PREAMBLE

These Medical Staff Bylaws, Rules and Regulations are established to govern the Al Adwani General Hospital Medical Staff. The bylaws provide guidelines for organizational processes to govern and evaluate practitioners applying for the hospital's medical staff and/or clinical privileges; utilization review, quality improvement activities, corrective action, hearing and appellate, responsibilities and accountability, education, training, and overall communication channels, as described herein.

These Bylaws shall not contradict any legally binding law and shall comply with the Rules and Regulations of the Ministry of Health, and the Laws of the Kingdom.

By the provision of these Bylaws, Al Adwani General Hospital acknowledges that the Medical Staff is responsible for providing quality and safe, care, treatment, and services to all its patients. To comply with this obligation, all Medical Staff of the Hospital must be provided with the duly approved and signed Medical Staff Bylaws upon joining the Organization, and all are expected to comply with the bylaws as established.

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ARTICLE 1: DEFINITION OF TERMS

The meanings set out in the Definition of Terms are to be attributed to such terms as used in these Bylaws and will be capitalized unless otherwise clearly required by the context in which such terms are used. In consulting these Bylaws the reader should first become familiar with the Definition of Terms.

When used in connection with the Medical Staff Bylaws, the following terms shall have the meaning given below, unless otherwise specified, or unless otherwise clearly required by the context in which they are used:

1. **Allied Health Professional -** an individual, other than a Practitioner (see definition below), possessing qualifications in one of the categories of ancillary health care, which may be determined from time to time to be beneficial to and required for patient care within the Hospital.

2. **Appeal -** an application from a Practitioner, who is the subject of a warning or limitation of clinical privileges, and is requesting a reconsideration of the decision.

3. **Categories -** descriptions of the types of Medical Staff according to status (e.g., "Permanent", "Trainee", "Temporary").

4. **Clinical Privileges -** specific rights granted to individual Practitioners authorizing the admitting of patients and/or carrying out of designated investigations and/or procedures.

5. **Code of Conduct -** A set of principles and expected behaviors that are expectations of employee performance within a healthcare setting or as defined by the leadership group.

6. **Competency -** Knowledge, skills, and attitudes required to perform the job. Knowledge is the understanding of facts and procedures. Skill is the ability to perform specific actions.

7. **Committee -** A multidisciplinary body of persons officially delegated to consider, investigate, take action on, or report on some matter or perform a specified function.

8. **Confidentiality -** The restricted access to data and information to individuals who have a need, a reason, and permission for such access. An individual's right to personal and informational privacy, including his or her healthcare records.

9. **Corrective Actions -** the process activated in the event of the finding of substandard professional practice.

10. **Credentialing -** The process of obtaining, verifying and assessing the qualifications of a healthcare professional to determine if that individual can provide patient care services in or for a healthcare organization.

11. **Emergency -** a situation in which there is an immediate danger of loss of life or serious disability and in which any delay in treatment might increase that danger.

12. **Ethics -** moral principles and values adopted by the particular profession of each Practitioner and Allied Health Professional, which shall be consistent with the policies of the Hospitals and Laws governing the practice of medicine within Kingdom of Saudi Arabia.

13. **Job Description -** A written statements that describes the duties, responsibilities, required qualifications of candidates, and reporting relationship and coworkers of a particular job.

14. **Licensure -** A license to practice in the indicated field of medicine issued from the Saudi Council for Health Specialties.

15. **Memorandum -** the written transmission of information, distributed to the intended recipients/department or for general announcements to inform and/or to carry out certain functions or activities.

16. **Most Responsible Physician (MRP) -** generally refers to the physician who has overall responsibility and accountability for directing and coordinating the care and management of an individual patient at a specific point in time.

17. **Notice -** the oral or written transmission of information by posting within the Hospitals, inclusion in publications distributed to the intended recipients, general announcements, telephone, personal delivery, mail delivery, or any other means reasonably calculated to inform.

18. **Policy -** A written document which outlines the rules and expected performance of staff within the organization. Policies are dynamic and reflect current knowledge and practice and need to be reviewed on a regular basis.

19. **Practitioner -** any physician or dentist licensed by the Saudi Council for Health Specialties (SCHS) to practice his profession within the Kingdom of Saudi Arabia.

20. **Pre-requisite -** a condition which must be demonstrated to exist with respect to a Practitioner or Allied Health Professional as a prior requirement for a status or position.

21. **Prerogative -** a participatory right granted to a Practitioner or Allied Health Professional within the limitations provided by these Bylaws and other Policies of the Hospitals.

22. **Privileging -** The process of reviewing an individual's credentials through credentials body to determine the authority and responsibility to be granted to a practitioner for making independent decisions to diagnose, initiate, alter, or terminate a regimen of medical or dental care. Privileging determines the physician's scope of practice in the organization determined by his/her competencies.

23. **Probationary period -** The time period identified by the organization for determining if the employee is competent to perform his/her duties and continue employment with the organization. Generally, the time period of probation is 3 months.
24. **Procedure -** A written set of instructions that describe the approved and recommended steps for a particular act or sequence of acts.

25. **Protocols -** a plan or set of steps, to be followed in a study, an investigation, or an intervention.

26. **Qualifications -** all of the factors which are prerequisites to eligibility for, or which are relevant to, the evaluation of an individual for a particular appointment or undertaking.

27. **Terms of reference -** A formal document approved by the leadership that outlines the roles/responsibilities of a committee. This document describes the expected performance of the committee, how often the committee is expected to meet, and also includes a list of the membership and alternates if needed.

28. **Warning -** a verbal or written communication issued by way of Corrective Action to a Practitioner or Allied Health Professional indicating that his or her performance has been found to be below acceptable standards and requiring improvement to be demonstrated.

ARTICLE 2: OBJECTIVES

The objectives of Al Adwani General Hospital Medical Staff Bylaws are:

1. To ensure that all patients admitted to or treated in any part of the Hospitals shall at all times receive the best and same standards of possible care and attention.

2. To ensure the maintenance of the highest level of professional performance and behavior by all Medical Staff.

3. To provide an appropriate educational setting that will maintain high standards, and will advance professional experience and knowledge of the Medical Staff of the Hospitals.

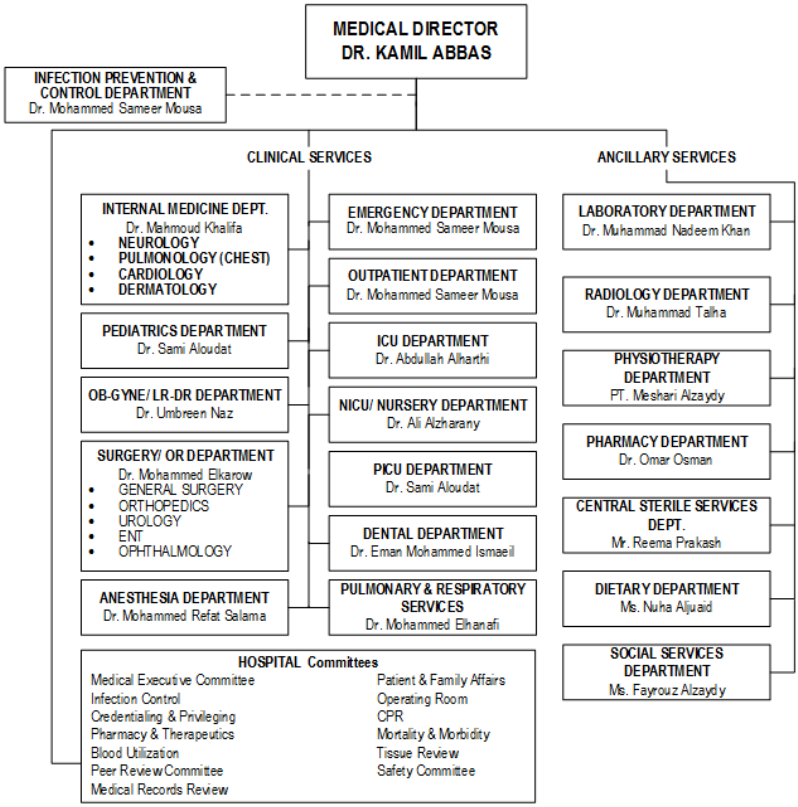
4. To serve as a reference for all administrators, medical staff members, and others when required on matters concerning the Medical Staff, such as the appointment and reappointment of Medical Staff and the policies and procedures to be followed by the Medical Staff in the performance of their duties.

5. To ensure compliance of all medical staff with high quality international practice and quality standards.

6. To facilitate the Medical Departments and Cross Functional Team meetings and to establish guidelines and the scope of such meetings.

ARTICLE 3: MEDICAL DEPARTMENT

MEDICAL SERVICE DEPARTMENT ORGANIZATIONAL CHART



Prepared By:

Dr. Kamil Abbas
Medical Director

Approved By:

Mr. Abdulrahman Al-Adwani
Hospital Executive Manager

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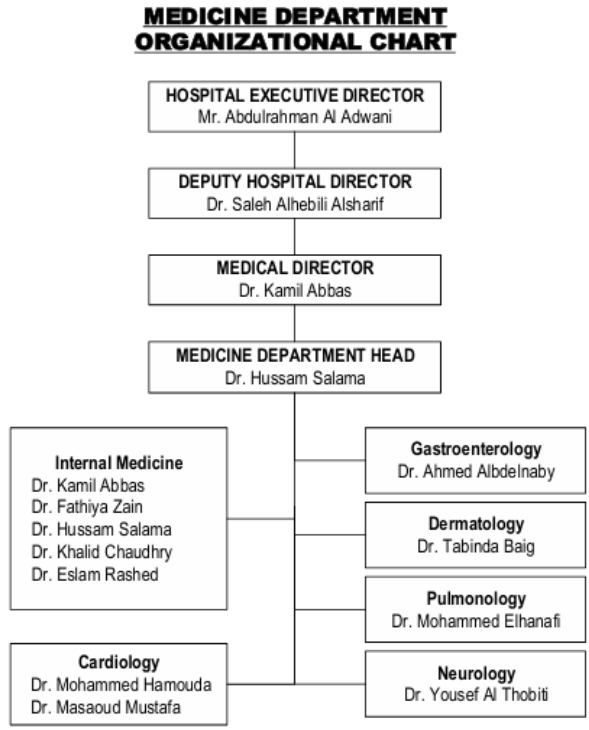
Effective Date: **December 2023**
Revision Date: **December 2024**

ORGANIZATIONAL CHART
ARTICLE 3: MEDICAL DEPARTMENT ORGANIZATIONAL CHART



Prepared By:	Reviewed By:	Approved By:
Dr. Hussam Salama	Dr. Kamil Abbas	Mr. Abdulrahman Al-Adwani
Head, Internal Medicine Dept.	Medical Director	Hospital Executive Manager

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ARTICLE 4: MEDICAL STAFF QUALIFICATION REQUIREMENTS

Any candidate requesting appointment to the Medical Staff shall be required to meet at least the following qualifications in order for his/her candidacy to be pursued:

1. Be a graduate of an accredited medical or dental school.

2. Hold a current licensure to practice medicine and /or dentistry in his/her country of origin and a current and valid License by the Saudi Council for Health Specialties.

3. Meet the qualification requirement outlines in the Job Description.

4. Provide an evidence of current competency, through relevant training and/or experience in his/her specialty, and in particular for the specific clinical privileges requested.

5. Provide an evidence of a physical and mental health status necessary to meet the practice requirements, and agree to submit to a physical and mental assessment, if deemed necessary.

6. Provide at least three (3) references from medical professionals with whom they have recently worked over a reasonable period of time and who can attest to the applicant's good standing and adherence to the principles of professional ethics, patient's right and medical code of ethics.

7. Report on the application, any voluntary and/or involuntary terminations, and any limitations, reductions, and/or loss of clinical privileges at another hospital.

8. Document his/her experience, background, training and physical and mental health status to demonstrate to the Medical Director, and the Medical Recruitment and the Credentials, Promotions, and Privileges Committee that the applicant has the ability and experience to treat assigned patient with high medical care.

The applicant shall also:

1. Authorize Al-Adwani General Hospital, or its recruiting agent, to consult with members of Medical Staff of other hospital with which the applicant has been associated, and with others who may have information bearing on his/her competence, character and ethical qualifications.

2. Consent to allow Al Adwani General Hospital or its recruiting agents to inspect all records and documents that may be material to his/her professional, moral, and ethical qualifications of competence.

3. Release from any liability all representatives of Al Adwani General Hospital for their actions performed, in good faith and without malice, in connection with evaluating the applicant

4. Submit a completed application, which shall be processed as indicated in the Al Adwani General Hospital policies governing the appointment process.

ARTICLE 5: CATEGORIES OF THE MEDICAL STAFFS

There shall be six categories of the Medical Staff:

1. **Permanent Medical Staff**

   This category applies to Medical Practitioners appointed to the Medical Staff on full time permanent basis. Members of the Permanent Medical Staff have defined clinical privileges, shall serve on the Hospital Standing Teams as appointed, and shall be required to attend the respective meetings.

2. **Visiting Medical Staff**

   This category applies to Medical Practitioners appointed to the Medical Staff subject to an invitation by the hospital administration to undertake the care of patients, teaching, or research within the Hospitals for a short period of time. Visiting Medical Staff may be granted the same privileges accorded to Permanent Medical Staff (with the exception of admission privileges) based on recommendations of the Credentials, Promotion, and Privileges committee.

