



CBAHI

المركز السعودي لاعتماد المنشآت الصحية
Saudi Central Board for Accreditation
of Healthcare Institutions

رؤية 2030
المملكة العربية السعودية
KINGDOM OF SAUDI ARABIA



المعايير الوطنية ل ERAKZ طب الأسنان

NATIONAL
STANDARDS FOR
DENTAL CENTERS

CBAHI

FIRST EDITION 2022

NATIONAL STANDARDS FOR DENTAL CENTERS

Saudi Central Board for
Accreditation of Healthcare
Institutions

First Edition
2022

The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) is a not-for-profit governmental organization, that has been required by its formation order to support all healthcare organizations in Saudi Arabia through different mechanisms, including the production of scientific peer-reviewed standards, materials, and publications.

The mission of CBAHI is to continuously improve the safety and quality of healthcare services in the Kingdom of Saudi Arabia, by supporting healthcare facilities to continuously comply with the accreditation standards. CBAHI does this through the provision of preparation, on-site assessment, monitoring, education, publications, and consultation services.

CBAHI is making every possible effort to separate its consultative and educational programs as well as all publications it produces from its accreditation activities. This manual is produced for the sole use of individual healthcare facilities and healthcare professionals in Saudi Arabia. CBAHI provides supplementary educational sessions to explain the intent of this manual and its contents and therefore, attendance at these activities helps achieve compliance with the quality and safety standards followed by accreditation. Attendees at CBAHI training, orientation, and educational programs and purchasers of its publications will not have distinctive treatment by any CBAHI associates including CBAHI surveyors, nor receive any privilege regarding assessment scoring results or outcome.

This is copyrighted material. No part of this publication may be reproduced or stored in a retrieval system for usage outside the concerned organization or transmitted for public use in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior permission of CBAHI.

Permission to use this copyrighted material, requests for copies, or permission to make copies of any part of this work can be addressed to this email:SSD@cbahi.gov.sa, or alternatively to the following mailing address below:

Department of Public Relations The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) P.O. Box 9264, Riyadh, 12264, Kingdom of Saudi Arabia

ISBN: 978-603-90504-6-9

Printed in the Kingdom of Saudi Arabia, Riyadh

For more information about CBAHI publications, please visit: <http://www.cbahi.gov.sa>

المركز السعودي لاعتماد المنشآت الصحية، ١٤٤٢هـ فهرسة مكتبة الملك فهد الوطنية أثناء النشر

المركز السعودي لاعتماد المنشآت الصحية
المعايير الوطنية لمركز الأسنان ./المركز السعودي لاعتماد المنشآت الصحية - الرياض، ١٤٤٢هـ

-طب الاسنان - السعودية - ضبط الجودة أو العنوان
١٤٤٢/٩٧٩٤ ديوبي ٩٥٣-٦٧٦٠

رقم الإيداع: ١٤٤٢/٩٧٩٤
ردمك: ٩٧٨-٦٣-٩٥٤-٦١٩

المركز السعودي لاعتماد المنشآت الصحية (سباهي) هو الجهة الرسمية المخولة منح شهادات اعتماد الجودة لكافة المرافق الصحية الحكومية والخاصة التي تعمل في المملكة العربية السعودية. ينبع المركز أساساً عن المجلس الصحي السعودي، ويعتبر جهة غير هادفة للربح، يتولى بشكلٍ أساسي تقييم المنشآت الصحية بغرض تحديد مدى التزامها بتطبيق معايير الجودة وسلامة المرضي التي صممتها المركز لهذا الغرض. بدأ المركز عمله تحت مسمى المجلس المركزي لاعتماد المنشآت الصحية بقرار ملكي ووزير الصحة رئيس مجلس الخدمات الصحية رقم (١٤٤١٨٧) وتاريخ ٩-٩-٢٠١٤هـ، واستمر في تأدية المهام المنطوبة به حتى صدور قرار مجلس الوزراء الموقر رقم (٣٧٦) وتاريخ ٢٤-١١-٢٠١٤هـ، القاضي بتحويله إلى المركز السعودي لاعتماد المنشآت الصحية، واستمراره في وضع وتطبيق المعايير الوطنية للجودة وسلامة المرضي في كافة المرافق الصحية ومنح شهادات الاعتماد المتعلقة بذلك. يعتبر الحصول على الاعتماد الوطني من قبل المركز السعودي الزامياً على كافة المرافق الصحية الحكومية والخاصة بموجب القرار سالف الذكر وبموجب قرار المجلس الصحي السعودي رقم (٥٨/٧) وتاريخ ٩-٣-٢٠١٤هـ، كما تشرط وزارة الصحة السعودية تطبيق معايير الاعتماد الوطني الموضوعة من قبل المركز وإثبات ذلك بالحصول على شهادة الاعتماد كمتطلب من متطلبات الاستمرار في الترخيص للمنشآت الصحية الخاصة.

The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) is the official agency authorized to grant accreditation certificates to all governmental and private healthcare facilities operating today in Saudi Arabia. CBAHI has emerged from the Saudi Health Council as a nonprofit organization. The principal mission of CBAHI is to set the healthcare quality and patient safety standards against which all healthcare facilities are evaluated for evidence of compliance. The Central Board for Accreditation of Healthcare Institutions (CBAHI) was founded in October 2005 by Ministerial Order Number (144187). Since its formation, CBAHI continued to pursue its mission until 30 September 2013 at which time the Cabinet of Ministers Decree Number #371 called for changing the name to become the Saudi Central Board for Accreditation of Healthcare Institutions, and also mandated national accreditation by CBAHI on all healthcare facilities. To encourage more participation in this ambitious national initiative, the Ministry of Health mandates CBAHI accreditation as a prerequisite for the renewal of operating licenses for all private Organizations.

Table of Contents

Foreword	5
Standards Development Committee/Advisory Committees and Experts Panel	6
Preface	7
PART I- INTRODUCTION	8
• CBAHI at a Glance	10
• Healthcare Accreditation: Definition and Importance	10
• Scope of Accreditation Surveys	11
• Structure of the National Standards for Dental Centers	13
• Accreditation Survey	13
PART II- ACCREDITATION POLICIES	18
• Eligibility for Accreditation	20
• Registration with CBAHI	20
• Accreditation Pathway	20
• Survey Team	21
• Rescheduling of Surveys	22
• Accreditation Decision Rules	22
• Appeal Against an Accreditation Decision	24
• Accreditation Maintenance (Post-Survey Requirements)	24
• Accreditation Suspension and Revocation	26
• Random Surveys	28
• Accreditation Certificate and Seal	28
• Release of Accreditation-Related Confidential Information	29
• Complaints against an Accredited Healthcare Facility	29
• Conflict of Interest	30
• Truthfulness and Ethics Clause	30
PART III- ACCREDITATION STANDARDS	32
• Chapter I - Leadership of the Organization (LD)	34
• Chapter II - Provision of Care (PC)	50
• Chapter III - Dental Laboratory (DL)	59
• Chapter IV - Management of Information (MOI)	63
• Chapter V - Infection Prevention and Control (IPC)	68
• Chapter VI - Facility Management and Safety (FMS)	76
Glossary	86

Foreword

The healthcare matrix in Saudi Arabia is witnessing an ambitious transformation at all levels, particularly in terms of service quality. This transformation is intended to bridge the gap between the current and desired healthcare system. The Kingdom's leadership has been eager to undertake such transformational actions to assure the availability, sufficiency, efficiency, and safety of the healthcare services offered to more than 35 million citizens and residents. The main goal, however, remains to focus on improving community health while increasing the capacity of healthcare services to meet the demands of one of the fastest-growing population rates.

The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) plays a vital role in the Saudi health system. It is the independent entity responsible for setting the healthcare provision standards and assessing the compliance of healthcare organizations against these standards. CBAHI has strived to establish evidence-based standards that encompass a wide range of healthcare organizations with various scopes, in order to enhance the quality and safety of healthcare services.

This manual is designed to serve for hundreds of dental care centers across the country, hence ensuring that the dental care provided at these centers is effective and meet the desired standards which is of prime importance in terms of the quality of care and patient satisfaction. We hope that this manual serves as a road map for administrators and health practitioners at these centers in building a patient-centric care system.

It is worth mentioning that the accreditation scheme in Saudi Arabia is an example to follow in other contexts in the middle east and internationally. The fact that CBAHI is complying with international requirements of accrediting bodies and is accredited by the International Society for Quality in Healthcare (ISQua), adds to its credibility as a trusted accreditation authority.

On behalf of all staff members working in the Saudi healthcare system, I extend our appreciation and gratitude for the limitless support coming from our top leadership to ensure the health and lasting prosperity of the people of Saudi Arabia.

Fahad AlJalajel
Minister of Health & Chairman of Saudi Health Council

Standards Development Committee/Advisory Committees and Experts Panel

Experts representing a variety of health sectors in Saudi Arabia, including dentists, physicians, nurses, pharmacists, laboratory specialists, infection control practitioners, biomedical engineers, administrators, and public policymakers, have actively guided the development of the National Standards for Dental Centers. Several professional bodies have assisted as well with the development and refinement of the standards. CBAHI would like to extend thanks and appreciation to all health authorities, organizations, and individuals who participated in or provided external commentaries to this important national initiative. The following is a list of participants in alphabetical order.

Dr. Abdullah S. Alkeraidis	Dr. Abdulmunim F. Alsuhaimi
CEO at Almeswak Dental Clinics Almeswak Dental Clinics - Riyadh	Assistant Director General for Research and Development CBAHI - Riyadh
Dr. Amal A. Alshedoukhi	Mrs. Corina P. Meissenheimer
Consultant in Pediatric Dentistry Prince Sultan Military Medical City - Riyadh	Accreditation Specialist CBAHI - Riyadh
Dr. Fahad A. Al Shehri	Mr. Fahad N. Almuhanna
Consultant and Associate Professor in Periodontics and Implant Dentistry King Saud University- Riyadh	Head of the Oral and Dental Health Unit - Dental Hygienist King Saud University - Riyadh
Dr. Hamad M. Alsalhi	Dr. Hossam M. Ghoneim
Assistant Director General for Accreditation Affairs CBAHI - Riyadh	Senior Healthcare Quality Consultant The Council of Health Insurance - Riyadh
Dr. Jamal Abo Shamalah	Dr. Majdah A. AlKhadhari
Senior Accreditation specialist CBAHI - Riyadh	Consultant & Residency Training Program Director Ministry of National Guard Health Affairs - Jeddah
Ms. Maha A. Albaalharith	Dr. Mashael S. AlMohrij
Principal Accreditation Specialist CBAHI - Riyadh	Assistant Accreditation Specialist CBAHI - Riyadh
Mr. Mohammed A. Alkhairi	Dr. Mohammed A. Hussein
Supervisor of Standards Development Committees CBAH - Riyadh	Group Quality Manager Saudi German Health - Jeddah
Dr. Muhammad A. Halwani	Dr. Omar S. Alajaji
Associate Professor and Head of the Department of Medical Microbiology Al Baha University	Chairman for Omar Alajaji Medical Company Omar Alajaji Medical Company - Riyadh
Dr. Mostafa M. Galwash	Dr. Salem A. Alwahabi
Group Chief Quality Officer Saudi German Health - Jeddah	Director General CBAHI -Riyadh
Dr. Saeed B. Alzahrani	Dr. Saud O. Alharthi
Deputy General Director of Dentistry Ministry of Health - Riyadh	Surveyor Affairs Department Director CBAHI – Riyadh
Prof. Sulieman S. Aljohani	
Consultant in Prosthodontics King Saud University- Riyadh	

Preface

In the healthcare industry, evaluation is an essential part of every executive activity. Globally, appealing approaches have been employed to regulate and evaluate healthcare quality internally and externally. Accreditation has been cited as the most commonly used strategic external quality evaluation tool in healthcare. It is a systematic evaluation based on predefined standards that focus on sustainable quality improvement, patient-centeredness, and patient safety. In Saudi Arabia, since its inception in 2005, the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) has strived to support healthcare facilities by ensuring continuous compliance with quality and patient safety standards.

Over the last decade or so, the Saudi health system has witnessed significant progress at all levels. One remarkable area was the great expansion in the number and complexity of dentistry facilities. This is in alignment with worldwide advancement in the medical field, with a greater emphasis on continuous performance improvement and measurement. In that, CBAHI is pleased to introduce the first edition of the National Standards for Dental Centers. These evidence-based standards are intended to support dental centers in Saudi Arabia improving the quality and safety of patient care. Being comprehensive, detailed, and occasionally prescriptive in design and nature, this edition of the standards was built to be as relevant and applicable to the licensed dental centers operating in the Kingdom of Saudi Arabia.

During the development of this manual, the development team considered the variety in the quality levels across the continuum of care in dental centers and strived to create a set of standards that would apply to all dental care centers. This manual contains important information on the accreditation eligibility, scheduling of surveys, survey preparation, survey visit, and accreditation decision rules. In the remaining part, accreditation standards are distributed among relevant chapters.

We sincerely thank the committees, teams, and task forces that contributed to the development, compilation, designing, reviewing, and producing this manual. We would like also to convey our appreciation to the healthcare professionals who have been obliging and generous with their professional feedback, time, constructive comments, and suggestions.

CBAHI welcomes all stakeholders' perspectives, suggestions, and comments. Only by this constructive collaboration, we can improve the quality and safety of our patients.

Dr. Salem Al Wahabi
Director General – CBAHI



PART I

INTRODUCTION

CBAHI at a Glance

The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) is the official agency authorized to grant healthcare accreditation to all governmental and private healthcare facilities operating today in the Kingdom of Saudi Arabia.

Having originally emerged from the Saudi Health Council as a nonprofit organization, CBAHI is primarily responsible for setting quality and safety standards to ensure a better and safer healthcare system. Its first official inauguration occurred after the Ministerial Decree number 144187/11 in October 2005, which called for the formation of the Central Board for Accreditation of Healthcare Institutions, tasked with the initiation of a national voluntary healthcare accreditation program. In 2013, the Council of Ministers mandated accreditation by CBAHI and gave the board its current name.

The mission of CBAHI is to set standards and assess performance for better healthcare, and the vision is to lead healthcare accreditation in the Middle East. CBAHI is aiming to achieve two conjoined initiatives, in congruence with the 2030 vision. The first initiative is to expand the range of efficient and effective accreditation programs to cover healthcare services. The second initiative is to work with a variety of partners to support the health system in Saudi Arabia and the region by increasing the depth of quality improvement and patient safety, as well as, by disseminating knowledge through training and education. Driven by its core values and a dedicated team of surveyors and staff, CBAHI is determined to be a major driving force and a recognized standard for the provision of safe and high-quality healthcare.

In addition to the accreditation program for dental centers, CBAHI currently provides other accreditation programs to healthcare facilities such as primary healthcare centers, hospitals, ambulatory centers, and clinical laboratories and blood banks.

CBAHI is proud to be one of the few healthcare accreditation agencies in the world to be accredited by the International Society for Quality in Healthcare (ISQua).

Healthcare Accreditation: Definition and Importance

Healthcare accreditation is an assessment process that involves a rigorous, transparent and comprehensive evaluation by an external, independent accreditation body. The healthcare facility (HCF) undergoes an appraisal of its systems, processes, and performance by peer reviewers or surveyors to ensure that all tasks are conducted in a manner that meets applicable predetermined and published national standards. Before the external evaluation, i.e., the survey visit, the HCF is expected to conduct a comprehensive self-assessment to determine its level of preparedness and how close it is to achieve full compliance with the standards. Therefore, accreditation represents the healthcare accreditation body's public recognition of the achievement of accreditation standards by an HCF. The standards set out a common framework to support HCFs in providing effective, timely, and quality services. They are designed to promote the delivery of improved levels of care and treatment to the citizens and residents of Saudi Arabia. Evidence from scientific research shows that engagement in a robust healthcare accreditation program improves the structures, processes, and outcomes of care that healthcare facilities provide. Accreditation is more than just a certificate to be obtained and hung on the wall. Accreditation, when used correctly, can provide the following advantages:

- Accreditation provides a framework for organizational structure and management. Accreditation standards focus on the governance and leadership structures and many diverse functions within a healthcare facility; and the appropriate management of its business and day-to-day activities.

- Accreditation helps improve patient safety and minimizes the risk of medical errors. Ensuring patient safety through risk management and risk reduction is at the center of all accreditation standards and is the ultimate goal of the self-assessment and survey activities.
- Accreditation enhances community confidence in the quality and safety of care provided. When a healthcare facility achieves accreditation, the message is clear – its leaders are committed to providing a nationally accepted standard of care in health services delivery.
- Surveyed healthcare facilities have found that seeing their operation through the eyes of experienced surveyors gave them a useful, more objective assessment of their internal administrative and clinical processes, as well as effective proposals for improving their processes and the services delivered to the community.
- In the long term, accreditation increases efficiency and enhances lean practices, which in turn leads to decreasing waste and achieving optimal results with less consumption of resources.
- Accreditation helps improve a healthcare facility's competitiveness. Increased public trust in an accredited facility will encourage more patients to seek care and treatment there. This will increase its market share and improve its competitiveness in the healthcare sector.
- Achieving accreditation will fulfill the regulations required by the national authorities as CBAHI national accreditation currently is linked to the licensing of healthcare facilities.
- Accreditation has a link to reimbursement from insurers and other third parties. There is a growing tendency, nationally and internationally, to link accreditation with eligibility for insurance reimbursement.
- Accreditation provides a robust tool for continuous quality improvement efforts in healthcare facilities and assists facility leadership to ensure the sustainability of quality improvement projects and initiatives.
- Accreditation provides excellent learning and educational opportunities. This is accomplished by educating staff on best practices and emphasizing the importance of patient education and patient rights.

Scope of Accreditation Surveys

The scope of the CBAHI survey includes all standard-related functions of the surveyed HCF. Each assessment survey is tailored to the type, size, and range of services the facility offers. CBAHI determines the applicable standards from this manual based on the scope of the services provided by the HCF undergoing a survey. Additionally, the on-site survey team will consider the specific applicability of individual standards.

Any special medical procedures/services performed in the dental center which are covered in any other CBAHI set of standards must be followed. This might include services such as dental day surgery, sedation, and medication use amongst others.

A standard is a 'statement of excellence' or an explicit predetermined expectation that defines the essential functions, activities, processes, and structures required from HCF to ensure the provision of safe, quality care and services.

Peer experts in their specific fields develop the standards. It is against these standards that conformity of the healthcare facility is evaluated. Stated succinctly, a standard describes a HCF/service's acceptable level of performance. Within this context, there should be no confusion between accreditation standards and licensure standards. When applied to the licensure of an individual practitioner or facility, the licensure standard is usually set at a minimal level designed to protect public health and safety. Accreditation standards, on the other hand, are

designed as optimal and achievable. When met, standards establish a high-quality level of service in the healthcare system.

CBAHI standards and those of all other relevant accrediting agencies focus on three significant aspects depending on which area they are addressing; structure, process, and outcome:

Structure: standards related to structure address the system's inputs, such as workforce, building design, and the availability of equipment and supplies such as personal protective equipment.

Process: standards address the clinical and administrative processes or interventions carried out within the HCF/service in terms of patient care, facility management, or staff management. Examples include patient assessment, patient education, and medication administration.

Outcome: standards related to outcome involve assessing an intervention's benefits and whether the activity's expected purpose was achieved. They provide information regarding predicted outcomes that are being realized. Examples include data regarding patient satisfaction, healthcare-associated infections, medication errors, and adverse events.

CBAHI standards set expectations for HCF's/service's performance that are reasonable, attainable, measurable, and therefore, conducive to a survey. Standards were built to serve as the basis of an objective evaluation process that can help HCFs measure, assess and improve performance. CBAHI strives to be a nationally recognized symbol of excellence, respected throughout the industry and by other relevant authorities as an assurance that accredited HCFs/services meet rigorous standards of quality and operational integrity that emphasize consumer protection and patient engagement. Therefore, the standards development process at CBAHI follows a long and robust methodology to ensure our standards are correct, evidence-based relevant, and straightforward.

There are a variety of methodologies or approaches that have been used globally for healthcare accreditation standards development such as department-oriented standards, scope of services-oriented standards, or quality System essentials. The National Standards for Dental Centers contains standards of quality and patient safety that are descriptive in nature. Standards are included in six chapters: Leadership of the Organization (LD), Provision of Care (PC), Dental Laboratory (DL), Management of Information (MOI), Infection Prevention and Control (IPC), and Facility Management and Safety (FMS). The aim of these standards and the surveyor programs is to provide answers to the following four questions:

- Is the healthcare facility well-led?
- Is the care delivered safe, effective, and patient-centered?
- Is the environment, in which the care is provided, good?
- Are the internal and external customers satisfied?

CBAHI used a 'hybrid methodology' to help answer these four questions positively. Some of the standards are departmental based, whereas others are based on quality metrics to ensure standards implementation, environmental safety, and internal and external customer satisfaction.

Specialized task forces, including focus groups and standards development committees, develop the first draft of CBAHI standards. A variety of sources are utilized including:

- The standards set by professional scientific societies, both locally and internationally.
- Scientific literature review and research studies.
- Relevant laws, rules, and regulations.
- National (or international) emerging issues related to healthcare quality and patient safety.
- Input from healthcare professionals, providers, and patients.

- Panels of experts and consensus on best practices, given the current state of knowledge and technology.
- Environmental inspection.
- Evaluation results from previous surveys, if available.

The process of standard development can last several months before an initial draft is produced. The draft standards are then distributed nationally for review and made available for comment on the standards through a field review process. Based on the feedback received during the field review, the draft standards may be revised and again reviewed by the relevant experts and technical committees. The draft standards are finally reviewed and approved by the Standards Development Steering Committee and provided to the CBAHI Board for comments and remarks before submission to the Saudi Health Council for approval. Thereafter, the standards are made available to the target HCFs and an e-version is made available too on the CBAHI website.

To comply with the guidelines of the International Society for Quality in Healthcare (ISQua), a period of six months is allowed for publishing of the standards before they are effective. Through this, HCFs are given adequate time to familiarize themselves with and implement the standards.

Also, CBAHI surveyors are taught how to assess compliance with these standards. No matter how robust the methodologies used in developing the standards, room for improvement will always exist. Therefore, once the standards are in effect, ongoing feedback is sought for continuous improvement purposes. This is one of several CBAHI initiatives for improving the efficiency and effectiveness of internal processes, including standards development to better meet the needs and expectations of our partners.

