مستشفى الإمام عبدالرحمن الفيصل
Imam Abdulrahman Alfaisal Hospital
Empowered by Riyadh First Health Cluster

IMAM ABDULRAHMAN AL FAISAL HOSPITAL BY-LAWS		
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1. INTRODUCTION

1.1. Imam Abdulrahman Al Faisal Hospital (IAFH) is a secondary healthcare facility operating under the Self-Operating Program and managed by the Riyadh First Health Cluster. The hospital's leadership and staff are committed to providing high-quality, safe, and advanced healthcare services to all patients. Recognizing the essential role of the Medical Staff (MS) in the hospital's overall decision-making and their dedication to prioritizing patient welfare above all else, the hospital leadership has developed a comprehensive set of rules and regulations to guide medical practice. These guidelines have been reviewed and approved by the governing body.

1.2. The IAFH Medical Staff By-Laws define the hierarchical structure, chain of command, and reporting relationships within the medical services. They describe the various departments, hospital-wide committees, and organizational linkages, serving as the governing framework for the organization, functions, and responsibilities of the medical staff.

1.3. This document outlines the integration and collaboration of medical services, defines the accountability and privileges of Medical Staff (MS) members, and details their ranks, qualifications, appointments, credentialing, privileges, and disciplinary procedures. It is also consistent with acceptable medical staff practices and laws and regulations.

1.4. IAFH Medical Staff By-Laws serves as a key reference for medical practice at IAFH and forms an integral part of the Staff Orientation Program. It aligns with the hospital's approved processes and supports the delivery of high-quality, safe patient care while contributing to the fulfillment of IAFH's mission and vision.

1.5. The Medical Staff By-laws define the accepted standards of patient care and professional conduct, covering admission, referral, transfer, and discharge procedures; medical record documentation; expected care practices such as daily rounds; and ethical and professional behavior of all medical staff members.

1.6. IAFH medical director and heads of medical departments shall ensure the medical staff by-laws are made accessible and communicated to all members of the medical staff, and enforce the medical staff by-laws along with relevant rules and regulations.

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2. OBJECTIVES

2.1. To define the functions of the medical staff and the rules and regulations that govern the medical practice in the hospital.

2.2. To regulate peer evaluation and review of the credentials and performance of the medical staff members.

2.3. To define the regulations pertaining to granting, suspension, and renewal of clinical privileges.

2.4. To ensure that patients are treated in the hospital in a uniform, equitable, and ethical manner.

2.5. To describe lines of authority, methods of delegating responsibility, and accountability of all medical departments, units, divisions, and committees.

2.6. To promote professional standards among medical staff members and delineate disciplinary and corrective actions.

2.7. To provide a mechanism for ensuring control over the quality of medical care in the hospital while at all times ensuring that the well-being of patients takes precedence over all other matters.

2.8. To provide an organizational structure that allows ongoing review of patient care practiced and accounts for the quality and appropriateness of services rendered by all medical staff members. To provide a method whereby the medical staff participates in the overall decision-making processes of the hospital.

3. DEFINITION

3.1. **Adverse Action**. An action that affects an individual's Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights, except as provided in these By-laws. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

3.2. **Allied Health Professional (AHP).** An individual, other than those defined under "Practitioner", who provides direct care services in the hospital under a defined degree or supervision, exercising AHPs are designated by the Board to be credentialed through the Medical staff system and are granted judgment within the areas of documented professional competence and consistent with applicable law. Allied Health Professionals (AHP) include various staff categories such as respiratory therapists, pharmacists,

physiotherapists, occupational therapists, laboratory technicians, radiology technicians, operating room technicians, anesthesia technicians, patient care technicians, midwives, and others.

3.3. **Board Certification**. A designation for a physician who has completed an approved educational training program and an evaluation process, including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in that specialty. Board Certification could be national or international.

3.4. **Clinical Departments**. Refer to those departments in medical services that are directly involved in patient care, education, and research.