   Visiting Medical Staff shall not be eligible to hold position nor serve on Hospital Standing Teams. A Visiting Medical Staff appointment may not exceed three months.

3. **Temporary (Locum) Medical Staff**

   This category applies to Medical Practitioners appointed to the Medical Staff on a locum basis. The appointment of a locum staff may not exceed six months. The Dean, based on the recommendations of the Vice Dean for Hospital Affairs and the

Credentials, Promotion, and Privileges committee shall have the authority to grant the clinical privileges according to the applicant's specialty and requirements.

4. Part Time Staff

This category applies to Medical Practitioners appointed to the Medical Staff on a part time basis. The Medical Director, after receiving the recommendations of the Credentials and Privileges committee shall have the authority to grant the clinical privileges according to the applicant's specialty and requirements.

5. Voluntary Staff

This category applies to the Medical Professionals who are permitted by the hospital administration to work on a voluntary basis to undertake patient care, teaching, and/or research. Voluntary staff may be granted privileges by the Credentials and Privileges committee.

6. Trainee Staff

This category consists of interns, residents, fellows, or any other individual who is a trainee. Except in the case of rotating interns, trainee staff shall be assigned to a specific clinical department, and shall be required to meet the educational and training standards of that department and their training program

7. **Clinical Supportive Staff: (Pharmacist, Technicians and Therapist)**
All of the above categories may be applied to the clinical supportive services staffs who are not physicians.

ARTICLE 6: DUTIES AND RESPONSIBILITIES OF THE MEDICAL STAFFS

1. The Medical Staff shall evaluate practitioner and institutional performance, through valid and reliable measurement systems based on objective, clinically-sound criteria, and internationally accepted standards.

2. The Medical Staff shall recommend to the Hospitals Administration the establishment and provision of professional standards in accordance with the Ministry of Health Rules and Regulation, the Rules of the Saudi Council for Health Specialties, and the relevant, recognized worldwide standards and applicable advances in medical care.

3. The Medical Staff shall conduct or obtain others to conduct and arrange for Medical Staff participation in education programs, designed to meet the needs of staff members.

4. The Medical Staff shall evaluate practitioner credentials for appointment and reappointment to membership in the Medical Staff organization and for the delineation of clinical privileges that may be exercised by each individual practitioner in the Hospitals.

5. The Medical Staff shall assure that medical and health care resources at the Hospitals are appropriately employed for meeting patients' medical, social, and emotional needs, consistent with sound health care resource utilization practices.

6. The Medical Staff shall conduct a systematic review of all members regarding the quality of care provided by the medical staff, departments, division, and members in relation to the established standards as part of the Hospitals' Quality Management Program.

7. The Medical Staff shall analyze the results of review activities in order to identify problems in the provision of care.

8. The Medical Staff shall review and, if necessary, revise these Bylaws every (2) years or as deemed necessary by the Medical Staff and/or Hospitals' Administration.

9. The Medical Staff shall ensure that all members are subject to the Medical Staff Bylaws rules and regulations and the relevant department policies and procedures.

10. To ensure that all patients admitted to or treated in any of the facilities, departments, or divisions of the hospitals receive the best possible quality patient care and treatment.

11. To comply with the standards set forth by the relevant International Accreditation Agency that has been selected by the Hospitals and perform duties necessary to support and achieve accreditation.

12. To constitute a professional collegial body to provide its members mutual education, consultation, and professional support, and to maintain a level of quality and efficiency at the Hospitals, this is optimally achievable given the state of the healing arts and the available resources.

13. To serve as the collegial body through which individual practitioners may obtain membership prerogatives and clinical privileges at the Hospitals in order to provide clinical services to patients and to engage in teaching and research.

14. To provide a method whereby the Medical Staff may participate in the decision-making process pertaining to medical matters

15. To provide a mean by which members of the Medical Staff can formulate recommendations for the Hospitals' policy-making and

planning processes, and through which such policies and plans are communicated to and implemented by each member of the Staff.

16. To prepare a mechanism whereby all physicians are systematically integrated into the Medical Staff.

17. To assume the responsibility for the quality of professional services provided by the individuals with clinical privileges.

18. To provide a framework whereby medical staff members can understand their duties and obligations to be able to act with a reasonable degree of freedom and confidence.

19. For Call responsibilities of medical staff, please refer to these policies;

19.1. MPP-NR-004 - Verified Telephone Order
19.2. MPP-NR-007 - Calling Physicians
19.3. IPP-MS-002 - Physician On-Call
19.4. MPP-L&D-001 - Call a Pediatrician to L & D Area
19.5. MPP-ER-015 - On-Call Rotas
19.6. MPP-ER-014 - Calling the Consultants

Related Duties of the Medical Staff

1. **Consultant -** A consultant, in addition to his routine clinical duties may be assigned as:

    1.1. The Chairman/Head of a medical department/division and carryout the duties of a department chairman.

    1.2. A consultant responsible for advising clinical staff in their department on clinical, educational, and/or research matters. This position may be assigned on a rotational basis and may be renewed yearly by the Credentials and Privileges committee.

    1.3. A consultant responsible for advising, supervising and teaching the senior registrar/junior medical staff attached to their department. He/she must also adhere to the following:

    1.4. Adhere to Medical Staff Bylaws, Code of Medical Ethics, and policies, procedures, and guidelines specific to their respective department.

    1.5. Provide the highest attainable standard of medical care for the patients for whom he/she is responsible.

    1.6. Supervise the work of his/her team including the professional performance and ethical behavior of the medical staff assigned to him/her.

    1.7. Participate in departmental educational activities.

    1.8. Represent his/her department and/or Hospital in assigned departmental and/or cross functional teams.

1.9. Participate in medical education programs and maintain the necessary current clinical licenses as required by the Saudi Medical Council.

1.10. Perform a full range of clinical activities in his/her field of specialty as an active consultant, including on-call duties.

1.11. Participate in the disaster and emergency drills, including the Major Disaster Plan, Code Blue, Code Red Plan of the hospital, as per assignment.

1.12. Carryout other duties/responsibilities within the realm of his/her specialty and skills, as assigned by their supervisor.

2. **Associate Consultant (Acting Consultant) -** An Associate Consultant will perform all the clinical duties of a full consultant, except that he/she must be supervised by a Consultant. He/she will perform all other duties assigned to him/her by the Director of the Department. In addition to his/her clinical duties, an Associate Consultant will also perform the following responsibilities:

    2.1. Adhere to Medical Staff Bylaws, Code of Medical Ethics, and policies, procedures, and guidelines specific to their respective department.

    2.2. Provide the highest attainable standard of medical care for the patients for whom he/she is responsible.

    2.3. Supervise the work of his/her team including the professional performance and ethical behavior of the medical staff assigned to him/her.

    2.4. Participate in departmental and educational activities.

2.5. Participate in the disaster and emergency drills, including the Major Disaster Plan, Code Blue, Code Red Plan of the hospital, as per assignment.

2.6. Carry out other duties/responsibilities within the realm of his/her specialty and skills, as assigned by their supervisor.

3. Senior Registrar

A Senior Registrar shall be accountable to a named member of the Consultant Staff for the care of both inpatients and outpatients and shall be responsible for advising, supervising, and teaching the Junior Medical Staff in the Department, in addition to his/her clinical responsibilities.

4. Specialist

A Specialist Shall be accountable to a named member of the Consultant Staff for the care of both inpatients and outpatients and shall be responsible for advising, supervising and teaching the Junior Medical Staff in the Department, in addition to his/her clinical responsibilities.

5. Fellow

A Fellow shall be the holder of a training post occupied by a doctor who has obtained postgraduate qualifications, such as a Saudi Specialty Certificate, Arab Board, or equivalent in the field of his/her specialty and will progress through a period of higher professional training in a major or a sub-specialty discipline. The training period will range from two to three years according to the requirements of his/her sub-specialty.

6. Chief Resident

A Chief Resident shall be a Senior Resident elected by the educational committee of the department. It is an honorary nomination with one chief resident per department. He/she will represent all the Residents within the department, liaise with the Supervisor of Training in all matters, and serve as a member of the Educational Committee. He/she will also be responsible for coordinating the on call rotation.

7. Senior Resident

The Senior Resident shall report to the Consultant in the care of both inpatients and outpatients. The Fellow and Consultant in charge will supervise the clinical responsibilities of the Senior Resident within the limits of his/her privileges. He/she shall be responsible for teaching and training Junior Residents and Interns.

8. Resident

The Resident does not have independent privileges to admit or treat patients. Residents shall be accountable to a named member of the Consultant Staff for the care of both inpatients and outpatients within the limits of his/her clinical privileges, based on their training program guidelines and shall be directed by the Consultant, Senior Registrar, and Registrar in the department in which he/she is employed. An official list of current Residents will be kept in the Postgraduate Medical Office.

ARTICLE 7: OFFICERS

The Officers of the Medical Staff have the overall responsibility for the quality of professional services provided by individuals with clinical privileges, as well as the responsibility of accounting thereof to the Hospital.

1. **The Medical Director.** The Medical Director as appointed by the Hospital Executive Manager is held accountable for the quality of medical care in the Hospital and provides advice regarding medical affairs to the Hospital Executive Manager.

RESPONSIBILITES:

1.1. To ensure that appropriate system for the on-going review and analysis of care provided by all physicians are affected, be aware of the results of all review activities and ensure that corrective actions are taken.
1.2. To regularly report to the Hospital Executive Manager regarding such matters.
1.3. To call, preside and be responsible for the agenda of all general meetings of the Medical Staff.
1.4. To represent the views, policies and needs of the Medical Staff.
1.5. To represent the Medical staff in its external professional and public relations.
1.6. To be responsible with and through Head of Department to the Hospital Executive Manager for the professional performance of each physician in striving for excellence in patient care.
1.7. To work closely with the Heads of the Department and committees in ensuring Medical Staff input in the Hospital and project decision-making.
1.8. To ensure adequate physician manpower to met the medical care needs of the patients.
1.9. To evaluate the Department Heads in accordance with pre-established criteria and Hospital policies.

AUTHORITY:

1. He shall have the authority to enforce Medical Staff By-Laws, Rules and Regulations.
2. He shall have the authority to initiate any investigation into the performance or conduct of the Medical Staff where there may be cause for concern.
3. He shall chair the medical staff meetings.

2. **Department Heads.** The Head of the Department is responsible to the Medical Director for the quality of medical care and the administrative activities of the department as well as for fulfilling the purposes and functions of the Medical Staff as they relate to the Department.

RESPONSIBILITIES:

2.1. To ensure that programs are designed for the establishment, maintenance and continuing improvement in the quality of medical care in the Department.
2.2. Report regularly on such activities to the Medical Director.
2.3. To ensure the development and maintenance of appropriate rules and regulations governing the conduct of the members of the Department and their compliance therewith.
2.4. To recommend to the Medical Director, criteria for the delineation of clinical privileges.
2.5. To recommend the appointment and privilege delineation for each member of the Department.
2.6. To identify physician manpower requirements to meet the medical care responsibilities of the Department.
2.7. To closely supervise the patient care activities of all members of the Department holding temporary privileges or provisional appointment.
2.8. To keep members of the Department informed of all matters concerning Hospital policy, goals or objectives or administrative matters and to solicit their input.

2.9. To chair all Departmental Meetings, serve on all departmental committees and keep records on the activities of departmental members.

AUTHORITY:

1. To request a consultation on any patient under the care of a department member.
2. To recommend appointments and hold accountable Heads of Department who shall also have Saudi Board specialist qualification or equivalent, and to whom he may delegate, medical care and administrative matters and responsibilities.

ARTICLE 8: PATIENT REGISTRATION AND ADMISSION PROCESS

PURPOSE:

To ensure that the patient's journey through the registration, admission process and subsequent hospital stay and discharge, are as smooth and trouble free as possible.

DEFINITION:

1. **Patient registration.** A process in which patient is being registered in the hospital information system.

2. **Hospital Admission.** The formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with room, and continuous nursing service in an area of the hospital or facility where patients generally reside at least overnight. An inpatient admission is categorized as an emergency, urgent or routine admission. The appropriate admission category depends on the clinical condition of the patient as assessed by the receiving consultant.
    - **1.1 Emergent/Emergency.** A medical condition classified as life-threatening manifests itself by acute symptoms of sufficient severity (including severe pain) and needs emergent treatment within 30 minutes. Conditions requiring emergent care are included but not limited to the following:
        - **1.1.1** Uncontrolled bleeding
        - **1.1.2** Head injury or broken bones
        - **1.1.3** Poisoning or suspected overdose
        - **1.1.4** Inability to breathe or shortness of breath
        - **1.1.5** Seizure or loss of consciousness
    - **1.2 Urgent.** Hospital admissions and/or treatment that cannot be delayed but is not classified as life-threatening. Urgent

conditions require timely and within 4 hours diagnostic work-up and/or treatment to avoid a subsequent emergent situation. The following symptoms that generally indicate an urgent care includes but not limited to the following:

1.2.1 Bruises, abrasions and minor cuts
1.2.2 Minor burns
1.2.3 Eye, ear or skin infections
1.2.4 Respiratory infections

1.3 Routine or Preventive (Non-Emergent). Postponement of treatment will not endanger life, limb or mental faculties of patient, i.e., patient's condition permits adequate time or within 24 hours to schedule necessary history and physical, laboratory, radiology or other diagnostic investigations on an outpatient basis.