Structure of the National Standards for Dental Centers

The National Standards for Dental Centers are assembled into six chapters consisting of key services and functions that dental centers provide in Saudi Arabia. The chapters are:

- Leadership of the Organization (LD)
- Provision of Care (PC)
- Dental Laboratory (DL)
- Management of Information (MOI)
- Infection Prevention and Control (IPC)
- Facility Management and Safety (FMS)

Each chapter includes a brief introduction that explains the chapter's relevance and contribution to safety and quality patient care. Each standard consists of a stem standard that consists of a concise statement, followed by a number of sub-standards to further illustrate the standard's requirements. Each sub-standard is constructed to independently serve as the evidence of compliance that is going to be measured and scored during the on-site survey. Each standard is accompanied by an explanation to help the HCFs understand the intent behind it.

Accreditation Survey

CBAHI determines applicable standards from this book based on the scope of services and the on-site survey team's decision regarding the applicability of individual standards. CBAHI surveyors typically employ a variety of techniques and strategies to objectively decide whether the facility meets the standards related to key systems and functions such as governance and leadership, patient care processes, medication management, infection prevention and control, and safety of the facility environment. For example, the survey team may review

written documents such as strategic and operational plans and budgets as well as clinical policies and procedures. In addition to reviewing documents, surveyors will interview facility leaders, physicians, nurses, employees, and patients to determine the facility's performance and compliance with standards. For example, the surveyor might interview a staff member to check on the process he or she would complete to report a medical error that caused harm to any of the patients receiving care in that facility. Similarly, a surveyor might interview a patient about his or her level of satisfaction with the care the HCF provides.

Facility leaders, including members of the governing body, may be interviewed regarding facility processes and how they are designed to meet standards related to planning, budgeting, quality improvement activities, and human resources management. Surveyors tour the facility's buildings and patient care areas to evaluate standards related to overall cleanliness, building safety, fire safety, waste management, equipment and supply management, infection control, and emergency preparedness. Diagnostic and support services such as the laboratory, radiology, pharmacy, and central sterile services are also assessed for safety, effectiveness, and quality control.

In summary, during an on-site survey, surveyors use a variety of evaluation approaches to determine the facility's compliance or performance regarding applicable structure, process, and outcome standards. These methods might include any combination of the following:

- Interviews with facility leadership, clinical and support staff, patients, and families.
- Observation of patient care and services.
- Facility tour and observation of patient care areas, building facilities, equipment management, and diagnostic testing services.
- Review of written documents such as policies and procedures, orientation and training plans, budgets, and quality improvement plans.
- Review of personnel files
- Review of patients' medical/dental records.
- Evaluation of the facility's achievement of specific outcome measures (e.g., acquired infection rates, patient satisfaction) through review and discussion of monitoring and improvement activities.

This manual contains 78 standards distributed throughout six chapters. The standards are:

List of Standards	
Number	Standard
LD.1.	The governing body defines its structure and operational responsibilities in a written document.
LD.2.	The governing body approves and evaluates the center's quality and patient safety program, and risk management initiatives.
LD.3.	The center has a defined, current, and clear organizational chart.
LD.4.	The dental center is effectively managed by a qualified director.
LD.5.	The dental has a clear center's scope of services based on community needs.
LD.6.	The leaders work collaboratively to develop the center's strategic plan.
LD.7.	The leaders transform the approved strategic plan into an operational plan.
LD.8.	The center's leaders work collaboratively to develop and maintain a center-wide staffing plan.
LD.9.	All categories of staff have clearly written job descriptions.
LD.10.	There is a process in place for credentialing and re-credentialing all healthcare providers.
LD.11.	All dentists have current delineated clinical privileges.
LD.12.	All new employees attend a mandatory orientation program.
LD.13.	There is a policy that ensures dental assistants and other healthcare staff are competent in specific procedures and operating equipment.
LD.14.	There is a program for continuing education and training of all categories of staff.
LD.15.	The leaders develop an effective process to evaluate staff performance at least annually.
LD.16.	The center implements a comprehensive program to protect the health and safety of staff.
LD.17.	The leaders develop ethical standards to guide patients' care and employees' code of conduct.
LD.18.	The leaders support and protect the patient and family's rights.
LD.19.	The leaders develop and implement a policy and procedure to describe the patients' right to voice their complaints, concerns, and suggestions.
LD.20.	Patients and their families have the right to accurate billing for provided services.
LD.21.	The center provides assistance to patients with special needs.
LD.22.	The center has a policy and procedure for controlling the development and maintenance of key documents.
LD.23.	The center collaboratively develops a comprehensive quality improvement and patient safety program.
LD.24.	The center prioritizes and selects a set of relevant indicators that focus on the structure, process, and outcome of the dental and non-dental services provided.
LD.25.	The center develops and implements a comprehensive risk management program.

List of Standards

Number	Standard
LD.26.	The center implements an incident reporting policy.
LD.27.	The center has a program to select and monitor clinical and operational contracts.
LD.28.	The leaders implement policies and procedures to guide efficient procurement of equipment, either purchased or donated, medications, and medical consumables following national laws and regulations.
LD.29.	The center maintains an aesthetic appeal.
PC.1.	Patients have access to services based on their dental needs and the available services, and are registered with the center for providing such services.
PC.2.	The center has a process to ensure the correct identification of the patients and teeth.
PC.3.	Patients are clinically assessed through an established assessment policy and procedure.
PC.4.	The center provides the dentists with the results of investigations as per an agreed time frame.
PC.5.	The center develops and implements a process for reporting critical test results, whether performed on-site or outsourced.
PC.6.	The dentist develops a treatment plan to meet the patient's needs.
PC.7.	The dentist records the dental procedures performed in the dental record.
PC.8.	The dental center develops and monitors the implementation of evidence-based clinical practice guidelines.
PC.9.	The dental center ensures all required safety measures are performed for moderate sedation.
PC.10.	The center has a policy and procedure to safely provide care to patients who require cardiopulmonary resuscitation (CPR).
PC.11.	Dentists assist patients, and when appropriate their families, to fully participate in making informed decisions about their care, treatment, and procedures.
PC.12.	Informed consent is obtained from the patient or the guardian.
PC.13.	The center develops a policy and procedure on safe medication management.
PC.14.	The center provides appropriate storage for medications and dental materials.
PC.15.	Intraoral radiology services are available in dental centers and operated safely. Other radiology services are outsourced, as needed, to meet patient needs.
PC.16.	The center develops a radiation safety program.
DL.1.	The center develops and implements policies and procedures to guide the dental laboratory services in accordance with applicable laws and regulations.
DL.2.	The center develops a process for identifying patient-related dental prostheses, impressions, and appliances.
DL.3.	Dental laboratory staff minimize the risk of infection in their workplace.
DL.4.	The structure and equipment of the dental laboratory ensure staff safety.
DL.5.	The structure of the dental laboratory ensures proper ventilation and airflow.
MOI.1.	The center defines, in a policy, the information that may be shared among the staff internally and with other external entities, and its format.
MOI.2.	All patients seen in the center have unique dental record files.
MOI.3.	The center has a policy for making entries in dental record files.
MOI.4.	The center has a process for completing the patient dental record files.

List of Standards	
Number	Standard
MOI.5.	The center develops a policy and procedure for the use of information technology.
MOI.6.	The center implements an effective clinical documentation improvement (CDI) program.
IPC.1.	The center implements a coordinated program to reduce the risk of infection to patients and staff.
IPC.2.	The dental center's design and structure support the national infection prevention and control requirements.
IPC.3.	The center adopts an evidence-based and effective hand hygiene program.
IPC.4.	The center develops a process to prevent the spread of infection inside the dental procedure room contaminated zone.
IPC.5.	Personal protective equipment is available, readily accessible, and is used correctly by staff in all patient care areas.
IPC.6.	The center minimizes the risk of infection from dental impressions and dental appliances.
IPC.7.	The dental center minimizes the risk of water contamination.
IPC.8.	The center minimizes the risk of infection encountered with the use of intraoral radiographs.
IPC.9.	Sterilization services support infection prevention and control.
IPC.10.	The center defines, in a policy, the environmental cleaning, decontamination, and disinfection processes in all patient care areas.
IPC.11.	The center develops a policy and procedure for the prevention and management of sharps injuries.
IPC.12.	The center implements a program for the safe collection, storage, and disposal of medical waste that is consistent with laws and regulations.
IPC.13.	The center develops policies and procedures that address employees' screening, immunization, and post-exposure management.
FMS.1.	The center establishes and supports a facility management and safety program.
FMS.2.	Interdisciplinary rounds are scheduled and conducted to ensure safety.
FMS.3.	The center's environment is safe for patients, families, and staff.
FMS.4.	The leaders develop and monitor the implementation of a fire prevention program.
FMS.5.	The center is secure and protects its users.
FMS.6.	The center has an updated plan for the proper installation, inspection, testing, and maintenance of medical/dental equipment.
FMS.7.	The center has an emergency plan in case of emergencies.
FMS.8.	The dental center develops a hazardous material (HAZMAT) and wastes disposal plan.
FMS.9.	The center has a policy and procedure for the safe use of various types of compressed medical gases.

PART III

ACCREDITATION POLICIES

Eligibility for Accreditation

Dental centers licensed to practice in the Kingdom of Saudi Arabia are eligible for CBAHI accreditation. However, eligibility for a survey visit is contingent upon the following requirements:

- The HCF meets all licensing requirements to operate as indicated by the statutes and regulations of the Ministry of Health.
- The HCF meets any additional licensing requirements as per by other relevant authorities such as Civil Defense, Saudi Commission for Health Specialties, or Saudi Food and Drug Authority.
- The HCF meets the legal definition, for dental care centers:
 - Licensed as a dental center under the laws governing healthcare institutions in Saudi Arabia.
 - Maintains an organized dental staff and nursing services.
 - Provides diagnostic and therapeutic services for dental patients.
- The HCF provides healthcare services addressed by CBAHI's National Standards.
- The HCF has been in operation for at least 12 months prior to the on-site survey.
- The HCF completes an accreditation application form.

Registration with CBAHI

Registration with CBAHI for accreditation is required for all eligible HCFs. This is the first step toward accreditation. HCFs are required to register by completing the Healthcare Facility Registration Form located on CBAHI's website. Registration is a quick yet essential step, that provides the Healthcare Accreditation Department at CBAHI with the necessary information about the registering facility. Upon successful registration, a system-generated code number will be provided to the registering facility. This code number will be used for all future communications with CBAHI

Accreditation Pathway

To obtain CBAHI accreditation, a healthcare facility must complete several activities. Upon successful registration, the following resources will be provided to HCFs seeking CBAHI accreditation:

- Manual of the National Standards
- Healthcare Accreditation Guide

The Accreditation Guide provides all the required information to help the HCF prepare for the survey visits. It contains an abstract of each survey activity, logistical needs, session objectives, and suggested participants in the survey activities.

Each year CBAHI decides on which HCFs to be visited in its specific accreditation program, based on the operational plan and the HCF accreditation cycle, for that particular year. CBAHI will notify those HCFs included in its yearly accreditation plan by the manner of a letter of enrolment.

CBAHI provides ongoing HCF Orientation Programs in different locations throughout the year. HCFs are encouraged to attend at least one of these orientation programs. Although any HCF can attend, preference is given to facilities selected for the current year's accreditation plan. During these orientation sessions, accreditation policies and survey processes are explained in detail. In which, HCF representatives are given the opportunity to enquire about the intent of standards and how they should be implemented. The dates and venues of the orientation programs will be communicated to the HCFs promptly.

All HCFs enrolled in accreditation are encouraged to conduct a comprehensive self-assessment using the Self-Assessment Tool (SAT) that CBAHI provides upon registering for accreditation. This tool is intended to help the facility assess how close it is to satisfactory compliance with the standards and requirements. It also provides an idea of how much preparation and time the HCF needs prior to the real survey visit. If objectively and effectively conducted, self-assessment provides better insight into the baseline situation of each facility and provides a common communication tool between the facility seeking accreditation and the accrediting body. As a rule, the SAT is for the HCF's internal use, but CBAHI might require it before conducting the survey to help determine the level of facility preparedness.

Some HCFs may choose to have a mock Survey visit. This visit is offered by CBAHI mainly as an educational tool by experienced peer surveyors to clarify accreditation policies, standards, and their explanation. In addition to determining the applicability of the accreditation chapters and verifying the self-assessment's findings. It should be noted, however, that mock surveys are subject to the available resources at CBAHI and the level of commitment demonstrated by the HCF towards achieving compliance with the standards.

The HCF may choose to participate directly in an on-site real survey visit. The time interval between registration and the achievement of accreditation is 6 to 18 months, on average. HCFs are allowed to have a maximum of (2) on-site accreditation survey attempts within (2) years time frame. Therefore, the facilities that will eventually prove incapable of achieving accreditation, as reasonably persuaded by CBAHI, will be suspended temporarily from participation in the national accreditation program and referred to the relevant authorities for further action.

Once a HCF has applied for an on-site real accreditation survey visit and completed the pre-survey requirements as mentioned above, the tentative year of the visit will be determined based on CBAHI operational plan and communicated to the HCF by the registration department. As CBAHI real accreditation visits are unannounced, HCF will be notified about the date of the survey and the survey team, seven days before the date of the real survey. The time frame may be extended in some circumstances.

In all cases, the service agreement must be acknowledged and duly signed by the facility and a copy returned to CBAH, and the HCF must provide evidence of payment of the required accreditation fee.

Survey Team

To earn and maintain accreditation, the HCF must undergo an on-site survey conducted by the CBAHI survey team. The date of the survey visit will be determined in accordance with CBAHI's yearly operational plan.

Generally, the survey team is composed of two healthcare professionals. The size and specialties of the survey team members are usually fixed, but this might change according to the size of the HCF and its scope of services.

The survey is conducted under the leadership of a Visit Team Leader (VTL) that has been designated by CBAHI. The visit team leader is responsible for assuring that all survey activities are completed within the specified timeframe and according to CBAHI's policies and survey guide. The HCF under survey is required to facilitate the work of the survey team members and to allow the visit team leader to practice his/her role and responsibilities, which include:

- Preparing and communicating the survey plan to the HCF;
- Chairing the opening and closing meetings;
- Communicating with facility leadership regarding survey progress and initial findings;
- Evaluating team progress and adjusting survey plans as needed; when required;
- Coordinating and preparing the survey report and submitting it to CBAHI.

Rescheduling of Surveys

HCFs scheduled for surveys are strongly encouraged to adhere to the survey date set by CBAHI. However, rescheduling may be considered for review at CBAHI's discretion on a case-by-case basis, and in accordance with the postponement of the accreditation survey policy.

CBAHI makes every possible effort to carry out survey visits as per schedule. Under limited circumstances, postponement may be considered if the two conditions of accepting postponement exist. The two conditions are; a justifiable cause, and an official letter reaching CBAHI at least 60 calendar days prior to the survey date. Justifiable causes may include;

- Significant natural or internal disasters (e.g. flood, thunder, earthquake, major fire).
- Major renovation work that hinders the daily operation of the facility.
- Change of ownership or affiliation (e.g. merge and/or acquisition) within 6 months prior to the date of the survey.
- A mandate to stop operation by a governmental authority.
- Relocation of the healthcare facility to another building/campus within 6 months prior to the date of the survey.
- State of war when the healthcare facility might be affected or involved.

In all cases, postponement must not exceed 6 months. For an extended period, in case the postponement cause still exists, approval from the CBAHI director general is required.

Accreditation Decision Rules

The HCF must meet all applicable standards at an acceptable level to be accredited. CBAHI utilizes a multilevel process for making accreditation and reaccreditation decisions. This is to ensure fairness, consistency, objectivity, and accuracy. As such, CBAHI benefits from any relevant report and/or significant finding or issue related to the surveyed facility that was brought to CBAHI's attention by relevant health authorities or previous accreditation surveys.

Accreditation decisions are released and communicated to the HCF within 30 days after the conclusion of the survey visit. The accreditation decision-making process is based on:

- The findings of the survey team members as recorded in the survey report.
- The factual accuracy review of the draft report by the participating HCF of any issue of fact found in the report before the accreditation decision is made.
- Review/discussion during the meeting of the accreditation decision committee (ADC) for a significant finding that makes the survey outcome undetermined. This committee may request additional evidence before making a final recommendation for an accreditation decision. All accreditation decisions are then ratified by the CBAHI Director General.

It is important to note that the decision to grant accreditation is based primarily on the findings of the on-site survey as recorded by the surveyors in the survey report. However, the overall numerical score the HCF obtains is one important factor, among others, upon which the ADC members rely when making their recommendations. Other factors include the non-compliant standard(s); for example, the degree of severity and immediacy of risk to patients, families, or staff safety.

Criticality has several levels. The most serious is when the surveyor notices an immediate threat to safety or quality of care. Examples include, expired material being used, a bare electrical wire is hanging down without any protection, and a patient is not properly identified.

When a CBAHI surveyor notices an immediate threat, whether or not it is directly linked to the standards, the survey team leader will notify the HCF director and include the findings in the survey report.

Each standard is composed of a stem statement and sub-standard/s. The sub-standard is the measurable element to be scored by the surveyor during the on-site survey. Each sub-standard has equal weight and is scored on a three-point scale as follows:

- 0 = Insufficient Compliance (less than 50% compliance with the standard).
- 1 = Partial Compliance (from 50% to less than 85% compliance with the standard).
- 2 = Satisfactory Compliance (85% and more compliance with the standard).
- N/A = Not Applicable.

The score of each standard is calculated using the sum of the scores of the sub-standards. The overall score of the HCF is calculated using the sum of the scores of all the applicable sub-standards divided by the maximum score. When one or more standards of this manual do not apply to a particular HCF, they are indicated by "NA." Non-applicable standards are not scored and are not included in either the numerator or denominator of the overall score.

The accreditation decision committee (ADC) shall recommend one of the following accreditation decisions:

- **Accredited**

Accreditation will be awarded when the surveyed HCF demonstrates overall acceptable compliance with all applicable standards at the time of the initial (or re-accreditation) on-site survey, and when there are no criticality or concern related to non-compliant standard(s) that may impact the safety of patients, families, staff, or the facility itself. Accreditation will also be recommended when the HCF has successfully addressed all post-survey requirements and does not meet any rules for denial.

Scoring Guidelines:

- Overall score of 75% or above.
- No other significant concern related to the safety of patients or staff.

- **Denial of Accreditation**

Denial of accreditation results when an HCF shows significant noncompliance with the accreditation standards at the time of the on-site survey. It also results if one or more of the other reasons leading to the denial of accreditation have not been resolved. When the HCF is denied accreditation, it is prohibited from participating in the accreditation program for six months unless CBAHI, for good reason, waives all or a portion of the prohibition period. Factors cited as reasons leading to the denial of accreditation include:

- Overall score of less than 75%.
- The presence of an immediate threat, to the safety of patients, families, or staff, is observed by CBAHI surveyors during the on-site survey.
- Failure to submit the post-survey requirements promptly.
- The HCF was subjected to a focused survey but still could not meet the requirements for accreditation.
- Reasonable evidence exists of fraud, plagiarism, or falsified information related to the accreditation process. Falsification is defined as the fabrication of any information (given by verbal communication or paper/electronic document) provided to CBAHI by an applicant or accredited HCF through redrafting, additions, or deletions of a document's content without proper attribution. CBAHI perceives plagiarism as the deliberate use of another HCF original (not common knowledge) material without acknowledging its source.
- Refusal by the HCF to conduct a survey.

Appeal Against an Accreditation Decision

A surveyed HCF can appeal against the following accreditation outcomes:

- Denial of Accreditation, provided this is not due to a failure to submit the post-survey requirements in a timely manner after granting accreditation or a failure to meet requirements after a follow-up focused survey.
- Suspension/Revocation of Accreditation.

All appeals shall be made within a maximum of fifteen calendar days from receipt of the official survey report by submitting a cover letter to be sent from the Center Director to the CBAHI Director General via registered mail/fast courier. This should include documentation to support the argument for the appeal and a completed Appeal Request Form (ARF) located on CBAHI's portal. Letters sent via electronic mail or facsimile will not be considered.

Grounds for Appeal

The HCF is entitled to an appeal if the appeal is based on one or more of the following grounds:

- Relevant and significant information which was available to the survey team was not considered in the making of the accreditation decision.
- The report of the surveyors was inconsistent with the information presented to the survey team.
- The existence of perceived bias among the surveyor(s).
- The outcome of the appeal, if in favor of the appealing HCF, will result in a change in the accreditation status. CBAHI will not consider appeals that will not result in a change of accreditation status.

Initial acceptance of the appeal request can occur only when clear and convincing evidence indicates that the facility meets at least one of the grounds for appeal. The appeal request shall set forth the specific grounds for the request, and shall include a statement of the reasons for each ground, along with any other relevant statements or documents the healthcare facility desires to include. Centers applying for an appeal must identify the specific alleged procedural failures or the specific manner in which the decision was arbitrary or unreasonable and not based on, or consistent with, CBAHI standards and policies. Accepted appeals, including all relevant reports and evidence, are thoroughly studied by the appeal committee. One of the following decisions shall be made and communicated to the appealing HCF in a timely manner:

- The adverse decision is upheld.
- The healthcare facility's appeal is upheld, and the denial of accreditation is modified or reversed. In this circumstance, a full or focused re-survey may be conducted.

Accreditation Maintenance (Post-Survey Requirements)

CBAHI has designed its accreditation to represent a continuous process versus a once-every-three-years evaluation. Accredited HCFs must maintain their accreditation status by demonstrating their continued compliance with the standards and requirements of CBAHI throughout the accreditation cycle and in accordance with the specified time frames. This translates into standing and ad hoc requirements.

Standing Requirements for Accreditation Maintenance

- Corrective Action Plan (CAP)

When accreditation is awarded to a HCF, a Corrective Action Plan (CAP) addressing some or all standards that were not in satisfactory compliance during the on-site survey will be requested by CBAHI for review and acceptance within a specified time frame from the date of the accreditation decision. The CAP ideally focuses on demonstrating what has been done rather than what will be done. The CAP addresses all non-compliant standards, the requirements for improvement, the corrective actions that have been or will be taken (with dates and responsible individuals) and, as applicable, the monitoring measures to ensure the sustainability of the actions taken. A delay in the submission of the CAP that exceeds 30 days beyond the due date without justification can result in the suspension of the accreditation certificate.

- **Midterm Self-Assessment**

Accredited HCFs must participate in a mid-cycle self-evaluation of standards compliance known as the Midterm Self-Assessment. Fifteen months from the date of accreditation, the HCF should start utilizing the self-assessment tool to assist in the periodic review of its performance against the standards. The HCF then has three months to complete the assessment.

Completion of the midterm assessment will allow the HCF to identify areas of standards non-compliance and create a plan for correction of deficient areas to ensure the HCF comes into compliance before the next on-site survey. For those areas self-identified as non-compliant with CBAHI standards, the HCF is required to submit a CAP to CBAHI that includes evidence to substantiate the fact that the standard has been brought into compliance. The relevant department at CBAHI will review each facility's plan of action to indicate whether the action plan and timetables are acceptable for bringing the standard into compliance.

