keeping systems, either manual or computerized. Computerized systems are now normal practice in modern laboratories.
2. Computer systems are reliable and data is properly stored and backed up.

3. Stored data is protected from hazards such as fire, water and theft.
4. The data storage system ensures patient confidentiality
5. The record keeping system is organized so that it can be used as starting point for audits such as:
 - a. number and types of specimens processed
 - b. results obtained
 - c. turn around time
6. Data is retained for a period of at least two years, to allow year to year comparisons e.g.:
 - a. for epidemiological purposes
 - b. to determine whether based on previous reports, new tests need to be introduced or old tests discontinued

I. Specimen Collection and Handling

1. There are written procedures for the collection of all types of specimen including:
 - a. required specimen containers- anticoagulant, transport medium etc.
 - b. patient preparation - fasting, washing, skin disinfections etc.
 - c. collection techniques.
 - d. acceptable time delay between collection and processing.
 - e. special transport facilities if required - cool box, biohazard container
 - f. special procedures for high risk specimens - hepatitis. HIV etc.
 - g. completion of the request form - including time of collection

- h. procedures for dealing with breakages and spillages during transport.
2. Staff involved in the collection and transport of specimens, including ward staff phlebotomists and porters understand requirements pertaining to them in the procedures.

J. Specimen Receipt and Dispatch

1. Time of arrival of specimens in the laboratory is logged.
2. There are written procedures for dealing with spillages. breakages. soiled containers and forms.
3. Appropriate materials for dealing with spillages and breakages are available including:
 - a. appropriate disinfectant solutions for the type of specimen.
 - b. disposable gloves.
 - c. sharps containers.
 - d. dustpan and brush (suitable to withstand decontamination procedures).
 - e. autoclavable biohazard disposal bags.
4. There are written procedures for dealing with incompletely or incorrectly labelled specimens.
5. There are written procedures for dealing with incompletely or incorrectly labelled request forms.
6. There are written procedures for handling specimens for dispatch to other laboratories (e.g. Hormone laboratory, Chest Hospital Laboratory, Virology Laboratory) including:
 - a. specimens required- anticoagulant, transport medium etc.
 - b. transport conditions- coolbox, biohazard container.
 - c. special procedures for high risk specimens e.g., hepatitis. HIV

K. Specimen Processing

1. Every specimen has a unique laboratory acquisition number.
2. Time and date of receipt of the specimen in the section is logged.
3. There is a set of approved and dated Standard Operating Procedures (SOPs) pertaining to the work carried out in each section, written according to an accepted format. (NCCLS, CPA etc.) These include:
 - a. basic principle of the test.
 - b. reagent requirements.
 - c. consumable requirements.
 - d. equipment requirements.
 - e. specimen requirements.
 - f. safety requirements
 - g. test protocol.
 - h. quality control requirements.
 - i. reporting criteria.
 - j. references
4. The reporting criteria for each test include as appropriate:
 - a. validation data
 - b. reference ranges
 - c. interfering factors and substances
5. There are written procedures for rapid e.g. oral or telephone reporting of urgent results, including:
 - a. results requiring rapid reporting

- b. to whom they should be given.
 - c. by whom they should be given.
 - d. documentation procedures for oral and telephone results.
6. There are written criteria concerning to whom written laboratory reports can be issued.
 7. There are procedures for updating and modifying SOPs including:
 - a. designated time interval between routine reviews.
 - b. review process.
 - c. performance of old and new protocols in parallel.
 - d. signing and dating of new or modified protocols.
 8. Procedures given by equipment and reagent manufacturers may be acceptable if these are followed exactly. Modifications to such procedures should be signed and dated. Modification usually invalidates manufacturers' liability.
 9. Laboratory reports should be subject to regular audit to ensure that reporting criteria are adhered to.

L. Reagents/ Kits, Storage and Inventory

1. There is adequate suitable storage space for reagents and kits.
2. Storage facilities are at the correct temperature.
3. Reagents and kits are used in rotation.
4. There are appropriate facilities for disposal of expired and unused reagents.
5. All storage containers are appropriately labelled, including any known hazards.
6. Records of ordering, receiving, storage. issuing and disposal of reagents and kits are maintained.

7. Procedures for the preparation of reagents made in the unit e.g., solutions, stains, culture media etc., are available including:
 - a. formulation
 - b. method of preparation
 - c. quality control
 - d. expiration period
8. Reagents are labelled with date of preparation and hazard information e.g., toxic, corrosive, inflammable etc.

M. Quality Control

- I. All procedures undertaken in the unit are subject to quality control.
2. Equipment, such as incubators, refrigerators and analytical instruments, is functioning at the correct temperature and this is documented.
3. Quality control materials e.g. calibrants, sera purchased from manufacturers are stored and used according to manufacturers' specifications.
4. Quality control procedures are documented in the standard operating procedures and/or a quality control manual including:
 - a. timing requirement e.g., daily, weekly, each batch etc.
 - b. expected result
 - c. corrective action in the event of quality control failure
5. Results of all internal quality control procedures are documented.
6. Results obtained with external quality control specimens are documented and available.
7. Records are preserved for at least two years to allow comparative analysis.

8. Quality control results are regularly audited.

MEDICAL IMAGING ACCREDITATION STANDARDS

Diagnostic Services must reach a standard which will meet the needs of the patients. Following are some basic concepts which must be considered in order to attain proper accreditation of a Department of Medical Imaging.

Leadership

- The leadership team in a Medical Imaging department consists of the director of diagnostic radiology services, superintendent radiographer, chief radiographer, senior radiographers and Senior radiologists. The roles and functions of all these should be clearly defined and written job descriptions made available to each member of the staff
- The director of Medical Imaging services in cooperation with the leadership team should establish and promulgate the organization's mission, renew and revise it as necessary.

The leadership team has the following functions:

1. Planning services;
2. Directing services;
3. Implementing and coordinating services;
4. Improving services which includes supervision, monitoring, periodic evaluations, setting expectations; maintaining the quality of the organization's management, clinical and continuous professional development of staff; and
5. Establish written, appropriate policies and procedures.

Management of Human Resources

The leadership team of the radiology department identifies its personnel needs and matches these with the clinical experience and professional qualifications of new applicants.