RESPONSIBILITY:

1. **Reception Staff -** responsible for registering patients in the hospital information system.

2. **Admitting Nurse/Midwife.** It is the responsibility of the nurse/midwife to assist the patient upon arrival to the clinic or to the hospital and do proper assessment by taking the vital signs, asking for the chief complaint/s and do Cephalocaudal assessment. The admission nurse/midwife is responsible also to look for entire medical histories and report files which are related to patient's condition.

3. **Admitting Section.** The Admitting Section is responsible in fulfilling all initial formalities such as admission of patient, explaining patient and his/her family members regarding medical facilities which will be provided during the stay. Apart from medical services, the Admission Officer is also responsible in getting pertinent data's such as complete name of the patient and Iqama number and making sure that consent form is signed prior to admission.

Patient's right and responsibilities is also explained to the patient and his/her relatives who will govern them during their stay in the hospital.

4. **Admitting/Attending Physician**. It is the responsibility of the doctor to assess the patient on admission and do treatment and procedures whenever needed. The doctor is also responsible in completing an admission sheet including medical history of the patient and the medications currently taking, physical exam and systemic assessment and making the treatment plan. The admitting or attending doctor is responsible for the decision on admission reflected in the physician's order form.
5. **Medical Records Officer.** It is the responsibility of the medical record staff to maintain records and file of the patient making sure that the content of the file belongs to the correct patient.

POLICY:

The Al Adwani General Hospital will ensure:

1. All patients are treated as individuals and that their needs are met in a manner that recognizes this.
2. All patients and their relatives are involved in planning their care from the moment they are admitted to hospital.
3. The admission process is monitored to ensure it meets the requirements of our patients and, where problems occur; we will take action to rectify them.
4. Any concerns of the patient and relatives have regarding the progress of their admission will be listened to. Where appropriate, action will be taken to address these concerns.
5. The importance of early planning to facilitate a smooth discharge is recognized; therefore this process will begin as soon as practical after admission.

PROCEDURE:

1. All patients are admitted by the most responsible physician on his orders.
2. While the relatives are still present the information submitted to the admission clerk, professional nurse or staff midwives should be checked and filled in on the patient file. The information should include the following:
    - **2.1.** Full Name and address of patient
    - **2.2.** Age and date of birth
    - **2.3.** Religion
    - **2.4.** Gender, Single, married, widow, widower, divorced
    - **2.5.** Medical Records Number
    - **2.6.** Occupation
    - **2.7.** Nearest relative for emergency, telephone number
    - **2.8.** Attending Physician
    - **2.9.** Provisional Diagnosis
    - **2.10.** Date and time
    - **2.11.** Any kind of allergies
    - **2.12.** (For Insurance Purposes) Main member name
    - **2.13.** Postal address and contact telephone number for main member
    - **2.14.** ID number of main member
    - **2.15.** The consent form is signed and witnessed.
    - **2.16.** A patient record admission note to be completed.
    - **2.17.** A care plan to be completed.
    - **2.18.** A nursing admission assessment to be completed.
    - **2.19.** A patient education chart to be completed.
3. The patient's rights and responsibilities which will govern them during their stay in the hospital should be explained in the Admitting Section to the patient and relatives prior to admission. Admission Consent is signed also prior to admission.
4. All patients shall be received in a friendly warm and reassuring manner.

5. The registered nurse performs an initial screening and assessment, using the appropriate Admission Assessment Form and pain measurement tool(s).
6. General areas for Adult and Pediatric patients use the Pain Scale of 0-10. If they cannot understand or are unwilling to use the scale, the Wong Baker FACES pain rating scale is used.
7. When patients are not able to give any form of self-report of pain for whatever reason; e.g., pharmacological/physiological paralysis, developmental level, persistent vegetative state, severe mental retardation, visual and hearing impairment, the Nonverbal Pediatric/Adult Pain Scale is used.
8. The physician performs an initial pain assessment for pain factors, history and physical.
9. When pain is identified, a comprehensive assessment is performed and documented. This assessment is appropriate to the patient's age and measures pain intensity and quality, such as:
   - **8.1.** Pain character;
   - **8.2.** Frequency;
   - **8.3.** Onset;
   - **8.4.** Location
   - **8.5.** Duration
10. Reassessment occurs with each new report of pain, at a suitable interval following any pain control intervention (particularly if a new medication or dosage is involved), and at regular intervals appropriate to individual person status.
    - **10.1** Acute/chronic pain will be reassessed within 1 hour depending on the medication and/or alternative treatment administered. The physician is notified when the pain score ≥ 4 indicating the prescribed pain management regimen, is not effective.
11. The relatives are requested to remain outside until the patient is comfortably in bed, unless they are leaving immediately, in which case they should be allowed to see the patient before they go. They are informed of the visiting hours (for ICU Patient).
12. The blood pressure, glucostix, temperature, pulse and respiration are taken, recorded and abnormalities reported to the sister in charge.

13. A laboratory specimen is obtained as soon as possible – tested, charted and abnormalities reported.

14. If the patient is in a fit state he/she is allowed to bath in the bathroom, if not he must have a bed bath.

15. After the assessments and initial management done by the nurse upon receiving the patient, patient should be oriented and educated of their rights and which will govern them and their relative while being confined in the hospital.

16. All patients and relatives should be oriented of all the facilities in the room upon admission, like: the usage of call bell, how to operate the bed, how to use the phone to call the operator & to make an outside calls, light switches and the air conditioning regulator, and other related equipments they might be using while being in the hospital.

17. All patients and relatives shall be oriented of the "No Smoking" Policy, the Safety Measures, Fire Exits and Safety Precautions needed in case of emergencies in the hospital.

18. All patients for admission shall follow the Criteria for Admission strictly:

18.1 Patients referred from other hospital shall be admitted following the priority of admission within 24 hours with prior notice to assure bed availability.

18.2 No patient shall be admitted without payment of a part of the agreed price or the Referral Letter from the referring hospital.

18.3 No patient shall be refused of hospitalization except those prohibited by the rules and regulations and the laws governing the Kingdom of Saudi Arabia.

18.4 No patient for surgery shall be admitted without their valid identification.

18.5 No patient shall be admitted by delivery without Iqama or Saudi ID and marriage certificate, incompliance to the Saudi Laws.

18.6 Emergency patients must be prioritized and immediately assessed, treated and where appropriate, admitted for treatment.

19. If the patient is wearing a "Medic-Alert" identification disc this must be reported.
20. All patients to be weighed.
21. All valuables of the patient should be secured and listed on the “safe keeping form” provided by the nurse on duty.
22. Record the admission on the Daily Statistical Return and the Day and Night Report.

Prior to Admission. Upon accepting an emergency admission the most responsible physician will:

1. Inform the relevant clinical area i.e. Accident and Emergency or the Ward in order that preparations can be made for the patient’s arrival.
2. Where indicated organize the appropriate tests for when the patient arrives, thus reducing delays and facilitating a swift admission process.
3. Ensure that the ward team has all relevant equipment ready to hand, and that appropriate documentation is prepared for the patient’s arrival.

Elective Admission to the Hospital. An elective admission is defined as a planned admission from the patient’s home (or temporary place of residence), that occurs after a period of consultation, usually with a doctor.

Emergency Admissions to Hospital. Emergency admissions may be defined, as those where individuals require prompt in-patient assessment and treatment in a hospital setting. By their nature, emergency admissions allow for little planning.

Day Case Admissions. Although the patient’s stay is much shorter for day cases the general principles of admission highlighted previously still apply. Patients will be given an admission time so that they can see the appropriate professionals before going to theatre. As there will be a number of procedures on the days operating list, there may be a delay between admission and operation. Patients should be made aware of this, and therefore that they might need to spend the majority of the day in hospital before being discharged.

Plan of Care. Strategies designed to guide health care professionals involved with patient care. Such plans are patient specific and are meant to address the total status of the patient. Care plans are intended to ensure optimal outcomes for patients during the course of their care. Please refer to policy number MPP-MS-005 Plan of Care for more details.

ARTICLE 9: TRANSFER AND REFERRAL PROCESS

PURPOSE:

To establish a policy for transferring and/or referring patients;

1. Consultations between specialty services
2. To another facility or institutions in accordance with applicable law and regulations of the Kingdom.

DEFINITION:

1. **Transfer -** The formal shifting of responsibility for the care of a patient from one care unit to another, one clinical service to another, one qualified practitioner to another, or one organization to another organization. "Transfer" does not include such movement of a patient who leaves the facility against medical advice. The term "transfer" does not apply to the discharge or release of a patient who is no longer in need of hospital care, or to the hospital's lawful refusal, after an appropriate medical screening, to render any medical care upon the ground that the person does not have a medical need for care.
2. **Referral -** The process by which a patient is sent (1) from one clinician to another clinician or specialist; or (2) from one setting or service to another, either for consultation or care that the referring source is not prepared or qualified to provide.

RESPONSIBILITY:

1. **Most Responsible Physician (MRP) -** If the Attending Physician or Consultant determines that the patient's condition can be more appropriately evaluated by an attending Physician in another specialty (and/or at another hospital), or if the patient's condition requires specialized capabilities or facilities not available in our facility but available in the referring hospital. It is within the MRP's responsibility to assess the need for transfer and matches the condition of the patient with admission criteria of the unit; to order for referral to another specialty or transfer to another hospital and discuss the referral with the patient and relatives, to determine the need for transfer, the most suitable time for transfer, resources required during

transfer, and whether the receiving organization can meet the patient's health and supportive needs.

2. **Nurse -** It is the responsibility of the nurse to;
   2.1 Prepare a consultation referral form filled up by the referring physician and to inform the accepting physician regarding the referral.
   2.2 Prepare all appropriate medical records or copies thereof, including necessary information regarding the medical history of the patient, observations of signs or symptoms, preliminary diagnosis, results of laboratory investigations or treatment provided. Other appropriate medical records not available at the time of transfer must be sent as soon as practicable thereafter. Additionally, it is the responsibility of the nurse to properly and accurately document the transfer.

POLICY:

1. It is the policy of this hospital to correctly document all information related to the referral and/or transfer of patients in order to avoid risk to patients which could be caused by errors of omission or commission, and to provide continuity of care after transfer and/or referral to other specialty. The patient who requires emergency care must be stabilized first in transferring unit/service before transfer.
2. Verbal or written agreement as received from the receiving unit is documented in the patient's medical record, including the name of the receiving physician.
3. Summary of the patient medical and nursing assessment findings including reason for transfer, diagnoses, clinical findings, and current medications is available in the patient's medical record before transfer.
4. The physician and the nurse at the receiving unit assess the patient at arrival to ensure safe and smooth handover.
5. Transfer is based on the patient's health needs for continuing care and the resources available for both referring and receiving organizations.

PROCEDURE:

TRANSFERRING PATIENTS FROM ONE UNIT TO ANOTHER UNIT:

1. Patients who are transferred from the General Ward to other Department or vice versa, must be transferred with their patient file and be noted on the medical file of the patient.
2. The medical record contains, the following information for patient transfer:
   - **2.1.** Reason for transfer
   - **2.2.** Patient diagnosis
   - **2.3.** Medication list
   - **2.4.** Condition at the time of transfer
3. The transferring unit must notify the receiving unit prior to transfer about the patient's condition and necessary preparation for receiving the patient.
4. A transfer-out form must be completed prior to transfer.
5. The transferring physician and the accepting physician must each make an entry in the progress notes and order sheet about the transfer/referral.
6. For Intensive care unit :
   - **6.1.** ICU physician in-charge shall order for the discharge/transfer out of the patient to ward from ICU, jointly with the attending physician. He shall design detailed plan of management, treatment and care to be followed in ward.
   - **6.2.** ICU Charge Nurse will reserve bed in the specified ward and inform receiving ward charge nurse about patient condition, patient's specific medical requirements, and necessary preparation for receiving the patient.
   - **6.3.** The ICU physician will write ICU transfer note and revised physician orders in patient medical record.

TRANSFER OF PATIENTS TO OTHER FACILITIES:

1. 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 of care to the other institutions to the concern department heads.

2. Any transfer of an individual with emergency medical/surgical condition must be initiated by a radio call or Fax of a medical report by the responsible attending physician for acceptance and to where patient can be transferred.
3. Arrangements for the patient transport include an estimation of the length of time required for transport, and an assessment of patient needs during transfer and includes:
   - **3.1.** An assessment of the patient's need of any form of transportation vehicle.
   - **3.2.** Communication of patient's needs during transfer to appropriate staff.
   - **3.3** An attending physician determining the patient's need for transfer to appropriate staff.
   - **3.4.** 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.
   - **3.5.** Staff accompany patient according to patient condition.
4. Patients transferring to another health care facility for consultation or further care must have a complete transfer information documents and copies of other relevant parts of the medical record, if necessary, sent with them.
5. If a patient transfer does not take place until after the time period (dates) covered in the transfer information documents, an addendum will be dictated for the period from the original date of transfer (as noted on the summary) to the actual date of transfer and will reflect any subsequent care provided to the patient or changes in the patient's condition.
6. A copy of the transfer information documents will go with the patient on transfer. The original will remain in the hospital's medical record.