A delay in submitting the midterm assessment by more than 60 days from the due date without an acceptable justification to CBAHI will result in the suspension of accreditation, followed by revocation of accreditation if the total delay exceeds 90 days.

During the next on-site visit following the submission of the midterm assessment, the surveyor will look for evidence of compliance/correction that the HCF provided as part of the plan of action. When there is a legitimate concern about the safety and quality of services provided by an accredited Center at the time of the mid-term assessment, CBAHI may require the Center to undergo a mid-cycle survey, (a fee will be charged to cover costs) and to submit a plan of action for areas of non-compliance.

Ad Hoc Requirements for Accreditation Maintenance

- **Reporting of a sentinel event**

When a sentinel event occurs, as defined by CBAHI, in an accredited facility, it must be reported immediately. A subsequent root cause analysis (RCA), and the risk reduction action must be submitted within the time frame defined by CBAHI.

A sentinel event is defined as any event leading to serious patient harm or death that is caused by healthcare rather than the patient's underlying illness. By investigating sentinel events, one can identify deficiencies in healthcare systems and processes and put actions in place to prevent a recurrence. CBAHI calls for the following with regard to sentinel events:

- Open disclosure/open communication. Patients and their families are entitled at all times to truthful and transparent communication and explanation of any sentinel events happening to them.

- When a reportable sentinel event occurs in a HCF accredited by CBAHI, the HCF must provide evidence of reporting to CBAHI. Healthcare facilities that are not accredited by CBAHI are not required to report. In addition to reporting, CBAHI may become aware of the occurrence of a sentinel event through communication from one of CBAHI's surveyors, the media, a patient or relative, the healthcare facility's employees, or through other means of communication.
- CBAHI is interested in knowing about reportable sentinel events when they occur in accredited facilities for learning and disseminating lessons learned to the medical community, thereby avoiding the recurrence of such events in the future. Medical errors and adverse events are opportunities for education and quality improvements.
- Reporting must be safe. Patients, families, and staff are encouraged and should be empowered by the HCF leadership to report any sentinel event without fear of retribution. CBAHI has zero tolerance for accredited HCFs taking disciplinary actions against a staff member who reports a sentinel event. If the disciplinary action proves to be related to reporting, this can negatively impact the HCF's accreditation status.
- The outcome of a reported sentinel event is dependent on the level of commitment the HCF demonstrates towards studying the root cause(s) of the incident and re-designing its processes and systems to prevent a recurrence. When CBAHI is persuaded of this constructive approach by the concerned HCF in dealing with sentinel events, accreditation is usually maintained. When this is not the case, CBAHI will pursue this further to decide on the HCF's eligibility to maintain its accreditation until the required corrections are made. In situations where the accreditation certificate is valid for less than six months and CBAHI is not persuaded that the corrections have been made, an early full re-accreditation survey may be warranted.

- Notification of significant changes**

Accredited HCFs must notify CBAHI in writing about any significant structural/functional/regulatory changes that took place after the accreditation survey was conducted. Written notification should be submitted no more than 30 days after the initiation/occurrence of such changes through the CBAHI portal. These changes include, but are not limited to the following:

- A national regulatory body has mandated closure for all or part of the HCF.
- HCF is not in compliance anymore with other relevant rules and regulations (e.g. civil defense license).
- HCF accreditation by other international accrediting organizations has been suspended or revoked.
- A new service is initiated for which CBAHI has standards, and that was not included in the last survey.
- Any of the services are being offered in a new location or branch.
- Major construction/destruction/renovation work has been undertaken in any of the facility's buildings, floors or units.
- A significant increase (30% or above) or decrease in the volume of services/bed capacity has been experienced.
- The HCF has merged with or acquired an unaccredited facility,
- A significant change has occurred in the governance or ownership.

CBAHI will evaluate the impact of these changes and a decision for conducting a focused survey may be warranted accordingly.

Accreditation Suspension and Revocation

CBAHI expects nothing but the truth, honesty, and sincere intentions in all dealings and propositions from HCFs engaged in its accreditation program. This "good faith" engagement is a constant throughout the accreditation cycle, and the HCF must ensure that it is not violated.

In addition, accredited HCFs must maintain the same momentum both before and after accreditation. Some might argue that it is a natural tendency to ease back after a survey visit, but compliance with the standards must not drop simply because the survey is completed, and accreditation has been awarded. If CBAHI becomes aware, by any means, of an accredited HCF that is not in compliance with the standards, CBAHI will verify the situation and take appropriate action.

CBAHI may receive information regarding possible violations from accredited HCFs through several channels including, reports of related government agencies, written or verbal complaints, and the media. Types of violations include, but are not limited to, the following:

- CBAHI becomes aware of the presence of an immediate threat to the safety of patients or staff in an accredited HCF.
- The HCF is not committed to the specified timeframes for accreditation maintenance. For example, timely submission of a corrective action plan after accreditation or timely submission of a midterm self-assessment.
- The HCF failed to report a sentinel event as per the relevant policy without an acceptable justification.
- The HCF is committing an act of, deception or any deliberate misrepresentation of the truth.
- The HCF is discouraging communication or taking disciplinary action/reprisal against patients or staff members trying to communicate directly with CBAHI about concerns regarding safety or quality of care.
- The HCF intentionally lacks commitment to continuous compliance with CBAHI standards. This might represent an overweening behavior and is a strong violation of the CBAHI accreditation process.
- The HCF is deliberately violating any of the other accreditation policies mentioned in this manual or other supporting documents and manuals provided by CBAHI for accreditation.

Once CBAHI is convinced that one or more of the aforementioned violations exists in an accredited HCF, it responds by taking one of the following actions, in any order:

- Issuing a letter of "At Risk of Suspension of Accreditation"
- Suspension of Accreditation
- Revocation of Accreditation

CBAHI's level of response to a certain violation depends on several factors, including the severity of the violation, its frequency, previous accreditation history, the source of information regarding the violation, and the findings and conclusion of CBAHI's inquiry. When necessary, a focused or full survey might be conducted for validation purposes before a response can be given or an action taken. This kind of survey is always for one or more of the above causes (e.g., when concerns have been raised about an accredited facility's continued compliance with CBAHI standards). An accredited HCF may undergo a survey at any time, at the discretion of CBAHI, and the survey is usually unscheduled with the HCF receiving 48 hours' notice before the survey or unannounced with no advance notice depending on the seriousness and type of violation. Surveys can include either all of the HCF's services or only those areas in which a serious concern exists. HCFs are usually charged for these surveys, regardless of the outcome, and the results can affect the HCF's accreditation status. If the HCF does not allow CBAHI surveyors to conduct the survey, CBAHI may change the facility's status to Revocation of Accreditation.

It should be noted that if a facility's accreditation is suspended, the facility can regain accreditation once the causative violation has been rectified. However, the suspension will not be lifted before the specified prohibition period of 12 months from the date of suspension as per CBAHI policy.

Revocation of accreditation is a serious consequence that prohibits participation in the CBAHI accreditation program for a minimum of 18 months from the date of revocation as per CBAHI policy.

For both suspension and revocation of accreditation, CBAHI will communicate the new accreditation decision to the relevant authorities and display it publicly. The Director General of CBAHI, with appropriate reason, can waive all or a portion of the prohibition period of the suspension or revocation decisions.

Random Surveys

To support CBAHI's ongoing quality assurance initiatives, an accredited facility may be selected for a random survey any time after an accreditation survey. Random surveys are unannounced. A sample of 5% of all accredited HCFs is randomly selected each year for this activity. These random, unannounced surveys are a means by which CBAHI evaluates the consistency and quality of its program, while also demonstrating to the public and regulators that accredited HCFs remain committed to CBAHI standards throughout the accreditation cycle. Random surveys also provide CBAHI and its surveyors with opportunities to further assess the accredited HCFs in the interval between regular surveys. No fee shall be charged to the HCF when a random survey is conducted.

The HCF may be selected for a validation survey visit as part of an inter-rater reliability program for CBAHI surveyors within one month after receipt of the accreditation decision report. The visit outcome has no impact on the accreditation status granted in the actual accreditation survey visit. The HCF will not bear any financial cost.

Accreditation Certificate and Seal

Once accreditation is granted, HCFs are encouraged to display the CBAHI logo, accreditation certificate, and seal on the facility's bulletin boards, banners, website, newsletters, brochures, and headed stationery denoting their accreditation status.

CBAHI requires all accredited healthcare facilities to follow the guidelines and conditions for the appropriate use of the CBAHI logo, accreditation certificate, and seal. Specifically, CBAHI works to ensure that no accreditation material is used in a way that may mislead the public or others or provide false information related to a healthcare facility's accreditation status.

The Guidelines for proper use of the CBAHI logo and certificate include the following:

- The printing of the accreditation seal is accurate and legible, with no degradation or distortion.
- The size of the CBAHI logo and its accreditation seal should remain in the same permitted proportion as that provided.
- The CBAHI logo, certificate, and seal should be used in the same format, with no added graphics or words.
- The HCF abides by the same colors used in the CBAHI logo, or black and white when the logo is used for certain printed materials such as newspaper advertisements, newsletters, brochures, flyers, and posters.
- The HCF is prohibited from using the CBAHI logo or accreditation seal on business cards.

Upon expiry of the certificate validity period or suspension/revocation of the accreditation, the HCF shall immediately take action to refrain from using the CBAHI logo, accreditation certificate, and seal.

Release of Accreditation-Related Confidential Information

CBAHI asserts that HCFs undergoing its accreditation survey are expected to provide access to information related to the evaluation of their compliance with CBAHI standards.

As a guiding policy to HCFs engaged in any accreditation programs, CBAHI commits to keeping all information obtained or received during the accreditation process confidential, including all survey data and information that surveyors come across during the survey process.

For an HCF that is a participating member of the CBAHI accreditation program, some information is subject to public release. This includes:

The healthcare facility's accreditation status.

- The healthcare facility's accreditation status.
- The areas of the HCF that were included in the accreditation survey.
- The standards under which the accreditation survey was conducted.

Other accreditation-related information is not subject to public release except to the HCF on a question. The exception to this rule is when the CBAHI receives an official request for clarification from relevant health authorities or public health agencies. This information includes:

- Accreditation Committee minutes and agenda materials.
- The accreditation certificates.
- The post-survey requirements, including any CAPs.
- The results of investigations related to a sentinel event, including the root cause analysis prepared in response to that event.
- The results of investigations involving any falsified information the healthcare facility provided to CBAHI.
- Any other information related to compliance with CBAHI standards obtained from the HCF before, during, or after the accreditation survey.

Complaints against an Accredited Healthcare Facility

CBAHI is interested in collecting information from a variety of sources to improve the quality and safety of all accredited HCFs. These sources include complaints from patients, their families, HCF staff, government agencies, the media, and the public. Staff members at any HCF accredited by CBAHI must be informed that they may make complaints directly to CBAHI without fear of retaliatory actions from their complaints.

CBAHI addresses all complaints that would help identify possible noncompliance with its accreditation standards, thereby posing a possible threat to the safety of patients, staff, or the public. More precisely, CBAHI can evaluate complaint information only in terms of its relevance to compliance with CBAHI's standards. Issues of personal nature or individual disputes should be dealt with by the concerned facility or the regional health authority. CBAHI cannot follow up on complaints about HCFs that are not accredited.

When CBAHI receives a complaint against an accredited HCF, CBAHI will conduct an initial screening to determine its relevance to compliance with CBAHI standards and its impact on patient safety. If the complaint does not relate to compliance with CBAHI standards, a response of "non-relevance" will be forwarded to the complainant, who will be advised to forward the complaint to the HCF leadership or the regional health authority. If the complaint relates to compliance with one of the CBAHI standards, a response shall be made accordingly. The response will depend on a risk assessment matrix that determines the probability and severity of the complaint. CBAHI will check for any other complaints regarding the same HCF. Broadly speaking, CBAHI will give one or both of the following responses:

- CBAHI may write to the HCF about the complaint. When requested, the HCF must make available its records of complaints and subsequent actions taken.

- CBAHI may decide to visit the healthcare facility to verify whether a problem exists in terms of standards compliance involved in the complaint. Such visits are usually unannounced, and the outcome may change the accreditation decision.

It is CBAHI policy not to disclose any information related to patients or complainants unless it is authorized to do so. In addition to information about the complaint's relevance to CBAHI standards, the complainant will receive the following information:

- The course of action CBAHI took regarding the complaint.
- Whether CBAHI has decided to act regarding an HCF accreditation decision following completion of the complaint's investigation.

To file a complaint against a CBAHI-accredited healthcare facility, an individual can send his/her concern via the contact form on the CBAHI website. The individual can also file the complaint directly by calling the Universal Access Number 920012512. CBAHI requires that the complainant reveals his or her identity. Therefore, CBAHI will not consider anonymous complaints.

Conflict of Interest

CBAHI works to ensure the integrity and fairness of all businesses conducted by employees working in the central office as well as the surveyors. In addition, all healthcare facilities engaged in the CBAHI accreditation process are required to refrain from any actual or potential act or behavior that might create a conflict of interest, including:

- Proposing any fee, remuneration, gift, or gratuity of any value to CBAHI employees or surveyors for the performance of their duties or survey-related activities.
- Employing, contracting, or having any financial relationship with CBAHI employees or surveyors for the purpose of providing consulting or related services in any capacity, either directly or through another party. This includes services provided in preparation for the survey, assisting in the preparation of the self-assessment, conducting mock surveys, and helping with the interpretation of the standards. All requests for consulting services utilizing CBAHI employees or surveyors shall be directed to CBAHI.
- Not declaring to CBAHI any business (including consulting) or recruiting relationship with one or more CBAHI surveyors either directly or through another party with whom he or she is affiliated at any time during the preceding three years.

Truthfulness and Ethics Clause

CBAHI strives to maintain the highest ethical and legal standards in the conduct of its business. This includes honesty, transparency, and truthfulness in all its dealings, and avoidance of all situations that might appear unethical or illegal. The same is expected from the HCFs seeking CBAHI accreditation. CBAHI employees are committed to politely declining any gifts or gratuities offered to them or to members of their families, including spouses, children, and parents, when the donor expects something in return. Such gifts or gratuities may be attempts to gain an unfair advantage or influence the manner in which the employee or surveyor performs his/her job duties. Gifts of nominal value may be accepted as tokens of appreciation or goodwill provided they are given as gestures of a professional relationship and do not involve or create the appearance of any commitment in terms of survey results or accreditation decisions.

Business lunches, tea, coffee, and snacks during the survey are permitted. Other social gatherings are prohibited, and HCFs are encouraged to not offer such activities to the survey team. Using the HCF vehicle to transport the survey team to and from the survey site is acceptable.

CBAHI's confidential and proprietary business information is safeguarded and is utilized only in keeping with the best interests of CBAHI, its obligations to third parties, and the highest ethical and legal standards. Such information must not be disclosed to a third party without prior approval of a duly authorized member of CBAHI management for an acceptable reason. In line with CBAHI's core values, CBAHI maintains the confidentiality of all data and information about both CBAHI and HCFs. CBAHI is also committed to resolving complaints and ethical issues raised by CBAHI employees or client HCFs to ensure justice, confidentiality, impartiality, timeliness, and feedback to the complainants.



PART III

ACCREDITATION STANDARDS

Leadership of the Organization (LD)

Introduction

For any dental center, quality and patient safety depend on effective leadership. governing body is ultimately responsible for the provision of safe and quality patient care. The center's director, who is selected by the governing body, is accountable for ensuring the provision of safe and quality patient care. The center may be directed by a single owner who then carries the responsibility of both governance and leadership simultaneously. All dental centers need to have a clearly stated mission. It is the responsibility of the leadership of the center to develop the mission and provide adequate resources to fulfill this mission. To ensure the quality and safety of healthcare services, the members of the leadership group must work collaboratively, communicate effectively through clear lines of authority and coordinate and integrate all services provided.

This chapter addresses the roles and responsibilities of the governance and leadership group for the following processes:

- Organizational structure
- Structure and function of the governing body
- Roles and responsibilities of the center's leaders
 - Mission and vision, scope of services, and strategic planning
 - Effective human resource management
 - Staffing plan and recruitment
 - Job descriptions for all types of employees
 - Credentialing and privileging
 - Staff orientation and education
 - Staff performance evaluation
 - Staff health and safety program
 - Patients and family rights
 - Quality improvement and patient safety
 - Developing and maintaining the center's policies
 - Developing and supporting quality and patient safety program
 - Developing and supporting a risk management program
 - Contract oversight

LD.1. The governing body defines its structure and operational responsibilities in a written document.

- LD.1.1.** The governing body approves and periodically reviews the center's mission, vision, and values and makes it public.
- LD.1.2.** The governing body approves the center's strategic plan, the scope of services, and key policies and procedures.
- LD.1.3.** The governing body approves the center's operating and capital budgets, as well as other resources required to manage the center efficiently.
- LD.1.4.** The governing body defines and approves the process of authority delegation.
- LD.1.5.** The governing body appoints a qualified director responsible for managing the dental center.

Explanation

The governing body (owner(s), board of directors) should highlight its structure, role, and responsibilities in a written document. Roles and responsibilities include approval of the strategic plan, operational plan, budget, mission and vision, the scope of services, and policies and procedures. Roles and responsibilities of the governing body also include appointing the center's director and defining any leadership delegation authority that highlights the person responsible for managing the center in the absence of the center's director.

LD.2. The governing body approves and evaluates the center's quality and patient safety program, and risk management initiatives.

- LD.2.1.** The governing body annually approves the quality and patient safety program, including the risk management initiatives.
- LD.2.2.** The governing body receives and evaluates the quality and patient safety reports, including the risk management, corrective actions, and outcomes from the center, at least quarterly
- LD.2.3.** Recommended corrective actions by the governance are documented and received by the center director for implementation.

Explanation

The governing body must always ensure patient, family, and staff safety by approving the quality and patient safety and risk management programs and periodically evaluating their effectiveness. At least every three months the governance should receive and review reports on selected indicators, all safety concerns that staff have reported, all medical complications, and all financial and other administrative risk issues. The governing body, together with leadership, should recommend corrective actions, as necessary, to prevent errors and mitigate risks. These recommended actions must be documented and communicated with the centers for implementation.

LD.3. The center has a defined, current, and clear organizational chart.

- LD.3.1.** An approved and updated organizational chart identifies the relationship between the center's governance, leadership, and other directors with titles.
- LD.3.2.** The staff are aware of the organizational chart and its intent, and can demonstrate their relationship to it.

Explanation

Efficient and effective healthcare organization management requires effective staff communication and clear reporting lines. The organizational chart should be developed to present the relationship between the governance (the owner or board of directors) and the center's managing director(s); and between the managing director(s) and the front-line staff. Managerial positions in the chart should be reported by titles. All center staff Members should be aware of their position in relation to the organizational chart and their line of command and required reporting. The chart should be updated regularly, signed by the center's director and communicated to all staff members.

LD.4. The dental center is effectively managed by a qualified director.

- LD.4.1.** The center director, with other leaders, develops the mission, vision, and values statements, and communicates them to all staff.
- LD.4.2.** The center director ensures the center's compliance with all relevant laws, regulations, and policies.
- LD.4.3.** The center's director ensures the availability of adequate and proper resources for the planned services in accordance with the approved operating budget.
- LD.4.4.** The center's director ensures a safe and functional facility environment for patients, families, and staff.

Explanation

The center needs to be managed by a director qualified through education, skills, training, and experience. The center director must participate in developing the mission, vision, and values of the center. The director is responsible for the center's compliance with all applicable governmental laws, regulations, and policies including, but not limited to: patient care regulations, medication management, licensure regulations, staffing licensure and certification, civil defense requirements, and municipality requirements. The director ensures the availability of an adequate number and the right composition of staff required for the day-to-day activities. He/ she also ensures the continuous availability of the required supplies, medications, and resources to safely run the center. The director ensures the facility is designed to deliver the intended services in a safe and secure environment for patients, families, and staff.

LD.5. The dental has a clear center's scope of services based on community needs.

- LD.5.1.** The scope of services includes the specialty services available, the number of clinics for each specialty, the level of professional coverage for the age group served, and working hours.
- LD.5.2.** The scope of service is available to the public.

Explanation

The center shall function according to a predefined scope of services document that is developed collaboratively between the governing body and the center's leaders. The center's leaders may include the center's director, medical director, nursing director, human resources director, finance director, and administration director, as applicable. The scope of services includes the range of clinical services in each provided specialty in addition to the level of professional coverage (i.e. consultants and specialists). The scope of services also includes the number of clinics for each specialty, age group, and working hours.

LD.6. The leaders work collaboratively to develop the center's strategic plan.

- LD.6.1.** The strategic plan is guided by the mission, vision, and inputs from patients/service users, their families, staff, and where possible the wider community.
- LD.6.2.** The strategic plan is based on a comprehensive evaluation of both internal and external environmental factors.
- LD.6.3.** The strategic plan addresses all clinical and non-clinical services and programs.
- LD.6.4.** The strategic plan spans a period of three to five years and is reviewed regularly.
- LD.6.5.** The strategic plan includes the goals and objectives required to fulfill the center's mission.

Explanation

Dental centers require planning to continue their mission and achieve their vision. This long-term three or five years of strategic planning must address clinical and non-clinical services, and must be reviewed regularly. The planning may include mastering current services or introducing new services. This strategic planning should be based on a comprehensive evaluation and analysis of the internal and external operational and environmental factors that may affect the center's mission and vision, such as SWOT (strengths, weaknesses, opportunities, and threats) analysis and PEST (political, economic, social, and technological) analysis. The plan should have clear goals and objectives to achieve in a specified time frame.

LD.7. The leaders transform the approved strategic plan into an operational plan.

- LD.7.1.** Leaders translate the center's goals and objectives into operational plans with defined projects, clearly delineated responsibilities, required resources, and time frames.
- LD.7.2.** Leaders communicate the plans to all staff.
- LD.7.3.** Departmental directors develop annual departmental plans in alignment with the center's strategic plan.
- LD.7.4.** The leaders ensure the use of evidence-based and best practice information to develop and improve the center's services.
- LD.7.5.** The leaders plan and budget for the upgrade or maintenance of buildings, equipment, and other resources.
- LD.7.6.** The leaders meet regularly to review the key performance indicators of services, surveys, audits, and feedback, and use the collected data to improve the center's operations.