- The department of radiology provides an individual who is new to the department with an orientation of sufficient scope and duration to inform the individual about his/her responsibilities and how to fulfill them within the

department so that the department's mission, policies and procedures are adhered to.

- Continuous professional development (CPD). The department provides for education and training designed to maintain and improve the knowledge and skills of all professional grades of staff members. The training and education needs of the staff members should be continuously assessed by the department and criteria for such training/education should be established. These needs may be based on:
 1. findings from infection control activities;
 2. information from quality assessment and improvement;
 3. individual staff member needs;
 4. findings from department performance appraisals of individuals.
- The orientation, training and education programs run by the department should be evaluated through its quality assessment and improvement activities.
- The net result of orientation, training and education programs should be that each individual in the department is competent, as appropriate to his/her responsibilities.

Radiation Safety, Protection and Quality Control

- In any hospital there should be set policies and procedures to assure effective management, proper performance of equipment, effective communication and quality control in the diagnostic radiology department.
- The policies and procedures regarding proper performance of equipment, quality control and radiation safety and monitoring are developed in cooperation with the director of diagnostic radiology services, superintendent radiographer, radiographers and medical radiation physicists.
- The written policies and procedures are reviewed periodically by a chief medical radiation physicist.

The written policies and procedures on radiation safety may include:

- (i) Monitoring of doses from diagnostic radiology procedures and radiation surveys;

- (ii) Guidelines for protecting personnel and patients from radiation,
- (iii) The monitoring of staff and personnel for exposure to radiation;
- (iv) Monitor performance evaluations of diagnostic equipment;
- (v) Implementation of an effective quality control program designed to minimize patient, personnel and public risks and to maximize the quality of diagnostic information.
- (vi) Guidelines developed in consultation with the infection control committee for the protection of staff, patients and equipment; and
- (vii) orientation and a safety program for all personnel.

Infection control

- Each hospital should develop a hospital wide program for the surveillance, prevention and control of infection. The radiology department should be represented in a hospital infection control committee. The hospital infection control committee should produce and circulate written policies and procedures for infection surveillance, prevention and control for all patient care departments/services.
- There should be written policies and procedures that describe the role and scope of participation of the Medical Imaging department in infection prevention and control activities.
- The department of diagnostic radiology should communicate in writing the role its staff members will have in prevention and control activities. The department should provide the necessary training, facilities, cleaning agents and state the cleaning procedures to be followed.

PHYSICAL THERAPY ACCREDITATION STANDARDS

Definition of Physical Therapy

Physical therapy is an art and a science which contributes to the promotion of health and the prevention of disease through the understanding of physiology, anatomy, pathology and pathokinesiology. It works through the prevention, correction and alleviation of the effects of disease and injury. Its primary goal is to attain and maintain the possible highest level of function. It achieves this goal through:

- Examination and evaluation of patients with impairments, functional limitations, and disability or other health-related conditions in order to determine a diagnosis, prognosis, and intervention
- Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions
- Preventing injury, impairments, functional limitations, and disability, including the promotion and maintenance of fitness, health, and quality of life in all age populations
- Engaging in consultation, education, and research

Terminology Reference:

1. **Physical Therapist** as was refers to all Physical Therapists in the State of Kuwait whether employed within the Ministry of Health or outside the Ministry of Health
2. **Staff** refers to Physical Therapists unless otherwise stated.
3. **Physical Therapy Technician** refers to all Diploma Physical therapists working in the State of Kuwait
4. **Support Staff** refers to other physical therapy department staff who provide services to patients that meet the qualification of their individual positions, for example a nurse working in the physical therapy department.
5. **Patients** are individuals who are the recipients of physical therapy care and direct intervention.
6. **Clients** are individuals who are not necessarily sick or injured but who can benefit from a physical therapist's consultation, professional advice, or

prevention services. Clients also are businesses, school systems, and others to whom physical therapists provide services.

Practice Settings

Physical therapists practice in a broad range of inpatient, outpatient, and community-based settings, including the following, in order of most common setting:

- Hospitals (e.g., critical care, intensive care, acute care, and subacute care settings)
- Outpatient clinics or offices
- Rehabilitation facilities
- Skilled nursing, extended care, or sub acute facilities
- Homes
- Education or research centers
- School and playgrounds (preschool, primary, and secondary)
- Hospices
- Corporate or industrial health centers
- Industrial, workplace, or other occupational environments
- Athletic facilities (collegiate, amateur, and professional)
- Fitness centers and sports training facilities

Scope of Practice

Physical therapy is the care and services provided by or under the direction and supervision of a physical therapist. The American Physical Therapy Association (APTA) emphasizes that an examination, evaluation, or intervention unless provided by a physical therapist or under the direction and supervision of a physical therapist – is not physical therapy, nor should it be represented or reimbursed as such.

Physical Therapists

- Provide services to patients/clients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes.
- In the context of the model of disablement on which this guide is based, impairment is defined as loss or abnormality of physiological, psychological, or anatomical structure or function; functional limitation, as restriction of the ability to perform-at the level of the whole person- a physical action, activity, or task in an efficient, typically expected or competent manner; and disability, as the inability to engage in age-specific, gender-specific, or sex-specific roles in a particular social context and physical environment.
- Interact and practice in collaboration with a variety of professionals, including physicians, dentists, nurses, educators, social workers, occupational therapists, speech-language pathologists, and audiologists. Physical therapists acknowledge the need to educate and inform other professionals, government agencies, third-party payers, and other health care consumers about the cost-efficient and clinically effective services that physical therapists render.
- Provide prevention and wellness services, including screening and health promotion. Physical therapists are involved in wellness initiatives, including health promotion and education, that stimulate the public to engage in healthy behaviors. They provide preventive care that forestalls or prevents functional decline and the need for more intense care. Through timely and appropriate screening, examination, evaluation, and intervention, they frequently reduce or eliminate the need for costlier forms of care, such as surgery, and also may shorten or even eliminate institutional stays.
- Consult, educate, engage in critical inquiry, and administrate.
- Direct and supervise physical therapy services, including support personnel.

Qualifications of a Physical Therapist in the State of Kuwait

All physiotherapists hired to work in the State of Kuwait must have a Bachelor Degree from the University of Kuwait or a Ministry of Health Approved equivalent Degree from another University. All Physical therapists must have, also, completed a period of practical instruction under qualified supervision. Physical therapists may also obtain clinical specialist certification through a recognized Board of Physical Therapy Agents.

