Chapter II

Medical Staff and Provision of Care (MS)

Introduction

The Medical Director has a major role in the effort to provide high quality medical care with a high degree of clinical safety. He is ultimately responsible for the professional conduct of his Medical staff and all of the standards of medical care. He is expected to play a leading role in minimizing risk to patients and maintaining a high quality standard of care.

The Medical Director works collaboratively with the Nursing Director/leader and other Department heads to monitor the provision of care from the time of the patient's admission to the time of the patient's discharge in order to ensure that safe and appropriate care is provided.

This chapter is the responsibility of the Medical Director. The Medical Director needs to work with the Nursing Director/leader and form the necessary teams to meet all of the standards.

He then needs to work closely with the Quality Management Director or Leader and the Risk Manager to monitor the provision of patient care.

Monitoring is required to ensure safe patient care. This includes adverse events, sentinel events, medication errors and adverse medication reactions, conscious sedation, etc.

Information is analyzed and the Medical Director ensures that system improvements take place so that these same mistakes are not repeated. The Medical Director adapts a non-punitive approach and uses a collaborative approach to study these issues honestly and openly and focus on the system and not the individual.

It is advised that the Medical Director learn the basics of Quality Management principles, so he can quickly master the patient care processes in an organized manner.

Scoring:

Medical Staff and Provision of Care (MS)

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.1.	The Medical Director is qualified for the position by:					
	MS.1.1 Having the appropriate experience and education.					
	MS.1.2 Having basic knowledge of quality management principles.					
MS.2.	The Medical Director has a current (at least 3 years) written job description that clearly describes his roles and responsibilities					
MS.3.	The Medical Director is responsible and accountable to the Hospital Director for the clinical performance of the medical staff and their professional conduct.					
MS.4.	The Medical Director appoints or recommends the appointment of department heads to the Hospital Director.					
MS.5.	The Medical Director holds regular formal at least (monthly) meetings with all clinical department heads to ensure that all department heads work together to coordinate the provision of care.					
MS.6.	The Medical Director reviews and approves policies and procedures written by the department heads when collaboration with other departments occurs.					
MS.7.	The Medical Director co-signs all staff evaluations (appraisal forms) completed by department heads in the Medical Division.					
MS.8.	The Medical Director supports the Hospital Quality Management plan and works closely with the Quality Director/leader and Nursing Director/leader to implement the standards. Formal meetings are documented.					
MS.9.	The Medical Director works closely with the Nursing Director/leader and other department heads to develop and maintain the following policies for the care of vulnerable dependent patients (Immune-compromised, comatose, elderly and/or frail, terminally ill, neonates, Infants, and children). The policies include the following:					
	MS.9.1 Infection control guidelines.					
	MS.9.2 Security and safety guidelines.					