Explanation

The strategic plan should be converted into an operational plan that contains steps to follow and staff assigned to lead and execute. Plans and resources are all approved by governance and tabulated for further timely implementation. Staff involved in and/or affected by the plan should be informed accordingly. The services should be evidence-based, and all policies and practice guidelines that the leaders develop should be based on referenced and updated practices. Regular leadership meetings shall take place to ensure that all plans are carried out effectively and that policies and practice guidelines are followed. The leaders should develop an annual budget, taking into consideration any additional cost for replacing or upgrading equipment, upgrading services, and periodic maintenance and repair. The budget should be distributed between the different patient care areas to ensure seamless and safe patient care.

LD.8. The center's leaders work collaboratively to develop and maintain a center-wide staffing plan.

- LD.8.1.** The staffing plan ensures that services meet the needs for safe patient care
- LD.8.2.** The staffing plan defines the number, type, and credentials of required staff, and their roles.
- LD.8.3.** The center recruits and assigns appropriately qualified staff in accordance with the staffing plan and recruitment policy.
- LD.8.4.** The staffing plan is updated annually, monitored to identify deficiencies, and actions for improvement implemented as required.

Explanation

The center's leaders should formulate a staffing plan for the center based on the scope of services the center provides and the center's capacity, and working hours. The plan should include the number, type, qualifications, and roles of staff required in all the center's areas (medical and non-medical) to ensure safe patient care. The center must recruit staff based on the staffing plan and the recruitment policy at the center. The staffing plan must be updated annually to respond to the needs and deficiencies.

LD.9. All categories of staff have clearly written job descriptions.

- LD.9.1.** The job description outlines the knowledge, skills, and attitude necessary to perform the job responsibilities for the specified position.
- LD.9.2.** The job description clearly defines the roles and responsibilities for the position.
- LD.9.3.** Job responsibilities and clinical work assignments are based on the evaluation of staff credentials.
- LD.9.4.** The job description is discussed with and signed by the employee upon hiring and is located in his/her personnel file.

Explanation

For smooth operational performance and accountability, each staff member must have his/her own job description that outlines daily responsibilities, necessary qualifications, skills, and experience. This job description will assist in recruiting the right staff for vacant positions and shall constitute the basis for the staff evaluation, whether it is probationary or carried out at the end of the year. This job description must be discussed with each staff personally, and it must be signed at the time of hiring to acknowledge that the staff is fully aware of the job, its requirements, and responsibilities.

LD.10. There is a process in place for credentialing and re-credentialing all healthcare providers.

- LD.10.1.** The credentialing process applies to all dental staff, dental assistants, and other clinical staff licensed to provide patient care on a full-time, part-time, or visiting basis.
- LD.10.2.** The credentialing process includes gathering, verifying, and evaluating staff credentials including licenses, educational certificates, training certification, and evidence of experience.
- LD.10.3.** Credentials are verified from the original source directly or through a third party with documented evidence.

- LD.10.4.** The center ensures the registration of healthcare professionals with the Saudi Commission for Health Specialties and licensing by the Ministry of Health (MOH) in accordance with the national laws and regulations.

Explanation

This process of credentialing applies to all clinical staff licensed to provide patient care such as dentists, dental assistants, and technicians. The credentialing process involves collecting all the information related to the staff education, training, experience, and licensure, verifying it from the primary source, and evaluating it to ensure the staff fits his/her assigned position. Credentialing must be performed upon employment and re-credentialing must be performed every two years thereafter. In addition, all healthcare practitioners must be registered with the Saudi Commission for Health Specialties and licensed by the Ministry of Health (MOH).

LD.11. All dentists have current delineated clinical privileges.

- LD.11.1.** The center has a policy and procedure for granting privileges to its dental staff.
- LD.11.2.** Clinical privileges are determined based on the dentist's current competence, the center's privileging policy, and the available services.
- LD.11.3.** The dental staff's clinical privileges are recommended by the dental center director and approved by the governing body, either directly or by appropriate delegation.
- LD.11.4.** The clinical privileges are reviewed and updated every two years or earlier if needed.

Explanation

The privileging of dentists is the most beneficial proactive risk management approach concerning patients' safety. It allows dentists to perform procedures and surgeries for which they are qualified through education, training, and certification. This prevents patients' exposure to the risk of morbidities. Each dentist should have a list of the invasive procedures that he/she is allowed or privileged to perform.

The center must have a policy and procedure for granting individual privileges. Clinical privileges should be distributed in the areas where the dentist is practicing. The privileging process should be reviewed and updated every two years, and earlier if a dentist receives new training on a certain procedure or is found to be potentially negligent in performing other procedures.

LD.12. All new employees attend a mandatory orientation program.

- LD.12.1.** The general orientation program for newly hired staff includes information about the center's mission, vision, values, organizational structure, patient and family rights, safety and security, infection control, and quality, patient safety, and risk management programs.
- LD.12.2.** Each new employee attends a departmental-specific orientation program that assists him/her in properly executing the specific job responsibilities as outlined in the job description.

Explanation

All new employees (full-time, part-time, visiting, and volunteers) should be oriented to the center. A general orientation program should provide information about the center including; the mission, vision, and values, organizational structure, code of conduct, ethical framework, patient and family rights, safety and security plans, infection control policies, and the quality, patient safety, and risk management programs. In addition, new employees must attend a departmental-specific orientation program that provides information related to specific job requirements. This program orients the new employee about the daily operations in the department and the specific tasks assigned to him/her as per the job description.

LD.13. There is a policy that ensures dental assistants and other healthcare staff are competent in specific procedures and operating equipment.

- LD.13.1. The policy contains a list of all procedures requiring competency assessment.
- LD.13.2. All staff are tested upon hiring and annually for the required competencies.
- LD.13.3. The policy is in place to ensure staff are trained on the safe operation of current and newly introduced equipment and devices.
- LD.13.4. Only properly trained and competent staff are allowed to use specialized equipment and medical devices.

Explanation

To ensure patients' safety, staff must be tested when initially hired and annually on their competency in certain procedures, according to their scope of work. Procedures requiring competency assessment may include:

- Infection control practices and precautions include hand hygiene, the use of personal protective equipment, prevention of needle stick injuries, and disinfection of the dental chair in-between and after patient treatment.
- Proper use and management of dental materials (impressions, fillings, & cement).
- Selection of the appropriate hand instruments and equipment required for each clinical procedure.
- Practical chairside assisting during clinical procedures.
- Following proper protocol during emergencies.
- Performing most common radiological procedures (if applicable).
- Collection and transfer of used instruments to the CSSD (If applicable).

Staff who pass the competency checks are allowed to perform tasks related to the practice under assessment. Competency assessment results are documented in the staff personnel files.

LD.14. There is a program for continuing education and training of all categories of staff.

- LD.14.1. The center has a regularly scheduled educational and training program based on the center and staff needs including quality, patient safety, risk management, and infection control practices.
- LD.14.2. The leaders encourage and compensate staff to attend educational and training activities relevant to the center's scope of services and in line with the national labor law.
- LD.14.3. All staff members who provide direct patient care maintain a valid certificate on basic life support (BLS).
- LD.14.4. Information about staff credentials, privileges, competencies, orientation, training, education, and evaluation are securely kept in an updated personnel file.

Explanation

Staff professional development is crucial to improving the center's services. The center should drive continuous education for clinical and non-clinical staff. The simplest way to promote education is to provide a regularly scheduled educational program addressing person-centered care, the center's scope of services, quality, patient safety, risk management, infection control practices, patient/service use rights, complaint management, shared decision-making, communication skills, informed consent, cultural beliefs, and the needs and activities of different patient/ service user groups. All staff members providing direct patient care must have valid basic life support certification. The center can grant either financial support or time off so that staff can attend conferences, symposia, training courses, and other educational activities. Employees' personnel files should be updated with training and education certificates.

LD.15. The leaders develop an effective process to evaluate staff performance at least annually.

- LD.15.1.** The performance evaluation is based on objective criteria targeting staff knowledge, skills, and attitude.
- LD.15.2.** The evaluation is conducted at the end of the initial probationary period and at least annually thereafter.
- LD.15.3.** Evaluations include personal goals that the staff will aim to achieve over the next year.
- LD.15.4.** Staff are involved in the evaluation of their performance by signing the evaluation and commenting on the required corrective actions.
- LD.15.5.** Information about staff credentials, privileges, competencies, orientation, training, education, and evaluation are securely kept in an updated personnel file.

Explanation

To ensure satisfactory staff performance according to job descriptions and privileges, a standardized objective process for gathering and assessing the staff's performance, scope of practice, professional development, and attitude must be developed for each staff category. An employee is evaluated after the initial probationary and annually afterward. Staff should acknowledge their performance and comment on any required actions for improving their performance as set forth by their supervisors. The performance evaluation should always incorporate next year's objectives, which will be evaluated the following year. Both the employee and his/her supervisor should sign the performance evaluation, which is kept in the employee's personnel file.

LD.16. The center implements a comprehensive program to protect the health and safety of staff.

- LD.16.1.** The staff health and safety program covers all employees and is consistent with relevant laws and regulations.
- LD.16.2.** The staff health and safety program is based on the protection of staff from occupational health and safety hazards, and workplace violence.
- LD.16.3.** The patient health and safety program is coordinated with the center's quality, safety, risk management, and infection control programs, including health screening, immunization, and post-exposure management.
- LD.16.4.** Staff have confidential and secured medical records that reflect their health status.

Explanation

The health and safety of staff are vital for the provision of the best care. A staff health and safety program should be available in all dental centers. The program should include staff vaccination requirements, policy for needlestick injuries, ergonomics, and other occupational hazards such as radiation and chemical exposures. The program should be well-coordinated with the quality and patient safety and risk management programs, and should also emphasize security issues to manage violence and aggression against staff. Staff files containing information about staff members' vaccinations and illnesses should be available and kept safe and secure.

LD.17. The leaders develop ethical standards to guide patients' care and employees' code of conduct.

- LD.17.1.** Marketing for staff and services, if performed, is carried out ethically as per the laws and regulations.
- LD.17.2.** The leaders develop a set of values and a professional code of conduct for all employees.
- LD.17.3.** The leaders ensure that patients and their families are fully informed and protected when they are involved in clinical research projects.
- LD.17.4.** The leaders develop a process to monitor and resolve ethical dilemmas, patient and non-patient related, in a reasonable timeframe as determined by the center.

Explanation

The leaders are responsible for developing the professional code of conduct at the center to ensure that patient care is provided ethically. The values and professional code of conduct describe the center's expectations of staff regarding their behavior and communication with each other and with their patients. This includes the ethical portrayal of services; reasonable and accurate billing; assurance that staff are engaged in ethical behavior with patients, families, and staff; and an appropriate dress code. The ethical framework must include guidelines to resolve ethical dilemmas and regulate all issues related to the participation of patients and families in research projects. The leaders should establish a mechanism to monitor and address patient and non-patient ethical dilemmas in a reasonable timeframe.

LD.18. The leaders support and protect the patient and family's rights.

- LD.18.1.** The leaders develop and maintain a patient rights and responsibilities statement and develop processes that support their implementation.
- LD.18.2.** The leaders ensure that written documentation of patient rights and responsibilities is available to patients and families and ensure patients are informed about their rights and responsibilities in a manner they can understand.
- LD.18.3.** The leaders ensure that patients' dignity, privacy, and confidentiality are respected.
- LD.18.4.** The health team provides care and services that are respectful of the patient's values and beliefs.
- LD.18.5.** Vulnerable patients are identified and protected from additional risks.
- LD.18.6.** The leaders ensure that staff are provided with training and education on patient and family rights and responsibilities.
- LD.18.7.** The leaders ensure that patients and their families have the right to be involved in their own care and treatment, including the right to refuse treatment or request a second opinion.

Explanation

Patient and family rights and responsibilities are paramount for ethical and safe patient care. The leaders should develop all policies and procedures for patients and family rights, including the bill of rights. Such policies and procedures should be available to patients and their families in written documents that are close at hand or clearly displayed in the center. The leaders ensure that staff are fully aware of - and trained on executing - the rights and responsibilities. The leaders should exert all efforts to ensure that patients are treated with dignity and that their privacy is always respected.

The dental center and its staff must be committed to providing quality dental care. Patients and their families should have the right to be informed of the patient's illness, professional assessment, and prognosis and decide whether to consent or decline the recommended treatment. The dental staff should provide accurate information in a language they understand. Patients should agree to their care plans and should have the right to manage their pain effectively. Patients are granted the right to ask for a second opinion if necessary, without fearing that their care may be compromised. Patients have the right to obtain a detailed medical report to be presented to other centers and sick leave notification for regulatory purposes.

LD.19. The leaders develop and implement a policy and procedure to describe the patients' right to voice their complaints, concerns, and suggestions.

- LD.19.1.** Patients' complaints are resolved within the time frame described in the policy.
- LD.19.2.** The center assigns a staff member to be responsible for managing complaints.
- LD.19.3.** Patient satisfaction surveys are conducted regularly.
- LD.19.4.** Data collected from surveys, complaints, and suggestions are analyzed and trended, with the information collected used for improvement and integrated into the quality and safety program.

Explanation

The center should have a well-defined policy and procedures for collecting patient feedback and resolving patient complaints. The policy should identify the individual and department responsible to investigate and manage patient complaints in a specified timeframe. In addition, patient satisfaction surveys must be conducted quarterly to evaluate services from the patient perspective. A regular report on patient feedback and complaints is provided to the leaders for corrective action development and implementation. The findings and recommendations are incorporated into the quality and safety program.

LD.20. Patients and their families have the right to accurate billing for provided services.

- LD.20.1.** The leaders ensure the availability of a price list for services provided to patients and their sponsors.
- LD.20.2.** The patients and their families have the right to receive an initial estimated cost of required services.
- LD.20.3.** The patients and their families have the right to obtain an invoice for services rendered.

Explanation

The center ensures that dental treatments performed adhere to a pricing list that is displayed or accessible to patients and families and that a receipt is issued; this includes insured patients. The center should provide a cost estimate upon patient request.

LD.21. The center provides assistance to patients with special needs.

LD.21.1. Street parking and drop-off points dedicated to patients with special needs are available near the center's entrance.

LD.21.2. The center's entrance, elevators, and toilets allow wheelchair access.

LD.21.3. Staircases have handrails.

LD.21.4. Elevated areas have ramps.

Explanation

The center should take into account the requirements necessary for enabling access for patients with special needs. Patients with special needs should have designated parking spaces, entrances, accessible elevators, ramps for elevated areas, handrails in hallways and staircases, and accessible restrooms.

LD.22. The center has a policy and procedure for controlling the development and maintenance of key documents.

LD.22.1. The center maintains a unique identifier for each key document, with title, number, date of issue, and date of revision.

LD.22.2. Key documents are developed, approved, revised, and terminated by authorized individuals.

LD.22.3. Key documents are communicated to relevant staff and are always accessible.

LD.22.4. A process is in place to ensure that key documents are always implemented

Explanation

For the proper execution of key function documents, policies, procedures, and processes, there must be a standardized written structure and format. These documents should indicate the originating department, date of issue, date of revision, date of implementation, and date of expiry. Key documents should be reviewed, approved, and updated accordingly by authorized individuals. Key function documents, policies, procedures, and processes carry the name(s) of the author(s) and approving authority. A system must be in place to ensure that only approved and non-expired policies are circulating and available to staff. All staff should be familiar with the available key function documents, policies, procedures, and processes relevant to their practice.

LD.23. The center collaboratively develops a comprehensive quality improvement and patient safety program.

LD.23.1. The quality improvement and safety program utilize key performance indicators, and patient and staff surveys to measure performance and improve clinical and managerial areas.

- LD.23.2.** The information generated from key performance indicators is readily accessible on a timely basis to those responsible for and/or involved in the delivery of the center's services, and is utilized for making improvements and supporting the leaders' decision-making.
- LD.23.3.** The center implements at least one improvement project per year utilizing an evidence-based quality improvement method such as "FOCUS PDCA".
- LD.23.4.** The center leaders assess and support the patient safety culture in the center.

Explanation

The center should ensure the quality of its services and its continuous improvement by developing a quality management and patient safety program. The center should utilize key performance indicators to measure the performance of the services provided. Staff are notified of the performance findings, and the information provided is utilized to further improve the clinical and managerial areas (structure, process, and outcome). Improvements in quality utilize an evidence-based approach such as FOCUS PDCA.

- LD.24.** **The center prioritizes and selects a set of relevant indicators that focus on the structure, process, and outcome of the dental and non-dental services provided.**

- LD.24.1.** The selection process of performance indicators is based on the center's most important processes and priorities.
- LD.24.2.** Each indicator has an operational definition, defined numerator and denominator, data collection method and frequency, a mathematical expression such as ratio or percentage, and a desirable target.
- LD.24.3.** The indicators are collected, validated, and analyzed by staff with appropriate knowledge and skills.
- LD.24.4.** The performance monitoring results are discussed with staff, utilized in their evaluation, and reported regularly to the governance together with the action plans taken for improvement.
- LD.24.5.** The indicators are compared internally by historical trends and externally by benchmarking to other similar centers when available.

Explanation

The collection of key performance indicators should follow an evidence-based approach as outlined in LD.24.1 through LD.24.5. The indicators should cover a variety of issues based on structure, process, and outcome. Information collected by measuring indicators should regularly be presented to staff to enhance their performance and is also utilized in their evaluation. Benchmarking of the center's performance is carried out internally (comparing historical data) and externally, either locally or internationally, to define the center's position in terms of performance. A quarterly report is presented to the governance with improvement action plans if required.

- LD.25.** **The center develops and implements a comprehensive risk management program.**

- LD.25.1.** The risk management program addresses clinical, managerial, and financial risks.
- LD.25.2.** The reporting of incidents, variances, and claims constitutes the program's essential reactive arm.

- LD.25.3.** The center develops and implements at least one proactive risk reduction approach per year.
- LD.25.4.** The center develops and periodically updates a risk register for all potential clinical, managerial, and financial processes in the center.
- LD.25.5.** The center utilizes an evidence-based process for grading risks based on severity, frequency, and likelihood of occurrence.
- LD.25.6.** Information from the risk management program, including incidents, analysis, and improvement projects, is communicated to staff and the governing body at least quarterly.

Explanation

The center should develop and implement a risk management program that covers all aspects of its activities: clinical, managerial, and financial. The program should be based on both reporting incidents and analyzing them to prevent recurrences as well as a proactive approach such as failure mode and effects analysis (FMEA) or any similar proactive risk management approach. The proactive approach should target improving practices that are high risk, problem-prone, or high volume, that have a substantial financial impact (such as insurance rejections), or that can markedly improve patient or staff satisfaction. Risks should be graded according to an evidence-based unified score system, and the center should maintain a list registering all its risky practices and procedures. Information collected from the risk management program should be used to improve the system, and staff should be informed of the findings and improvement projects at least quarterly.

LD.26. The center implements an incident reporting policy.

- LD.26.1.** The incident report policy outlines the types of incidents to be reported internally and to relevant regulatory authorities, the time frame, and the mechanism for reporting.
- LD.26.2.** Sentinel events and major incidents are reported, investigated, and the findings are utilized to prevent their recurrence.
- LD.26.3.** Incidences involving patients are documented in the dental record, and patients and families are informed by the physician/dentist of any investigation results.
- LD.26.4.** The center compiles a report on incidences according to type and severity, and an action plan to prevent its recurrence is distributed to staff and governance on a regular basis.

Explanation

The center should develop an incident reporting policy with a unified reporting mechanism for all occurrences, variances, accidents, and near misses. To encourage staff to report, it is preferable that the reporting be anonymous. Reporting adverse events to relevant authorities when required by rules and regulations is a must. The center prepares a report on all incidences, including near misses, by their type and severity, and leaders develop an action plan to prevent its recurrence. The report is distributed to the staff and governing body at least quarterly.

Sentinel events are situations that lead to the death or serious incapacitation of a patient, and may include the following:

- a. Unexpected death.
- b. Serious medication error leading to death or major morbidity.
- c. Wrong site, wrong patient, or wrong procedure or surgery.

LD.27. The center has a program to select and monitor clinical and operational contracts

- LD.27.1.** Contracted entities are selected based on evidence-based criteria that the relevant department develops.
- LD.27.2.** The center director ensures relevant leaders' recommendations and approval on contracts.
- LD.27.3.** The leaders ensure that the contracting entity and services provided meet applicable laws and regulations.
- LD.27.4.** When radiology services are provided through a contract; the center is responsible to provide oversight of the contract.
- LD.27.5.** The leaders ensure that the services provided are integrated into the overall quality and patient safety program.
- LD.27.6.** The leaders regularly monitor and document the compliance of contracted services with the appropriate standards and take documented corrective actions for improvement when standards are not met.

Explanation

To ensure the best cost-effective outcomes from contracted services, the process owners should closely monitor the implementation of contracts related to outsourced services, such as housekeeping or laboratory services. To ensure that the monitoring process is translated into an agreed-upon process and outcome indicators, the process owners should approve contracts before leaders give their final approval. Contract renewal should be based on the findings of the indicators' monitoring. When dental laboratory and/or radiology services are provided through contracts, the center is responsible to contract with centers complying with national laws and regulations. The center is also responsible to provide oversight of the contracts.

LD.28. The leaders implement policies and procedures to guide efficient procurement of equipment, either purchased or donated, medications, and medical consumables following national laws and regulations.

- LD.28.1.** The leaders ensure that contractors and suppliers of devices and consumables have a Medical Device Establishment License (MDEL).
- LD.28.2.** Leaders ensure that all newly purchased devices have a Medical Device Marketing Authorization (MDMA) certificate.
- LD.28.3.** Leaders approve newly introduced consumables based on a formal testing and feedback process from end-users.

Explanation

Non-approved medical equipment and supplies may not provide accurate investigation results, accurate monitoring parameters, or safe patient care. Therefore, leaders should develop a procurement policy to ensure the purchase of nationally approved medical equipment, medications, and essential supplies. The Saudi Drug and Food Authority (SFDA) provides such information and performs visits to institutions to ensure that only approved equipment, medications, and supplies are in use. Prior to purchasing newly introduced consumables, there should be formal testing conducted and feedback obtained from the end-user.

LD.29. The center maintains an aesthetic appeal.

- LD.29.1.** The center is clean and tidy.
- LD.29.2.** The center is free of broken furniture, scratched, and damaged walls and floors.
- LD.29.3.** The center maintains an ambient temperature between 20 - 24.4 Celsius.

Explanation

Patients' confidence in the center starts from the first impression. Patients' experience is also enhanced by feeling comfortable being treated in a clean and relaxing environment. The center should always maintain cleanliness at all times with room temperatures ranging between 20 and 24.4 Celsius as per Occupational Safety and Health Administration (OSHA) standards. The center's maintenance team should always ensure the integrity of wall paint, floor tiles, and furniture.