COMPLETE TRANSFER SUMMARY:

Receiving institutions receive the necessary information (such as, Reason for patient admission, Patient diagnosis, Brief summary of hospitalization, Medication list and time of last dose given, Condition at the time of transfer, Reason for transfer) indicated on the following:

1. A copy of medical report
2. Transfer Out Form
3. Referral Form
4. Copy of the patient's laboratory investigation and X-rays are sent with the patient for avoid further delay of treatment.

WAY OF TRANSFER:

1. Transfers are done quickly and safely especially in emergency cases (e.g. trauma or cardiac emergency) and the medical staff ensure the patient's needs are met.
2. Assigning a qualified physician or paramedic (as appropriate) to accompany the patient and handle any emergency that might happen during transfer.
3. Assigning a physician certified in BLS (preferably ACLS) to accompany all critical patients or intubated patients.
4. Having adequate equipments and supplies on the ambulance.
5. The patient is continuously monitored by qualified physician during the transfer.

REFERRAL OF PATIENT FROM ONE ATTENDING PHYSICIAN TO ANOTHER OR TO CONSULTANT:

1. The Attending Physician may opt to consult the care of a patient to another Specialty Doctor/Consultant for co-management, the Attending Physician shall clearly document in the Physician's Order form the referral to another attending physician.
2. The attending physician shall completely fill up the consultation referral form that defines;

2.1. Date and time of consultation.
2.2. Name and designation of consulting physician.
2.3. Urgency of consultation
2.4. Brief history / Case summary.
2.5. Reason for consultation

3. The consulting physician and the consulted physician and work together for the management of the patient, whether in the same or a different service, to ensure that patient receives the standard of care.

4. The consulting physician and the consulted physician must make each entry in the progress notes and order sheet about the referral;
4.1. Date and time of consultation visit.
4.2. Name and designation.
4.3. Opinion and recommendations, including the need to transfer the patient under his name.

ARTICLE 10: DISCHARGE PROCESS

PURPOSE:

To outline a policy to ensure patient's continuity of care after discharge or referral.

DEFINITION:

1. **Discharge Planning.** Is an interdisciplinary, collaborative process across the continuum of care. The plan identifies all health care team members, providers and agencies responsible for follow –up of care. The plan is available in the patient's medical record on the Discharge Planning of Care. Health care team members are those multidisciplinary professionals and other staff that have direct involvement and responsibility in meeting the needs of the patient during a specific episode of illness

2. **Discharge from the hospital.** Is the point at which the patient leaves the hospital and either returns home or is transferred to another facility such as one for rehabilitation or to a nursing home.

3. **Continuity of Care** - A performance dimension addressing the degree to which the care for a patient is coordinated among practitioners and organizations and over time, without interruption, cessation, or unnecessary repetition of diagnosis or treatment.

RESPONSIBILITY:

1. **Most Responsible Physician** - is responsible for articulating the Discharge Plan of care and progress towards meeting those needs by incorporating activities, including educational activities, into the shift plan of care that progresses the patient and significant others toward meeting discharge goals. Documentation of education is charted on the Interdisciplinary Patient and Family Education Record.
2. **Nurse on duty** - is responsible for assuring verification and finalization of the plan with the patient, relatives and all designated providers at the time of discharge from the inpatient setting. The nurse is responsible for assuring the patient has received and acknowledge written instructions.

POLICIES ON DISCHARGING OF PATIENTS:

1. Patients shall be discharged only on a written order of the attending physician. Should a patient leave the hospital Against Medical Advice of

the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

2. It shall be the responsibility of the attending physician to write a letter of justification for every denial of days or stay by Medicare, Medicaid or other agency. Compliance with this policy will be considered at the time of each member's reappointment to the medical staff.
3. In the event of a hospital death, the deceased shall be pronounced dead by a physician within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff or the house physician. Policies with respect to release of dead bodies shall conform to local law.
4. The Most responsible physician is responsible for ensuring that discharge instructions and follow up appointment are given to the patient whenever required, prior to patient's discharge. Also for ensuring that the record is complete with final diagnosis, that the discharge summary is dictated, and that the record is signed off. If the patient leaves the hospital Against Medical Advice of the physician, the patient should sign an AMA Form.
5. The need for discharge planning is assessed within 24 hours of admission.
6. A verbal or written order for discharge by the attending practitioner or designee is required.

DISCHARGE PLANNING:

1. Discharge Planning is the responsibility of all Physicians and care givers.
2. Discharge Planning starts at day one of Admission. It involves planning for the care of patient at and after discharge to ensure a continuum of care. All Physicians and care givers shall actively participate in discharge planning and document the instructions for discharge in the Medical record.
3. Discharge planning needs / criteria are assessed at admission by the attending physician and includes the following:
   3.1. An assessment of the patient's social status as needed

3.2. An estimation of the length of stay
3.3. Implementation of clinical practice guidelines (if available)
3.4. Identification of medications and medical equipment that the patient will need to take home.
3.5. Identification of any continued care the patient will need on discharge such as home health services etc.
3.6. Other staff members such as discharge planning officer who can assist with the coordination of care at discharge
3.7. Documentation of discharge planning in the medical record.

4. A proposed discharge date is set soon after admission.
5. Staff members are aware of the discharge planning process particularly for common cases with predictable outcome.

PROCEDURE FOR DISCHARGING OF PATIENTS:

1. The patient may only be discharged on the instruction of the attending physician.
2. The patient is to be informed about the discharge, and if possible, also the relatives.
3. A discharge plan to be completed.
4. If the patient did not pay the hospital fees on admission, this must be done before the discharge at the Admission and Discharge Office.
5. The nurse must assist the patient to dress and pack his clothes. The patient's file must be taken to the Pharmacy by a professional nurse for the issuance of the take home medication.
6. When medication is given to the patient or care it must be explained how to use the medication at home. All "take out" medicine must be recorded on the progress report.
7. A discharge plan must be completed and an Appointment Card regarding follow-up check-up must be completed and given for every patient and the following must be outlined in the discharge instruction form:
7.1. Final diagnosis and significant illness
7.2. Medical Records Number
7.3. Medications
7.4. Health education
7.5. Diet / Dietary restrictions
7.6. Follow-up dates
7.7. Referred to

8. Provide a copy of the discharge summary or medical report to the patient upon request and retain a copy in the patient's medical file. Discharge summary and medical report are type written.
9. If the patient is too weak to walk, he/she must be taken by a Medical Porter to the entrance of the hospital by wheelchair.

DISHARGE AGAINST MEDICAL ADVICE (DAMA):

1. Should a patient leave the hospital Against Medical Advice of a doctor, the following steps must be taken:
   - **1.1.** Try to establish the reason for the patient wanting to leave.
   - **1.2.** Try to dissuade the patient.
   - **1.3.** Warn the patient of any possible consequences.
   - **1.4.** Notify the doctor.
   - **1.5.** If the patient still insists on leaving, the Against Medical Advice Form must be completed which states that he/she is leaving the hospital at his own responsibility and risk.
     - **1.5.1.** The document must be signed by the patient and witnessed by the nurse.
     - **1.5.2.** The document must be affixed to the patient's file and documented in doctor's order and nurse's notes.
     - **1.5.3.** In the case of minors, the parent/guardian are required to sign the abovementioned form.
2. All patients must leave the hospital with an appointment card, a receipt if they have paid or a reminder to pay when money is available and a copy of a type written discharge summary / medical report upon request.

PATIENT DISCHARGE INSTRUCTIONS:

1. All patients and/or significant others will be given written instructions for care when discharged from hospital.
2. The Attending Physician educates his/her patient on the following issues prior to discharge:
   - 2.1 The patient's illness and how to provide self-care.
   - 2.2 Times to take the medication and special instructions.

2.3 Any equipment that the patient will use at home.
2.4 When to call the physician when there is “urgent” care.
2.5 Why the patient needs any sub specialist (if applicable)
2.6 The reason the patient needs to be transfer to another institution (if applicable)
2.7 Involving the family of the members whenever patient cannot fully understand the information provided to them (if applicable).

3. An alternate form of instruction is used when the patient, family member or significant other is unable to read and/or write English.

4. The alternative used is documented clearly in the Medical Record.

GUIDELINES:

1. The Discharge Instruction form is given to the patient and explained by the nurse.

2. Follow-up appointments are listed. The provider to be seen, the provider’s location, and the date and time of the appointment are indicated.

3. The discharge diet is recorded. Dietary restrictions are listed.

4. The discharge activity is indicated. Specific instructions are detailed.

5. Discharge medications are listed.

5.1 The dose prescribed, route of administration, the time after discharge to take the first dose, and times of subsequent doses are indicated.

5.2 A check mark is placed in the "Instructions Given" box to indicate medication instructions.

5.3 Additional instructions may be written in the space provided on the teaching record or in the notes.

5.4 When the prescriptions are written and received, the corresponding box is checked.

6. When referral has been made to an agency (ies), the name and phone number is recorded. The attending physician is obliged to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital.

7. Other special instructions are recorded.

8. The individual who the patient or family is to contact in the event of problems following discharge is indicated. The phone number of that individual is provided.

9. Obtain signatures from patient, family member, or significant other that the information has been discussed with them and they indicate understanding. If

the information is to be shared with other care providers or agencies, the signature also indicates permission to send the information.

PATIENT ABSCONDS:

1. If a patient absconds:
   - **1.1** The family is notified.
   - **1.2** The time and date is documented on the patient's progress chart, as well as, what is being done.
   - **1.3** An OVR Form is completed.
2. All separations are recorded on the Day and Night Report and Daily Statistical Return.
3. The patient's file must be collected and sent to the Medical Records Department where documents are filed. The discharge summary form must be completed by the admitting doctor within seven (7) days after discharged.

ARTICLE 11: LIST OF COMMITTEE

1. HOSPITAL EXECUTIVE

Chairman:	**Mr. Abdulrahman Al Adwani**
Vice Chairman:	**Dr. Saleh Al Hebili**
Members:	
Mr. Sultan Al Adwani	**Hospital Administrator**

Dr. Kamil Abbas	**Medical Director**
Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**
Dr. Ghulam Joyo	**Laboratory Chairman**
Dr. Muhammad Talha	**Radiology Chairman**
Dr. Omar Osman	**Pharmacy Head**
Dr. Mohammed Sameer	**Infection Control Director**
_____	**Out-Patient Department Head**
Dr. Zenaida Orpilla	**Director of Nursing**
Dr. Mohammed Ragab	**TQM Director**
Mr. Mohammed Madani	**Finance Head**
Mr. Mohammed Abdulrahman	**FMS Director (In-Charge)**
Ms. Sahar Al Malky	**HRD Head**

- **Department Heads on ad-hoc basis**

2. UTILIZATION REVIEW

Chairman:	**Mr. Abdulrahman Al Adwani**
Vice Chairman:	**Mr. Sultan Al Adwani**

Members:

Dr. Saleh Al Hebili	**Deputy Hospital Director**
Dr. Kamil Abbas	**Medical Director**
Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**

Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**
_____	**OPD Head**
Dr. Muhammad Talha	**Radiology Chairman**
Dr. Ghulam Joyo	**Laboratory Chairman**
Dr. Mohammed Sameer	**Infection Control Director**
Dr. Omar Osman	**Pharmacy Head**
Mr. Mohammed Madani	**Finance Head**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Engr. Hitham Hamza	**IT Dept Head**
Mr. Mohammed Abdulrahman	**FMS Director (In-Charge)**
Ms. Sahar Al Malky	**HRD Head**
Ms. Fayrouz Al Zaydy	**Social Services**

3. MORTALITY AND MORBIDITY

Chairman:	**Dr. Moh'd Hamdy Elkarow**
Vice Chairman:	**Dr. Kamil Abbas**

Members:

Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**

Dr. Mohammed Refaat	**Anesthesia Head**
Dr. Mohammed Sameer	**Infection Control Director**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Mr. Almuariff Amilhasan	**ICU Head Nurse**

4. INFECTION CONTROL

Chairman:	**Dr. Kamil Abbas**
Vice Chairman:	**Dr. Mohammed Sameer**

Members:

Ms. Christine Joy Paragas	**IPC Practitioner**
Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**

Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman/ Staff Health Clinic**
Dr. Abdullah Alharthi	**Intensive Care Unit**
Dr. Ghulam Joyo	**Laboratory Chairman**
Dr. Omar Osman	**Pharmacy Head**
Dr. Ghulam Joyo	**Laboratory, Microbiologist**
Dr. Mohammed Sameer	**ER Head**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Mr. Mohammed Abdulrahman	**FMS Director (In-Charge)**
Mr. Reema Prakash	**CSSD Head**
Ms. Iman Taher	**Housekeeping Dept.**
Ms. Nuha Al Juaied	**Dietary Head**
Mr. Mohammed Madani	**Finance Head**
_____	**Central Supply Head/ In-Charge**

5. CARDIO PULMONARY RESUSCITATION (CPR) / RAPID RESPONSE TEAM (RRT)

Chairman:	**Dr. Masoud Mohammed**
Vice Chairman:	**Dr. Kamil Abbas**

Members:

Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**

Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**
Dr. Mohammed Sameer	**ER Dept. Head**
Dr. Mohammed Refaat	**Anesthesia Head**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Mr. Almuariff Amilhasan	**ICU Head Nurse**
_____	**ER Head Nurse**

- **RRT Team will be called if necessary**

6. CREDENTIALING AND PRIVILEGING

Chairman: **Dr. Kamil Abbas**

Members:

Ms. Sahar Al Malky	**HRD Head**
Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**