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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.9.3 Ethical guidelines.					
MS.10.	The Medical Director works closely with the Nursing Director/leader and the Quality Management Director/leader to implement the patient safety plan and formal meetings are documented.					
MS.11.	The Medical Director works closely with the Quality Management Director/leader and Risk Manager in handling all near misses and incidents and:					
	MS.11.1 Root cause analysis is performed when appropriate.					
	MS.11.2 Emphasis is placed on improving systems.					
	MS.11.3 The "Actions taken" are documented.					
MS.12.	The Medical Director together with the department heads and Quality Director, monitors departments for the following:					
	MS.12.1 Patient assessments.					
	MS.12.2 Adverse events.					
	MS.12.3 Conscious sedation					
	MS.12.4 Quality of medical records.					
	MS.12.5 Medication errors.					
	MS.12.6 Sentinel events.					
	MS.12.7 High-risk services and procedures (e.g. angiogram, ERCP, etc).					
MS.13.	The Medical Director together with the department heads and Quality Director, monitors departments for the following:					
	MS.13.1 Mortality and morbidity.					
	MS.13.2 Blood and blood product usage.					
	MS.13.3. Outcomes of surgeries.					
	MS.13.4 Any discrepancies between preoperative and postoperative diagnosis.					
	MS.13.5 Appropriateness of admissions from the emergency room.					
	MS.13.6 Appropriateness of admissions from the outpatient area.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.14.	The Medical Director or the clinical department heads uses the above information, to continuously improve the system, and this includes but is not limited to:					
	MS.14.1 Counseling of staff regarding their performance.					
	MS.14.2 Amending clinical privileges as necessary through Credentialing Privilege Committee CPC.					
	MS.14.3 Studying and correcting variances in processes within the system.					
	MS.14.4 Recommending any necessary equipment to the appropriate area.					
	MS.14.5 Recommending training and refresher courses as needed.					
MS.15.	The Medical Director reviews all Hospital committee minutes within his scope and uses this information for:					
	MS.15.1 Guiding and prioritizing the services needed.					
	MS.15.2 Guiding the credentialing and privileging process.					
MS.16.	Every Department has a department head who is the qualified in his field and:					
	MS.16.1 He has the appropriate experience and education (Saudi Board or equivalent)					
	MS.16.2 He has basic knowledge of quality management principles (participated or attended quality activities).					
MS.17.	The department head's managerial responsibilities include:					
	MS.17.1 Recommending space, equipment, and supplies for the existing unit and new programs within the hospital scope.					
	MS.17.2 Recommending the necessary staffing for their area.					
	MS.17.3 Writing internal policies and procedures ensuring that they are consistent with hospital and other department's policies and procedures.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.18.	The department head's clinical responsibilities to evaluate the clinical standard within his/her department includes:					
	MS.18.1 Defining the necessary skills required of the medical staff to safely provide care to patients and recommend the training programs as needed.					
	MS.18.2 Ensuring that the patient admitted by physicians within his/her service is within the staff's capabilities and the hospital's resources to meet their needs by periodic monitoring of admissions.					
MS.19.	All department heads ensure that the physicians working within their area limit their scope of practice to the clinical privileges assigned to them by the Credentialing & Privileging committee.					
MS.20.	The department head holds regular meetings with his staff (documented minutes) to ensure that they all work together to coordinate the provision of care.					
MS.21.	The department head has a written scope of service for his/her area and this includes:					
	MS.21.1 The range of service i.e., Pediatrics, Gynecology or a general hospital.					
	MS.21.2 The age groups who receive care.					
	MS.21.3 The number of patients seen annually.					
	MS.21.4 The major diagnostics or therapeutic methods used.					
	MS.21.5 The scope of services is signed by the Medical Director, the Administrator, or both.					
MS.22.	The department head has a method (like a peer review committee) to:					
	MS.22.1 Assess the appropriateness of admissions.					
	MS.22.2 Assess the appropriateness of care.					
	MS.22.3 Assess the effectiveness of care and its outcome.					
	MS.22.4 Assess the efficacy of care.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.22.5 Assess the length of stay.					
	MS.22.6 Assess appropriate utilization of services.					
MS.23.	The department head shares his/her findings with the Medical Director and works closely to improve and correct their deficiencies.					
MS.24.	The hospital has adequate equipment and supplies to safely provide care to patients who require Cardio Pulmonary Resuscitation (CPR) such as:					
	MS.24.1 Crash carts which contain emergency medications, intubation equipment and, venous access equipment, IV fluids, that are age specific (e.g. neonate, infant, child, adult).					
	MS.24.2 Defibrillators that are in good working order.					
	MS.24.3 Oxygen cylinder.					
	MS.24.4 Portable suction machine.					
MS.25.	Staff who are on the code team have the proper educational training and the CPR team is led by:					
	MS.25.1 A physician or an Anesthetist who is certified in ACLS for adult codes.					
	MS.25.2 A physician who is certified in PALS for pediatric codes.					
	MS.25.3 A physician who is certified in NRP for neonatal codes.					
MS.26.	The documentation for CPR is standardized by using a “CPR form” and includes the following:					
	MS.26.1 The name of the patient, time and location of the code.					
	MS.26.2 The names of the responders to the code.					
	MS.26.3 The medications used, and a record of all treatments given (electrical shocks, central lines inserted, intubation, etc the times administered).					
	MS.26.4 The outcome of the code.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.27.	All codes are discussed in the CPR committee and the summary of these discussions is sent to the Medical Director and the Quality Management Director/leader.					
MS.28.	The Medical Director works closely with the Nursing Director/leader and other department heads as needed to ensure there is an effective system to handle all cases of CPR at all times (24 hours/day) and includes:					
	MS.28.1 Standardization of all crash cart contents and includes medications, airway access, venous access, oxygen, and a defibrillator that is maintained and charged at all times.					
	MS.28.2 A process for checking the crash cart every shift by nursing or as appropriate by the pharmacy.					
	MS.28.3 A process for restocking the cart and/or exchanging the crash cart after use.					
	MS.28.4 A process to keep a defibrillator on each crash cart that is maintained and fully charged.					
	MS.28.5 A simple number such as 999 to call when summoning help for a code.					
	MS.28.6 Training for nurses on how to use the alarm system or call the code.					
MS.29.	The roles and responsibilities of the following staff handling CPR are outlined in the hospital policy:					
	MS.29.1 The staff who first discover the code.					
	MS.29.2 The code team leader.					
	MS.29.3 The code team members.					
MS.30.	The Medical Director supports the Infection Control program by:					
	MS.30.1 Empowering the Infection Control practitioner to perform his/her role and enforcing his/her recommendations.					
	MS.30.2 Approving required resources.					