Responsibilities of Physical Therapist

All physical therapists must obey the law of the State of Kuwait governing the practicing of physical therapy in public or private sectors. Their responsibilities to patient / client include:

1. Examination, evaluation, diagnosis* (problem list), prognosis intervention and outcomes.
2. Documentation of the course of physical therapy action, decision, consultation, goals and plan of treatment.
3. Consult with other health professionals and in reasonable manner with patient, family, agencies to provide great benefit for the patient.
4. Engage in education of patient, family and the public in general about the role of physical therapy in prevention of disease and injuries including screening and health promotion.
5. Engage in critical inquiry, administration, budget planning, recruitment of staff and maintaining the clinical standard for clinical practice.
6. Provide safe, effective, efficient and cost effective physical therapy services to the patient.
7. Maintain an up-to-date level of clinical knowledge and record of continuing education and successful clinical practice.

*(*Diagnosis is a fundamental process in today's physical therapy. However, it may not be allowed in some countries such as Kuwait. Therefore, diagnosis can be replaced by identification of problem list, a practice which currently takes place in the State of Kuwait. Please refer to Appendix 1 for more details on elements of patient management criteria leading to optimal outcomes.)*

STANDARDS

Standards pertaining to specific areas are discussed below:

Standards for Referral Process

In order to treat a patient, a physiotherapist must receive a written referral from a practicing physician registered in the State of Kuwait. The referral must include the following information from the physician:

1. Personal information about the patient
2. Medical diagnosis or impression
3. Relevant medical, psychological, or social history
4. Medical precautions or contra-indications,
5. Aim of referral.
6. Other investigations (results if available and relevant) from the patient file.
7. Physician's signature and date of referral to physical therapy.

Note: When receiving referral that does not contain all of the necessary information for a patient, then the physical therapist must contact the physician and request more information. Should a physical therapist be presented with a referral that is not dated recently (this means that a significant time has passed since the patient was assessed and referred to physical therapy by the physician), then the physiotherapist should conduct an initial assessment and determine if the patient's condition has changed significantly to warrant a re-assessment by the physician.

Standard for Informed Consent

Informed consent refers to the patient's granting of agreement to participate in treatment by the patient, after receiving clear information about the physical therapy plan and objective.

It reflects the ethical principle of autonomy, the right to be self-governing, that is to be in control of choice and a particular plan of action.

In order for a physical therapist to be granted informed consent from a patient, a patient's guardian or surrogate, the physical therapist must provide the patient with the following:

1. A clarification on what is the patient problem
2. A description of the physical therapy treatment
3. A clear explanation of the risks associated with the physical therapy treatment
4. The benefits of the physical therapy, the risks of not participating in physical therapy
5. The timetable for the physical therapy and the risks of not complying with the scheduled time
6. The patient's rights to file a legal complaint
7. Any costs associated with the therapy.
8. Alternative choices of physical therapy

Documentation Regarding Informed Consent

The patient may provide the informed consent either in written form or verbally. The physiotherapist must document, accurately and comprehensively what was communicated to the patient. This documentation is to be part of the patient's file. External sources to be notified, may include physicians, lawyers, others.

Standard for Initial Assessment

An initial assessment is the first step in determining the appropriate approach to care. An initial assessment shall be completed before starting treatment. It must be relevant to the patient's condition.

The report must be written in an organized way.

The documentation will be completed as soon as possible and no later than two sessions following the initial physical therapy visit.

The documentation will be kept in the patient's medical file, forwarded to the referring physician and maintained in the physical therapy department when applicable to do so.

The following are to be included in an initial assessment:

1. **Personal Data:** shall include name, age, gender, address, demographic data, social information, health insurance, occupation and employer.
2. **Referral Information:** referring practitioner, diagnosis, date of referral, signature, aim of referral
3. **Subjective information:** case history (include patient profile, past medical history, current history, medication, investigations (imaging, lab findings), and subjective complaints from the patient.
4. **Objective Information:** Physical and functional examination,
5. **List of patient problems:** Current and previous ones
6. **Aims of treatment:** Long and short term
7. **Type of interaction:** Time schedule, modalities, frequency etc.
8. **Prognosis**
9. **Documentation**
10. **Date of assessment and name of physical therapist with signature**

(Note: The physical therapy department can maintain patient record until the patient is discharged at which time the patient record should be placed on the patient's file.)

Standard for Treatment Plans

A treatment plan is a plan to be set according to diagnosis and initial assessment. It should be clearly explained to and approved by the patient. Treatment plans are based on the subjective and objective information and data gathered from the initial assessment visit.

A treatment plan should include:

1. Problem identification list
2. Treatment goals and objectives
3. Prognosis

4. Methods of intervention

A treatment plan is a guideline for physical therapy services. It should be monitored, adjusted, and revised according to reassessments, patients' responses, impressions and status, team consultations and further diagnostic information. It is important to include other professions' treatment goals in the plan of treatment, and to offer or accept suggestions or recommendations as appropriate.

The treatment plan should be documented as part of the initial assessment and in progress reports. Any changes in the treatment plan are to be recorded in the progress reports. Copies of the documentation should be kept in the medical file, or patient's file.

Standards for Progress Reports

A progress report is a report that describes the patient's status under treatment. It should include the following information.

1. The report should be dated and signed by the physical therapist needing the service.
2. In acute settings, at every visit or communication
3. In chronic settings, according to the physical therapist's judgement, consultation with other health professionals and the patient's condition
4. Subjective and objective information in an organized manner
5. Information about change in the clinical status
6. Treatment methods and recommendations
7. Attendance, appointment times and duration of treatment session
8. Progress reports should be kept in the physical therapy department's file, or in the patient's file (hospital inpatient)
9. Patient status reports are to be completed at the physical therapist's discretion or upon request. They are to include all relevant aspects (as outlined under discharge summary report standards). Status reports should be written at every review of the patient's status. A copy is to be maintained on the patient's file and a copy forwarded to the referring physician or to the party requesting the report (subject to release of information and confidentiality standards)

Standard for Discharge Summary

A discharge is the process of discontinuing interventions. It occurs as physical therapist analyses the achievement of anticipated goal and desired outcome.