3.5. **Clinical Privileges.** Refers to the specific professional, diagnostic, therapeutic, medical, surgical, or admitting privileges granted to a physician, dentist, or other professional persons by the Governing Body, as represented by the Chairman of Credential and Privileging Committee, based on the regulations of the Riyadh First Health Cluster and the Ministry of Health.

3.6. **Dentist.** Refers to a currently licensed general dentist, specialist dentist, or oral surgeon.

3.7. **Head of Department.** This refers to the individual designated to oversee and take responsibility for managing the operations of a duly recognized Medical Services Department.

3.8. **Hospital Leaders**. The senior executives of the hospital comprise the Hospital Director, Medical Director, Director of Nursing, and the Quality and Patient Safety Director.

3.9. **Locum Tenens**. Refers to one temporarily taking the place of another, filling a position or office for a short period of time.

3.10. **Medical Staff**. Refers to all physicians, dentists, and ancillary clinical providers who have been granted privileges by the Governing Body to diagnose and or treat patients in Imam Abdulrahman Al Faisal Hospital (IAFH).

3.11. **Medical Staff Membership Status.** Refers to all matters relating to medical staff member appointments or any subsequent re-appointment to the medical staff.

3.12. Most Responsible Physician (MRP) or Most Responsible Dentist. Refers to a physician or dentist who is primarily responsible for the management of a patient and who has been granted privileges to practice independently in the hospital or ambulatory healthcare centres.

3.13. Performance Evaluation. A method of identifying professional practice trends that impact on the quality of care rendered and patient safety, using the routine monitoring and evaluation of clinical competency and performance for medical staff, nurses, and allied health professionals.

3.14. Physician. Refers to a currently licensed doctor of medicine and/or surgery.

3.15. Policy & Procedures. Refers to administrative and operational guidelines, objectives, plans, values, principles, and practices established by IAFH with respect to facilities and operations.

4. HOSPITAL MISSION, VISION, VALUES

4.1. Mission: "*Deliver an innovative and sustainable model of care for better quality of life, for all.*"

4.2. Vision: "*Advancing care to elevate health and wellbeing for all*."

4.3. Values:

4.3.1. Deliver with **C**ompassion

4.3.2. Passion for **E**xcellence

4.3.3. Lead with **I**nnovation

4.3.4. Empower with **T**rust

4.3.5. Act as **O**ne

5. SCOPE OF SERVICE AND CARE

5.1. General Profile

5.1.1. Imam Abdulrahman Al Faisal Hospital is a secondary healthcare facility operating under the Self-Operating Program and managed by the Riyadh First Health Cluster, located in the South of Riyadh City, the capital of the Kingdom of Saudi Arabia, in an area with an overcrowded population. The hospital officially opened on 03/12/1433H (corresponding to October 19, 2012) and currently has a capacity of 200 beds. IAFH serves the population living in the nearby areas. The hospital operates under a special legal and ethical environment determined by MOH rules and regulations, and follows

Islamic Laws and Culture, which is a characteristic feature of the country. Different categories and types of medical and non-medical staff are working in the hospital, including seven different nationalities (Arab and non-Arab, Muslims and non-Muslims). These medical practitioners comply with the rules and regulations of the Saudi Commission for Health Specialties and the Ministry of Health by undergoing advanced courses outside the hospital, i.e., BLS, ACLS, and ATLS.

5.2. Hospital Profile "Scope of Services for the Provision of Care"

5.2.1. The hospital is a secondary care hospital that offers various medical services. There are three main sections in the hospital, which are the OPD, Inpatient Department, and Emergency Department.