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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.30.3 Communicating with the Ministry of Health for reportable infectious diseases.					
MS.31.	The hospital has a Medical Credentialing & Privileging committee chaired by the Medical Director or his designee that ensures only qualified physicians are hired.					
MS.32.	Applications for credentialing require the submission of a complete set of documents by the candidate for hire and include:					
	MS.32.1 The CV which contains the entire professional history of the candidate.					
	MS.32.2 Education, training, certificates, courses, experience credentials, and published research.					
	MS.32.3 A list of references and methods to contact them.					
	MS.32.4 A list of the privileges requested for approval and any requirements for skill upgrades.					
MS.33.	The evaluation process for the Credentialing & Privileging committee ensures that every candidate undergoes the same standards for hire and includes the following:					
	MS.33.1 The physician's past experience is evaluated to determine if he/she possesses current skills.					
	MS.33.2 The physician's are registered with the Saudi Council for Health Specialists.					
	MS.33.3 The physician's mental and physical capabilities are evaluated by obtaining letters of reference and making inquiries as needed.					
	MS.33.4 The physician's past experience is evaluated when "new" skill upgrade by the physician is required.					
	MS.33.5 The physician's continued scope of practice (privileging) is determined by his/her continued performance and outcomes of care rendered.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.33.6 Temporary or emergency privileges are approved by the Medical Director for up to 90 days while the physician's papers are being processed by the Credentialing and Privileging committee and are not renewable.					
MS.34.	Privileges for all surgical and invasive procedures are reviewed and updated every (2) years, and as needed.					
MS.35.	The hospital ensures that all physicians working as locums, part time, or any physicians from outside institutions go through the Credentialing & Privileging process and follow the Bylaws to practice within the hospital.					
MS.36.	The hospital has a set of documents that describes how the medical staff are organized and how the medical staff carry out the required functions of their service (Bylaws or other methods) and includes:					
	MS.36.1 The organizational structure of the medical division, and all the related medical sub units and the reporting relationships.					
	MS.36.2 The qualification requirements for every type of medical staff position that is being considered for hire (credentialing).					
	MS.36.3 The membership categories (e.g. full time, part time, locum, etc).					
	MS.36.4 The roles and responsibilities of all levels of the medical staff.					
	MS.36.5 The admitting, referral, transfer, and discharge process.					
	MS.36.6 The list of medical departments and committees.					
	MS.36.7 The medical record documentation guidelines.					
	MS.36.8 The conduct of care expected for all levels of medical staff (e.g. daily rounds).					
	MS.36.9 The professional conduct (e.g. handling ethical issues).					