It should include the following information:

1. Personal data, diagnosis, date of admission, date of discharge, number of sessions, number of sessions absent, initial status, present status at discharge, treatment methods whether the patient benefited or not benefited from the treatment plan.
2. A discharge summary should be written at the end of treatment. The discharge summary should be kept in the patient's file (medical record). A copy is to be forwarded to the referring physician. Another copy may be given to the patient.
3. Physical therapist opinion for future treatment, prosthetics and orthotics, another health care services, prevention plan, advises, ergonomical advises.

Standard for Patient Confidentiality and Release of Information

All information about a patient in the medical record or otherwise stated by the patient or his family, friends are to be considered confidential. This includes information regarding social and financial status, anything beyond public knowledge, and any personal information about the patient that the patient has requested not be released.

It is acceptable not to honor patient confidentiality in the following circumstances:

1. The information may affect the health status of others
2. The information will lead to improve the health or save the life of the patient.
3. If required by law

The following process is to be followed for **releasing information**:

1. Consent must be obtained from the patient before releasing information to others outside of the facility. Consent must be obtained from the guardian(s) if the patient is too young or mentally incompetent. Approval must also be obtained from the institution where the patient is being treated.

2. Written approval from the patient or legal guardian is required in normal situations. In an emergency, other types of legal approval could be accepted. Anyone to whom the patient or legal guardian has given the right, through a written consent to release of information, has access to information.
3. Information may be released to medical team members directly involved with the patient and to guardians without consent.

Standard for Staff and Personnel

1. Physical therapy services are provided by or under the direction and supervision of a qualified physical therapist.
2. The Superintendent, team leader or senior physical therapist shall have at least a total of five professional years of experience in outpatient clinic or hospital setting.
3. All physical therapists shall meet the legal regulations and shall discharge their duties in a manner consistent with the code of conduct and of Kuwait Act on Physical Therapy.
4. All physical therapy treatments shall be given under the supervision of a licensed physical therapist.
5. Support personnel, employed for tasks related to patient care should have completed appropriate on-the-job training or formal training.
6. Physical therapy treatment given by support staff shall be under the immediate supervision of a qualified physical therapist.
7. There should be sufficient physical therapists and support staff to meet the scope and volume of services offered and to achieve the purpose and objectives of the service.
8. All assessments are to be conducted by a registered physical therapist. Support staff, under the direct supervision of the therapist, may be of assistance.

Standard for Accreditation and Licensing

All physical therapists practicing in Kuwait must be registered. In order to be considered qualified and be registered to practice physical therapy in the State of Kuwait, a physical therapist must demonstrate that the following criteria are met:

1. Graduate of a University level physical therapy program (B.Sc.)
2. Practical training-internship for one year
3. A physical therapist may add to these qualifications through graduate level education, continuing education, attendance at seminars, workshops, etc.
4. A physical therapist must register with the Office of Physical therapy Affairs, the applicable Ministry and the Kuwait Physical Therapy Association (KPTA). A list of all registered physiotherapists should be available from the KPTA.
5. All physical therapists must practice within the established scope of practice and subject to any applicable laws.
6. All physical therapists must follow the established code of conduct.
7. It is recommended that all physical therapists be member of a professional association.

Standard for Continuing Education

Physical therapists practicing in Kuwait shall accept responsibility for continuing their education in proper manners in order to keep up-to-date with current scientific and professional changes in physical therapy art and science.

Preparatory Education

1. The curricula for physical therapy education should be relevant to the health and social needs of Kuwait.
2. The term “ accredited” is used in relation to physical therapy education to describe a program which is regularly evaluated according to established educational standards
3. The first professional qualification will present completion of a minimum of four years curriculum that qualifies the physical therapist for practice as a physical therapist.
4. The goals, content, format and evaluation of the education programs provided for physical therapists are the responsibility of the faculty but

should involve the active participation of the national physical therapy association.

Continuing Education

All physical therapists should seek continuing education/continuing professional development (CPD). Its advantages and modalities are given below:

1. Participation in continuing education contributes to the development and maintenance of quality physical therapy practice.
2. It ensures that the physiotherapist continues to grow and develop as a professional
3. It ensures easy and appropriate access to professional groups, from which information and guidance can be sought (mentoring)
4. It ensures easy and appropriate access to recent advances in research through publication
5. It ensures reading and writing professional papers for professional advancement.
6. Participating in national and international conferences
7. Attending specialized certification courses, seminars, and workshops
8. Seek education from peers, life experience, and exposure to other professions literature, advanced technology, etc.
9. Physical therapists should be encouraged to undertake post-basic education in scientific methodology in order to contribute to a critical and research based professional approach that may extend into daily practice.

Standard for Quality Assurance and Continuing Quality Improvement

Quality assurance is the process put in place to make sure that the quality of physical therapy services are maintained at an acceptable standard. This assurance is gained through ongoing assessment of several important areas of the practice of physical therapy and the services provided by physical therapists.

Major areas to be considered include:

1. Patient Orientation to the Service and Patient Satisfaction with Services

2. Efficient and effective services
3. Staff Satisfaction
4. Staff Performance
5. Facilities, equipment and safety

Methods of Assuring the Requirements

The above listed requirements are assured through the following:

1. Patient Orientation to the Service and Patient Satisfaction

Customer satisfaction surveys and their analysis will assist staff in determining the level of satisfaction of patients, with the services they are providing.

Surveys can assist in determining:

- if the patient orientation is adequate?
- if the efficiency such as waiting times were satisfactory?
- if effectiveness of physical therapy meets their needs?
- if staff were polite and respectful?
- if treatment was beneficial?
- if departments are clean and tidy?
- if space was adequate and privacy available?
- other general service requirements.

2. Service Effectiveness Assurance

- a. Chart audits will assist in assuring that patients are being provided with physical therapy services in a manner consistent with the standards of care described in this document. Chart Audit assesses the levels of patient documentation in accordance with the documentation standards required for the practice of physical therapy.

The following items for documentation are the minimum requirement.

- signed Physician Referral
- informed consent.