5.2.2. The following department provides the services:

5.2.2.1. Medical departments, including the following specialties:

5.2.2.1.1. Internal medicine

5.2.2.1.2. Nephrology

5.2.2.1.3. Cardiology

5.2.2.1.4. Pulmonology

5.2.2.1.5. Neurology

5.2.2.1.6. Psychiatry

5.2.2.1.7. Dermatology

5.2.2.1.8. GIT Endoscopy

5.2.2.1.9. Hematology

5.2.2.1.10. Endocrinology

5.2.2.1.11. Pediatrics

5.2.2.2. Surgical departments include the following specialties:

5.2.2.2.1. General Surgery

5.2.2.2.2. Urology

5.2.2.2.3. Orthopedics

5.2.2.2.4. ENT

5.2.2.2.5. Neurosurgery

5.2.2.2.6. Dental.

5.2.2.2.7. Maxillofacial Surgery

5.2.2.2.8. Pediatric Surgery

5.2.2.2.9. Obstetrics and Gynecology Department

5.2.2.2.10. Anesthesia Department

5.2.2.2.11. Operating Room

5.2.2.2.12. AICU/PICU/NICU

5.2.2.3. Supporting services departments, include:

5.2.2.3.1. Laboratory and Blood Bank.

5.2.2.3.2. Radiology Department.

5.2.2.3.3. Pharmacy.

5.2.2.3.4. Physiotherapy.

5.2.2.3.5. Dietary Services.

5.2.2.3.6. Infection Control.

5.2.2.3.7. Quality and Patient Safety

5.2.2.3.8. BLS Centre

5.3. Major Diagnostic and Therapeutic Methods

5.3.1. General Surgery - Orthopedic Surgery - Urology Surgery - ENT Surgery.

5.3.2. Medical treatment for intimal disease, including cardiac, gastroenterology, chest diseases, nephrology - pediatric.

5.3.3. Obstetrics and Gynecology Department with all facilities for normal and operative delivery.

5.3.4. Laboratory Department, Radiology Department with CT, MRI, and other conventional radiology.

5.3.5. Adult Intensive Care, Neonatal Intensive Care, and Pediatric Intensive Care Units.

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5.4. Customers/Target Population

5.4.1. The hospital serves a wide area of populations living in the nearby areas. This increases the needs and demands for health services.