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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.36.10 How the medical staff may be promoted, appointed, or reappointed.					
	MS.36.11 The disciplinary process for the medical staff including corrective action and appeals.					
	MS.36.12 How the scope of practice is determined for each medical staff position that is being considered for hire (privileging).					
	MS.36.13 How privileges will be maintained and updated for each physician.					
	MS.36.14 How temporary privileges are granted by the Credentialing & Privileging committee to the medical staff (locums and emergency situations).					
MS.37.	The hospital has a Mortality/Morbidity committee that is chaired by the Medical Director or his designee.					
MS.38.	The Mortality/Morbidity committee evaluates cases to see if the standard of care was met and makes recommendations for system improvement. The work of the committee includes the following:					
	MS.38.1 Referral sources for case review include the patient complaint committee, department heads (after performing departmental review) and the Medical Director.					
	MS.38.2 Cases are evaluated for appropriateness of care, timeliness of care, and efficacy of care.					
	MS.38.3 Findings are summarized and sent to the Medical Director and the Quality Management Director/leader.					
MS.39.	All departments have a monthly Mortality/Morbidity meeting which includes the following:					
	MS.39.1 The departmental Mortality/Morbidity meetings focus is educational.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.39.2 Attendance at the Mortality/Morbidity meetings is considered essential and documented.					
	MS.39.3 All cases of mortality and morbidity are reviewed and minutes are taken with corrective actions included.					
	MS.39.4 The discussions at these meetings are confidential and kept in a locked file.					
MS.40.	The department head's responsibilities for case findings from the Morbidity and Mortality meeting includes:					
	MS.40.1 Working with the Medical Director to decide which cases are referred to the Hospital Mortality/Morbidity committee.					
	MS.40.2 Sending a monthly summary report to the Medical Director and the Quality Management Director/leader.					
MS.41.	The hospital has a Medical Record Review committee including the following members: Medical staff, Nursing staff and others who document in the medical record.					
MS.42.	The Medical Record Review committee monitors completeness and evaluates the quality of the medical record documentation by reviewing a 5% sample (quarterly) of discharged patients and patients who are still in the hospital for:					
	MS.42.1 History and physical.					
	MS.42.2 Admission assessments.					
	MS.42.3 Operative notes.					
	MS.42.4 Histopathology report.					
	MS.42.5 Lab results.					
	MS.42.6 Typed x-ray reports.					
	MS.42.7 Discharge summaries.					
	MS.42.8 Documentation of patient education activity.					
	MS.42.9 Progress notes.					
	MS.42.10 Plan of care.					