- assessment
 - treatment plan
 - treatment description
 - reassessment.
 - discharge planning
 - discharge summary
- b. Workload and Wait List Management Strategies will assist in assuring efficient and cost effective services to the public.
- c. Development and ongoing reassessment of the following strategies will provide assurance:
- Weekly, Monthly and Annual Statistical Analysis of Workload including:
 - Number of patients.
 - Length of treatment.
 - Modalities used
 - Category of treatments.
 - Demographic data.
 - Patient compliance with attendance, cancellation, cooperation with treatment recorded.
 - Documentation of outcome measures to determine effectiveness of treatment.

3. **Staff Satisfaction**

Assessment of staff satisfaction with services can be a useful tool to define problem areas which need improvement. A staff satisfaction questionnaire would be anonymous and would include questions about:

- Autonomy - Is there support for physiotherapists to practice according to standards?
- Safety - Are staff practicing in a safe environment?
- Do the therapist's duties reflect expected responsibilities?
- Are patients and superintendent respectful and appreciative?

- Are they working in a collegial atmosphere with supportive management and team collaboration?
- is there appropriate support and opportunity for continuing education?

4. **Staff Performance**

Evaluation of staff performance is a necessary tool to maintain quality care. Performance evaluation is completed annually with each staff member.

5. **Facilities, Equipment and Safety**

Facilities

The following will be considered in determining the location of the physical therapy department: safety, convenience and access:

- The physical layout and location of equipment shall allow for the safe movement and function of staff and patients.
- There shall be evidence that the building housing the physical therapy service conforms to applicable building and fire codes.
- There shall be adequate space for reception of patients, storage of equipment, clerical personnel, professional personnel, conferences and teaching, and for research if applicable.
- The service area shall be accessible to people using any means of transportation.
- There shall be appropriate space for treatment of patients considering the need for privacy and respect for patient gender.
- There should be a library within the service area or readily accessible in the facility including appropriate instructional material and information available.
- There should be subscriptions to physical therapy, rehabilitation-oriented journals, and other professional journals.
- Facilities must be smoke - free (policy is advisable). A non-smoking sign should be visible.

Equipment

There will be adequate equipment and supplies available in the physical therapy department to meet the needs of patient care according to the standard of practice described in this document. There will be continuous inventory and an assessment of equipment need, to provide physical therapy service to the public.

Safety

a. Electrical Equipment Safety

1. There shall be written evidence that electrical equipment is annually serviced, and subjected to biomedical inspection, calibration and approval, as part of a preventative maintenance program.
2. There shall be documentation outlining the elements of the preventative maintenance program, i.e. annual check, calibration, replacement and repair procedures.
3. Electrical equipment shall conform to appropriate safety standards, or have appropriate biomedical approval.
4. All electrical equipment shall have three point plugs, and the voltage be 220-240 volts.
5. All electrical outlets shall be well maintained and grounded.
6. All electrical circuits in the hydrotherapy area shall be part of a ground fault circuit interrupter system or equivalent.
7. There shall be written evidence that all equipment is calibrated regularly in accordance with the Ministry of Health guidelines.
8. There shall be written evidence that all equipment is installed in accordance with the Ministry of Electricity and Water guidelines.
9. Precautions shall be posted in hazardous areas, i.e. electrically hazardous area for patients with pacemakers, etc.

b. Infection Control

1. Cleaning and infection control procedures for all areas of physical therapy shall be documented and followed.
2. There shall be visible evidence of infection control procedures specific to the physical therapy service.

3. Physical therapy staff will all be aware of infection control procedures and abide by the facility infection control program.
4. There should be evidence that the physical therapy staff have been made aware of potential hazards: e.g. wax spillage.
5. Linen or table paper shall be changed regularly.
6. The treatment area and equipment shall be clean and tidy.

c. **Fire Safety**

1. There shall be written evidence of current inspections by fire prevention authorities and public health services, i.e. water inspection.
2. Each staff member shall be instructed in fire regulations for the service area and the facility.
3. There shall be evidence of regular review of fire safety procedures involving all personnel.
4. Fire extinguishers shall be readily available and maintained.
5. Fire exits shall be unobstructed and clearly marked.

d. **Code of Conduct**

The provision of effective quality care while respecting the right of the patient, shall be the primary consideration of each member of the profession.

Responsibilities to The Patient

1. Physiotherapists shall respect the patient's rights, dignity, needs, wishes and values.
2. Physiotherapists will not put personal profit or advancement above duty to the patient.
3. Professional judgement will be exercised as independently as possible and not influenced by political pressures or by social factors such as social standing of patients, race, religion, nationality, sex, or health status.
4. Physiotherapists must respect the patient or surrogates rights to be informed about the effects of treatment and inherent risks.

5. Physiotherapists will respect the patient or surrogates' decisions to consent to or decline treatment or alternatives in the treatment regime unless it will do harm to others.
6. Physiotherapists shall assume full responsibility for all care they provide.
7. Physiotherapists confine themselves to practice within the scope of practice.
8. Physiotherapists shall not treat patients when the medical diagnosis or clinical condition indicates that the commencement or continuation of treatment is not warranted or contraindicated.
9. Physiotherapists shall respect consultation with or refer patients to colleagues, or members of other health professions when it is in the best interest of the patient.
10. Physiotherapists shall document the patient's history and relevant subjective information the physiotherapists objective findings, clinical diagnosis, treatment plan and procedures, explanation to patient, progress notes and discharge summary.
11. Physiotherapists shall respect all patient information as confidential. Such information shall not be communicated to any person without the consent of the patient or surrogate except when required by law. Exceptions include: when the information would affect the health status of others, or will improve or extend the health status of the patient.
12. Physiotherapists are responsible for all duties they delegate to personnel under their supervision.

Responsibilities to Society

1. Physiotherapists shall recognize their responsibility to improve standards of healthcare.
2. Physiotherapists shall comply with all laws and regulations pertaining to the practice of physical therapy.
3. Physiotherapist shall report to the appropriate authorities, any member of the profession who appears to be incompetent or whose conduct, while practicing as a physiotherapist, appears to be unethical or illegal.