- **Other members will be called as necessary.**

7. OPERATING ROOM

Chairman:	**Dr. Mohd. Hamdy Elkarow**
Vice-Chairman:	**Dr. Kamil Abbas**

Members:

Ms. Catherine Sy	**OR Head Nurse**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**

Dr. Mohammed Refaat	**Anesthesia Chairman**
Dr. Mohammed Sameer	**Infection Control Director**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Mr. Mohammed Abdulrahman	**FMS Director (In-Charge)**

- **Other members will be called as necessary.**

8. TISSUE REVIEW

Chairman:	**Dr. Nadeem Khan**
Vice Chairman:	**Dr. Kamil Abbas**

Members:

Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**

Dr. Mohammad Talha	**Radiology Chairman**
Dr. Ghulam Joyo `	**Laboratory Chairman**
Dr. Mohammed Sameer	**Infection Control Director**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Ms. Catherine Sy	**OR Head Nurse**
Mr. Joseph Ancheta	**Lab TQM Coordinator**

9. BLOOD UTILIZATION REVIEW

Chairman:	**Dr. Ghulam Joyo**
Vice Chairman:	**Dr. Kamil Abbas**

Members:

Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**

Dr. Mohammed Sameer	**Infection Control Director**
Dr. Mohammed Ragab	**TQM Director**
Dr. Zenaida Orpilla	**Director of Nursing**
Ms. Myra Amangan	**Lab TQM Coordinator**
Mr. Joseph Ancheta	**Lab TQM Coordinator**

10. SAFETY

Chairman:	**Dr. Kamil Abbas**
Vice-Chairman:	**Mr. Mohammed Abdulrahman**

Members:

Dr. Mohameed Sameer	**ER Dept. Head**
Dr. Omar Osman	**Pharmacy Head**
Dr. Ghulam Joyo	**Laboratory Chairman**
Dr. Mohammed Sameer	**Infection Control Director**

Dr. Mohammed Ragab	TQM Director
Dr. Zenaida Orpilla	Director of Nursing
Mr. Faisal Al Adwani	Security Head
Ms. Iman Taher	Housekeeping Head
Mr. Mesfer Al Ghamdi	Safety Officer
Engr. Mohammed Elhefnawy	Biomed Technician
Ms. Christine Joy Paragas	IPC Practitioner
Mr. Rayan Al Suwat	Radiation Safety Officer
Mr. Shakwat Hussain	Non-Medical Maintenance Supervisor

- Fire Safety Officer
- All Safety Coordinators of all Departments

11. QUALITY AND PATIENT SAFETY

Chairman:	Dr. Mohammed Ragab
Vice Chairman:	Dr. Kamil Abbas

Members:

Dr. Mohd. Hamdy Elkarow	OR/Surgery Chairman
Dr. Umbreen Naz	OB/DR Chairman
Dr. Sami Faleh Aloudat	Pedia/NICU Chairman
Dr. Mahmoud Ibrahim Khalifa	Int. Medicine Chairman
Dr. Mohammed Sameer	Infection Control Director
Dr. Ghulam Joyo	Laboratory Chairman

Dr. Muhammad Talha	Radiology Chairman
Dr. Zenaida Orpilla	Director of Nursing
Dr. Omar Osman	Pharmacy Head
_____	Out-Patient Department Head
Mr. Mohammed Elsayed	FMS, Director
Mr. Joseph Alvin Repotente	TQM Officer
Ms. Rachiel Monica Lumba	TQM Staff

- Department TQM Coordinators

12. MEDICAL RECORDS

Chairman:	Mr. Ahmed Omran
Vice Chairman:	Dr. Kamil Abbas

Members:

Dr. Mohd. Hamdy Elkarow	OR/Surgery Chairman
Dr. Umbreen Naz	OB/DR Chairman
Dr. Sami Faleh Aloudat	Pedia/NICU Chairman
Dr. Mahmoud Ibrahim Khalifa	Int. Medicine Chairman
_____	OPD Head
Dr. Muhammad Talha	Radiology Chairman

Dr. Mohammed Ragab	**TQM Director**
_____	**Reception Supervisor**
Engr. Hitham Hamza	**IT Dept. Head**
Dr. Zenaida Orpilla	**Director of Nursing**

13. PATIENT AND FAMILY AFFAIRS

Chairman:	**Dr. Mohammed Sameer**
Vice Chairman:	**Dr. Kamil Abbas**

Members:

Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**
Dr. Ghulam Joyo	**Laboratory Chairman**
Dr. Mohammed Ragab	**TQM Director**
Dr. Muhammad Talha	**Radiology Chairman**

Dr. Zenaida Orpilla	**Nursing Directress**
Mr. Joseph Alvin Repotente	**TQM Officer**
Ms. Fayrouz Al Zaydy	**PFA Staff**

- **All patient educators and counselors.**

14. PHARMACY AND THERAPEUTICS

Chairman:	**Dr. Kamil Abbas**
Vice Chairman:	**Dr. Omar Osman**

Members:

Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chair**
Dr. Umbreen Naz	**OB/DR Chair**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chair**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chair**
Dr. Mohammed Ragab	**TQM Director**
Dr. Mohammed Sameer	**Infection Control Director**
Dr. Zenaida Orpilla	**Director of Nursing**

_____ **Pharmacy TQM Coordinator**

15. MEDICAL EXECUTIVE

Chairman:	**Dr. Kamil Abbas**
Vice Chairman:	**Dr. Saleh Al Hebili**

Members:

Dr. Mohd. Hamdy Elkarow	**OR/Surgery Chairman**
Dr. Umbreen Naz	**OB/DR Chairman**
Dr. Sami Faleh Aloudat	**Pedia/NICU Chairman**
Dr. Mahmoud Ibrahim Khalifa	**Int. Medicine Chairman**
Dr. Ghulam Joyo	**Laboratory Chairman**
Dr. Muhammad Talha	**Radiology Chairman**
Dr. Omar Osman	**Pharmacy Head**
Dr. Mohammed Refaat	**Anesthesia Head**

Dr. Mohammed Ragab	**TQM Director**
_____	**Out-Patient Department Head**
Dr.Mohammed Sameer	**ER Dept. Head**
Dr. Mohammed Sameer	**Infection Control Director**
Ms. Nuha Al Juaid	**Dietary Dept. Head**
Dr. Abdullah Alharthi	**ICU Head**
Dr. Eman Ismaeil	**Dental Dept.**
Dr. Tabinda Baig	**Dermatology Dept.**
Dr. Salah Abdulghaffar	**Orthopedic Dept.**
Dr. Mohammed Elhanafi	**Respiratory Dept.**
Dr. Masaoud Mustafa	**Cardiology Dept.**
Dr. Ashraf Ibrahim	**Urology Dept.**
Dr. Sameer Shokr	**ENT Dept.**
PT Meshary Alzaydy	**Physiotherapy Dept.**

- **Other members will be called as necessary.**

ARTICLE 12: MEDICAL RECORD DOCUMENTATION GUIDELINES

Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The following elements reflect a set of commonly accepted standards for medical record documentation. An organization may use these elements to develop standards for medical record documentation.

1. Each page in the medical record contains the patient's full name and file number.
2. All entries are dated and time is indicated.
3. The record is legible to someone other than the writer.
4. All entries in the medical record contain the author's identification. Author identification should be legibly written with date, time and signature.

5. The Admission Sheet should contain the significant illnesses (past and present), medical conditions, comprehensive assessment, provisional diagnosis, the name and signature, date and time of the admitting physician. The Admission Sheet should contain the following:
   - **5.1.** Medical Records Number (MRN) - generated by the Information Network system
   - **5.2.** Patient's Complete Name
   - **5.3.** Identification Card Number (National ID No. or IQAMA No. for Foreigners)
   - **5.4.** Registration Date
   - **5.5.** Age
   - **5.6.** Gender
   - **5.7.** Marital Status
   - **5.8.** Nationality
   - **5.9.** Address
   - **5.10.** Mobile Number / contact number
   - **5.11.** Relationship to the patient
   - **5.12.** Contact Number of the relative
   - **5.13.** Signature of the patient (verifying that the abovementioned information is true and correct as entered in the Information Network System).
6. The Most Responsible Physician is identified as the Primary Attending Physician (consultant) of the patient. He is responsible in the Over-all medical management including but not limited to referral of patient to other specialty.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.

8. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
9. Laboratory and other studies are ordered, as appropriate.
10. Working diagnoses are consistent with findings.
11. Treatment plans are consistent with diagnoses and Clinical Practice Guidelines.
12. If a consultation is requested to the other physician, it shall be written in the physician's order form with a corresponding referral form.
13. Consultation, laboratory and imaging reports filed in the chart are initialed by the physician who ordered them, to signify review. If the reports are presented to the other physician, there is also representation of review by the ordering physician and consultant. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
14. The medical history will be taken at the time of admission and shall include the following: Chief complaints, present illness, allergy, steroids, DM, epilepsy, past medical history, social history, family history, medical history should be obtained from the patient if condition permit. Medical History shall be on patient file within 24 hours after admission.
15. The physical examination shall be recorded within 24 hours after admission or prior to surgery and shall reflect a current comprehensive physical examination. A report of physical examination will include all body systems, pelvic, rectal and breast examinations, when applicable.
16. Physician will write the provisional diagnosis and must authenticate the recorded physical examination with his name, and stamp and signature.

17. Clinical observations are made daily in the progress notes by the physicians. These progress notes give a pertinent chronological report of the patient's course in the hospital and reflect any change in conditions and the results of treatment.
18. Nurses Note should contain pertinent and meaningful information and observations with the patient and is documented on the respective forms.
19. All reports of procedures, tests, and their results are documented and authenticated in patient medical record.
20. Informed Consent: Medical Record shall contain evidence of the patient's informed consent for any procedures or treatment for which it is appropriate.
21. The discharge summary shall be complete and type-written. It shall also include the following listed below and will be accomplished by the admitting physician:
    - **21.1.** Admitting Diagnosis/Reason for Admission
    - **21.2.** Final Diagnosis and any associated diagnosis
    - **21.3.** Summary of hospitalization
    - **21.4.** Pertinent laboratory findings
    - **21.5.** All procedures performed
    - **21.6.** Treatment
    - **21.7.** Discharge Medication
    - **21.8.** Recommendation/Special Care/Discharge instructions
    - **21.9.** Condition of patient on discharge

ARTICLE 13: PROFESSIONAL CONDUCT

THE SPIRIT OF PROFESSIONAL GUIDELINES

Practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners. The term “profession” means “a dedication, promise or commitment publicly made”.

To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one’s fellow human beings and society. In essence, the practice of health care professions is a moral enterprise. In this spirit the Al Adwani General Hospital presents the following ethical guidelines to guide and direct the practice of health care practitioners. These guidelines form an integral part of the standards of professional conduct against which a complaint of professional misconduct will be evaluated.

[Note: The term "health care practitioner" in these guidelines refers to persons registered with AAGH)

1. INTRODUCTION

1.1 Being registered as a health care professional with the AAGH confers on us the right and privilege to practice our professions. Correspondingly, practitioners have moral or ethical duties to others and society. These duties are generally in keeping with the principles and the obligations imposed on health care practitioners by law.

1.2 This general ethical guidelines contains value-oriented principles and express the most honorable ideals to which members of the health care profession should subscribe in terms of their conduct

1.3 More specific ethical guidelines and rules are derived from these general ethical guidelines. They offer more precise guidance and direction for action in concrete situations. They also make it possible for the AAGH to implement sanctions against transgressors.

1.4 It is impossible, however, to develop a complete set of specific ethical prescriptions applicable to all conceivable real-life situations. In concrete cases, health care professionals may have to work out for themselves what course of action can best be defended ethically. This requires ethical reasoning.

This guideline lists thirteen core ethical values and standards that underlie professional and ethical practice in health care professions, and gives a short explanation of how one makes practical decisions through ethical reasoning. It then explains what a duty is, and catalogues the general ethical duties of health care professionals.

1. CORE ETHICAL VALUES AND STANDARDS FOR GOOD PRACTICE

1.1 Everything ethically required of a professional to maintain good professional practice is grounded in core ethical values and standards – the latter are the directives that follow the core values. These core values and standards are presented as a linear list for the sake of simplicity.

1.2 In concrete cases, the demands of these core values and standards may clash, thus making competing demands on health care practitioners. The only way to address such clashes is through ethical reasoning.

1.3 The core ethical values and standards required of health care practitioners include the following:

1.3.1 Respect for persons: Health care practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.

1.3.2 Best interests or well-being: Non-maleficence: Health care practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.

1.3.3 Best interest or well-being: Beneficence: Health care practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest.

1.3.4 Human rights: Health care practitioners should recognize the human rights of all individuals.

1.3.5 Autonomy: Health care practitioners should honor the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.

1.3.6 Integrity: Health care practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible health care professionals.

1.3.7 Truthfulness: Health care practitioners should regard the truth and truthfulness as the basis of

trust in their professional relationships with patients.

1.3.8 Confidentiality: Health care practitioners should treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer a moral or legal right to disclosure.

1.3.9 Compassion: Health care practitioners should be sensitive to, and empathize with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.

1.3.10 Tolerance: Health care practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.

1.3.11 Justice: Health care practitioners should treat all individuals and groups in an impartial, fair and just manner.

1.3.12 Professional competence and self-improvement: Health care practitioners should continually endeavor to attain the highest level of knowledge and skills required within their area of practice.