References

Agency for Healthcare Research and Quality (AHRQ). TeamSTEPPS®: Strategies and Tools to Enhance Performance and Patient Safety. Rockville, MD: AHRQ, 2016. Retrieved June 2022 from
<https://www.ahrq.gov/teamstepps/index.html>

Alharthi H. Healthcare predictive analytics: An overview with a focus on Saudi Arabia. *J Infect Public Health*. 2018;11(6):749-56. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/29526444/>

Arabiat D, et al. Parents' experiences of family centered care practices. *J Pediatr Nurs*. 2018;42:39–44. Retrieved June 2022 from
<https://doi.org/10.1016/j.pedn.2018.06.012>.

Carroll RL. Enterprise Risk Management: A framework for success. Chicago, IL: American Society for Healthcare Risk Management, 2014. Retrieved June 2022 from
<http://www.ashrm.org/resources/patient-safety-portal/pdfs/ERM-White-Paper-8-29-14-FINAL.pdf>

Chassin MR, Loeb JM. High-reliability health care: getting there from here. *Milbank Q*. 2013;91(3):459-90. Retrieved June 2022 from
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3790522/>

Gluyas H. Patient-centred care: Improving healthcare outcomes. *Nurs Stand*. 2015;30(4):50–7. Retrieved June 2022 from
<https://doi.org/10.7748/ns.30.4.50.e10186>.

Lee H, Lee H, Baik J, et al. Failure mode and effects analysis drastically reduced potential risks in clinical trial conduct. *Drug Des Devel Ther*. 2017;11:3035-43. Retrieved June 2022 from
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5655157/>

National Institute for Occupational Safety and Health (2019). CDC - Health Care Workers - NIOSH Workplace Safety and Health Topic. Retrieved June 2022 from
<https://www.cdc.gov/niosh/topics/healthcare/default.html>

Shamsuddin Alaraki M. Assessing the organizational characteristics influencing quality improvement implementation in Saudi hospitals. *Qual Manag Health Care*. 2018;27(1):8–16. Retrieved June 2022 from
<https://doi.org/10.1097/QMH.0000000000000152>

The International Society for Quality in Health Care (ISQua). Guidelines and Standards for External Evaluation Organisations.
<https://www.isqua.org>

US Centers for Disease Control and Prevention. Recommended vaccines for healthcare workers. (Updated: Apr 15, 2014). Retrieved June 2022 from
<http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>

World Health Organization. WISN: Workload Indicators of Staffing Need User's Manual. 2010. Retrieved June 2022 from
<https://www.who.int/publications-detail-redirect/9789241500197>

World Health Organization (WHO). Health Workforce: Numerous Tools and guidelines for human resources for health (2016). Geneva CH; WHO. Retrieved June 2022 from
https://www.who.int/health-topics/health-workforce#tab=tab_1

Provision of Care (PC)

Introduction

Dental centers provide preventive, curative, and rehabilitative oral services. The center should accept patients for services based on its capability to provide the services that meet the identified patient's needs.

Providing optimum care requires careful planning, coordination, and communication. The dental center must provide an appropriate and thorough assessment for each patient, and patient care must be planned and implemented to ensure the best possible outcome. To support continuity of care, patient assessment and care must be documented in a completed dental record. The healthcare team must receive test results at the appropriate time. Patients' and families' participation in the care plan is crucial for its success, therefore, their proper education is of the utmost importance. Informed consent to some dental procedures is one of the patients' and families' rights. As the care process may need to be distributed between multiple providers, a collaborative process should be in place to promote continuity and coordination of care when the patient is referred, transferred, or discharged. Staff training and the dental center's readiness for cardiopulmonary resuscitation is an integral part of the management of unexpected complications from dental procedures.

Important processes and activities addressed in this chapter include the following:

- Access to care and referrals services
- Patients' identification
- Scope and content of the patient assessment
- Treatment planning
 - Clinical practice guidelines
 - Moderate sedation
- Effective cardiopulmonary resuscitation process
- Patients' and families' education and participation in the treatment plan.
- Medication management
- Safety of radiology services

PC.1. Patients have access to services based on their dental needs and the available services, and are registered with the center for providing such services.

PC.1.1. A standardized process is in place for screening and registering patients for services using their full name and identification number.

PC.1.2. Registration creates a dental record number that is unique to every patient.

PC.1.3. An appointment system is in place to book patients in advance.

Explanation

The center should ensure that each patient is assigned a unique dental record number based on the standardized registration process and that this number is linked to their dental records. A patient's complete name, an ID (or passport number for visitors), and dental record number prevent miscorrelation with investigation findings or the wrong patient receiving a procedure. There is an appointment system in place to reduce congestion and ensure the availability of services. Appointment staff should be made fully aware of the services provided and trained to direct patients to the appropriate services. If the appointment staff are not fully aware of the services, at a minimum, a dental assistant should be available at the appointment desk to book patients into the appropriate clinics. Dental centers should be able to handle the patients' dental requirements either by providing fully comprehensive treatment or, if required, referring part of the treatment cycle to a specialized center or a hospital with inpatient and surgical services. Therefore, the center should maintain a list of the cases that require referrals as well as formal agreements with the referring centers.

PC.2. The center has a process to ensure the correct identification of patients and teeth

PC.2.1. Patients are identified by at least two (2) identifiers: the full name as in the identification document, and a unique dental record number.

PC.2.2. Patients are identified before blood withdrawal, before any investigation, before administering medications, and before any surgery or procedure.

PC.2.3. Patients are actively involved in the process of patient identification.

PC.2.4. An approved tooth numbering system (TNS) is used to identify the tooth in each intervention.

Explanation

Ensuring that the right patient receives the right care is an essential aspect of safe care. Patient identification errors can occur in all types of clinical activities, whether diagnostic or therapeutic. The intent is to precisely identify the individual as the person for whom the service or treatment is intended and, additionally, to match the service or treatment to that individual. Acceptable identifiers may be the patient's name (at least three names) and dental record number, date of birth, etc. At least two identifiers are used, and the patient's name should be one of them. Patients are identified at the point when they enter the healthcare facility. Patient identification is reconfirmed during the collection of blood samples and other specimens for clinical testing, administration of medications, performing surgery or other procedure, and performing an X-ray or imaging procedure. Ensuring the right procedure for identifying the tooth is very important. The three primary tooth numbering systems (TNS) used in dentistry worldwide are the Federation Dentaries International (FDI) TNS, the Palmer TNS, and the Universal TNS.

PC.3. Patients are clinically assessed through an established assessment policy and procedure.

- PC.3.1.** The assessment policy is developed collaboratively, highlighting the scope and content of assessment by both general and specialty dentists, and other healthcare workers participating in the patient's care process.
- PC.3.2.** The assessment policy highlights the minimum assessment required by the dentist before treating the patient.
- PC.3.3.** The assessment policy ensures the availability of a comprehensive patient assessment including assessing vital signs.
- PC.3.4.** The assessment policy highlights the required screening for nutritional needs.
- PC.3.5.** The assessment policy highlights the required screening for the presence or absence of pain.
- PC.3.6.** The assessment policy highlights the required screening for fall risk and the measures used to reduce the risk of injury resulting from falls.

Explanation

Patient assessments are of foremost importance to ensure the right diagnosis and establish the appropriate plan of care. The center should have an assessment policy and procedure that the various entities have developed collaboratively. This policy should clearly identify the scope and content of the history and physical examination of the different specialties. During their first clinic visit, all patients should undergo a comprehensive history and physical examination, regardless of the nature of the disease. Patients should be screened for nutritional needs, the presence or absence of pain, and the risk of falls. Those patients who screen positive should be fully assessed and managed according to the findings.

PC.4. The center provides the dentists with the results of investigations as per an agreed time frame.

- PC.4.1.** The time frame for routine and stat (urgent) investigations is developed collaboratively with the laboratory, radiology, and other services, on-site or outsourced.
- PC.4.2.** Turnaround time is available for routine and stat (urgent) radiology and laboratory tests.

Explanation

For effective treatment planning, the dentist should receive the results of ordered investigations in a time frame acceptable for the type of investigation carried out. A document should be available specifying the turnaround time of routine and urgent investigations, whether carried out inside or outside the center.

PC.5. The center develops and implements a process for reporting critical test results, whether performed on-site or outsourced.

- PC.5.1.** The process defines which staff is responsible to receive critical test results. The process involves writing down the test result by the receiver and reading back the findings to the result provider.
- PC.5.2.** The process involves writing down the test result by the receiver and reading back the findings to the result provider.
- PC.5.3.** The read-back process and the dentist's intervention are documented in the patient dental record.
- PC.5.4.** The center develops a process for contacting patients that left the center when critical test results are reported.

Explanation

Critical test results are reported following a process that clearly defines the notified parties, means of communication, read-back sequence, and elements required for documenting the event (date, time, patient identification, critical test result, read-back documentation, and identification of both the notifying and notified persons).

PC.6. The dentist develops a treatment plan to meet the patient's needs.

- PC.6.1.** The treatment plan is developed and documented by the dentist utilizing the assessment information and the investigation results.
- PC.6.2.** The treatment plan is designed to achieve desired outcomes or measurable goals.
- PC.6.3.** The treatment plan is reviewed every visit, based on the outcome measures and other significant changes in the patient's condition.

Explanation

A documented treatment plan is vital to managing a patient's condition. The treatment plan is developed according to the assessment information that the healthcare team obtains and should be tailored to the patient and family's spiritual and cultural needs. The treatment plan should identify measurable goals; for example, maintaining a pain score below 4. The attending dentist should review the care plan during every visit and change it according to the patient's response, if necessary.

PC.7. The dentist records the dental procedures performed in the dental record.

- PC.7.1.** The dental record contains the name of the procedure and its location.
- PC.7.2.** The dental record highlights any material used in the procedure.
- PC.7.3.** The dental record contains the type of sedation or analgesia utilized and its dose.
- PC.7.4.** The dentist reports the procedure details, outcome, and any complications.

Explanation

The dentist should maintain complete documentation for all dental procedures performed. This documentation must include the name of the procedure, location, materials used, type and dose of sedation and analgesia, procedure details, outcomes, and any complications

PC.8. The dental center develops and monitors the implementation of evidence-based clinical practice guidelines.

- PC.8.1.** The center's clinical guidelines cover the management of patients with relevant medical conditions.
- PC.8.2.** The clinical guidelines cover the use of prophylactic antibiotics.
- PC.8.3.** The clinical guidelines are updated at least every two years and their implementation is monitored.

Explanation

Certain chronic medical diseases and conditions can pose a great risk to the performance of dental procedures. The center is required to adopt and implement updated and evidence-based guidelines for the management of patients with these medical conditions. When a dental procedure or surgery is indicated, staff should comply with the clinical guidelines and leaders should monitor the implementation to ensure the safety of the patient population. These clinical practice guidelines must be reviewed every two years and updated as necessary.

PC.9. The dental center ensures all required safety measures are performed for moderate sedation.

- PC.9.1.** The procedure room is equipped with an appropriate nitrous oxide/oxygen mixing device and the appropriate monitoring equipment that permits continuous recording of the patient's ECG and oxygen saturation, with an intermittent recording of the blood pressure.
- PC.9.2.** The dentist performing the procedure is certified competent in moderate sedation and managing its possible complications.
- PC.9.3.** The dental assistant is certified/competent in monitoring patients under moderate sedation.
- PC.9.4.** The center has a recovery room, with monitoring equipment, adjacent to the procedure room or the patient is recovered in the same procedure room.
- PC.9.5.** The patient is discharged home after full recovery utilizing evidence-based recovery criteria that are documented in the patient dental record.

Explanation

Moderate sedation is a risky procedure that can lead to cardiopulmonary arrest if not performed as per recognized standards of practice. The procedure room should be equipped with necessary devices (as per sub-standard PC.9.1). The dentist and assistant should be certified as per sub-standard PC.9.2 and PC.9.3. To ensure patient safety and hemodynamic stability following the procedure, the center should have a recovery room that is equipped with monitoring equipment.

PC.10. The center has a policy and procedure to safely provide care to patients who require cardiopulmonary resuscitation (CPR).

- PC.10.1.** The CPR policy highlights the availability of a standardized crash cart(s) or automated external defibrillator (AED) in the patient care areas.
- PC.10.2.** The policy describes the process for qualified staff to check the crash cart every shift and after each use.
- PC.10.3.** The role of staff involved in the CPR process is clearly defined in the CPR policy and monitored for implementation.

Explanation

A policy and procedure must be developed to ensure that staff can safely and successfully resuscitate patients in cardiopulmonary arrest. The policy should emphasize the standardization of all crash carts so that staff can easily familiarize themselves with crash carts in different locations. The policy should define the frequency of checking the crash cart by the responsible nursing staff to ensure its readiness at all times and identify the team members responsible for resuscitation, and the role of each member.

PC.11. Dentists assist patients, and when appropriate their families, to fully participate in making informed decisions about their care, treatment, and procedures.

- PC.11.1.** Dentists provide patients and their families with honest and accurate information, in a manner they can understand, about their illness, options for treatment, proposed treatment, potential benefits, potential complications, and the likelihood of success of treatment.
- PC.11.2.** Patients' and families' education is based on their healthcare needs.
- PC.11.3.** Patients are supported to discuss their plan of care with the dentist and have all their questions answered.
- PC.11.4.** To assist the patient and family to give informed consent when surgery or a procedure is to be performed in the center; the patient and family receive information related to surgery and sedation by the dentists.
- PC.11.5.** Patient and family education is evaluated for effectiveness through demonstrating learning or verbalizing understanding.

Explanation

Patient and family education is a cornerstone of the success of any treatment plan. A patient and his/her family must be educated on their healthcare needs. Staff should make every effort to ensure the patient and their family clearly understand the education provided. To help patients and families in making the right decision regarding accepting treatment or procedure, the elements in PC.11.1 through PC.11.5 should be strictly followed by the treating staff.

PC.12. Informed consent is obtained from the patient or the guardian.

- PC.12.1.** The center develops and regularly updates a list of the procedures and conditions requiring consent.
- PC.12.2.** Informed consent is obtained before surgery, invasive procedures, and the use of sedation.
- PC.12.3.** Informed consent is obtained before taking photographs of the oral cavity or face.
- PC.12.4.** Informed consent is obtained before involving the patient in a research project.

Explanation

Patients have the right to be fully aware of the benefits, risks, complications, and consequences of refusing treatments or investigations of invasive nature, such as surgery, sedation, or anesthesia. This consenting process should also take place before the taking of any photographs of the patient or body parts and before the patient's involvement in any research project that may expose the patient's identity or jeopardize the patient's safety.

PC.13. The center develops a policy and procedure on safe medication management

- PC.13.1.** The medication management policy describes the requirements for safe medication prescriptions including patient name, age, dental record number, and allergy history.
- PC.13.2.** Adverse drug reactions are documented in the dental records and reported to relevant authorities as per local regulations.

Explanation

Medication prescription in the center should have a policy and procedure on the safe prescribing of medications which ensures that all prescriptions are identified by accurate patient demographics (name, age, dental record number). Allergy status must be clearly identified on the prescription and all pediatric prescriptions have the weight identified. Abbreviations are not to be used in prescriptions and a copy of the prescription is kept in the patient's dental record. To ensure that patients are treated as safely as possible, the center must have an established mechanism for reporting adverse events and a specified time frame for reporting them.

PC.14. The center provides appropriate storage for medications and dental materials.

- PC.14.1.** Dental materials and medications are stored at the correct temperature and humidity as per the manufacturer's recommendation.
- PC.14.2.** Storage areas are clean and tidy.
- PC.14.3.** Stored items have an inventory with identified quantities and expiration dates.
- PC.14.4.** Items are stored according to the first expired, first out (FEFO) concept.
- PC.14.5.** Storage refrigerators are dedicated to dental materials only.

Explanation

Medications can lose their potency if not stored in the appropriate environment as recommended by the manufacturer. Loss of potency during storage may influence pharmaceutical efficacy and safety. Proper environmental control (i.e., proper temperature, light, and humidity; sanitation, ventilation, and segregation conditions) must be maintained wherever drugs and supplies are stored anywhere in the center. There should be a routine inventory record that indicates the quantities and expiration dates of medications and it should adhere to the FEFO concept. All medication refrigerators must be connected to an outlet with an immediate backup power supply. The center must determine what to do with medications stored in a temperature-impaired area.

PC.15. Intraoral radiology services are available in dental centers and operated safely. Other radiology services are outsourced, as needed, to meet patient needs.

- PC.15.1.** The center has functional in-house intraoral and panoramic radiology services.
- PC.15.2.** Intraoral radiography, dental panorama, and cephalometric radiographs are carried out by the dental assistant or a radiology technician.
- PC.15.3.** Dental cone-beam CT scans are carried out by a licensed radiology technician or a trained dental assistant.
- PC.15.4.** Intraoral, panoramic, and cephalometric radiographs are read and reported by the ordering dentist.
- PC.15.5.** Dental cone-beam CT scans are read and reported by a qualified trained dentist.

Explanation

Basic radiological services should be available in the center performed by a qualified radiology technician or dental assistant, or the center should contract with a licensed radiology unit to ensure timely performance of the investigations and receipt of the written radiology report. In the case of contracted radiological services, the center should ensure the safety of its patients and the quality of its procedures by periodically reviewing the radiation safety report and the maintenance reports of the radiology machine(s).

PC.16. The center develops a radiation safety program.

- PC.16.1.** The radiation safety program covers all areas where ionizing radiation is used for either intraoral or extraoral x-rays.
- PC.16.2.** All rooms where ionizing radiation is administered are tested and certified radiation leakproof by the appropriate certifying local authority.
- PC.16.3.** Radiology equipment is periodically inspected, calibrated, and maintained for proper functioning.
- PC.16.4.** Safety warnings are posted in clear and appropriate locations on the doors.
- PC.16.5.** Women of childbearing age with missed menstruation are checked for the possibility of being pregnant prior to having X-ray tests.
- PC.16.6.** Personnel are monitored for radiation exposure by thermoluminescence dosimeters (TLD) that are regularly checked.
- PC.16.7.** Personnel shielding devices, including radiation protection aprons, are available for patients and staff, and periodically inspected and tested for integrity and safety compliance as per the documentation.

Explanation

Patients, staff, and the environment should be protected from radiation by a well-constructed radiation safety program that includes all areas utilizing ionizing radiation, such as the dental panorama and mobile x-rays. Radiology rooms and equipment should be tested initially to ensure the absence of a radiation leak. Equipment should be tested periodically to ensure proper functioning. Similar safety testing should be conducted for the dental panorama. Warning signs should be clearly posted. Prior to radiation exposure, women of childbearing age should undergo a pregnancy test if they have missed a period. Staff exposure to radiation should be monitored using thermoluminescence dosimeters that are examined periodically, and staff should receive replacement cards during the test time. Radiation protection aprons should also be tested periodically for their integrity.

References

- Agency for Healthcare Research and Quality (AHRQ). Care Coordination. 2016. Retrieved June 2022 from
<https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>
- ECRI Institute. Patient identification: Executive summary. 2016. Retrieved June 2022 from
<https://www.ecri.org/Pages/Patient-Identification-Deep-Dive.aspx>
- Hughes P, Latino RJ, Kelly T. Preventing patient identification errors. Patient Safety & Quality Healthcare. 2017. Retrieved June 2022 from
<https://www.psqh.com/analysis/preventing-patient-identification-errors/>.
- Institute for Safe Medication Practices (ISMP). List of High-Alert Medications in Acute Care Settings. 2018. Retrieved June 2022 from
<https://www.ismp.org/sites/default/files/attachments/2018-08/highAlert2018-Acute-Final.pdf>
- Institute for Safe Medication Practices (ISMP). ISMP's list of error-prone abbreviations. Horsham PA; ISMP (2021). Retrieved June 2022 from
<https://www.ismp.org/tools/errorproneabbreviations.pdf>
- Institute for Safe Medication Practices (ISMP). Guidelines for Safe Preparation of Compounded Sterile Preparations, rev. ed. 2016. Accessed Nov 4, 2019.
https://www.ismp.org/sites/default/files/attachments/2017-11/Guidelines%20for%20Safe%20Preparation%20of%20Compounded%20Sterile%20Preparations_%20revised%202016.pdf
- Müller M, Jürgens J, Redaelli M, et al. Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. BMJ Open. 2018;8(8):e022202. Retrieved June 2022 from
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6112409/pdf/bmjopen-2018-022202.pdf>
- Nasarwanji MF, Badir A, Gurses AP. Standardizing handoff communication: Content analysis of 27 handoff mnemonics. J Nurs Care Qual. 2016;31(3):238–44. Retrieved June 2022 from
<https://doi.org/10.1097/NCQ.0000000000000174>
- Saudi Arabian Ministry of Health. MOH Guideline on the Assessment of Radiology (2016). Retrieved June 2022 from
<https://www.moh.gov.sa/en/Ministry/MediaCenter/Publications %20 PagesPublications-2016-08-07-001.aspx>
- The International Society for Quality in Health Care (ISQua). Guidelines and Standards for External Evaluation Organisations.
<https://www.isqua.org>
- World Health Organization. (2010). WHO guidelines on drawing blood: best practices in phlebotomy. Retrieved June 2022 from
http://www.euro.who.int/__data/assets/pdf_file/0005/268790/WHOguidelines-on-drawing-blood-best-practices-in-phlebotomy-Eng.pdf?ua-1
- World Health Organization. WHO Global Strategy on People-Centred and Integrated Health Services: Interim Report. 2015. Retrieved June 2022 from
https://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf

Dental Laboratory (DL)

Introduction

Dental laboratories manufacture a variety of products to assist in the provision of oral health care by a licensed dentist. Due to the nature of the materials and the procedures performed in dental laboratories, the dental laboratory has specific safety issues that need special attention including structural and infection-related risks. Hence, the dental laboratory staff must exert all possible efforts to ensure safety and prevent the spread of infection inside the dental laboratories. If the center does not have an onsite dental laboratory, it should refer its cases to an external dental laboratory that complies with national laws and regulations.

This chapter addresses the following:

- Required policies in dental laboratories
- Identifying patient-related dental materials
- Infection control in dental laboratories
- Safety in the dental laboratories

DL.1. The center develops and implements policies and procedures to guide the dental laboratory services in accordance with applicable laws and regulations.

- DL.1.1.** The scope of work in the dental laboratory is aligned with the center's scope of service.
- DL.1.2.** Dental laboratory policies and procedures guide the process of identification, handling, processing, transporting, and disposing of dental materials and products.
- DL.1.3.** A licensed dental technician carries out dental laboratory services.
- DL.1.4.** The laboratory implements a standardized process to improve the effectiveness of communication between laboratory technicians, dentists, and other caregivers.
- DL.1.5.** The laboratory maintains a process for monitoring compliance with the policies and procedures through regular inspections, tracking, and analysis of the findings. This process is used to guide improvements.