Responsibilities to the Profession

1. Members shall abide by the policies of the professional association (if one exists) and support its mission.
2. Physiotherapists shall conduct themselves in such a manner as to merit the respect of the society for the profession and its members.
3. Physiotherapists shall engage in continuing education for growth and development.
4. Physiotherapists shall advance the science of physical therapy by sharing relevant information and by supporting, or engaging in, research activities.
5. Physiotherapists shall be responsible for ensuring that research protocols respect the rights of research subjects and are in compliance with standards accepted by the scientific community.
6. Physiotherapists shall be willing and diligent preceptors in the education of Physical therapy students.
7. Physiotherapists shall ensure that their professional judgement and integrity are not compromised by motives of profit.
8. Physiotherapists shall enter into contracts and agreements, only when professional integrity can be maintained.
9. Physiotherapists shall ensure that any advertising of their services is accurate, verifiable and acceptable according to the legal, social and professional norms of the times, and does not bring the profession into disrepute.

Bibliography

- 1) Bohmert J., Moffat M., and Zadai C. "Guide to Physical Therapist Practice. Second Edition", *Physical Therapy*, Vol. 81(1) January 2001; 1-737.
- 2) Commission on Accreditation in Physical Therapy Education, "1997-1998 Accreditation Handbook", American Physical Therapy Association, July 1997.
- 3) Office of Physical Therapy. "Kuwait Physical Therapy Standard of Practice", Ministry of Health, Kuwait, 1989.

I.C.U. ACCREDITATION STANDARDS

Significance as a Care Provision and Training Facility

Intensive care is a very important service within any hospital. It allows clinicians to look after critically ill people, and allows surgeons to perform difficult and complex procedures on patients and look after their critical health.

ICU also provides opportunity for nursing staff to pool their resources into one ward in order to look after critically ill patients who require monitoring for, say, cardiac or respiratory problems and may require ventilating support, instead of depleting the nursing resources in the general ward in looking after one very ill patient while giving below optimal care to other patients.

Nurses have to be specially trained for this service, particularly in the art of monitoring vital signs and looking after complex machines (e.g., Ventilators, Oxymeters, Wedge pressure, Cardiac output monitor, CVP, JV alimentation, Internal feeding, etc.).

These services would put tremendous pressure on the general Nurses. However, for ICU nurses are trained to meet the demands. This area can be used to train other nurses in the care of the ill and some of the trainees may themselves one day become critical care nurses.

As for doctors in training, ICUs offers excellent training opportunities and ground for treating ill patients. It provides opportunities for real-life experience of sound understanding of I.V. and fluid balance, acid base balance, IV. nutritional requirement, respiratory care and ventilatory functions and diseases, cardiovascular monitoring. ICU is, nowadays, essential in training of doctors and the absence of this service will handicap their ability to provide care of acceptable quality, to their patients.

Physical Layout

The ICU must have a physical layout which is compatible with and appropriate to carry out the functions listed above. In specific, the following are essential.

- a. The number of beds in each hospital must be sufficient to support the load of the critically ill patients that the hospital handles. It shall depend on the number of difficult surgeries performed, accidents in the area, etc. But a ratio of 2% of general beds in the hospital is suggested to be the minimum requirement.

- b. The beds must have access from all direction to carry out difficult procedures, e.g., intubation, catheterization, cardiac resuscitation, etc.
- c. There must be space for monitors, ventilators and all other equipment around the patient.
- d. It is appropriate to have a central monitoring facility.
- e. Enough storage space with easy access should be available for consumables and unused stand-by monitors.
- f. It must have easy access to theatre, X-rays, Lab services.
- g. Sufficient space for families to sit and get counselling and for doctors and nurses, to provide counselling, must be available.
- h. Washing facilities for hands be available
- i. Isolation area for very seriously infected patients (MRSA or other infections) be provided.

Care Staff

The care in the ICU is multi-disciplinary. Every speciality gets involved (e.g., anesthetist, surgeon, cardiologist, nephrologist, physiotherapist). While almost all disciplines in the hospital are involved, a core staff comprising the following must be available.

- a. Chief Intensivist: It could be anesthetist surgeon or intensive care specialist.
- b. Enough support staff to give 24 hours cover.
- c. Well-trained nurses: The ideal number is very high, but it should be 1 nurse/patient/shift. These nurses must have extensive training in life support, monitoring, ventilation, catheter care, operation of crash and defeb. machine.
- d. Physiotherapy staff.
- e. Small Lab. to support service for blood gases and acid base balance, 24 hours/day. Prompt response is crucially important.
- f. Maintenance support staff for all equipment is required.

- g. Infection control officers - direct involvement as cross infection is the most dangerous problem faced in the ICU.

Needed Guidelines

The ICU must have clear guidelines on:

- Admission/discharge policy
- Management of common problems - protocols - antibiotic policy.
 - Doctors must have consensus on the management of each patient. The outline on admission must be written clearly so that it can be followed by every body.
 - If and when the policy is changed in the management, every body must be aware of it and thorough review of protocols; and management policy be undertaken to produce optimal outcome results.
- Protocols for nursing care, catheter, I.V., ventilation care, mouth care, bed sore, prevention must be in place.
- Visiting by relatives be allowed on physicians' policy.
- Morbidity - mortality report must be clear.
- Outcome review - general audit must be held.
- Multi-disciplinary care protocols, interdisciplinary communication must be in place and followed.

CAUSALITY DEPARTMENT – A/E ACCREDITATION STANDARDS

This is one of the most important areas of a hospital because it is the area where different kind of patients pass through.

Causality, or ER is used for providing care to those people who generally do not know what is wrong with them, or they represent urgent cases of accidents and trauma patients who, if not attended by skilled medical staff, will probably succumb to injuries, or patients suffering from bleeding, tension pneumothorax, airway obstruction, flail chest, severe myocardial infarction with arrhythmia, etc.

On the other end of the spectrum are the patients who visit ER but have minor illness. They require little or no treatment apart from reassurance and advice.

It is the job of the Causality/ER staff to distinguish between the two and provide care to those who need it the most, but handle the minor cases appropriately, as well.

As for training of doctors, this is vital area in the training process as it allows the doctors to examine and evaluate patients under stress, and make a quick, reasonable diagnosis and initiate the most appropriate treatment. However, the doctor should first make sure that the other systems in the body are checked. The patient may have some other injury, such as ruptured spleen

The physical layout of casualty must be well designed and should meet the space requirements to fulfill the overall service requirements of the Department.