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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.43.	The hospital has a Pharmacy and Therapeutics committee.					
MS.44.	The committees' responsibilities include, but are not limited to:					
	MS.44.1 Approving the hospital formulary.					
	MS.44.2 Approving any new additions or deletions from the formulary.					
	MS.44.3 Approving the policy for the use of antibiotics in the hospital.					
MS.45.	The hospital has a Utilization Review committee that is chaired by the Medical Director or his designee, and has representation from medical, nursing and the paramedical division to ensure optimum use of resources. The monitoring includes and is not limited to:					
	MS.45.1 Length of stay for selected types of patients and services.					
	MS.45.2 Appropriateness of admissions.					
MS.46.	The Utilization Review committee studies all aspects of patient care, including drug usage and observes for:					
	MS.46.1 Over utilization of resources.					
	MS.46.2 Under utilization of resources.					
	MS.46.3 Inefficient utilization of resources.					
	MS.46.4 Inefficient allocation of resources.					
MS.47.	The hospital has a Blood Utilization committee that has representation from medical, nursing, and laboratory departments and is chaired by the Medical Director or designee.					
MS.48.	The Blood Utilization committee approves and monitors all policies and procedures that involve the administration of blood in the institution that includes but is not limited to:					
	MS.48.1 Taking blood samples from patients for type and cross matching; handling, storing and administration of blood products.					
	MS.48.2 Taking blood from the donors and processing it.					
MS.49.	The committee monitors the Blood Bank's performance and reviews all the procedures used for collecting, testing, and storing blood and blood products.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.50.	The hospital has a Tissue Review committee or ensures that the functions of the Tissue committee are handled by the Chief Pathologist or his designee.					
MS.51.	The Tissue Review committee or its equivalent ensures that specimens and/or tissues are obtained and handled according to policy and this includes monitoring of:					
	MS.51.1 The accuracy of the fine needle aspirations.					
	MS.51.2 Obtaining specimens and transporting them to the laboratory.					
	MS.51.3 The accuracy and completeness for Histopathology forms: site of biopsy, number of pieces taken, clinical history, previous biopsies etc.					
	MS.51.4 Any variation between the preoperative, the postoperative and/or the pathological diagnosis.					
	MS.51.5 Any specimens or tissue removed during surgery are sent to the laboratory for Histopathological examination (e.g. hernia sac or any lump).					
	MS.51.6 Any "frozen section" specimens obtained from surgery.					
MS.52.	The hospital has an Operating Room committee that include the following members: medical staff, nursing staff , OR technician, infection control, and safety personnel.					
MS.53.	The Operating Room committee approves all of the policies for conducting the work in the operating room, to include, but not limited to:					
	MS.53.1 Infection control measures.					
	MS.53.2 Supply of equipments and disposables.					
	MS.53.3 Proper identification of patients, and site of surgery.					
	MS.53.4 Code of ethical conduct in the operating room to protect patient privacy, and dignity.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS.53.5 Cancellation rate and designs process to reduce it.					
ON ADMISSION						
MS.54.	There is a hospital policy and process for admitting patients to the organization for the following types of admissions process:					
	MS.54.1 Routine admissions.					
	MS.54.2 Urgent and emergency admissions.					
	MS.54.3 How to handle patients when beds are not available.					
MS.55.	All patients are admitted under a Consultant's name, referred to as, "The Most Responsible Physician"(MRP) or the Attending Physician (AP).					
MS.56.	Physicians receive timely lab results that assist with the decision making for admissions and:					
	MS.56.1 The laboratory has established turn around times for lab results.					
	MS.56.2 The laboratory communicates the turn around times to all medical staff.					
	MS.56.3 The laboratory monitors the turn around times.					
PROVISION OF CARE						
MS.57.	Clinical practice guidelines are used to guide the clinical care of the patient as appropriate.					
MS.58.	Every physician is assigned a hospital code number and preferably a stamp that is used to identify him/her for medication prescriptions and in all entries in the patient file.					
MS.59.	There is at least (1) qualified physician available at all times for each specialty according to the hospital's scope of service.					
MS.60.	Physicians who are "on call" have to be physically available in the hospital within 30 minutes when called.					
MS.61.	There is a physician order sheet and only physicians write orders on it.					

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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.62.	There is sufficient medical staff at all times to meet patient needs and with no significant variation for holidays or weekends coverage.					
MS.63.	Medical assessments are complete and accomplished according to the following guidelines:					
	MS. 63.1 The assessment is done at the time of admission.					
	MS. 63.2 The attending physician sees patients admitted within 24 hours for routine admissions, within 4 hours for urgent cases, and within 30 minutes for emergencies.					
	MS. 63.3 The assessment includes the patient's social and psychological needs.					
	MS. 63.4 The contents of the history and physical examination are determined by the department heads.					
MS.64.	Patients are screened for nutritional status and nutritional risk on admission (The nutritional screening is documented).					
MS.65.	Patients are screened for pain (acute/chronic) on admission which includes:					
	MS. 65.1 An assessment appropriate to the patient's condition.					
	MS. 65.2 The pain intensity, frequency, location, and the type of pain experienced by the patient (e.g. sharp/dull.)					
	MS. 65.3 Documentation of the pain assessment in the clinical record.					
MS.66.	Consultants see their patients in a timely manner and this includes the following:					
	MS. 66.1 Consultants see their patients at least daily for routine patient needs.					
	MS. 66.2 Consultants see their patients anytime there is a significant change (deterioration) in the patient's condition.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.67.	The Medical Director ensures that physicians receive current, accurate, and timely communication when test results warrant immediate attention and this includes the following policies:					
	MS. 67.1 Timely notification to the attending physician regarding histopathology reports.					
	MS. 67.2 Notification to the physician regarding PANIC laboratory values within one hour and immediately for life threatening results.					
	MS. 67.3 Notification to the physician regarding PANIC findings of X-ray films within one hour and immediately for life threatening results.					
MS.68.	There is a comprehensive plan of care documented in the record for every patient admitted that includes but is not limited to:					
	MS. 68.1 Information on any surgical procedure required.					
	MS. 68.2 Any postoperative care needed including required follow up and referrals.					
	MS. 68.3 All patient education provided to the patient on his/her plan of care and the anticipated outcomes, including the benefits and associated risks (e.g. for proposed surgery, procedures, treatment, etc).					
MS.69.	The plan of care is revised and adjusted appropriately according to any change in the patient's condition and this is documented in the patient record.					
MS.70.	Progress notes are written at least daily and for any change or deterioration in the patient's medical condition.					
MS.71.	Detailed progress notes are written that include the provisional diagnosis, treatment, and the plan of care.					
MS.72.	The consultation requests clearly state the question of the consultation or define the services requested, from the consultant, and are handled in a timely and appropriate manner.					

