Egyptian Patient Safety Standards for Hospitals

Ministry of Health, 2013

Egyptian Patient Safety Standards
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Code		Standard
		General Patient Safety
A	**PS.1**	There are Policies & Procedures related to patient's safety in the organization.
A	**PS.2**	The patient's safety policy defines Egyptian and WHO Patient Safety recommendations and solutions that include at least the following:
	PS.2.1	Accurate standardized patient identification in all service areas.
	PS.2.2	Standardized process for dealing with verbal or telephone orders (Refer to standard MM.31).
	PS.2.3	Handing critical values/tests.
	PS.2.4	Hand hygiene throughout the organization (Refer to standard IC.12.2).
	PS.2.5	Prevention of catheter and tubing mis-connections.
	PS.2.6	Prevention of patient's risk of falling.
	PS.2.7	Prevention of patient's risk of developing pressure ulcers.
	PS.2.8	A standardized approach to hand over communications.
A	**PS.3**	The policy and procedure for handling critical values/tests includes at least the following:
	PS.3.1	List of the lab tests that have critical values/test results and the critical values/test results are defined for each test.
	PS.3.2	List of the radiology tests that have critical values/test results and the critical values/test results are defined for each test.
	PS.3.3	List of the clinical findings that have critical values results and the critical values are defined for each clinical finding.
	PS.3.4	Process of communication of the critical values/test results including the timing of reporting.
B	**PS.4**	The organization and staff are educated regarding the Egyptian and WHO Patient Safety recommendations and solutions. In addition to hospital policy.

B	**PS.5**	The patient safety standards and solutions are posted in all applicable areas.
B	**PS.6**	At least two (2) ways are used to identify a patient when giving medicines, blood, or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures.
B	**PS.7**	Current published and generally accepted hand hygiene guidelines, laws and regulations are implemented to prevent healthcare-associated infections.
B	**PS.8**	Single use injection devices are discarded after one time use to prevent healthcare-associated infections.
B	**PS.9**	A process for taking verbal or telephone orders and for the reporting of critical test results, that requires a verification by write down and "read-back" of the complete order or test result by the person receiving the information is implemented (Refer to standards IM.20 and IM.21).
B	**PS.10**	Systems are implemented to prevent catheter and tubing mis-connections.
B	**PS.11**	Each patient's risk of falling, including the potential risk associated with the patient's medication regimen is assessed and periodically reassessed.
B	**PS.12**	Action is taken to decrease or eliminate any identified risks of falling.
B	**PS.13**	Each patient's risk of developing pressure ulcers is assessed and documented.
B	**PS.14**	Action is taken to decrease or eliminate any identified risks of developing pressure ulcers.
B	**PS.15**	Preventive maintenance and testing of critical alarm systems is implemented and documented.
B	**PS.16**	Alarms are tested and activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.
B	**PS.17**	A standardized approach to hand over communications, including an opportunity to ask and respond to questions is implemented.

Medication Management Safety

A	**PS.18**	Policy & Procedures for medication management safety include at least the following:
	PS.18.1	Abbreviations not to be used throughout the organization (Refer to standard PS.21).
	PS.18.2	Documentation and communication of patient's current medications & discharge medication.
	PS.18.3	Labeling of medications, medication containers and other solutions.
	PS.18.4	Prevent errors from high risk medications.
	PS.18.5	Prevent errors from look-alike, sound-alike medications.
A	**PS.19**	The Policy to prevent errors from high risk medications defines:
	PS.19.1	The list of high risk medications including concentrated electrolytes.
	PS.19.2	Labeling and storage of high risk medications.
	PS.19.3	Dispensing and preparation of the high risk medications.
	PS.19.4	Frequency of reviewing and updating of the list.
A	**PS.20**	The Policy to prevent errors from look-alike, sound-alike medications defines the following:
	PS.20.1	The list of look-alike ,sound-alike medications.
	PS.20.2	Labeling and storage of look-alike ,sound-alike medication.
	PS.20.3	Dispensing and preparation of the look-alike ,sound-alike medication.
	PS.20.4	Frequency of reviewing and updating of the list.

B **PS.21** Abbreviations not to be used throughout the organization are:

U/ IU
Q.D., QD, q.d., qd
Q.O.D., QOD, q.o.d., qod
MS, MSO4
MgSO4
Trailing zero
No leading zero
Dose x frequency x duration

B **PS.22** Look-alike and sound-alike medications are identified, stored and dispensed to assure that risk is minimized.

B **PS.23** Concentrated electrolytes; including, but not limited to, potassium chloride (2 meq/L or greater concentration), potassium phosphate, sodium chloride (>0.9% concentration), magnesium sulfate (50% or greater concentration) and concentrated medications are removed from all patient care areas, whenever possible.

B **PS.24** Concentrated medications not removed are segregated from other medications with additional warnings to remind staff to dilute before use.

B **PS.25** All medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in peri-operative and other procedural settings are labeled.

B **PS.26** A process is implemented to obtain and document a complete list of the patient's current medications upon admission to the organization and with the involvement of the patient.

B **PS.27** A complete list of the patient's medications to be taken after discharge is provided to the patient.

B **PS.28** The discharge medication list is communicated to the next provider of service when the patient is referred or transferred outside the organization.

Operative and Invasive Procedure Safety

A	**PS.29**	Policy & Procedures for operative and invasive procedures safety includes at least the following:
	PS.29.1	Accurate documented patient identification preoperatively, and just before surgery (time out).
	PS.29.2	Process for verification of all documents and equipments needed for surgery or invasive procedures preoperatively.
	PS.29.3	Marking of site of surgery preoperative.
	PS.29.4	Verification of accurate counting of sponges, needles and instruments pre and post procedure.
B	**PS.30**	A process or checklist is developed and used to verify that all documents and equipment needed for surgery or invasive procedures are on hand, correct and functioning properly before the start of the surgical or invasive procedure.
B	**PS.31**	There is a documented process of accurate patient identification preoperatively and just before starting a surgical or invasive procedure (time out), to ensure the correct patient, procedure, and body part.
B	**PS.32**	The precise site where the surgery or invasive procedure will be performed is clearly marked by the physician with the involvement of the patient.
B	**PS.33**	There is a documented process to verify an accurate accounting of sponges, needles and instruments pre and post procedure.