Explanation

The dental laboratory should be able to handle the patients' dental requirements as determined by the dentist's treatment plan following a comprehensive assessment. Therefore, the laboratory should develop, implement, and monitor the effectiveness of its services. To ensure effectiveness and consistency, the policies and procedures guide the process of identification, handling, processing, transporting, and disposing of dental materials and products in accordance with applicable laws and regulations.

DL.2. The center develops a process for identifying patient-related dental prosthesis, impressions, and appliances.

- DL.2.1.** Dental impressions and biopsies are immediately identified after taking it.
- DL.2.2.** Dental appliances are identified.
- DL.2.3.** Avulsed teeth are identified immediately after receiving from the patient.
- DL.2.4.** Identification of patient-related dental prosthesis, impressions, and appliances performed using at least two (2) patient identifiers.

Explanation

Ensuring the right care is provided to the right patient is an essential aspect of safe care. The rationale is to precisely identify the individual for whom the service or treatment is intended and to match the service or treatment to that individual. Dental impressions and prosthesis are similarly identified. Acceptable identifiers may be the patient's name and dental record number or date of birth. At least 2 identifiers are used and the patient's name should be one of them. Dental prosthesis, impressions, and appliances are identified immediately after taking them.

DL.3. Dental laboratory staff minimize the risk of infection in their workplace.

- DL.3.1.** The laboratory has a designated area for receiving all incoming work, separate from the production area.
- DL.3.2.** Staff are not allowed to eat or drink in the dental laboratory except in a designated room.
- DL.3.3.** Gloves are worn when dealing with contaminated items. Masks and waterproof aprons are used to prevent contamination from splashes and aerosols.
- DL.3.4.** Workbenches, sinks, and model trimmers are wiped down with disinfectant at the beginning and end of the working day.

- DL.3.5.** Impressions and appliances received from the clinic are inspected for proper cleaning and disinfection and rejected if not found in compliance.
- DL.3.6.** Appliances are disinfected before being returned to the dental clinic.

Explanation

Dental laboratories deal with dental impressions and appliances that are in direct contact with saliva and mucosa. The center must exert all possible efforts to prevent the spread of infection inside the dental laboratories.

DL.4. The structure and equipment of the dental laboratory ensure staff safety.

- DL.4.1.** The flooring is made of a material that is easy to maintain, with no carpets, readily cleanable, and appropriately wear-resistant for the location. All floor joints for ducts and pipes are tightly sealed.
- DL.4.2.** Wall finishes are washable, moisture-resistant, and smooth. The walls do not have any grooves or cracks that can harbor dust and dirt.
- DL.4.3.** The unit has adequate hand wash facilities, an emergency shower, eye-flushing devices, adequate lighting, and appropriate storage for flammable liquids.
- DL.4.4.** There is a dedicated place to mold ceramics that is isolated from the other areas of the dental laboratory and is protected from dust.
- DL.4.5.** All propane and butane gas cylinders are stored safely and securely outside the lab, clearly marked, with emergency shut-off valves located inside the laboratory.
- DL.4.6.** Oxygen and argon gases, if used, are placed securely in a safe area away from flammable gases.
- DL.4.7.** Appropriate first aid kits are readily accessible and regularly maintained.

Explanation

Due to the nature of materials used and the procedures performed, dental laboratories are hazardous places to work in. The safety of staff is the responsibility of the center's director. The director should ensure that the dental laboratory structure and equipment comply with the sub-standards DL.4.1 through DL.4.7.

DL.5. The structure of the dental laboratory ensures proper ventilation and airflow.

- DL.5.1.** The laboratory maintains adequate ventilation.
- DL.5.2.** Air and vacuum systems for the dental clinic are dedicated for clinic use only and are not connected to the dental laboratory.
- DL.5.3.** Direct dedicated exhaust is placed over all burnout, casting, and/or boil-out areas. The exhaust is located within 18 inches of the source equipment to effectively remove heat, smoke, or odors.

Explanation

The design of the ventilation system in dental laboratories is crucial for staff safety. The type of materials used and the procedures performed in dental laboratories necessitate having separate, proper, and maintained air and vacuum systems to ensure safety and reduce risk. Because the ventilation system may interfere with the quality of work or safety, the layout of the ventilation system concerning the working benches is important to ensure effectiveness and adequacy.

References

- Al-Aali K, Binalrimal S, AlShedokhi A, et al. Infection control awareness level among dental laboratory technicians, Riyadh, Saudi Arabia. *J Family Med Prim Care.* 2021;10(4):1540-6. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/34123889/>
- Miyazaki T, Hotta Y, Kunii J, et al. A review of dental CAD/CAM: current status and future perspectives from 20 years of experience. *Dent Mater J.* 2009;28(1):44-56. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/19280967/>
- Schweiger J, Edelhoff D, Güth JF. 3D Printing in Digital Prosthetic Dentistry: An Overview of Recent Developments in Additive Manufacturing. *J Clin Med.* 2021;10(9):2010. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/34067212/>
- Sadid-Zadeh R, Sahraoui H, Lawson B, et al. Assessment of Tooth Preparations Submitted to Dental Laboratories for Fabrication of Monolithic Zirconia Crowns. *Dent J (Basel).* 2021;9(10):112. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/34677174/>
- The national board for certification in dental laboratory technology. Certified dental laboratory handbook and application (2019). Retrieved June 2022 from
<https://nbccert.org/pdfs/CDLApplication.pdf>
- The Dental Laboratories Association UK. Health and safety. Retrieved June 2022 from
<https://dla.org.uk/browse/health-and-safety/>
- The International Society for Quality in Health Care (ISQua). Guidelines and Standards for External Evaluation Organisations.
<https://www.isqua.org>
- USA National Association for Dental Laboratories. The Foundation for Dental Laboratory Technology. Retrieved June 2022 from
<https://nadl.org/index.cfm>
- Yang CJ, Chen MH, Lin KP, et al. Importing Automated Management System to Improve the Process Efficiency of Dental Laboratories. *Sensors (Basel).* 2020;20(20):5791. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/33066246/>

Management of Information (MOI)

Introduction

Information management is a cornerstone for patient care and the decision support process by the center leaders. The center leaders are required to design and implement an information management plan that achieves the following:

- Managing the information required by governmental and external agents
- Managing internal information requirements
- Security and confidentiality of information
- Records retention
- Patients' unique files documentation and completion

MOI.1. The center defines, in a policy, the information that may be shared among the staff internally and with other external entities, and its format.

- MOI.1.1.** The policy highlights how patient demographics and medical/dental information are shared among dental and administrative staff including paper format, electronic, or a combination.
- MOI.1.2.** The policy identifies how the information is disseminated from leaders to staff and vice versa.
- MOI.1.3.** The policy defines what information is required by the relevant external authorities, and the frequency of reporting.
- MOI.1.4.** The policy highlights the patients' personal and dental information required to refer a patient to a higher center.
- MOI.1.5.** The policy identifies the staff security levels required to access patient information.
- MOI.1.6.** The policy identifies how each type of information is secured and safely stored.
- MOI.1.7.** The policy highlights how long the center needs to retain the various types of information in accordance with the applicable national rules and regulations.

Explanation

Communication failures cause a third of all morbidities and mortalities in healthcare. Identifying and organizing the flow of information, both inside the organization and with external customers, helps to streamline communication and eliminate communication errors. All stakeholders should collaboratively develop a management of information plan that includes the following:

- The process of managing the patients' information.
- The process of managing the internal communication between staff and the leaders.
- The process of managing information that is required externally by regulatory bodies.
- The plan should identify how information is safely secured.
- The plan should identify the level of security for each type of document.
- The plan identifies how the information is backed up and restored if needed.
- The plan identifies the required retention time for different documents and information.

MOI.2. All patients seen in the center have unique dental record files.

- MOI.2.1.** The contents of the dental record are arranged according to a standardized process.
- MOI.2.2.** Dental record files contain the required patient demographics including national identification number, contact information, emergency contacts, and insurance history.
- MOI.2.3.** Medical/dental record files contain sufficient updated medical information to safely manage the patient and promote continuity of care including history, physical examination, plan of care, investigations, consultations, observations, consents, procedure/surgery reports, medications, allergies, and prior adverse reactions.

Explanation

To ensure continuity of care, each patient cared for in the center must have his/ her own dental record that has a unique dental record number. The dental record shall contain at a minimum all the elements identified in MOI.2.2 and MOI.2.3.

MOI.3. The center has a policy for making entries in dental record files.

- MOI.3.1.** The dental file documentation policy identifies the category of staff allowed to write in the dental record.
- MOI.3.2.** All entries in the patient file are legible, dated, timed, and signed by the author.
- MOI.3.3.** There is a uniform entry of data in dental records, whereby orders are written separately from assessments, care plans, and progress notes.
- MOI.3.4.** Entries written in error are not deleted or erased. Instead, a single line is passed through the error text and dated, timed, and signed by the author, or the system allows for electronic amendment tracing.
- MOI.3.5.** Only standardized and approved abbreviations and symbols are used in dental records.
- MOI.3.6.** The center uses diagnosis codes and procedure codes including international classification of diseases (ICD) or current procedural terminology (CPT) consistent with the requirements of relevant authorities.

Explanation

Uniformity of writing in dental records ensures proper documentation and avoids misinterpretation of written information. A policy should be developed and implemented based on the elements identified in MOI.3.1 through MOI.3.6. Abbreviations and symbols could be interpreted differently by different individuals throughout the patient journey, thus inadvertently changing the intended care plans. Therefore, a limited list of standardized abbreviations should be circulated to all staff in all areas, and their correct use monitored. Standardized diagnoses and procedure codes help centers track pathology and common procedures and comply with insurance companies' requirements.

MOI.4. The center has a process for completing the patient dental record files.

- MOI.4.1.** Regular checks are made on returned files to ensure completion. The check includes but is not limited to demographics, medical information, and authentication.
- MOI.4.2.** Incomplete files are separated from completed ones in the records storage area and are completed in a time frame defined by the organization.
- MOI.4.3.** The center keeps a record of the percentage of incomplete records over time and uses this information to improve staff compliance with record completion.

Explanation

At the end of a patient's visit, the dental record should be returned to the dental records store. This keeps the dental records safe, secure, and in good order. Upon its receipt in the store, the dental record should be checked for completeness according to a written process that includes complete demographics, dental information, and authentication. Every effort should be made to complete any incomplete records within a time frame that the organization has identified. The center should check a percentage of its records for completion and the collected information should be conveyed to staff and used to improve staff compliance with completion.

MOI.5. The center develops a policy and procedure for the use of information technology.

- MOI.5.1.** The policy and procedure for the use of information technology highlight how the generated information is stored and regularly backed up.
- MOI.5.2.** The information technology policy and procedure describe the manual procedures required to execute the various activities in the event of system failure, maintenance, or repair.
- MOI.5.3.** Staff can demonstrate the manual procedure for the downtime regulation of data generated by information technology.

Explanation

Despite advances in infrastructure robustness, many centers still face database, hardware, and software downtime, lasting short periods or shutting down work for days. To maintain the completeness and comprehensiveness of data, an adequate data capturing process during downtimes is critical. A complete manual system must be prepared for use during the downtime period and include both managerial and clinical activities to prevent the interruption of care processes. End users involved in providing center services should be trained on the planned manual system and know how to shift to the manual system if the electronic system is down. The downtime system must be assessed for effectiveness regularly and after actual downtime incidents. Documented reports of this assessment should be available, and actions taken in response to any deficiencies. Even though organizations may treat their stored media with care, media can still be damaged accidentally or on purpose, and dental records can be unconsciously changed or erased. The creation of regular backup copies limits the amount of information lost. Backup media should be safely stored. As part of information and data integrity, centers are expected to have a clear mechanism for backing up data to ensure ease of retrieval. The backup process is regularly implemented to avoid any data loss or gaps in information that may affect gaps in the care and service provided, as well as to avoid misinformed decision-making by leaders.

MOI.6. The center implements an effective clinical documentation improvement (CDI) program.

- MOI.6.1.** The center develops a policy and procedure for the clinical documentation improvement program.
- MOI.6.2.** The center has at a minimum, a dentist and a dental assistant, who are properly trained in clinical documentation improvement.

Explanation

Clinical Documentation Improvement (CDI) is fundamental in any healthcare organization. CDI ensures accurate reporting of diagnoses and procedures to the health authorities as per local regulations. The center has a developed policy and procedures that guide proper coding documentation to make it possible for healthcare leaders to plan for better delivery of healthcare services. The center ensures that clinical staff are well trained on all aspects of clinical documentation as per CBAHI guidelines. Auditing the quality of clinical documentation in the dental records is an essential part of the CBAHI survey activities.

References

Alotaibi, Y., & Federico, F. The impact of health information technology on patient safety. *Saudi Medical Journal*. 2017;38(12):1173-80. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/29209664/>

American Health Information Management Association (AHIMA). HIM Body of Knowledge. 2021. Retrieved June 2022 from
<http://bok.ahima.org/>

American College of Obstetricians and Gynecologists. Patient Safety and Health Information Technology (2015). Retrieved June 2022 from
<https://www.acog.org/-/media/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/co621pdf?dmc=1&ts=20190901T1157446882>

Feldman SS, Buchalter S, Hayes LW. Health Information Technology in Healthcare Quality and Patient Safety: Literature Review. *JMIR Medical Informatics*. 2018;6(2):e10264. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/29866642/>

Fernandez-Aleman JL, Garcia ABS, Garcia-Mateos G, et al. Technical solutions for mitigating security threats caused by health professionals in clinical settings. *Conf Proc IEEE Eng Med Biol Soc*. 2015:1389–92. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/26736528/>

Hamiel U, Hecht I, Nemet A, et al. Frequency, comprehension and attitudes of physicians towards abbreviations in the medical record. *Postgraduate Medical Journal*. 2018;94(1111), 254-8. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/29540451/>

Institute for Safe Medication Practices. ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations. 2017. Retrieved June 2022 from
<https://www.ismp.org/tools/errorproneabbreviations.pdf>

International Organization for Standardization. ISO 27799:2016. Health Informatics – Information Security Management in Health Using ISO/IEC 27002. Retrieved June 2022 from
<https://www.iso.org/standard/62777.html>

Jayabalan M, O'Daniel T. Access control and privilege management in electronic health record: A systematic literature review. *J Med Syst*. 2016;40(12):261. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/27722981/>

Mathioudakis A, Rousalova I, Gagnat AA, et al. How to keep good clinical records. *Breathe (Sheff)*. 2016;12(4):369-73. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/28210323/>

The International Society for Quality in Health Care (ISQua). Guidelines and Standards for External Evaluation Organisations.
<https://www.isqua.org>

Tsou AY, Lehmann CU, Michel J, et al. Safe practices for copy and paste in the EHR. Systematic review, recommendations, and novel model for health IT collaboration. *Appl Clin Inform*. 2017;8(1):12–34. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/28074211/>

World Health Organization (WHO). International Statistical Classification of Diseases (ICD) and related information (2021). Retrieved June 2022 from
<https://www.who.int/classifications/classification-of-diseases>

Infection Prevention and Control (IPC)

Introduction

Dental patients are uniquely vulnerable to the development of healthcare-associated infections because of multiple factors including exposure to invasive devices and body fluids and frequent contact with healthcare workers during procedures and care. The dental center requires processes in place to support the prevention and control of infection that might be acquired or transmitted by patients, families, and staff while in the center. In addition to standard precautions, more stringent precautions are recommended for dental centers because of the increased risk of contamination with blood and pathogenic microorganisms. These processes reduce the risk or spread of infection, and ensure that care is provided in a clean, sterile environment. To ensure staff and patient safety, infection prevention and control requires an effective center-wide infection prevention and control program that identifies, reduces, and eliminates infection risks.

This chapter outlines the requirements for the following processes and activities related to infection prevention and control including:

- A coordinated program and required policies
- Unit design and structure
- A hand hygiene program
- Standard precautions
- Water lines and water quality
- Infection control with radiographic procedures
- Sterilization services
- Sharp and waste management
- Clean environment
- Reporting of communicable diseases
- Employee screening and immunization

IPC.1. The center implements a coordinated program to reduce the risk of infection to patients and staff.

- IPC.1.1.** The infection control program is developed collaboratively by the center's staff and approved by the center's leaders.
- IPC.1.2.** The infection control program is based on current evidence-based guidelines and covers both patients and staff.
- IPC.1.3.** Policies and procedures targeting the most important infection risk processes are developed to guide the infection prevention and control program.
- IPC.1.4.** The components of the infection control program are combined in a manual that is available to all staff members.
- IPC.1.5.** The center provides the staff with annual education on infection prevention and control policies and any related updates, with evidence of staff education kept in their personnel files.
- IPC.1.6.** The infection control program implementation is monitored by the center's leaders.

Explanation

The center must establish an evidence-based infection control program according to its scope of services. The program must cover all related infection prevention and control activities that could ensure maximum safety for patients, families, staff, volunteers, contractors, etc. To ensure a safe workplace for all the center's attendees, all activities at the center should be regulated and controlled by scientifically based infection control policies and procedures. Infection prevention and control activities should be overseen by an individual qualified in infection prevention and control practices through education, training, experience, or certification. The qualified staff member should directly report to a higher administrative authority to ensure the presence of an independent administrative unit that oversees infection-related issues in the whole center. The designated administrator fulfills program oversight responsibilities as per standard requirements that should be described in the job description. Staff receive ongoing education to enhance their infection control practices and update their knowledge.

IPC.2. The dental center's design and structure support the national infection prevention and control requirements.

- IPC.2.1.** A dirty utility room is available for collecting medical and non-medical waste.
- IPC.2.2.** A janitorial room is available for storing all cleaning equipment and material.
- IPC.2.3.** All dental procedure rooms are equipped with two sinks that are easily accessible to the dentist and dental assistant.
- IPC.2.4.** Work surfaces and benchtops in dental procedure rooms are sufficient, uncluttered, nonporous, impervious to water, smooth, and have sealed joints to facilitate cleaning and prevent the accumulation of contaminated material.
- IPC.2.5.** Dental procedure rooms are functionally separated into a clean zone and a contaminated zone.
- IPC.2.6.** The dental sterilization unit has a dedicated contaminated zone for receiving and washing dental instruments and a dedicated clean zone for sterilization, with a unidirectional flow of instruments from dirty to clean.

Explanation

A properly designed center is essential for its proper function in terms of prevention and control of infection and the safety of staff, patients, and families. The structural elements in IPC.2.1 through IPC.2.6 are the minimum structural requirements for the dental examination and procedure rooms and the sterilization unit.

IPC.3. The center adopts an evidence-based and effective hand hygiene program.

IPC.3.1. Written policies and procedures on implementing and monitoring appropriate hand hygiene are available.

IPC.3.2. The center provides hand hygiene facilities sufficient to meet its needs such as sinks, alcohol hand rubs, plain and antiseptic soap, and disposable paper towels.

Explanation

Hand hygiene (HH) is the most effective method of preventing infectious disease transmission. The center should develop hand hygiene policies and procedures. The center supports hand hygiene by providing sinks and appropriate hand washing soap and sanitizers in appropriate locations in the facility. The center should maintain a monitoring process to continuously evaluate hand hygiene compliance among staff. In addition, data about hand hygiene compliance and monitoring should be analyzed and integrated into improvement projects.

IPC.4. The center develops a process to prevent the spread of infection inside the dental procedure room contaminated zone.

IPC.4.1. Opened boxes of gloves, cotton rolls, or gauze are stored outside the contaminated zone and protected from contamination caused by splashes and aerosols.

IPC.4.2. Equipment that is difficult to clean is covered with a protective plastic wrap that is replaced before each new patient.

IPC.4.3. Clinical contact surfaces are disinfected in between patients. Blood stained surfaces are disinfected with an intermediate-level disinfectant.

IPC.4.4. Cartridges of local anesthetic are kept in their individual packs and stored appropriately to prevent environmental contamination by aerosols and splashes.

IPC.4.5. The spittoon is cleaned after each patient by wiping it with neutral detergent using disposable paper towels.

IPC.4.6. Used instruments are transported in a closed prick-proof container to either the sterilization unit or the dirty utility, and not washed in the clinical area. Heavily soiled instruments are dried with a sponge.

IPC.4.7. Used instruments are sprayed or soaked with an enzymatic detergent if not immediately removed for washing and sterilization.

Explanation

The contaminated zone of the exam and procedure room is a source of infection to patients and staff if prevention and infection control standards are not followed before, during, and after each examination or procedure. Sub-standards IPC.4.1 through IPC.4.7 highlight the procedures required to prevent the spread of infection from a contaminated zone.

IPC.5. Personal protective equipment is available, readily accessible, and is used correctly by staff in all patient care areas.

IPC.5.1. Written policies and procedures are available on the appropriate use of gloves, gowns, facemasks, and protective eyewear.

IPC.5.2. Gloves and surgical masks are worn by the dentist and dental assistant for all clinical procedures. Sterile gloves are worn for any oral surgical procedures.

- IPC.5.3.** Dental assistants put on new gloves for cleaning the working surfaces during the changeover between patients.
- IPC.5.4.** Protective eyewear or face shields are worn by the dentist, dental assistant, and the patient. In case of patient refusal, risks are explained and refusal is documented in the dental record.
- IPC.5.5.** When a risk of large splashes with blood or body substances is anticipated, impermeable protective clothing or gowns are worn by the dentist and dental assistant.

Explanation

Personal protective equipment (PPE) is a fundamental tool in the implementation of proper infection prevention and control practices. The center identifies, in writing, those situations in which masks, eye protection, gowns, or gloves are required, and provides a sufficient supply of PPEs as well as training in their proper use.

IPC.6. The center minimizes the risk of infection from dental impressions and dental appliances.

- IPC.6.1.** Dental impressions are decontaminated by rinsing in running water, immersing in a diluted detergent with recommended exposure time, and then rinsing to remove the detergent, and placed in a sealed bag before transportation to the dental laboratory.
- IPC.6.2.** All materials, impressions, dental prostheses, intraoral and extraoral appliances are cleaned thoroughly before insertion and adjustment.
- IPC.6.3.** The orally soiled prosthesis is scrubbed with a brush and anti-microbial soap and placed in an ultrasonic cleaner, and later rinsed under tap water and dried before initiating any required work.

Explanation

Dental impressions and appliances are a known source of infection transmission. Every effort must be exerted by the center to eliminate the risk of infection from these items. Therefore, sub-standards IPC.6.1 through IPC.6.3 must be strictly followed.

IPC.7. The dental center minimizes the risk of water contamination.

- IPC.7.1.** The dental center uses softened water in all water lines with a colony count of less than (500) colony forming units/ml.
- IPC.7.2.** Sterile irrigants are used for aseptic procedures.
- IPC.7.3.** All waterlines are equipped with a biofilm and a non-return valve.
- IPC.7.4.** Waterlines are cleaned and disinfected in accordance with the manufacturer's instructions.
- IPC.7.5.** Air and water lines from any device are flushed for a minimum of two (2) minutes at the start of the day and for (30) seconds between patients.