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Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
MS.73.	Consultation requests provide appropriate answers to the issues raised by the Attending physician regarding the plan of care for the patient. Consultants respond within 24 hours for routine cases and 30 minutes for emergency cases after receiving proper notification.					
MS.74.	All procedures performed on patients (whether the procedure is done on the ward, in the X-ray department, or in the operating room) have a complete description entered in the medical record and includes the patient's outcome.					
MS.75.	The Medical Director, the Nursing Director/leader, and the department heads work together to ensure that each patient receives the same standard of care when moved from one service to another during the course of treatment and this includes the following policies:					
	MS. 75.1 Admission and discharge criteria for intensive care.					
	MS. 75.2 Transfer of patients within the hospital.					
	MS. 75.3 Admission of patients from the emergency room to the various services within the hospital.					
MS.76.	The medical record contains the following information for patients transferred from one service to another:					
	MS. 76.1 Reason for the patient's admission.					
	MS. 76.2 Patient diagnosis.					
	MS. 76.3 Brief summary of hospitalization (therapies, consultations, non-invasive procedures to date).					
	MS. 76.4 Medication list.					
	MS. 76.5 Condition at the time of transfer.					
	MS. 76.6 Reason for transfer.					
MS.77.	The Medical Director works with the Nursing Director/leader and appropriate department heads to implement the following policies for Day Surgery:					
	MS. 77.1 The types of surgical procedures that are performed as Day Surgery.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS. 77.2 The kinds of patients who are NOT candidates for Day Surgery such as Sickle cell patients and patients who require greater than (2) hours of anesthesia.					
	MS. 77.3 The assessments required prior to Day Surgery are followed.					
	MS. 77.4 The process for patients who have to be admitted to the hospital from Day surgery.					
MS.78.	Patients who are admitted for surgery have a medical assessment that includes a history and physical examination prior to surgery.					
MS.79.	Patients who are admitted for surgery have appropriate diagnostic tests performed and the results documented in the medical record prior to surgery.					
MS.80.	Patients who are admitted for surgery have an anesthesia assessment prior to surgery and includes:					
	MS. 80.1 Notifying the anesthesia staff in a timely manner that allows a complete anesthesia assessment to be completed (unless there is an extreme emergency).					
	MS. 80.2 Determining if patient is a good candidate for surgery based on findings.					
	MS. 80.3 Recording the anesthesia assessment in the medical record.					
MS.81.	No patient has surgery (except extreme emergencies) without the following documents in the chart:					
	MS. 81.1 History and physical examination.					
	MS. 81.2 The preoperative diagnosis.					
	MS. 81.3 Laboratory and X-ray results if applicable.					
	MS. 81.4 Signed consent.					
MS.82.	Physicians ensure that the following process is implemented for patients who will receive blood and/or blood products and:					
	MS. 82.1 Provides information and education to the patient about the need for blood, and the benefits and the associated risks involved in receiving blood.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS. 82.2 Obtains consent from the patient and documenting this in the patient's medical record.					
	MS. 82.3 Administration of blood strictly according to hospital policy as outlined by the Blood Utilization Review committee.					
	MS. 82.4 Monitors for any side effects or disease transmitted resulting from blood administration.					
MS.83.	The Attending physician or his designee provides adequate pain relief for patients following surgery and this includes:					
	MS. 83.1 A pain assessment by the attending physician or his/her designee after the patient's surgery.					
	MS. 83.2 Adjustments to pain medications according to the patients' response by the attending or his designee.					
TRANSFER TO ANOTHER INSTITUTION						
MS.84.	The hospital has informal or formal arrangements with other institutions to accept patients for transfer when the care required is beyond the scope of service provided by the hospital and includes communication of arrangements for care with other institutions to the concerned department heads.					
MS.85.	Arrangements for patient transport include an estimation of the length of time required for transport, and an assessment of patient needs during transfer and includes:					
	MS. 85.1 An assessment of the patient's needs for Medivac-transfer.					
	MS. 85.2 Communication of the patient's needs during transfer to appropriate staff.					
	MS. 85.3 An attending physician determining the patient's need for transfer to another institution, the most suitable time for transfer, and if the receiving institution is able to meet the patient's needs.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS. 85.4 Staff accompany patient are chosen according to patient condition.					
MS.86.	Receiving institutions receive the necessary information to provide care to the patient and this includes the following:					
	MS. 86.1 Reason for the patient's admission.					
	MS. 86.2 Patient diagnosis.					
	MS. 86.3 Brief summary of hospitalization (therapies, consultations, non-invasive procedures to date).					
	MS. 86.4 Medication list and time of last dose given.					
	MS. 86.5 Condition at the time of transfer.					
	MS. 86.6 Reason for transfer.					
	MS. 86.7 Copy of the patient's Laboratory investigation and X-rays are sent with the patient to avoid further delay in treatment.					
MS.87.	Transfers are done quickly and safely especially in emergency cases (e.g. trauma, or cardiac emergency) and the medical staff ensure that the patient's needs are met by:					
	MS. 87.1 Assigning a qualified physician or paramedic (as appropriate) to accompany the patient and handle any emergency that might happen during transfer.					
	MS. 87.2 Assigning a physician certified in BCLS (preferably ACLS) to accompany all critically ill patients or intubated patients.					
	MS. 87.3 Having adequate equipment and supplies on the ambulance.					
MS.88.	The patient is continuously monitored by qualified physician during the transfer.					
MS.89.	The hospital has a written policy and procedure regarding the acceptance of patients from other hospitals and the transfer of inpatients to other hospitals.					