The space must account for the following:

1. Waiting area
2. Examination rooms
3. Observation rooms with monitors
4. Resuscitation, emergency room, fully equipped crash trolley
5. Minor theatre
6. Laboratory or area for drawing of blood
7. X-rays
8. Treatment rooms, including rooms for:
 - Dressing

- Plaster - if orthopedic specialty is present

The following must be ensured:

- a. **Triage:** The role of triaging is to identify the patients who are at greater risk and should be attended first. This does not mean, however, that other patients will be ignored. This is particularly important because it is not uncommon to have stable patient slip into extreme instability within minutes.
- b. **Triaging Professional** - either well trained nurse or doctor
- c. Prompt examination and/or referral of patient
- d. Good observation during investigation
- e. Stabilization of the patient before either discharge or referral
- f. Good documentation of events
- g. Review of outcome cases:
 - Was referral substantiated
 - Unnecessary referrals
 - patients who need treatment, but were not treated

To achieve all of the above, it is advisable to have:

- a. Trained senior member of the medical staff as head of the dept.
- b. Trained emergency doctors, the number of which must be compatible with the number of patients and to attend the observation area.
- c. Trained nursing staff
- d. Trained resuscitation nursing staff
- e. Easy access to trained anesthesia and surgical staff to help in resuscitation of major accidents multi-organ trauma.

- f. Prompt access to X-ray and Laboratory services to ensure prompt response to test requests to facilitate prompt attention to patients' therapeutic needs.

Some schools do not have specialized E.R. systems, but have mutli-disciplinary Emergency Service, Medical, Surgical, Gynecology, Pediatric, etc.

This modality is still practiced and it is acceptable. However, it makes triaging much more crucial - it exerts a great strain on the individual service for all the staff, as they must be present in the Receipt area irrespective whether there are patients for that specialty or not.

It may be noted that such modality of service is less cost effective and less efficient.

ACCREDITATION REQUIREMENTS FOR A DEPARTMENT OF MEDICINE IN A GENERAL HOSPITAL

INTRODUCTION

The Department of Medicine in a general hospital provides one of the most essential services and represents the backbone of all medical services. It is essential for providing quality service to patients as well as education to various staff members including medical and para-medical. At both service and education, the department is clearly connected to various other service providers in the hospital. It is therefore, highly essential that a system is in place to review, upgrade and quality control the department periodically.

General Medicine education in a hospital is given to different levels of doctors, undergraduate medical students and paramedical staff. Therefore, the accreditation process has to ensure that the program meets the requisite standards in terms of minimum resources and that those resources are effectively utilized for the training needs.

The following are the **minimum requirements** for a teaching medical department applying for accreditation to postgraduate training. This document not only provides information on accreditation requirements but also relevant guidelines to the department on the pre-requisites.

1 DEPARTMENTAL RESOURCES

- a. **Drainage population:** The hospital should be a tertiary referral centre receiving patients from a drainage population of at least 300,000.
- b. **In-patient beds:** Should have minimum total inpatient bed strength of 120 beds (half for males and half for females) for medical admissions.
- c. **Patient turnover:** As evidenced by the admission-discharge data maintained by the Medical Records department, it should meet specific defined standards, in terms of number of admissions and discharges.
- d. **General medical units:** There should be at least 4 general medical units (Internal Medicine). Each unit must have an inpatient capacity of 30 beds (15 males and 15 females) to provide a trainee to bed ratio of 1 : 10, at all times.
- e. **Specialty Units and Services:** It is highly recommended that essential subspecialty services such as cardiology, gastroenterology and

respiratory are available in the department. Additional 30 inpatient beds are preferably identified for those subspecialties related patient admissions. In the absence of such subspecialty divisions in the department, a clear administrative arrangement with a tertiary referral centre must exist for consultative support.

2 OUT-PATIENT SERVICES

- a. There should be outpatient clinics run by the department every working day of the week.
- b. Each **medical unit** should have at least **5 out-patient clinics per week**.
- c. Additional subspecialty clinics be established depending on the availability of specialists. When specialist staff are not available within the department, specialists from other tertiary hospitals may be contracted to run outpatient clinics.
- d. Each **trainer** must have at least **2 outpatient clinics** per week.
- e. The **Registrar** (4th year trainee) should have **one clinic** per week.
- f. The **trainee** (Year 1 and 2) must **join the trainer** in the **outpatient clinic** and function under consultant supervision.
- g. Each **clinic** should see **20 patients** (new and follow up) **per day** on an average.
- h. Preferably, the **outpatient** be run on an **appointment system** by time and not by just 'first come first serve' basis.
- i. The clinic room must have all the needed **examination facilities**, such as functional ophthalmoscope, otoscope, etc.
- j. The outpatient responsibility shall not conflict with other professional activities of its staff.

3 ON-CALL DUTY AND EMERGENCIES

- a. There should be an **emergency indoor service/training unit** with minimum inpatient bed strength of 10.

- b. The service unit must be **appropriately equipped** to manage all common medical emergencies.
- c. An **independent emergency department** with its own professionally trained and skilled trainers is **preferred**.
- d. The emergency room should develop and institute a **proper TRIAGE** system to guide the patients. Qualified nurses may be trained to perform triage.
- e. Each medical unit shall be on '**on call**' duty at least **once in 4 days**.
- f. The **trainee** (Assistant Registrar and Registrar) **shall remain in the hospital premises** for the **24 hours** the unit is on call.
- g. The senior registrar (Trainer) shall remain in the hospital till 11.00 pm and receive calls from home thereafter on 'on call' duty days.
- h. The consultant/specialist will see all fresh hospital admissions along with the trainee from 6.00 pm and shall remain in the hospital as long as needed.
- i. A system must be established whereby systematic training and instructions are given to the trainee in order that he/she acquires hands-on experience in:
 - Initial assessment of emergency patients.
 - Planning and delivery of appropriate treatment modalities
 - Consultation service to sister disciplines

4 STAFF

a. Strength :

Each medical unit should have the following minimum staff strength:

- | | | |
|--------------------------------|---|---|
| • Consultant (head of unit) | - | 1 |
| • Senior specialist/specialist | - | 1 |
| • Specialist/Senior Registrar | - | 1 |

- Registrar - 1
(He/she shall be in the 4th year of training)
- Assistant Registrars - 2
(He/she shall be in the 1 – 3 years of training)

The **trainer/trainee ratio** shall be **1 : 1**

b. Responsibilities

- i. The house team (Trainer and Trainee) shall have well defined and documented service/teaching responsibilities. However, the entire staff shall function as one team.
- ii. The head of the unit shall be administratively responsible for all aspects relating to the unit.
- iii. The house team of the medical unit should have well defined assignment of daily work towards patient care and teaching.
- iv. A teaching coordinator should be chosen from the specialist/Senior Registrar.
- v. The coordinator shall plan/co-ordinate all teaching activities of the unit in consultation with the head of the Unit.
- vi. The coordinator will follow the established evaluation process for all the trainees in the unit.
- vii. The coordinator will follow the established appeal mechanism for all matters relating to in-training evaluation (ITE) and promotion of trainees.