Explanation

Dental procedures primarily depend on water jets running through the patient's oral cavity. Therefore, eliminating water contamination is an essential step in infection prevention and control. Sterile irrigants are used for aseptic procedures such as biopsies, periodontal surgery, apical surgery, implant surgery, tooth sectioning, and removal of bone. Air and water lines from any device (e.g., handpieces, ultrasonic scalers, and air/water syringes) are flushed appropriately. Sub-standards IPC.7.1 through IPC.7.5 are the minimum requirements to eliminate water contamination.

IPC.8. The center minimizes the risk of infection encountered with the use of intraoral radiographs.

- IPC.8.1.** Gloves are worn when exposing radiographs and handling contaminated film packets.
- IPC.8.2.** Intraoral devices are either disposable or heat tolerant.
- IPC.8.3.** Exposed radiographs are dried of saliva/blood and placed in a protective container before transport to the developing room.
- IPC.8.4.** Digital radiography sensors are covered with an appropriate barrier during exposure and disinfected in between patients using the manufacturer's recommendation.
- IPC.8.5.** Contaminated radiography equipment, including the radiograph tube head and control panel, is cleaned after each patient use. Alternatively, barrier protection can be applied and changed after each patient use.

Explanation

Intraoral radiographs are a potential source of infection through the oral cavity. Sub-standards IPC.8.1 through IPC.8.5 should be strictly followed to eliminate the risk of infection from intraoral radiographs.

IPC.9. Sterilization services support infection prevention and control.

- IPC.9.1.** The sterilization processes are conducted by qualified staff.
- IPC.9.2.** There is an adequate and dedicated space for sterilization services that supports the sterilization processes.
- IPC.9.3.** The center develops a policy and procedure for the safe reprocessing of single-use items.
- IPC.9.4.** Personal protective equipment is available and utilized during the decontamination process.
- IPC.9.5.** Sterilizers are in proper working order and sterilizer's instructions are available.
- IPC.9.6.** Proper sterilization parameters are recorded and records are retained for one year.
- IPC.9.7.** Chemical indicators are used in every package and biological indicators are used at least weekly. Records of results are kept for one year.

Explanation

Infection risk is minimized through proper cleaning, disinfection, and sterilization of surgical supplies and other invasive or non-invasive patient care equipment. To ensure the proper method of collection, decontamination, cleaning, and sterilization, these services must be centralized and maintained. The central sterile services department (CSSD) staff must set clearly written policies and procedures that guide collection and transportation, decontamination and disinfection, cleaning and sterilization, the storage of sterile items, and a mechanism for the recall of sterile items in the event that the sterilization process fails. The policy must be scientifically sound and should be reviewed and approved by the infection prevention and control, quality, and administration. When this service is outsourced, the center should ensure that the contractor complies with all required safety standards. Re-sterilization of single-use items should be carried out according to an evidence-based policy that ensures safe sterilization without affecting the integrity of the item's use and that specifies the number of re-sterilization cycles and the point at which the item cannot be further re-sterilized.

IPC.10. The center defines, in a policy, the environmental cleaning, decontamination, and disinfection processes in all patient care areas.

- IPC.10.1.** The center develops and regularly reviews the procedures and schedules for cleaning, decontamination, and disinfection.
- IPC.10.2.** The center keeps a schedule that lists all environmental surfaces, equipment, and items to be cleaned/disinfected in care areas.
- IPC.10.3.** The center keeps a list of appropriate detergents and disinfectants for dental instruments and prosthesis in accordance with the manufacturer's instructions.
- IPC.10.4.** Detergents and disinfectants are available and used properly in accordance with the manufacturer's instructions.
- IPC.10.5.** The center has a process to safely handle blood and body fluids spills.

Explanation

Environmental cleaning is a fundamental principle of infection prevention and control in the center. The environmental cleaning policy ensures appropriate decontamination of surfaces that could play an important role in the transmission of dangerous pathogens. Disinfectants are frequently used to eliminate infectious organisms. To ensure the proper use of disinfection, the selections and indications for use must be based on scientific references and national laws and regulations and reviewed and supervised by infection control personnel.

IPC.11. The center develops a policy and procedure for the prevention and management of sharp injuries.

- IPC.11.1.** To prevent injuries from sharps, needles are not bent, broken, or recapped except in special and approved circumstances, the "scoop method" is used if recapping is necessary.
- IPC.11.2.** Needles and sharps are disposed of in sharp boxes or containers of appropriate size and number.
- IPC.11.3.** Needle sticks or sharp injuries are timely reported and investigated.
- IPC.11.4.** Data on sharp injuries are analyzed and trended over time and findings are utilized for further prevention of injuries.

Explanation

To prevent sharps injuries with exposure to blood-borne infections, the center should have a defined system to prevent sharps injuries and ensure their proper handling. The handling, use, and disposal of sharps within the center should be practiced according to a written policy and procedure. Staff should have the knowledge and skills necessary to handle sharps (i.e., needles are not bent or broken, the scoop method is used for necessary recapping, etc.). The center should analyze the recorded sharp injuries over time to assess and develop further preventive measures.

IPC.12. The center implements a program for the safe collection, storage, and disposal of medical waste that is consistent with laws and regulations.

- IPC.12.1.** Medical waste is stored for final disposal in a dedicated, cleaned, and maintained waste collection room.
- IPC.12.2.** Medical waste, including sharp boxes, is discarded by a registered medical waste company.
- IPC.12.3.** Yellow bags are used for all non-sharp disposable materials contaminated with the patient's blood or body fluids.
- IPC.12.4.** Hazardous signs are fixed on all medical waste containers.

Explanation

To protect the public and the environment from infectious organisms and to provide a safe healthy environment to the patient, families, and healthcare workers, the center should implement a Medical Waste Management Program that regulates the segregation, handling, storage, and disposal of medical waste and provides oversight for its implementation as per the center's policy. The program should be implemented in accordance with national laws and regulations. The center should ensure the availability of the required waste management supplies (yellow bags, red bags, medical waste containers... etc.). Medical waste workers should be vaccinated, as reflected in their employee health records, and trained on the safe handling of medical waste.

IPC.13. The center develops policies and procedures that address employees' screening, immunization, and post-exposure management.

- IPC.13.1.** Screening, immunization, and post-exposure management of employees are consistent with the laws and regulations, and the recommendations of professional organizations.
- IPC.13.2.** All employees have baseline screening for hepatitis B, hepatitis C, HIV, and tuberculosis.
- IPC.13.3.** The immune status of newly hired staff against hepatitis B is determined by serological testing and appropriate vaccine(s) are administered to those who are non-immune.
- IPC.13.4.** The response to hepatitis B vaccination is monitored in vaccinated employees four weeks after completing the vaccine series. Non-responders to the hepatitis B vaccine are offered at least a second series of the vaccine.

Explanation

Dental staff are at risk of encountering infection from patients and their protection must be a high priority. The center must develop and implement an evidence-based policy governing staff vaccination and post-exposure management in line with the laws, regulations, and recommendations of professional organizations. All new employees must be screened for hepatitis B, hepatitis C, HIV, and tuberculosis; and vaccinated as necessary.

References

- Carling PC, Huang SS. Improving healthcare environmental cleaning and disinfection: Current and evolving issues. *Infect Control Hosp Epidemiol.* 2013 May;34(5):507–513. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/23571368/>
- International Society for Infectious Diseases (ISID). Guide to Infection Control in the Healthcare Setting: Infection Prevention in the Healthcare Setting. Retrieved June 2022 from
<https://www.isid.org/guide/infectionprevention/>
- Ling ML, Apisarnthanarak A, Thu LTA, et al. APSIC Guidelines for environmental cleaning and decontamination. *Antimicrob Resist Infect Control.* 2015;4:58. Retrieved June 2022 from
<https://doi.org/10.1186/s13756-015-0099-7>
- National Guard Health Affairs. Infection prevention and control manual, 3rd Edition (2018). Retrieved June 2022 from
<https://ngha.med.sa/English/MedicalCities/AlRiyadh/MedicalServices/Lab/Documents/InfectionControlManual.pdf>
- National Guard Health Affairs. HEalthcare Associated infection – surveillance manual, 3rd Edition (2018). Retrieved June 2022 from
https://ngha.med.sa/English/MedicalCities/AlRiyadh/MedicalServices/Documents/3rd_edition_Surveillance_Manual.pdf
- Ren W, Sheng X, Huang X, et al. Evaluation of detergents and contact time on biofilm removal from flexible endoscopes. *Am J Infect Control.* 2013;41(9)e89–92. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/23663861/>
- Saudi Arabian Ministry of Health. MOH manual of infection prevention and control in dental settings (2nd Edition). 2018. Retrieved June 2022 from
<https://www.moh.gov.sa/Ministry/MediaCenter/Publications/Documents/2018-11-22-005.pdf>
- The International Society for Quality in Health Care (ISQua). Guidelines and Standards for External Evaluation Organisations.
<https://www.isqua.org>
- US Centers for Disease Control and Prevention. Infection Control: Guidelines & Guidance Library. (Updated: 2019). Retrieved June 2022 from
<http://www.cdc.gov/infectioncontrol/guidelines/index.html>
- US Centers for Disease Control and Prevention. CDC Guideline for Disinfection and Sterilization in Healthcare Facilities (2019): Rutala WA and Weber DJ. Retrieved June 2022 from
<https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf>
- van Buijtenen A, Foster D. Does a hospital culture influence adherence to infection prevention and control and rates of healthcare associated infection? A literature review. *J Infect Prev.* 2019;20(1):5–17. Retrieved June 2022 from
<https://doi.org/10.1177/1757177418805833>
- World Health Organization (WHO) - Revised CSSD Manual and Guidelines - Infection Control Africa. 2014. Retrieved June 2022 from
<http://www.icanetwork.co.za/wp-content/uploads/2014/03/N.-Damani-CSSD-WHO-guidelines.pdf>

Facility Management and Safety (FMS)

Introduction

A safe, functional, and effective environment for patients, staff, and other individuals is crucial to prevent or minimize risks in the environment of care. The center leadership must provide all necessary support and resources to improve safety in the workplace in alignment with regulatory requirements.

The center must have implemented plans for managing the safety, security, fire safety, medical/ dental equipment, emergency preparedness, hazardous materials, and utilities. The center must collect and analyze data to determine the effectiveness of the plans and facilitate continuous quality improvement. Staff must also be educated on their responsibilities. Education must commence at orientation and continue regularly thereafter.

Important aspects of the facility management and safety addressed in this chapter include the following:

- Building safety
- Security
- Fire safety
- Emergency
- Medical/dental equipment
- Hazardous materials
- Utilities

FMS.1. The center establishes and supports a facility management and safety program.

- FMS.1.1.** There is a qualified individual responsible for the facility management and safety program as a full-time or part-time employee.
- FMS.1.2.** The safety management program includes plans for emergency management, utility systems, hazardous materials, fire safety, medical dental equipment, building safety, fire safety, and security.
- FMS.1.3.** The safety management program includes regular inspection, testing, and maintenance of all the operating components of the program.
- FMS.1.4.** The center maintains adequate and complete documentation for the facility management and safety program.
- FMS.1.5.** Data related to safety concerns are reviewed and analyzed and proper actions are taken to prevent reoccurrences.
- FMS.1.6.** All staff including new hires, locums, and trainees receive education on the facility management program that is repeated annually as relevant.

Explanation

The center develops individual programs or one master's program that includes the following components:

- a. Safety and Security
 - Safety—The degree to which the center's buildings, grounds, and equipment do not pose a hazard or risk to patients, families, and staff.
 - Security—Protection from loss, destruction, tampering, or unauthorized access or use
- b. Hazardous materials—Handling, storage, and use of hazardous materials are controlled, and hazardous waste is safely disposed of.
- c. Emergencies—Response to disasters and emergencies is planned and effective.
- d. Fire safety—The property and its occupants are protected from fire and smoke.
- e. Medical technology—Technology is selected, maintained, and used in a manner that reduces risks.
- f. Utility systems—Electrical, water, and other utility systems are maintained to minimize the risks of operating failures. A backup system is available in case of failure.

The facility management program recommendations are written, relevant, and up to date. When the center has other entities within the facilities to be surveyed (e.g., coffee shop or gift shop), the center should ensure that these independent entities comply with the facility management and safety program. Training and education must be provided for all staff including new employees to ensure awareness about the facility management and safety program at the center.

FMS.2. Interdisciplinary rounds are scheduled and conducted to ensure safety.

- FMS.2.1.** The center establishes an interdisciplinary team for overseeing and monitoring the facility management and safety program.
- FMS.2.2.** A facility inspection round is conducted at least four times per year by the interdisciplinary team.
- FMS.2.3.** The resulting information is documented and is used for the development and implementation of corrective actions and planning and budgeting for long-term facility upgrading and replacement.

Explanation

Safety rounds by the safety team and other disciplines should take place regularly in the center. The rounds are designed to discover any inconsistencies and to identify any existing safety or security hazards related to settings and the environment. The results of rounds are formally documented and any required corrective actions are taken to ensure that safety requirements are met. The center should be able to establish a systematic approach for the necessary safety expenditures.

FMS.3. The center's environment is safe for patients, families, and staff.

- FMS.3.1.** The leaders ensure that the building and its services comply with national standards, environmental protection standards, laws and regulations, and the recommendations of professional organizations.
- FMS.3.2.** The building and its surroundings are free from hazards such as potentially loose objects, exposed outlets or wiring, slippery floors, sharp ends, holes in the ground, or any other hazards.
- FMS.3.3.** Periodic preventive maintenance (PPM) and corrective maintenance are done for all electrical and mechanical systems.
- FMS.3.4.** Maintenance records are kept for all electrical and mechanical systems including periodic preventive maintenance.
- FMS.3.5.** The center has adequate parking spaces, waiting areas, and toilets.
- FMS.3.6.** The center implements measures to ensure the safety of patients and staff during construction, renovation, and demolition.
- FMS.3.7.** The center implements measures to ensure the safe use of lasers in dental procedures and treatment. Measures include but are not limited to using warning signs, using protective eye goggles, and removing refractive surfaces.

Explanation

To ensure occupants' safety and manage the risks within the healthcare environment, all centers, regardless of size and resources, must comply with national standards, environmental protection standards, laws and regulations, and the recommendations of professional agencies. The leadership is responsible for:

- Ensuring the building and its surroundings are free of hazards such as: potentially loose objects, exposed outlets or wiring, slippery floors, sharp ends and holes in the ground.
- Knowing which national and local laws, regulations, and other requirements applicable to the center's facilities.
- Planning and budgeting for the necessary upgrading or replacement of equipment or other materials as identified by monitoring data or to meet applicable requirements; and providing evidence of progress toward implementing the improvements.

The center must develop and implement a plan for periodic preventive and corrective maintenance for the center's setting, including electrical and mechanical systems. Maintenance records are kept for all mechanical and electrical equipment, such as air conditioning, power and other equipment to help in decisions regarding replacement or upgrades. When the center has been cited for not meeting specific requirements, center leadership takes responsibility for planning for and meeting the requirements in the prescribed time frame.

FMS.4. The leaders develop and monitor the implementation of a fire prevention program.

- FMS.4.1.** Staff are trained regarding fire drills and evacuation plans at least annually, and training records are kept in staff personal files.
- FMS.4.2.** Egress routes, corridors, and fire escapes are marked with exit signs and are free from obstacles.
- FMS.4.3.** Fire extinguishers are tested and distributed in the center according to the type of extinguisher required in each area.
- FMS.4.4.** Fire systems, including the fire alarm and fire prevention and protection equipment, are in place and functioning.
- FMS.4.5.** The fire alarm system is maintained and tested, and all maintenance records are maintained.
- FMS.4.6.** A "No Smoking" policy is approved and enforced.
- FMS.4.7.** "No Smoking" signs are posted at all entrances and waiting areas.

Explanation

The fire safety of the center and its occupants must be ensured through a number of facility control measures. In addition, staff receive training on fire drills including the use of acronyms such as RACE/PASS and safe evacuation techniques. Fire safety measures include the procurement of fire-rated materials such as furniture and curtains (proven through the materials' specifications) and the establishment of fire and smoke compartments, especially for high-risk areas like the laboratory. Fire rating should also include windows, glass, and doors along the compartment. A staff training schedule on using fire extinguishers should be provided and includes training on different types of fire extinguishing systems. The fire alarm system is to be maintained and tested, and all maintenance records are to be kept and updated. "No Smoking" signs are posted and a no smoking policy is enforced.

FMS.5. The center is secure and protects its users.

- FMS.5.1.** Sufficient trained security personnel are available in the center according to its size and design complexity.
- FMS.5.2.** Security personnel or security systems restrict access to sensitive and high-risk areas.
- FMS.5.3.** The patient's privacy is respected.
- FMS.5.4.** The center's equipment and data are secured.
- FMS.5.5.** Patient and staff files are accessible only to authorized persons.
- FMS.5.6.** All staff wear properly displayed identification badges.

Explanation

The center's security program must ensure that everyone in the center is protected from harm, loss, or property damage. Staff, vendors, and others specified by the center, such as contractors, must wear badges (temporary or permanent) or other forms of identification. Restricted areas such as operating rooms, labs, dental records, and IT server rooms must be secure and monitored by security personnel and/or security access control systems. The remote or isolated areas of the facility and grounds may require the use of security cameras or the presence of security staff is required in remote or isolated areas within the center. Security program policies and procedures must be disseminated to center staff to clarify their roles and responsibilities in different situations. To ensure appropriate security coverage of the facilities, a security risk assessment must be conducted to determine the number of security personnel necessary to cover the center's main gates, entrances, and security-sensitive areas. Patients, employees, and others must be able to sense the security presence in the center. This presence must be available throughout the center's operational time. Security personnel must be oriented to and familiar with their job descriptions, roles, and responsibilities during various security scenarios and emergency cases. Female security personnel must be available as required, and security personnel must be able to communicate properly with the center's employees and patients, without language barriers.

FMS.6. The center has an updated plan for the proper installation, inspection, testing, and maintenance of medical/dental equipment.

- FMS.6.1.** There is an updated inventory list of all medical/dental equipment.
- FMS.6.2.** Medical equipment with special installation requirements, including special ventilation or room modifications, is installed in accordance with the manufacturer's recommendations and safety requirements.
- FMS.6.3.** Dental air compressors and vacuum pumps are housed in a well-ventilated and secured area.
- FMS.6.4.** Medical/dental equipment is periodically maintained by qualified staff in accordance with the manufacturer's recommendation.
- FMS.6.5.** All defective medical/dental equipment is labeled and removed from the clinical area.
- FMS.6.6.** Medical equipment is discontinued according to a clear policy incorporating lifespan, beyond economic repair, and vendor or governmental recalls. Equipment is disposed of in accordance with governmental rules and regulations.

Explanation

The medical equipment management program must be supported by policies and procedures that mitigate the risks associated with the introduction of new medical equipment, the tagging of medical equipment, the removal of equipment from service, and agent/sub-contractors repairs.

A medical equipment management program must be implemented to ensure that medical equipment is safe to use through proper installation, regular inspection, maintenance, and testing. The medical equipment management program includes:

- An inventory of medical equipment that covers, at a minimum, the equipment name, its manufacturer, its model, its serial number, its location, its organization number, and its maintenance history.
- Implementation of medical equipment Installation requirements which include modification of heating, ventilation, and air conditioning (HVAC) requirements, and safety precautions for some types of laser equipment in dental clinics.
- The availability of a system for medical equipment alerts and recall monitoring through the Saudi Food and Drug Authority (SFDA) and manufacturer notifications and reporting medical equipment failures in a serious injury or illness to SFDA.
- The availability of a necessary service and operation manual, whether a hardcopy or softcopy, for reference when needed.
- The availability of calibration test supply and calibration equipment.

Because medical equipment failures are expected, the center must develop a risk-assessment-based backup plan for failed medical equipment through the provision of standby medical equipment or by shifting to an equal medical intervention alternative.

FMS.7. The center has an emergency plan in case of emergencies.

FMS.7.1. The center's emergency plan details how to respond to different emergencies and how to minimize risks in the center.

FMS.7.2. The emergency plan defines the staff roles in different emergency cases.

FMS.7.3. The emergency plan includes contact persons and authorities.

FMS.7.4. The emergency plan identifies the nearest healthcare facilities and staff know where to refer patients during emergencies if needed.

FMS.7.5. The center has alternative power and water sources as part of its emergency preparedness.

FMS.7.6. Staff are trained annually on emergency drills.

FMS.7.7. The emergency plan is documented, evaluated annually, and updated as needed.

Explanation

To ensure the life safety of all occupants within the center and provide the utmost protection for the facility and its equipment, staff must participate positively in protecting the environment and responding to emergencies. The center has a documented, evaluated, relevant, and updated (as needed) emergency plan. The center must assess the types of emergencies it is most likely to encounter and determine the types of action needed to ensure that patients and staff remain safe and include this information in the emergency plan. The plan must clearly outline leadership and staff duties and responsibilities in emergencies. Staff are well trained in emergency drills and know where to refer patients during emergencies if needed. Regular training is required to help ensure that staff are aware of their duties and responsibilities during an emergency. To test staff readiness, all departmental staff must participate in both announced and unannounced drills, which must be documented. Contingency plans are available for water and power sources during an emergency to ensure the availability of alternate sources if needed.

FMS.8. The dental center develops a hazardous material (HAZMAT) and waste disposal plan.

- FMS.8.1.** The center keeps an updated register of all hazardous materials in the center, along with their "Safety Data Sheets".
- FMS.8.2.** Staff are trained in properly dealing with available hazardous materials and waste disposal.
- FMS.8.3.** The center controls and reduces the risk associated with the use of hazardous materials and wastes.
- FMS.8.4.** Hazardous materials are stored, handled, transported, used, and disposed of as per the "Safety Data Sheets".
- FMS.8.5.** Waste disposal is done in an effective manner within the facility or through an authorized contractor.
- FMS.8.6.** Fire-rated cabinets are used for flammable hazardous materials.

Explanation

The center must protect its occupants from the effects of hazardous materials and waste. There should be a hazardous materials plan in place that includes identifying and safely controlling hazardous materials and waste throughout the facility. A hazardous material is any solid, liquid, or gas that can harm people, other living organisms, property, or the environment. Hazardous materials may be radioactive, flammable, explosive, toxic, corrosive, oxidizers, asphyxiants, pathogens, or allergens, or may have other characteristics that render them hazardous in specific circumstances.