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
DISCHARGE / REFERRALS						
MS.90.	The Attending physician ensures that patient's discharge needs are met and communicates the patient's readiness for discharge home to appropriate hospital staff.					
MS.91.	The Attending physician educates his / her patient on the following issues prior to discharge:					
	MS. 91.1 The patient's illness and how to provide self-care.					
	MS. 91.2 Times to take the medication and any special instructions.					
	MS. 91.3 Any equipment that the patient will use at home.					
	MS. 91.4 When to call the physician and how to obtain "urgent" care.					
	MS. 91.5 Why the patient needs to see any sub specialist. (If applicable).					
	MS. 91.6 The reason the patient needs to be transferred to another institution (if applicable).					
	MS. 91.7 Involving the family members whenever patients cannot fully understand the information provided to them (if applicable).					
	MS. 91.8 Documenting all education and information provided to the patient and/or family in the medical record.					
MS.92.	The Attending physician ensures that continuity of care occurs after discharge or referral by:					
	MS. 92.1 Assigning the follow up appointment for the patient.					
	MS. 92.2 Arranging any referral services for the patient.					
	MS. 92.3 Communicating with other receiving physicians in case of transfer.					
DOCUMENTATION AFTER DISCHARGE						
MS.93.	After the patient is discharged, a discharge summary is written in the medical record by the Attending physician and includes:					

Medical Staff and Provision of Care (MS)

Standard		FM (3)	PM (2)	MM (1)	NM (0)	NA
	MS. 93.1 The reason for the patient's admission.					
	MS. 93.2 The patient's diagnosis.					
	MS. 93.3 A brief summary of hospitalization (therapies, consultations, non-invasive interventions and results of any important diagnostic testing).					
	MS. 93.4 A list of medications used.					
	MS. 93.5 Any surgery or procedures performed.					
	MS. 93.6 The outcome of surgery and treatment.					
	MS. 93.7 The patient's condition at discharge.					
	MS. 93.8 All the medications to be taken by the patient after discharge.					
	MS. 93.9 Any special care the patient requires after discharge.					
	MS. 93.10 A copy of the discharge summary kept by the medical record department.					