1.3.13 Community: Health care practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community.

2. HOW TO RESOLVE ETHICAL DILEMMAS

2.1 The core values and standards referred to above are the foundation that grounds the general ethical guidelines in these booklets. Being general, such guidelines may be applied to many different concrete cases.

2.2 Questions arise as to how health care practitioners may use these guidelines to make practical decisions or choices

about the provision of health care. For example, how does a guideline apply in a specific case? And, how do health care practitioners handle difficult situations where two (or more) principles appear to be in conflict?

2.3 Briefly, what is needed is ethical reasoning. In general, such ethical reasoning proceeds in four steps:

2.3.1 Formulating the problem: Determine whether the issue at hand is an ethical one once this has been done it must be decided whether there is a better way of understanding it. Gathering information: All the relevant information must be collected - such as clinical, personal and social data.

2.3.2 Consult authoritative sources such as these guidelines, practitioner associations, and respected colleagues and see how practitioners generally deal with such matters.

2.3.3 Considering options: Consider alternative solutions in light of the principles and values they uphold.

2.3.4 Making a moral assessment: The ethical content of each option should be weighed by asking the following questions:

2.3.4.1 What are the likely consequences of each option?

2.3.4.2 What are the most important values, duties, and rights? Which weighs the heaviest?

2.3.4.3 What are the weaknesses of the health care practitioner's individual view concerning the correct option?

2.3.4.4 How would the health care practitioner himself or herself want to be treated under similar circumstances – that is, apply the Golden Rule?

2.3.4.5 How does the health care practitioner think that the patient would want to be treated in the particular circumstances?

2.3.5 Discuss your proposed solution with those whom it will affect

2.3.6 Act on your decision with sensitivity to others affected

2.3.7 Evaluate your decision and be prepared to act differently in the future

3. WHAT IT MEANS TO HAVE A DUTY

3.1 Ethical guidelines express duties. A duty is an obligation to do or refrain from doing something.

3.2 If we have a duty to another person, it means we are bound to that person in some respect and for some reason. We owe that person something, while he or she holds a corresponding right or claim against us.

3.3 An example of a right with a corresponding duty is the following: Suppose a health care practitioner reaches an agreement with a colleague that the latter will do a locum for him while he is away on family business: The colleague has a duty to do the locum and the health care practitioner has a right to the colleague's services. At the same time the colleague has a right to fair remuneration and the health care practitioner has a duty to compensate her/him.

3.4 To have a duty is to ask the question "What do I owe others?" To have a right is to ask the question "What do others owe me?"

3.5 Duties may be ethical, legal or both at once, and operate in the personal, social, professional or political spheres of our lives.

3.6 Health researchers fulfill different roles. Accordingly, they have different kinds of duties:

3.6.1 As human beings we have "natural duties", namely un-acquired general duties simply

because we are members of the human community - for example the natural duties to refrain from doing harm, to promote the good, or to be fair and just. As is the case with everyone, health care professionals owe these duties to all other people, whether patients or not, and quite independently of our professional qualifications.

3.6.2 As professionals we have "moral obligations", namely general duties we acquire by being qualified and licensed as professionals, that is, professionals entering into contractual relationships with patients - for example the professional duties to provide medical care, relieve pain, gain informed consent, respect confidentiality, and be truthful.

3.6.3 Institutional duties: Institutional duties are imposed upon health care practitioners working in specific institutions. They are specific to the health care practitioner's particular institutionalized role, for example the duties of a practitioner employed by a company, a health care practitioner working in a governmental research agency, or a doctor engaged in private practice. These duties are contained in employment contracts, job descriptions, conventional expectations etc. Institutional duties must be consistent with the ethical and legal duties of health care practitioners.

3.6.4 Legal duties: Legal duties are duties imposed by the common law and by statute law that require health care (Saudi National Law) practitioners to follow certain procedures and to use particular skill and care when dealing with patients.

3.7 The duties listed in these general guidelines mostly fall into the second category – the general but acquired duties of a health care practitioner as a professional.

3.8 No duty is absolute or holds without exception irrespective of time, place or circumstance. This is not surprising, since different duties may prescribe quite opposite decisions and actions in a specific concrete or real-life situation.

3.9 For example, our duties to our patients may compete with our duties to our employer. Or our duty to respect a patient's confidentiality may clash with our duty to protect innocent third parties from harm. (HIV/AIDS examples are particularly perplexing.) These are instances of conflicts of interest or dual loyalties.

3.10 No list of such duties is ever complete, but the catalogue of duties below presents a fairly comprehensive picture of what it is, in general, that binds any health care provider as a professional to his or her patients, as well as to others. However, it should be noted that these duties, if not honored without justification, may constitute the basis for sanctions being imposed on professionals by the AAGH management.

3.11 Any classification of duties is arbitrary, because specific duties may be owed to different parties simultaneously. Therefore, the classifications used below should be viewed only as a rough guide. However, underlying these duties is a set of core ethical values and standards of good practice that are regarded as basic ethical principles.

4. DUTIES TO PATIENTS

4.1. PATIENTS' BEST INTERESTS OR WELL-BEING. Health care practitioners should:

4.1.1 Always regard concern for the best interests or well-being of their patients as their primary professional duty.

4.1.2 Honor the trust of their patients.

4.1.3 Be mindful that they are in a position of power over their patients and avoid abusing their position.

4.1.4 Within the normal constraints of their practice, be accessible to patients when they are on duty, and make arrangements for access when they are not on duty.

4.1.5 Make sure that their personal beliefs do not prejudice their patients' health care. Beliefs that might prejudice care relate to patients' race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability.

4.1.6 If they feel that their beliefs might affect the treatment they provide, they must explain this to their patients, and inform them of their right to see another health care practitioner.

4.1.7 Not refuse or delay treatment because they believe that patients' actions have contributed to their condition, or because they – the health care practitioners - may be putting their own health at risk.

4.1.8 Apply their mind when making diagnoses and considering appropriate treatment.

4.1.9 Act quickly to protect patients from risk if they believe that they or their colleagues are impaired.

4.1.10 Respond to criticism and complaints promptly and constructively.

4.1.11 Not employ any intern, health care provider in community service, or health care practitioner with restricted registration with the HPCSA, as a locum tenens - or otherwise - in their own or any associated health care practice.

4.1.12 Inform their patients if they are in the employ of, in association with, linked to, or have an interest in any organization or facility that could be

interpreted by an average person as potentially creating a conflict of interest or dual loyalty in respect of their patient care.

4.1.13 In emergency situations, provide health care within the limits of their practice, experience and competency. If unable to do so, refer the patient to a colleague or an institution where the required care can be provided.

5. RESPECT FOR PATIENTS. Health care practitioners should:

5.1 Respect the privacy and dignity of patients.
5.2 Treat patients politely and with consideration.
5.3 Listen to their patients and respect their opinions.
5.4 Avoid improper relationships with their patients, their patients' friends or their patients' family members (for example, sexual relationships or exploitative financial arrangements).
5.5 Guard against human rights violations of patients, and not allow, participate in or condone any actions that lead to violations of the rights of patients.

6. INFORMED CONSENT. Health care practitioners should:

6.1. Give their patients the information they ask for or need about their condition, its treatment and prognosis.
6.2. Give information to their patients in the way they can best understand it. The information must be given in a language that the patient understands and in a manner that takes into account the patient's level of literacy, understanding, values and belief systems.
6.3. Refrain from withholding from their patients any information, investigation, treatment or procedure the health care practitioner knows would be in the patient's best interests.
6.4. Apply the principle of informed consent as an on-going process.

6.5. Allow patients access to their medical records.

7. **PATIENT CONFIDENTIALITY.** Health care practitioners should:

   7.1. Recognize the right of patients to expect that health care practitioners will not disclose any personal and confidential information they acquire in the course of their professional duties, unless they agree to such disclosure, or unless health care practitioners have good and overriding reason for doing so (for example, if disclosure is not made, there is the likelihood of serious harm to an identifiable third party, or there is a public health emergency, or any overriding and ethically justified legal requirement).

   7.2. Not breach confidentiality without sound reason and without the knowledge of their patients.

   7.3. When claiming from medical schemes explain to patients the significance of ICD-10 coding and get the permission of patients to breach confidentiality when making a medical scheme claim.

8. **PATIENT PARTICIPATION IN THEIR OWN HEALTH CARE.** Health care practitioners should:

   8.1. Respect the right of patients to be fully involved in decisions about their treatment and care even if they are not legally competent to give the necessary consent.

   8.2. Respect the right of patients to refuse treatment or to take part in teaching or research.

   8.3. Inform their patients that they have a right to seek a second opinion without prejudicing their future treatment.

9. **IMPARTIALITY AND JUSTICE**. Health care practitioners should be aware of the rights and laws concerning unfair discrimination in the management of patients or their families on the basis of race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability,

communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability such as contained in health rights legislation.

9.1. ACCESS TO CARE. Health care practitioners should:

9.1.1. Promote access to health care. If they are unable to provide a service, they should refer the patient to another health care practitioner or to a health care facility where the required service can be obtained, provided that in an emergency situation practitioners shall be obliged to provide care in order to stabilize the patient and then to arrange for an appropriate referral to another practitioner or facility.

9.2. POTENTIAL CONFLICTS OF INTEREST. Health care practitioners should:

9.2.1. Always seek to give priority to the investigation and treatment of patients solely on the basis of clinical need.

9.2.2. Avoid over-servicing: They should recommend or refer patients for necessary investigations and treatment only, and should prescribe only treatment, drugs or appliances that serve the needs of their patients. Declare to their patients – verbally and by a displayed notice – any financial interest they may have in institutions, diagnostic equipment, or the like to which they make referrals, if the holding of such interest is permitted by the HPCSA.

9.2.3. Refrain from coercing patients or their family members to provide them (health practitioners) with gifts or any other undue benefit.

10. DUTIES TO COLLEAGUES AND OTHER HEALTH CARE PRACTITIONERS

REFERRALS TO COLLEAGUES AND POTENTIAL CONFLICTS OF INTEREST. Health care practitioners should:

10.1. Act in their patients' best interests when making referrals and providing or arranging treatment or care. They should not ask for, or accept, any undue inducement or incentive, from colleagues to whom they refer patients because it may affect or be seen to affect the health care practitioner's judgment.

10.2. Treat patients referred to them in the same manner in which they would treat their own patients.

11. **WORKING WITH COLLEAGUES**. Health care practitioners should:
    - **11.1** Work with and respect other health-care professionals in pursuit of the best health care possible for all patients.
    - **11.2** Not discriminate against colleagues, including health care practitioners applying for posts, because of their views of their race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability.
    - **11.3** Refrain from speaking ill of colleagues or other health care practitioners.
    - **11.4** Not make a patient doubt the knowledge or skills of colleagues by making comments about them that cannot be fully justified.
    - **11.5** Support colleagues who uphold the core values and standards embodied in these guidelines.
    - **11.6** Advise colleagues who are impaired to seek professional assistance.

12. **DUTIES TO PATIENTS OF OTHER HEALTH CARE PRACTITIONERS.** Health care practitioners should:

12.1 Act quickly to protect patients from risk due to any reason.
12.2 Report violations and seek redress in circumstances where they have a good or persuasive reason to believe that the rights of patients are being violated.

13. DUTIES TO THEMSELVES

13.1. KNOWLEDGE AND SKILLS. Health care practitioners should:

13.1.1. Maintain and improve the standard of their performance by keeping their professional knowledge and skills up to date throughout their working life. In particular, they should regularly take part in educational activities that would enhance their provision of health services.

13.1.2. Acknowledge the limits of their professional knowledge and competence. They should not pretend to know everything.

13.1.3. Observe and keep up to date with the laws that affect professional health care practice in general and their practice in particular (for example, the provisions of the Saudi national Laws).

14. MAINTAINING A PROFESSIONAL PRACTICE. Health care practitioners should:

14.1 Keep their equipment in good working order.
14.2 Maintain proper hygiene in their working environment.
14.3 Keep accurate and up-to-date patient records
14.4 Refrain from engaging in activities that may affect their health and lead to impairment.
14.5 Ensure that staff members employed by them are trained to respect patients' rights; in particular the right to confidentiality

15. DUTIES TO SOCIETY

15.1. ACCESS TO SCARCE RESOURCES. Health care practitioners should:

15.1.1. Deal responsibly with scarce health care resources.

15.1.2. Refrain from providing a service that is not needed, whether it provides financial gain or not.

15.1.3. Refrain from unnecessary wastage, and from participating in improper financial arrangements, especially those that escalate costs and disadvantage individuals or institutions unfairly.

16. HEALTH-CARE POLICY DEVELOPMENT. Health care practitioners should include ethical considerations, legal requirements and human rights in the development of health care policies.

DUTIES TO THE HEALTH CARE PROFESSION

17. REPORTING MISCONDUCT. Health care practitioners should:

17.1.1. Report violations and seek redress in circumstances where they have good or persuasive reason to believe that the rights of patients are being violated and / or where the conduct of the practitioner is unethical.

17.1.2. Where it is in their power, protect people who report misconduct from victimization or intimidation.

18. ACCESS TO APPROPRIATE HEALTH CARE. Health care practitioners should promote access to health care. If they are unable to provide a health service, they should refer the patient to another health care practitioner or health care facility that can provide the service.