5.4.2. The services are provided to all patients in different age groups.

5.5. Average Number of Patients Seen

5.5.1. Outpatient Department:

5.5.1.1. The average number is 6688 patients per month.

5.5.2. Emergency Department

5.5.2.1. The average number is 10225 patients per month.

5.5.3. Inpatient Department

5.5.3.1. The range of inpatients is approximately 792 patients/month

5.6. Working Hours

5.6.1. OPD: working timing is from 0800H – 1630 H daily from Sunday to Thursday

5.6.2. Emergency Department: 24 hours, 7 Days.

5.6.3. Inpatient Departments: 24 hours, 7 Days.

5.6.4. The shift duty working hours are from:

5.6.4.1. 0700-1500 H

5.6.4.2. 1500 -2300 H; and

5.6.4.3. 2300 - 0700 H

5.6.5. Hospital administrative staff working hours are from 0800 - 1600H, from Sunday to Thursday.

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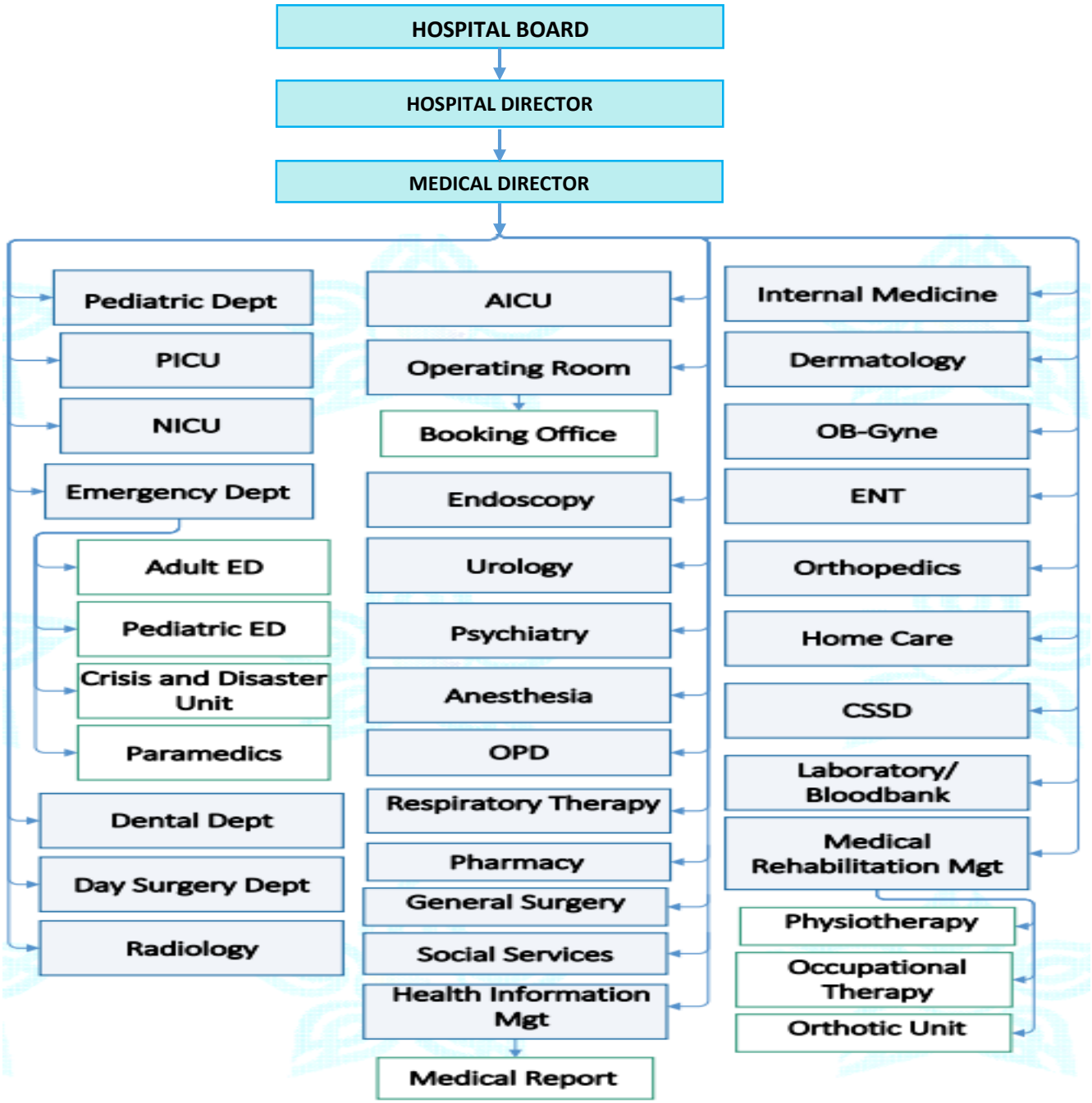
6. ORGANIZATIONAL CHART OF THE MEDICAL STAFF



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7. HOSPITAL BED CAPACITY

7.1. Hospital Bed Capacity: 200 beds distributed as follows:

Delivery Room	(LR/DR) / OB	22 Beds
Neonatal Intensive Care Unit	(NICU)	24 Beds
Pediatric Intensive Care Unit	(PICU)	06 Beds
Pediatric Ward	(PEDIA)	16 Beds
Intensive Care Unit 1	(ICU 1)	22 Beds
Intensive Care Unit 2	(ICU 2)	8 Beds
Step Down Unit	(SDU)	4 Beds
Surgery Ward 1	(S1)	30 Beds
Surgery Ward 2	(S2)	22 Beds
Medical Ward 1	(M1)	30 Beds
Medical Ward 2	(M2)	16 Beds