5 THE TRAINER

The trainer should:

- a. hold joint appointment preferably with the Faculty of Medicine/Ministry of Health.
- b. hold a post-graduate medical qualification from a recognized university.
- c. be involved in teaching of undergraduate medical students.

- d. be registered with the CME programme of the KIMS.
- e. achieve the minimum required credit hours of Continuing Professional Development (CPD) each year.

6 ACADEMIC ACTIVITIES

- a. Appropriate physical facilities (lecture rooms, seminar rooms, access to computer facilities etc.) must be available.
- b. The minimum required CPD activities of a teaching department are:
 - Morning sign-in rounds for all staff.
 - Once weekly grand rounds in Internal Medicine
 - Once weekly subspecialty round/meeting
 - Once weekly radiology meeting
 - Once monthly morbidity/mortality meeting
- c. It is expected that the department shall have:
 - Monthly journal reviews
 - Clinico-pathological meetings and other combined conferences with related specialties
 - Didactic cyclical lectures to reinforce basic scientific principles.
 - Yearly 'update' review meetings (2-3 days) and participation
- d. All teaching activities should be registered with KIMS for credit purposes.
- e. Attendance and participation at meetings should be strictly monitored and recorded.

7 MEDICAL LIBRARY

The department must provide easy access to the sources of biomedical information essential to the educational programme, in particular the following:

- a. The staff should have access to the sources preferably 24 hours a day, but at least till 10:00 pm.

- b. A medical library should carry the needed recent journals, textbooks, and monographs.
- c. A common computer site equipped with free internet access to medical information.
- d. State-of-the-art audio-visual facilities.

8 PRACTICE GUIDELINES

- The department should have practice guidelines for common medical problems and medical emergencies.
- The guidelines should be periodically updated.

9 OPERATIONAL POLICY

The department should have well defined and printed operational policies for all of their activities. These should include:

- Admission – discharge policies
- Consultative service
- On-call duty
- Leave for staff

Also, should monitor adherence of the staff to prescribed practices.

10 QUALITY CONTROL OF PATIENT CARE AND DIAGNOSTIC PROCEDURES

- a. Critical assessment in relation to:
 - Medical audit
 - Utilization studies
 - Postmortem studies
 - Peer review
 - Technical quality control
- b. Implementation of the information-based decision arrived at, from above
- c. Monitoring of adherence to practice guidelines

11 SUPPORTING SERVICES

a. Most essential to an active training programme is availability of and participation in supporting other clinical and para-clinical departments. Their active involvement in training of physician is highly essential. Those include:

- Department of Radiology
- Department of Pathology
- General and Specialized Laboratory Services

b. Additional services include:

- An emergency department with at least 10 inpatient beds
- A coronary care unit with at least 6 inpatient beds
- A critical care unit (ICU) with at least 10 beds.

12 RESEARCH ACTIVITIES

The department should evidence their interest in research activities by:

- A minimum of two research publications (including case reports) by each medical unit, annually.
- Holding a minimum of two research seminars per year

13 RECORD MAINTENANCE

The patient case files must be appropriately maintained and should include:

- Admission case history
- Daily progress as an inpatient
- Typed detailed discharge summary with all pertinent medical information.
- Outpatient follow-up

14 LIAISON WITH REGIONAL POLYCLINICS

a. There should be a well-defined referral system from the polyclinics in the region.

- b. Referred patients requiring no further institutional management should be returned to the polyclinic with a written report.
- c. CPD programme aimed at physicians in the polyclinics be established.

15 ADMINISTRATIVE SUPPORT

- a. There should be at least one typist (preferably computer trained) with each medical unit.
- b. The departmental chairman's office should liaison all medical units within and supporting services outside;45 and
- c. Should have required physical facilities for computing, photo-copying etc.

16 IN-TRAINING EVALUATION (ITE)

- a. The programme director should form a committee of at least 3 professionals, including him/herself, who will assess the progress of each trainee every 3 – 6 months based on the overall performance of the trainee on a day-to-day basis.
- b. Those ITE's should be discussed with the trainee and his/her signature obtained.
- c. All ITE's related discussions are mutual and should be used to the benefit of the trainee as well as the trainer.

DEPARTMENT OF SURGERY ACCREDITATION STANDARDS

- For the Department of Surgery, the **theatre experience** is a very important issue. The number of operations and the variety should be such that it is optimal to train the number of trainees allocated to the department.
- The number of available **operations** must be **spread** across the department in such a manner that each member of the department will have sufficient material (cases) for teaching and training.
- The **number** of all **Registrars** and **Senior Registrars** in the department must be kept to the minimum required by the accreditation criteria. This is important because the excess number of those type of professional will reduce the availability of the surgical material (cases) in the theatre for training purposes.
- The **presence** of **Consultants** during **night duty** is extremely important in Surgery, in order to make use of the huge number of surgical procedures for training purposes and to make use of complicated trauma management available for training, as a teaching tool.
- Because surgical training entails learning a large number of skills, the **time spent** with the **Consultant** must be **higher** than that in other departments. We suggest 14 hours per week of direct contact between trainers and trainees, as a minimum of requirement.
- **Bed-to trainee ratio** must be **higher** in case of surgical trainees because of the amount of dexterity required by the trainees to learn. We suggest a 10-bed per trainee, as a minimum.
- The trainees must be encouraged to make the best of the available facilities, and it must be made **mandatory** to **attend** the following:
 - Basic surgical skills course
 - Advanced life support course
 - Basic Laproscopic training course