The hazardous materials program includes processes for:

- Inventory of hazardous materials.
- Handling, storage, and use of hazardous materials.
- Proper protective equipment and procedures to use and follow during use, spills, or exposure to hazardous waste.
- Proper labeling of hazardous materials and waste.
- Reporting and investigation of spills, exposures, and other incidents.
- Documentation, including any permits, licenses, or other regulatory requirements.
- Education and training on the signs and symptoms of exposure to hazardous materials and the appropriate treatment according to Safety Data Sheets (SDSs).

FMS.9. The center has a policy and procedure for the safe use of various types of compressed medical gases.

- FMS.9.1.** The medical gasses policy highlights the use of cylinder transporters.
- FMS.9.2.** The policy emphasizes secure storage of the cylinder(s) in well-ventilated areas.
- FMS.9.3.** The policy describes how to secure the cylinders by positioning them upright against a wall and securing it by either a chain or inside special containers.
- FMS.9.4.** The policy ensures the timely replacement of empty cylinders and the availability of a backup system.
- FMS.9.5.** Centers equipped with piped gas systems follow the regulatory body's testing and safety requirements.

Explanation

Compressed gas systems are a standard feature of most healthcare facilities, and they require special monitoring and maintenance to ensure their proper operation. Medical gas source equipment will vary depending on the type of gas and the size of the institution. Failing to properly monitor these complex pressurized systems can be costly, in terms of both increased use of consumables and damage to permanent equipment. Due to the nature of gas cylinders, special storage and handling precautions are necessary. The hazards associated with compressed gases include oxygen displacement, explosion, toxicity, and the physical hazards of a ruptured cylinder. The center must develop and implement a policy for handling, storing, transporting, and disposing of various types of compressed gasses. Centers equipped with piped gas systems should follow the regulatory body's testing and safety requirements.

References

ALBashtawy M, Alazzam M, Rawashda A, et al. Workplace violence toward emergency department staff in Jordanian hospitals: A cross sectional study. *J Nurs Res.* 2015 Mar;23(1):75–81. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/25668738/>

Agency for Healthcare Research and Quality. Health Care Facility Design Safety Risk Assessment Toolkit (2020). Accessed June 2022 from
<https://www.ahrq.gov/patient-safety/settings/hospital/resource/safety-assess.html>

Center for Health Design. Designing for Patient Safety: Developing Methods to Integrate Patient Safety Concerns in the Design Process. Joseph A, et al. 2012. Retrieved June 2022 from
https://www.healthdesign.org/sites/default/files/chd416_ahrqreport_final.pdf

National Fire Protection Association. Structure Fires in Health Care Facilities. Campbell R. 2017. Retrieved June 2022 from
<https://www.nfpa.org/-/media/Files/News-and-Research/Fire-statistics-and-reports/Building-and-life-safety/oshealthcarefacilities.pdf>

National Fire Protection Association (NFPA). Medical Gas Cylinder Storage, 2018. Retrieved June 2022 from
<https://www.nfpa.org/~/media/4B6B534171E04E369864672EBB319C4F.pdf>

Organization for Safety, Asepsis and Prevention (OSAP). Dental Unit Waterline Toolkit. Accessed June 2022 from
<https://www.osap.org/topics-dental-unit-waterlines-duwl>

Pankhurst CL, Scully C, Samaranayake L. Dental Unit Water Lines and their Disinfection and Management: A Review. *Dent Update.* 2017;44(4):284-5, 289-92. Retrieved June 2022 from
<https://pubmed.ncbi.nlm.nih.gov/29172350/>

Sarangi S, Babbar S, & Taneja D. Safety of the medical gas pipeline system. *Journal of Anaesthesiology Clinical Pharmacology,* 34(1), 99-102. Retrieved from
<http://www.joacp.org/text.asp?2018/34/1/99/227571>

Saunders LW, McCoy AP, Kleiner BM, et al. International benchmarking for performance improvement in construction safety and health. *Benchmarking: An International Journal.* 2016;23(4):916–936. Retrieved June 2022 from
<https://www.emerald.com/insight/content/doi/10.1108/BIJ-11-2013-0105/full/html>

Sharma R, Kumar A, Koushal V. Fire incidents in healthcare organizations: Readiness, response, and preparedness. *I J Sci Res.* 2019; 8(8): 40-41. Retrieved June 2022 from
[https://www.worldwidejournals.com/international-journal-of-scientific-research-\(IJSR\)/article/fire-incidents-in-healthcare-organizations-readiness-response-and-preparedness/MjA0MTk=/](https://www.worldwidejournals.com/international-journal-of-scientific-research-(IJSR)/article/fire-incidents-in-healthcare-organizations-readiness-response-and-preparedness/MjA0MTk=/)

The American Society for Health Care Engineering (ASHE). Critical features of emergency power generators. *Health Facil Manag.* 2015. Accessed June 2022 from
<http://www.hfmmagazine.com/articles/1712-critical-features-of-emergency-power-generators>

The American Society for Health Care Engineering (ASHE). Medical Gas Cylinder and Bulk Tank Storage. 2012. Accessed June 2022 from
http://www.ashe.org/compliance/ec_02_06_01/01/pdfs/mg2012mclaughlin.pdf

The International Society for Quality in Health Care (ISQua). Guidelines and Standards for

External Evaluation Organisations.
<https://www.isqua.org>

US Centers for Disease Control and Prevention. CDC Dental unit water quality (Mar 2022). Accessed June 2022 from
<https://www.cdc.gov/oralhealth/infectioncontrol/summary-infection-prevention-practices/dental-unit-water-quality.html>

World Health Organization. Management and Safe Use of Medical Devices. Accessed June 2022 from
<https://www.who.int/teams/health-product-policy-and-standards/assistive-and-medical-technology/medical-devices/management-use>

World Health Organization. Health-Care Waste. Feb 8, 2018. Accessed June 2022 from
<https://www.who.int/news-room/fact-sheets/detail/health-care-waste>

World Health Organization. (2014). Safe Management of Wastes from Health-Care Activities(2nd ed.). Retrieved June 2022 from
https://apps.who.int/iris/bitstream/handle/10665/85349/9789241548564_eng.pdf?sequence=1

Zakaria H, Abas H, Roslinda R, et al. A systematic literature review of security perimeter in hospital facility. Open International Journal of Informatics. 2018;6(4):104–129. Retrieved June 2022 from
<http://apps.razak.utm.my/ojs/index.php/oiji/article/view/68/49>

Glossary

Glossary

Access

A person's ability to get necessary medical care and services when needed. The ease of access is determined by components such as the availability of medical services and their acceptability to the individual and community, the locale of healthcare facilities, transportation, and the hours of operation.

Accountability

The ability of a system to track an individual's actions, or the acknowledgment and assumption of responsibility for actions, decisions, and policies.

Accreditation

A formal process by which a recognized body (accrediting body) assesses and recognizes that a healthcare organization meets applicable pre-determined standards.

Accident

An event or circumstance that could have resulted, or that did result, in unnecessary harm as a result of an unplanned deviation in system operation.

Action Plan

A list of actions that must be undertaken to implement a strategy. An action plan states what is to be done, who is to do it, and when it is to be completed.

Admission

A patient who has been physically placed in a bed. There are three types. Emergent: When there is an immediate threat to life or the function of a limb is endangered. Urgent: A prolonged delay might be injurious to the patient's health. Elective: When a patient's health will not be endangered by a delay in admission.

Adverse Drug Reaction

A response to a medicinal product that is noxious and unintended and that occurs at doses normally used in a human for the prophylaxis, diagnosis, or therapy of disease or the restoration, correction, or modification of a physiological function.

Appraisal

It is a process of performance formal assessment of employees over a specific period of time.

Auditing

An ongoing process of reviewing an organization, its processes, its projects, its products, its services, or the subsystem's performance and compliance with standards or expectations.

Authority

The power and right of a person to use and allocate resources efficiently, make decisions, and give orders to achieve the organizational objectives

Backup

The saving of files on magnetic tape or other offline mass storage media to prevent the loss of data in the event of equipment failure or destruction.

Benchmarking

A continuous process of measuring products, services, and/or practices against the competition to find and implement the best practices.

Best practice

A procedure that research and experience have shown to produce optimal results and that is established or proposed as a standard suitable for widespread adoption.

Clinical Practice Guidelines

Systematically developed statements that help practitioners and patients choose appropriate healthcare for specific clinical conditions.

Code of Conduct

A set of principles and expected behaviors that constitute the expectations of employee performance within a healthcare setting or as defined by the leadership group. How an organization ensures that all its decisions and actions conform to morals.

Competency

Possession of the required skills, attitudes, and knowledge to perform the job.

Committee

A multidisciplinary body of persons officially delegated to consider, investigate, act on or report on some matter or perform a specified function.

Complaint

A verbal/written statement by a patient/family/visitor explaining a problem and/or requesting a solution.

Confidentiality

Access to data and information only among individuals who have a need, a reason, and permission for such access. An individual's right to personal and informational privacy, including his/her healthcare records.

Consistency/Uniformity

Having control over a process, to repeat itself over time regardless of other factors that may introduce variability into the system.

Continuity of Care

The degree to which patient care is coordinated among practitioners and organizations and over time, without interruption, cessation, or unnecessary repetition of diagnosis or treatment.

Continuous Quality Improvement (CQI)

The culture, strategies, and methods are necessary for continual improvement in meeting and exceeding customer expectations. Patients and their families, staff, contractors, and visitors are all examples of an HCF's internal and external customers.

Continuous Quality Improvement Tools

Tools that focus on the process rather than the individual and promote the need to analyze and improve that process.

Corrective Maintenance

The repair of equipment/machinery to return it to its original operating condition.

Credentialing

The process of obtaining, verifying, and assessing a healthcare professional's qualifications to determine whether that individual can provide patient care services in or for a healthcare organization.

Critical Test

A stat test with critical values/results or other results that the laboratorian, radiologist, or other diagnostician has determined to be critical to the patient's subsequent treatment decisions.

Delegation of Authority

The division of authority and powers downwards to the subordinate.

Dosimeter

A device used to measure an individual's exposure to a hazardous environment, particularly when the hazard is cumulative over long intervals of time or one's lifetime.

Effectiveness

The degree to which care is provided, in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome for the patient.

Efficacy

The power to produce an effect, for example, clinical trials in medicine provide evidence of efficacy.

Equity

Fairness in the distribution of care and its effect on health.

Evaluation

The process of examining a subject and rating it based on its important features.

Evidence-Based Medicine

The practice of medicine or the use of healthcare interventions guided by or based on supportive scientific evidence.

External disaster

Any event in which there is a much larger demand for services than the usual load required.

Failure Mood Effect Analysis (FMEA)

A systematic method of identifying and preventing process problems before they occur through mitigation risk by determining what is likely to go wrong, the probability of it going wrong, and the severity if it does go wrong and then acting against it.

Formulary

An approved list of medications and associated information related to medication use. The list is subject to periodic review and modification.

Governance

The function of determining the organization's direction, setting objectives, and developing policy to guide the organization in achieving its mission.

Governing Body

In healthcare, it represents the individual(s), group, or agency with ultimate authority, responsibility, and accountability for the overall strategic direction, methods of operation (management and planning), the establishment of policies, and maintenance of the safety and quality of care that the facility provides.

Guidelines

Principles guiding or directing actions.

Harm

An unexpected or normally avoidable outcome that negatively affects a patient's health and/or quality of life and that occurs or has occurred during the course of receiving healthcare or services.

Hazardous Materials

Substances, such as chemicals, that are dangerous to humans and other living organisms.

Hazardous Waste

Waste materials that are dangerous to humans and other living organisms. Such materials require special precautions for disposal.

Hazards

Situations with the potential to cause harm.

Healthcare-Associated Infections (HAIs)

Infections that patients acquire during the course of receiving treatment for other conditions or that healthcare workers acquire while performing their duties within a healthcare setting. Specific criteria must be met to define infection as healthcare-associated.

HEPA Filter

A type of air filter. "HEPA" is an acronym for a "high-efficiency particulate air" filter.

High-Alert Medications

Medications that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these medications, the consequences of an error with these medications are clearly more devastating to patients.

Immunization

The process by which an individual's immune system becomes fortified against an agent (known as the immunogen).

Incidents

Events that are unusual or unexpected, may have an element of risk or may have a negative effect on patients, staff, or the healthcare facility.

Indicator

An observation expected to measure a certain aspect of performance. It is a quantitative measure that can be used to assess and improve the performance of important administration, clinical and supportive functions that affect patient outcomes.

Indicator of Performance

A measurement tool used as a guide to monitor, evaluate, and improve the quality of patient care and service.

Information Management

A term used to designate the manual or computer-based conveying of information throughout the department/organization, or the creation, use, sharing, and disposal of data or information across an organization. This practice is critical to the effective and efficient operation of organization activities.

Informed Consent

A person's voluntary agreement of one who has sufficient mental capacity with full knowledge of the risks involved, probable consequences, and alternatives to make an informed decision. It allows a patient to balance the probable risks against the probable benefits of any potential care.

Key Performance Indicators (KPIs)

Measures of performance that are central to success.

Leaders

The identified and designated individuals who have the responsibility of overseeing the effective functioning of processes within a defined scope of services and determining a correct path.

Licensure

A legal right granted or evidenced by documentation issued by SCFHS (such as a physician, nurse, psychiatrist, clinical social worker, or the operation of a health facility) in the form of a license, registration, or certification.

Manager

Someone who works with people and systems to produce predictable results and who does the correct things to stay on the path.

Medical Device

Any instrument, apparatus, machine, appliance, implant, reagent for in vitro use, software, material, or other similar or related articles that the manufacturer intends to be used, alone or in combination, for human beings for one or more specified medical purpose(s): diagnosis, prevention, monitoring, treatment or alleviation of disease, alleviation of or compensation for an injury, investigation, replacement, modification, support of the anatomy or a physiological process and the support or sustaining of life. Note: Products that may be considered medical devices in some jurisdictions but not in others include: disinfection substances, aids for persons with disabilities, devices incorporating animal and/or human tissues, devices for in-vitro fertilization, or assisted reproduction technologies.

Medical Equipment

Equipment used for the specific purposes of diagnosing and treating a disease or for rehabilitation following disease or injury. It can be used either alone or in combination with any accessory, consumable, or other pieces of medical equipment (e.g., EKG machines, diagnostic ultrasounds, surgical lights, patient beds, surgical tables, anesthesia machines, and defibrillators).

Dental Record

A record that contains patient health information generated by one or more encounters. Included in this information are patient demographics, assessment findings, problems, medications, diagnostic reports, provided education, and any other relevant patient-specific information.

Medication Error

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is under the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems including prescribing, order communication, product labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

Medication Management

The overall effort by facilities and manufacturers to reduce medication errors that can occur throughout the various stages of the medication use cycle: selection, procurement, prescription, transcription, dispensing, distribution, administration, and monitoring.

Mission Statement

A written expression that states the purpose of an organization or one of its components.

Monitoring

A planned, systemic, ongoing process to gather, organize, and review data/information on a regular basis with the purpose of identifying changes in a situation.

Near-Miss

An event or situation that could have resulted in an adverse event that caused patient harm but that did not, either by chance or through timely intervention.

Organization Structure

The style in which resources are assigned to tasks.

Organizational Chart

A diagram representing the structure of the facility and reporting relationships. It shows employee positions, reporting relationships, and lines of authority.

Orientation

The introductory process by which staff become familiar with all aspects of the work environment and their responsibilities.

Outcome

A broad term used to describe the end result of service, practice, procedure, or intervention.

Patient Assessment

The gathering of information to evaluate a person's health and healthcare needs.

Patient Complaint Process

The defined process describing the roles/responsibilities and time frames for handling any patient complaint regarding the provision of his/her care.

Patient Safety

Freedom from accidental harm during the course of medical care; activities to avoid, prevent, or correct adverse outcomes that may result from the delivery of healthcare.

Patient Satisfaction

A measurement that obtains reports or ratings from patients about services received from an organization, hospital, physician, or healthcare provider.

PDCA

A scientific method utilized to improve processes. Acronym components: Plan the improvement. Do the improvement. Check the results. Act to improve the process and hold gains. Also known as the Shewhart cycle or learning cycle of change.

Personnel File

Collection of information about a staff member, covering personnel issues such as licensure, certifications, leaves, appraisal reviews, and job description.

Plan

To formulate or describe the approach to achieving goals related to improving the organization's performance.

Plan of Care (Care Plan)

A treatment plan especially designed for each patient, based on individual strengths and needs. The caregiver(s) develop(s) the plan with input from the family and communication with each other. The plan establishes goals and details appropriate treatment and services to meet the patient's special needs. Planning is an interdisciplinary process.

Policy

A written document that outlines the law, rule, regulation, or set of guidelines that drives the processes or procedures. Policies are dynamic and reflect current knowledge and practices and must be reviewed regularly.

Periodic Preventive Maintenance

Performing tasks based on a historical pattern of breakdown, or techniques that help determine the condition of in-service equipment to predict when maintenance should be performed. Completing routine tasks at set intervals to prolong the life of the equipment. The scheduling of planned maintenance actions aimed at preventing breakdowns and failures.

Privileging

The process of reviewing an individual's credentials through a 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.

Probationary Period

The time period that the organization identifies for determining whether the employee is competent to perform his/her duties and continue employment with the organization. Generally, the time period for probation is three months.

Procedure

A written set of instructions that describes the approved and recommended steps for a particular act or sequence of acts, or a specific, detailed series of actions that staff members must take to implement a process and comply with a policy.

Process

A high-level set of interrelated steps (procedure) that must be executed, outlining what must happen to ensure compliance with a policy.

Process Improvement

Mechanisms utilized to make improvements to a process through the use of continuous quality improvement methods.

Project

A temporary activity aimed at achieving specific/narrow organization objectives.

Program

Organizational activities aimed at achieving broader organizational objectives by coordinating a group of projects.

Protocols

A plan, or set of steps, to be followed in a study, an investigation, or an intervention.

Quality

The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) has adopted the following definition of quality “The extent to which processes, products, and services are free from constraints, waste, variation, and defects with stability around the optimum target, on a consistent basis even under stressful condition, to achieve customer’s trust and loyalty”.

Quality Control

A management process in which performance is measured against expectations and corrective actions are taken.

Quality Improvement Team

Individuals (cross-department functions/services) knowledgeable about a particular aspect of care or service and commissioned to improve a process that has been identified as requiring attention.

Recovery Room

A place to provide immediate close observation to a post-anesthesia patient.

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.

Risk

The combination of the assessment of the magnitude of an injury or potential injury, with the probability that certain actions/events will occur.

Root Cause

The ultimate reason for an event/condition.

Root Cause Analysis

A collective term used to describe a wide range of approaches, tools, and techniques used to uncover causes of problems.

Safe Care

The degree to which the risk of an intervention and the risk in the care environment are reduced for a patient and others, including the healthcare practitioners.

Safety Data Sheet (SDS)

A form containing data regarding a particular substance's properties. An important component of workplace safety, it is intended to provide workers and emergency personnel with procedures for handling or safely working with that substance and includes information such as physical data (melting point, boiling point, flash point, etc.), toxicity, health effects, first aid, reactivity, storage, disposal, protective equipment, and spill handling procedures. The exact format of an SDS can vary from source to source.

Scope of Practice

The range of activities that practitioners perform. The scope is determined by training, law or regulations.

Scope of Services

The range of activities provided to patients and/or other customers by the leadership, clinical, and support personnel. This describes the full range of services, the demographics (age groups, types of patients), the diagnostics provided, the therapeutic interventions provided, and the number of patients who receive each service annually. All the resource and competency requirements flow from the organization's scope of services.

Sedation

Minimal sedation: A medication-induced state during which patients respond normally to verbal commands. Moderate Sedation: A medication-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or after light tactile stimulation. Deep Sedation: A medication-induced depression of consciousness during which patients respond purposefully following repeated or painful stimulation.

Sentinel Event

An event that, when noted, requires intensive assessment and prompt response. An unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof, and any event that might cause embarrassment or risk to the healthcare organization, with potential legal ramifications and/or media inquiries or coverage. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "Sentinel" because they signal the need for immediate investigation and response.

Staff

A group of persons, as employees, charged with carrying out the work of an establishment, or executing some undertaking, e.g., independent practitioners (temporary, visiting, part-time) and volunteers.

Staffing Plan

The database document listing all HCF employees and positions. This also includes all other details pertaining to the HCF's manpower resources.

Stakeholders

Individuals and groups of people who have the ability to influence direction and success, either positively or negatively.

Standard

A statement of excellence, or an explicit predetermined expectation that defines the key functions, activities, processes, and structures required for healthcare facilities to assure the provision of safe and quality care services.

Strategic Planning

A management tool to help an organization do a better job. It is a disciplined effort to produce fundamental decisions and actions that shape what an organization is, what it does, and why it does it, with a focus on the future direction.

Strategy

The process that involves goal setting, the specific actions to achieve those goals, and the allocation of the resources to execute the actions.

Surveys

Methods by which an organization can measure customer satisfaction and obtain feedback on written materials and oral presentations.

Terms of Reference

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

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. Temporary Transfer: This shifting will be for a short period of time, usually for the duration of the care to be provided by the entity receiving the temporary transfer. Permanent Transfer: The permanent shifting of responsibility to another institution or unit constitutes a discharge situation from either the unit or organization.

Transport

The movement of an individual from one place to another using a transport aid or vehicle, either motorized or manual (wheelchair, trolley, bed).

Values

The beliefs and philosophy of an organization establish the basis for the operation and provide guidelines for daily behavior.

Vision

A description of what the organization would like to be or reach in the future.

Waste

Anything other than the minimum amount of equipment, materials, parts, space, and worker's time that are essential for adding value to the product/service, or any activity that does not contribute to the operation.

About This Manual

This first edition of the National Standards for Dental Centers was developed through a consensus process which entailed the participation of all the relevant stakeholders.

From the beginning, the aim was to have a set of standards that are detailed and descriptive, assembled around the key elements of Dental Centers, based on the current best healthcare practices.

The goal of this manual is to be used as a reference for achieving the optimal care for patients and their families, given the national challenges that we are facing today.

About CBAHI

The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) is a non-profit organization emerging from the Saudi Health Council and is responsible for setting and assessing the quality and patient safety standards in Saudi Arabia.

CBAHI began a few years ago with only a few hospitals enrolled in the accreditation process and a limited number of surveyors and staff.

Today, CBAHI is proud to have a comprehensive set of evidence-based standards that are utilized for the assessment of thousands of healthcare facilities across the country.

ص.ب: 9264، الرياض 12264، هي المروج، الرياض، المملكة العربية السعودية

P.O.Box 9264, Riyadh, 12264, Kingdom of Saudi Arabia

📞 920012512

✉ cbahi@cbahi.gov.sa

www.cbahi.gov.sa