DUTIES TO THE ENVIRONMENT

CONSERVATION OF NATURAL RESOURCES. Health care practitioners should recognize that they have a responsibility to ensure that in the conduct

of their affairs they do not in any way contribute to environmental degradation.

19. **DISPOSAL OF HEALTH CARE WASTE.** Health care practitioners should protect the environment and the public by ensuring that healthcare waste is disposed off legally and in an environmentally friendly manner.

ARTICLE 14: EVALUATION OF MEDICAL STAFF

The evaluation process for Medical Staff members is a multi-level procedure. Each different level completes his/her evaluation using the performance appraisal form and forwards it to his/her superior for consideration, as described below:

1. The annual evaluation form will be completed by the Chairman/Head of the department and forwarded to the Medical Director.

2. Medical Staff: The annual evaluation (performance appraisal form) of Medical Staff will be completed, initialed by the Head/Chairman of Departments, and forwarded for consideration to the Medical Director and approved by the Hospital Director General.

3. All hospital staff must receive a formal evaluation annually.

4. Medical Staff members are requested to sign their evaluation forms.

5. All evaluation forms shall be submitted to the Human Resources Department.

6. The Medical Director will then initiate and convene a meeting with the evaluated physician, his/her corresponding department head and HRD head to discuss the evaluation.

ARTICLE 15: PROMOTION OF MEDICAL STAFF

1. Medical Staff members seeking promotion have to submit an application with supporting documents (certificates/degree and/or experience) to the head of the relevant department for the position that he/she is seeking.

2. The Medical Staff will be asked to present an official classification from the Saudi Council for Health Specialties for the position that he/she is applying.

3. The chairman/head of the relevant department after reviewing the application and the supporting documents will make recommendations to the medical director.

4. The recommended application will be submitted to the Medical Director, who will send it to the Credentialing and Privileging Committee.

5. The Credentialing and Privileging committee will review the application and follow the guideline for Medical Staff Promotion.

6. In case of approval positive recommendation, the case will be sent to the Hospital Director General for his/her recommendation and subsequent action by the Head.

7. The papers will then be sent to the Human Resources Department for processing, based on the availability of positions.

8. Salary raises and changing of status will be determined by the Human Resources Department according to the Medical Staff By-Laws.

9. Once the promotion has been approved and the Medical Staff has been officially promoted, he/she should apply for a change in clinical privileges, if necessary. The usual clinical privileging process will be applied.

ARTICLE 16: CREDENTIALING AND CLINICAL PRIVILEGES

1. The process for verification of the medical staff credentials has separate policy. Please refer to policy number **APP-HRD-007 (Employment Verification, References and Request for Information Policy).**

2. Every member of the Medical Staff shall be entitled to exercise only those clinical privileges approved by the Department Head and countersigned by the Medical Director.

2.1. For New Applicants

2.1.1. Individual requesting to be credentialed and privileged will be provided an Application Form by the Hospital.

2.1.2. The form must be filled properly and truthfully.

2.1.3. Original Curriculum Vitae and photocopies of all Credentials must be attached in the Form.

2.1.4. Credentialing and Privileging Form must also be filled up.

2.1.5. After all documents has been filled up, the Medical Director together with the department head will conduct personal interview with the applicant to verify and confirm all information regarding the applicant.

2.1.6. After confirmation, the Medical Director will now initiate and convene a meeting with the committee members to decide whether or not requested privileges will be granted.

2.1.7. After the discussion, the Medical Director will inform the applicant of the result of the discussions as to whether the requests are granted or not.

2.1.8. The initial granting of clinical privileges shall be provisional. Periodic re-determination of clinical privileges shall be based on the direct observation of the care provided, review of the reports of the chairman of the relevant department in which the practitioner is employed.

2.2. For Re-Appointments

2.2.1. The physician will be required to fill up a new Credentialing and Privileging form.

2.2.2. The process of granting and extending privileges for each member shall be delineated in the general and departmental rules and regulations.

2.2.3. The clinical privileges to be granted on re-appointment shall be based upon the Medical Staff member's record of professional competence and clinical judgment in the treatment of patients, including an examination of the individual's pattern of care as demonstrated by peer reviews that have been conducted and based on the following points:

2.2.3.1. The individual's maintenance of timely, accurate and complete medical records.

2.2.3.2. The individual's attendance at required staff departmental meetings.

2.2.3.3. The individual's ethical conduct and general behavior.

2.2.3.4. The individual's general application to his/her works.

2.2.3.5. The individual's compliance with the Hospitals' Policies, Medical Staff Bylaws, and Rules and Regulations.

2.2.3.6. The individual's physical and mental health.

2.2.3.7. The individual's administrative and academic activities in his/her department.

2.2.3.8. The individual's attendance and performance at required cross functional team meetings.

2.2.3.9. The appropriate use of discharge planning and efficient use of hospital resources, including patient length of stay among other factors.

2.2.3.10. Prompt morbidity and error reporting.

2.2.3.11. Timely completion of mortality reports.

2.2.3.12. Participation in the Hospitals' quality programs.

2.2.4. Any recommendation to alter or to limit a physician's privileges in whole or in part shall be elevated to the Credentialing and Privileging Committee as stated in the hospital ByLaws.

2.3. Request for Additional Privileges

2.3.1. Any physician can request additional privileges anytime.

2.3.2. Physician must fill up and submit a new Credentialing and Privileging form to indicate his additional requests.

2.3.3. Physician must present added credentials to support his request of additional privileges.

2.3.4. The process of granting additional privileges for each member shall be delineated in the general and departmental rules and regulations.

2.3.5. With the Department Head's recommendation, the request for additional privileges will be elevated to the Credentialing and Privileging Committee.

2.3.6. The Medical Director will then initiate and convene a meeting to all committee members to decide whether or not additional privileges will be granted to the physician.

3. The chairman of the relevant department, after consultation with the unit head, will recommend granting or denying the requested medical staff privileges.

4. The Credentialing and Privileging Committee shall review the Department Heads recommendation to finalize the privileges to be granted to each member of the Medical Staff.

5. All recommendations shall be based upon the practitioner's education and training, qualifications, professional experience, current licensure to practice in the country from which the person was recruited, health status (physical and mental) and any other relevant information, including the capabilities and facilities of the Hospitals.

6. Based upon all the above recommendations, the Hospital Director General may grant or deny the clinical privileges.

7. Temporary clinical privileges of Visiting or Locum Medical Staff may be granted by the Credentialing and Privileging Committee. For those receiving temporary clinical privileges, an application for privileges will be provided as soon as possible to the Credentialing and Privileging Committee to initiate the normal credentialing process. Temporary or emergency privileges are not granted for more than 90 days and are not renewable.

8. In all such cases, Visiting Medical Staff members shall act under the supervision of the Head of the Department to which he/she has been

assigned and he/she shall abide by the Medical Staff Bylaws, Rules and Regulations of Medical Staff.

9. In cases of emergency, any member of the Medical Staff, even junior doctors, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility at the hospital necessary, including the calling of any consultation necessary or deemed appropriate. When an emergency situation no longer exists, the appropriate member of the Medical Staff shall assume treatment of the patient and the emergency clinical privileges shall no longer be in effect. Temporary or emergency privileges are not granted for more that 90 days and are not renewable.

10. Clinical privileges will be contingent upon medical staff membership and will be for two years. Action on clinical privileges will be withheld until the applicant's credentials are verified. Every two years re-privileging and re-appointment to the medical staff will be based upon assessment of performance, including ethical conduct, peer relationship, clinical performance as assessed by the Head of the Department, his peers and in consultation with other heads of the department, Medical Quality Improvement activities and his personal health status. The process of granting and extending privileges for each member shall be delineated in the general and departmental rules and regulations. Any recommendation to decision or alter or limit clinical privilege in whole or in part shall be made in Accordance with Article 17 and 18 of the By-laws concerned with discipline. 17 and 18 of the By-laws concerned with discipline.

ARTICLE 17: REVOCATION, SUSPENSION OF CLINICAL PRIVILEGES

Temporary Suspension of Clinical Privileges

1. Notwithstanding adherence to the General Terms and Conditions of Employment of Al Adwani General Hospital if the professional standards of conduct of any member of the Medical Staff is considered to be lower than the desired standards, or where it is thought that the member of staff is acting in a professionally incompetent manner, the matter will be referred to the Medical Director by the Head of the respective department.

2. The matter shall be dealt with in the Credentialing and Privileging Committee as soon as possible and a recommended decision will be reached.

3. Medical Director having been informed by the recommendations from the Head of the relevant department and after consultation with the Hospital Director General for the Hospital, has the authority to suspend temporarily and immediately all, or any portion of the clinical privileges, of any member of the Medical Staff, whenever it is felt that the personal or professional conduct of that member of the staff:

3.1. Jeopardizes, or may jeopardize the safety or best interest of a patient if immediate action is not taken.

3.2. Constitutes a willful disregard of the Hospitals' policies.

4. Such temporary suspension shall become effective immediately upon the decision of the Medical Director after an Informal investigation. An **informal investigation** will be facilitated in the form of OVR.

5. Immediately following the temporary suspension, the Hospital Executive Manager shall send a special written notice to the suspended staff member, confirming the said suspension and stating the reasons for the suspension.

6. To decide on further action and the future of clinical privileges, the affected medical staff shall be requested to appear before the Credentialing and Privileging Committee for an interview at the place and time specified in the special written notice.

7. The affected Medical Staff member shall have the following rights:

7.1. To call and examine witnesses.
7.2. To introduce documentary evidence.
7.3. To cross-examine witnesses.
7.4. To challenge any evidence.

8. To call a colleague from the same hospital to the hearing as his/her spokesman and advisor.

9. The Credentialing and Privileging Committee, after examining all the evidence and listening to the Chairman of the applicable department and to any relevant witnesses, will recommend action regarding the suspended clinical privileges. Possible actions may include the recommendation to :

9.1. Return to usual clinical privileges immediately.

9.2. Return to usual clinical privileges after a certain probation period.
9.3. Be subjected to special direct supervision or additional extra training or education.
9.4. Suspend clinical privileges permanently.
9.5. Suspend from medical staff membership.
9.6. In case of conflict, the matter shall be raised to the Hospital Director for the final decision.

Automatic Suspension of Clinical Privileges

1. Revocation or suspension of a Medical Staff member's license to practice in any country shall automatically suspend all his clinical privileges at Hospitals.

2. A Medical Staff member who makes false or incorrect statements in his/her application for appointment to the Medical Staff shall be subject to temporary suspension. Failure of a Medical Staff member who is credentialed, to notify Hospitals' Administration of significant changes of status, as outlined on the credentials application, shall be grounds for temporary suspension.

3. If at any time a Medical Staff member or applicant fails to provide the requested information pursuant to a formal request by the Credentialing and Privileging Committee, the clinical privileges shall be deemed to be temporarily suspended until the required information is provided to the satisfaction of the requesting party.

4. A Medical Staff member who does not comply with the Hospitals' Communicable Disease Policy by failing to be tested for Tuberculosis, Hepatitis B/C, HIV, or other diseases identified by such policy, or by failing to submit the results of such screenings, shall have his/her admitting and clinical privileges suspended immediately and automatically until he/she are in compliance with the policy.

5. It shall be the duty of the Medical Director to apply and follow these automatic clinical privileging suspension policies.

Mandatory Revocation

1. Loss of License: If a Medical Staff member's license to practice his/her profession is revoked, or if he/she fails to renew such license, then the admitting and clinical privileges of such Medical Staff member shall immediately and automatically be revoked.

2. Conviction of a Felony: Any Medical Staff member, upon exhaustion of appeals after conviction of a felony in any court in Saudi Arabia, or proved in any other country court, the Medical Staff member's appointment and clinical privileges shall be automatically revoked. Revocation pursuant to this section of the Bylaws does not preclude the Medical Staff member from subsequently applying for Medical Staff appointment.

ARTICLE 18: APPEAL IN THE EVENT OF TERMINATION OF APPOINTMENT, REDUCTION OR LOSS OF CLINICAL PRIVILEGES AND THEIR ACTIONS

Appeal

1. When a Medical Staff member has been recommended to be terminated or have his/her clinical privileges reduced or suspended through any of the above mentioned ways, that member of staff should be notified in writing immediately by the Medical Director. This letter must have attached a copy of the current Medical Staff Bylaws with the section on appeal rights highlighted.

2. The affected member shall have the right to appeal.

3. The affected member, within seven (7) working days of being informed of an adverse decision, must inform the Medical Director in writing that he/she wishes to make an appeal and shall submit the reasons for doing so. If he/she fails to do so within the specified time, he/she shall be deemed to have waived his/her right of appeal and the action shall stand.

4. The Credentialing and Privileging Committee will study this appeal in detail and examine any new evidence or information.

5. Within thirty (30) calendar days after the conclusion of the appeal review, the Credentialing and Privileging Committee will make a final recommendation regarding the appeal. The Medical Director will issue the final decision regarding the appeal and its outcome.

6. Notwithstanding any other provision of these Bylaws, no Medical Staff member shall be entitled as a right to more than one (1) hearing,

and one (1) appeal review, on any matter which shall have been the subject of adverse action.

7. There is no right to appeal for an individual who is not approved for initial appointment for continuation following completion of the probationary period or for re-appointment to the Medical Staff.

Corrective Actions

❖ Nature of Misconduct:

1. **Professional Misconduct -** The failure or inadequacy of performance, or unacceptable behavior, arising from the exercise of medical or dental skills, or professional judgment.