7.2. Other Allied Services:

7.2.1 Quality and Patient Safety Department

7.2.2 Academic Affairs (Skills and Training Center)

7.2.3 Information Technology

7.2.4 Health Information Management

7.2.5 Patient Experience

7.2.6 Home Health Care Providers for Home Care Services

7.2.7 Supply Chain Management

7.2.8 Radiology

7.2.9 Pharmacy

7.2.10 Laboratory

7.2.11 Infection Control, Occupational Health, Medical Waste, Environmental Health

7.2.12 Others (Medical Stores, Maintenance, Security, CSSD, Laundry, etc.)

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8. MEDICAL STAFF STRUCTURE

8.1. Membership: Medical Staff is licensed by SCFHS and contracted under the Ministry of Health (MOH) & R1

8.2. Medical Staff Categories

8.2.1. Medical Director

8.2.1.1. Statement of Purpose**:** Reports to the Hospital Director

Responsible for: Head of the Clinical Departments such as Pediatric, PICU, NICU, Emergency (Adult ED, Pediatric ED, Crisis and Disaster Unit, and Paramedics), Dental, Day Surgery, Radiology, AICU, Operating Room, Endoscopy, Urology, Psychiatry, Anesthesia, Outpatient, Respiratory Therapy, Pharmacy, General Surgery, Social Services, Health Information Management (Medical Report), Internal Medicine, Dermatology, OB-Gyne, ENT, Orthopedics, Home Care, CSSD, Laboratory and Bloodbank, and the Medical Rehabilitation Management (Physiotherapy, Occupational Therapy, and Orthotic)

8.2.1.2. Major Functions:

8.2.1.2.1. Basic Functions – Serves as Director of the Medical Services Department. Supervises, coordinates, and monitors the health care provided in all the clinical departments to promote efficient and effective delivery of quality health care. Provides direction and control to all department activities.

8.2.1.2.2. Scope – Responsible for the provision of out-patient, emergency, and in-patient care provided by the entire medical departments, paramedical services, bed management office, medical coordination, social workers, and special health program, and also accountable for clinical performance of the medical staff at IAFH. Administers resources of the department in a manner that emphasizes cost-effectiveness and authority over department personnel.

8.2.1.2.3. Principal Contacts – Regularly interacts with clinical department heads and staff, patients, as well as other department directors and personnel to ensure coordinated health care delivery.

8.2.1.2.4. Experience and Other Qualifications:

1. Graduate from an approved Medical School.
2. Possession of a license to practice medicine in Saudi Arabia.
3. Consultant in his specialty or equivalent, desirable if a higher qualification in his specialty with at least two years of experience in the practice of clinical medicine or practice as acceptable to his / her specialty after being a consultant.
4. Registration and accreditation from the Saudi Council.
5. Has a degree in Quality Management or more than two courses in Quality Management.
6. Excellent command of oral and written English to ensure effective communication with a multi-national workforce. Arabic is preferred.

8.2.2. Head of the Department

8.2.2.1. Statement of Purpose: Reports to the Medical Director

Responsible for: Consultants, Specialists, and Residents

8.2.2.2. Major Functions:

8.2.2.2.1. Serves as the Head of the Department/Unit. Supervises, coordinates, and monitors the health care provided by the staff in the department/unit to promote efficient and effective delivery of quality health care. Provides and controls all activities.

8.2.2.2.2. Responsible for providing efficient healthcare services and maintaining a high level of professional performance in accordance with

1. Professional Medical Ethics
2. Hospital Medical By-laws
3. Laws of the Ministry of Health in the Kingdom of Saudi Arabia and any other applicable regulations according to the departmental quality plan.
4. Responsible for administrative supervision and regulations within the department in accordance with the hospital policies and procedures. Provide effective leadership of the

department/unit. Maintain an appropriate quality plan using measurable performance improvement standards.