2. **Personal Misconduct -** The failure of performance or unacceptable behavior due to factors other than those associated with the exercise of medical or dental skills.

3. **Medical Malpractice -** In case of unacceptable mortality or morbidity resulting from inappropriate performance, medical incompetence, or proven negligence – even in the absence of patient's complaint – it is the responsibility of the Medical Director to follow the Regulations of Practicing Medical Professionals in the Kingdom of Saudi Arabia.

❖ Investigation

1. When a concern or issue involving professional or personal misconduct comes to the attention of the Medical Director, Hospital Director General, they should decide either to discuss the matter with the practitioner concerned, or to begin an investigation. If, in their opinion, the issue does not merit an investigation; the Medical Director shall invite the concerned Practitioner to a personal interview to discuss the matter.

2. If the Medical Director or Hospital Director General deems an investigation advisable, they may delegate the issues to a special investigation committee (formed by one unrelated Chairman of a department, a member of human resources, and two senior clinicians unrelated to the affected member) within a period of seven (7) days.

3. The Medical Director or Hospital Director General shall promptly notify the Head in writing that an investigation is in progress.

4. The individual being investigated shall have an opportunity to meet with the investigation committee before it starts its investigation. At this meeting the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain, or refute it, not less than ten (10) days before the start of the official investigation in order to give him the opportunity to prepare his case. He should be provided as soon as possible with copies of correspondence and with any statements made. He may present witnesses and/or documentary evidence to support his/her case. The investigation committee shall hold its meetings in private and any actions taken and/or recommendations made pursuant to these Bylaws shall be treated confidentially.

5. The investigation committee shall present its findings and recommendations for corrective actions in writing to the Medical Director. The Medical Director should submit this report to the Hospital Director General for action.

- **Disciplinary actions**

Any of the following disciplinary actions may be taken based on the recommendation of the investigation committee:

1. Revocation or suspension of clinical privileges
2. Reduction of clinical privileges
3. Imposed terms of probation
4. Letter of reprimand

5. Letter of warning
6. Salary deduction
7. Disciplinary transfer
8. Termination of employment
9. Referred to the applicable medical/legal court if a criminal act has occurred

ARTICLE 19: DEPARTMENT AND SERVICES

SECTION 1 – ORGANIZATION

The Medical Staff will be organized into services or Department. Each member of the staff will be assigned membership in one Department, but maybe granted clinical privileges in one or more Departments. New Departments shall be created only by the Hospital Board upon recommendation of the Medical Board. New services maybe created by the Medical Director in consultation with the members.

1. **Department -** The Department shall be defined as a principal independent group of Medical Staff, usually specialized and shall be managed by a Department Head. The Department Head will report to the Medical Director in all clinical and hospital related matters. The Head of the department may assign a deputy chairman to handle clinical matters in order to focus more on academic matters. However, the Head is ultimately responsible for all activities of the department.

2. **Division -** The Division shall be defined as a semi-autonomous organizational group of Medical Staff that is present in the same facility where the parent department is located or present in other facilities. A division shall be managed by a Section Head, who shall report to the Head of an applicable department.

3. **Unit -** The Unit shall be defined as an organizational structure of Medical Staff within a specialty, or sub-specialty, and shall be managed by a Head of Unit. The unit may have diagnostic, preventive, palliative, or therapeutic functions. The head of unit shall report to the Head of an applicable Department.

4. DEPARTMENTS

4.1 Emergency Room
4.2 Intensive Care Unit (ICU)
4.3 Labour and Delivery
4.4 Operating Room/Surgery and Anesthesia
4.5 Internal Medicine
4.6 Pediatric (NICU/PICU)
4.7 Pharmacy
4.8 Rehabilitation Service
4.9 Radiology
4.10 Pathology and Laboratory
4.11 Out-Patient Sevices

FUNCTIONS OF THE DEPARTMENTS

1. Each Department shall participate in the evaluation of medical care by members of the department through the mechanisms of quality improvement tools and meetings. Such regularly scheduled meetings shall review mortality, morbidity, incidents, and untoward occurrences, which relate to patient care and utilization of hospital resources.
2. Each Department shall develop and make recommendations for the establishment of operational policy and procedures.
3. Each Department shall develop and make recommendations for the establishment of standards of clinical practice, which are expected to be met by Practitioners who are awarded privileges in the Department.
4. Each Department shall develop and conduct programs to monitor and evaluate the provision of clinical services performed by the Department.
5. Each Department shall develop and conduct programs of continuing education for Practitioners who are awarded privileges in the Department.
6. Each Department shall meet monthly for the purpose of promoting the quality of care rendered by the Department including, but not limited to:

6.1 The review of appropriate performance improvement reports and studies.
6.2 The formulation of recommendations to the Medical Director.
6.3 The development and conduct of clinical studies and research programs.
6.4 Submission to the Medical Director and to Quality Department, minutes of its meetings and other reports concerning its activities and recommendations.

SECTION 2 - FUNCTIONS AND SERVICES

The primary responsibilities of Services are to carry out the purposes and functions of the Medical Staff Organization as they relate to the service. This involves making recommendations to the Medical Director through the Heads of the Department concerning professional standards, quality improvement studies, objectives, policies and procedures. In exercising these responsibilities, each Service shall:

1. Recommend policies and guidelines for the granting of clinical privileges within the Department and recommendations regarding the specific privileges each member or staff applicant may exercise and the specified professional personnel may provide.
2. Establish policies and procedures and conduct quality improvement studies for the purpose of improving and or maintaining the quality of medical work within the Department. Each Department shall review the studies made under its jurisdiction.
3. Make recommendations regarding and participate in the conduct of continuing medical education or program related to the changes in the practice of Medicine as they apply in the Department and to the findings of the Quality Improvement Studies.

4. Monitor on a continuing basis the adherence to the Medical Staff By-Laws, laws and customs of the Saudi Arabia, the sound principle of clinical practice and the Code of Ethics.
5. To coordinate patient care provided by the Department's members with nursing and other non-physician patient care services and with administrative support services.
6. The Medical Director will meet at least monthly to discuss patient safety issues and to prepare written reports of the Departmental meetings for review by them. Such meetings shall consider the findings of the Department review and evaluation activities and actions taken thereon, the results of such action and recommendation for maintaining and improving the quality of care provided in the Department and such other matters.
7. To make recommendations regarding the adequate physician manpower requirements to meet the services needed in the Medical Department.
8. To establish such department committees as necessary and desirable to properly perform the functions assigned to it.

SECTION 3 – MEDICAL STAFF MEETINGS

Meetings shall be conducted in accordance with the provisions of the Hospitals' Rules and Regulations:

- **Each Department of the Medical Staff shall conduct the following meetings:**

1. Regular departmental meeting (Scheduled monthly with at least nine (9) held per year).

2. Departmental Mortality and Morbidity meetings, once per month for applicable Departments. If not, all Mortality and morbidity reports shall be discussed in Mortality and Morbidity Committee Meeting quarterly.

Following items must be part of the agenda:

1. System Controls.
2. System and outcome improvements; including among other items, a discussion of incident, appropriate indicators, length of stays, appropriate audits and surveys.
3. Staff Development.
4. Other departmental problems.
5. The Head of Department must also conduct monthly meeting send minutes to the relevant department chairman.
6. Head of the Department/Division should encourage all the staff to participate in mission achievement activities, and work collaboratively to develop improvement plans and Policies, Procedures, and guidelines according to the scope and intensity of the services.

Departmental Mortality and Morbidity Meeting

1. All clinical departments must conduct Mortality and Mortality and Morbidity meetings in their Morbidity Department.

2. Copies of the minutes of the Mortality and Morbidity meetings must be sent to the Chairman of the Committee.

3. Right of Ex-Officio Members - Persons attending departmental meetings as ex-officio members shall have all rights and privileges of regular members, except that they shall not have the right to vote.

4. Minutes **-** Minutes of each regular meeting of a Department shall be prepared and shall include a record of the attendance of members. The minutes of the meetings shall be sent to the Medical Director.

5. Intra-Departmental Functional Committees/Meetings - The Chairman of departments has the right to form/hold intra-departmental functional committees/meetings to facilitate the organization of certain aspects of Departmental/Divisional activities or regulate such activities as a means of involving the Medical Staff in the management of the Department/Division.

6. Attendance Requirements - Each Consultant who is a member of the active Medical Staff shall be expected to attend all meetings of his/her Department and Team of which he/she is a member. Any member of the active Medical Staff who is compelled to be absent from such a meeting shall submit to the Head, in writing, the reason for such absence. The failure to attend such meetings, unless excused by the Head of the Department for good cause, shall be grounds for corrective action.

7. The Head of the Department shall report all excessive absences to the hospital administration.

8. Failure by a member of the Medical Staff to attend any meeting to which he/she was given notice that attendance was mandatory, unless excused by the Head upon showing good cause, may result in disciplinary action.

9. If the Medical Staff member shall make a timely request for postponement, and this is supported by adequate evidence showing that his/her absence will be unavoidable, the Head of Department may excuse the Medical Staff member.

10. The Head of Department shall report all excessive absences to the hospital administration.

11. Failure by a member of the Medical Staff to attend any meeting to which he/she was given notice that attendance was mandatory, unless excused by the Head upon showing good cause, may result in disciplinary action.

12. If the Medical Staff member shall make a timely request for postponement, and this is supported by adequate evidence showing that his/her absence will be unavoidable, the Head of Department may excuse the Medical Staff member.

ARTICLE 20: CONTINUING MEDICAL EDUCATION

1. The Hospitals and the Medical Staff shall provide a program of continuing education for all Medical Staff members, which shall be designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to update them in aspects of their basic medical education.

2. Each Medical Staff member's participation in hospital-based and outside educational activities shall be documented and entered in his/her personnel record and shall be used in his/her evaluation at the time of reappraisal and reappointment.

3. Hospital-based Program – The Hospital-based Continuing Medical Education Program shall:

   3.1. Regularly include at monthly programs which may be held on a departmental or a divisional level.
   3.2. Emphasize and encourage case discussion, clinical-pathological/ clinical-radiological conferences and grand rounds.
   3.3. Be relevant to the type and nature of patient care delivered in the Hospitals.
   3.4. Be related in part to the findings of quality improvement activities.
   3.5. Include basic cardio-pulmonary resuscitation training.
   3.6. Be consistent with the expressed educational needs of the Medical Staff.

ARTICLE 21: LEAVE COVERAGE

1. Head of the departments shall obtain approval from the Medical Director for any leave or absence of duty and assign appropriate

coverage at least one (1) week prior to the leave. For emergency leave, a verbal notification must be obtained.

2. Leaves of the staff will be signed by the respective head of the department, then medical director, then forwarded to the HR department, and finally approved by the Hospital Executive Manager.

3. All consultants shall complete and sign the clinical duties coverage form and make certain that all of their clinical duties are appropriately covered. The signature of the covering consultant must also be obtained.

4. It is the duty of the head of the department to assure that all the clinical services are appropriately and sufficiently covered by a qualified alternative before approving any medical staff leave. The Hospital Director General approving the leave will also make sure that there are no outstanding tasks like dictations of medical reports, signed out medical records, ongoing investigations, chairing of important committees that have not been performed or appropriately delegated.

ARTICLE 22: DRAFTING, ADOPTING AND AMENDING THE MEDICAL STAFF BY-LAWS

1. Drafting and Adopting

1.1. The amended Medical Staff Bylaws shall be approved by the Medical Director and the Hospital Executive Manager.

1.2. The approved Medical Staff Bylaws will be distributed to all Medical Staff and departments.

2. Periodic Review

2.1. The Medical Staff Bylaws shall be reviewed periodically every two (2) years by the Medical staff and approved by the Medical Director and Hospital Executive Manager.

3. Amendment and Addition:

3.1. Any Medical Staff member may submit a proposed amendment, which must be referred to the appropriate departmental meeting, which shall discusses the validity and necessity of the proposal.

3.2. If the proposed amendment is recommended for adoption by the Head of the Department, he/she shall recommend the proposal to the Medical Director. If appropriate, this will refer the amendment to the Quality Department for its opinion and recommendation.

3.3. If deemed appropriate, the amendment will be discussed in the meeting.

3.4. If approved, the Medical Staff Bylaws will be changed accordingly and the new changes announced.

APPROVAL			
	Name/ Title	**Date**	**TQM Stamp**

Prepared By:	**Ms. Rachiel Monica Lumba** **TQM Administrative Staff**	**11-15-2023**	
Reviewed By:	**Dr. Mahmoud Ibrahim Khalifa** **Head, Internal Medicine Dept.**	**11-15-2023**	
Reviewed By:	**Dr. Mohammed Elkarow** **Head, Surgery Department**	**11-15-2023**	
Reviewed By:	**Dr. Umbreen Naz** **Head, OB-GYN Department**	**11-15-2023**	TQM Approved
Reviewed By:	**Dr. Sami Faleh Aloudat** **Head, Pediatrics Department**	**11-15-2023**	
Approved By:	**Dr. Kamil Abbas** **Medical Director**	**11-15-2023**	
Approved By:	**Dr. Saleh Alhebili Alsharif** **Deputy Hospital Director**	**11-15-2023**	
Final Approved By:	**Mr. Abdulrahman Al Adwani** **Hospital Executive Manager**	**11-15-2023**	

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