5. The head of the department shall have the authority to:
    a. To request a consultation on any patient under the care of a department member.
    b. To appoint a chairperson and members to all committees of the department.
    c. To be a voting member of the Medical Executive Committee, in accordance with the Medical Staff By-laws
    d. To recommend appointments and hold accountable heads of the department, who shall also have a Saudi Board specialist's qualification or equivalent, and to whom he may delegate medical care and administrative matters and responsibilities.
    e. Responsible to the Hospital Director and Medical Director for ensuring the quality of medical care, treatment, and services provided to patients, subject to the authority and approval of the Hospital Director.
    f. Exercise such power as is reasonably necessary to discharge its responsibilities under these by-laws and under the rules and regulations of the hospital, including, without limitation, the authority to formulate and recommend.
    g. Professional education requirements. Clinical coverage requirements (including ED and on-call coverage).
    h. Teaching responsibilities.
    i. Committee assignments.
    j. Department and unit rules and regulations.
    k. Criteria for the granting of medical staff appointment and clinical privileges.
    l. Attendance requirements.
    m. Office location.
    n. Residence and response time requirements.

o. The authority to use outside consultants when performing peer review activities after the approval of the Hospital Director

8.2.2.3. Qualifications:

8.2.2.3.1. Registration in the Saudi Medical Council and/or Current license to practice medicine in Saudi Arabia as a Consultant.

8.2.2.3.2. Priority for Saudi Doctor

8.2.2.3.3. Minimum of three (3) years' post-degree experience.

8.2.2.3.4. A current, valid license to practice medicine in the area of his specialty. Three (3) years' experience in a similar position.

8.2.2.3.5. Previous administrative experience.

8.2.2.3.6. Demonstrates leadership and administrative skills.

8.2.2.3.7. Fluent in verbal and written English.

8.2.3. Consultant

8.2.3.1. Statement of Purpose**:** Reports to the Head of the Department

Responsible for: Specialists and Residents

8.2.3.2. Major Functions**:** Consultant is responsible for providing the care of his/her patients, maintaining a high level of professional performance in accordance with professional, medical ethics, hospital medical by law, law of MOH in KSA, respecting the Islamic rules and any other applicable regulations according to the Department Quality Plan. Collaborates with the Head of the Department in the planning, organization, coordination, implementation, and evaluation of the hospital policies and procedures. Functions in all departments of the hospital as necessary. Practices within the limits of the profession and Hospital policies and procedures, adheres to department standards, understands the legal implications, and is accountable for his/her actions.

8.2.3.3. Qualifications:

8.2.3.3.1. Saudi Board or equivalent degree from a recognized medical institute.

8.2.3.3.2. Minimum of 3 years' experience in a recognized hospital after qualifications.

8.2.3.3.3. Registration and accreditation from the Saudi Council as a consultant.

8.2.3.3.4. Fluent in verbal and written English.

8.2.4. Specialist

8.2.4.1. Statement of Purpose**:** Reports to the Consultants/Head of the Department

Responsible for: Residents

8.2.4.2. Major Functions**:** The specialist is responsible for providing the care of his/her patients, maintaining a high level of professional performance in accordance with professional, medical ethics, hospital medical by law, law of MOH in KSA, respecting the Islamic rules and any other applicable regulations. Collaborates with the Head of the department & consultant in the planning, organization, coordination, implementation, and evaluation of the hospital policies and procedures. Functions in all departments of the hospital as necessary. Practices within the limits of the profession and hospital policies and procedures adhere to department standards, understands the legal implications, and is accountable for his/her actions. He can carry out the work as a consultant in case of need (acting consultant) if this privilege is given to him by the medical director.

8.2.4.3. Qualifications:

8.2.4.3.1. Saudi Board or Equivalent

8.2.4.3.2. MSc or Diploma (2 years) in the specialty with at least 2 years' experience in a recognized hospital

8.2.4.3.3. Registration and Accreditation Certificates from the Saudi Commission for Health Specialties.

8.2.5. Residents

8.2.5.1. Statement of Purpose**:** Reports to the Specialists/ Consultants/ Head of the Department

8.2.5.2. Major Functions: Resident is responsible for providing the care of his/her patients, maintaining a high level of professional performance in accordance with professional, medical ethics, hospital

medical by law, law of MOH in KSA, respecting the Islamic rules and any other applicable regulations.

8.2.5.3. Qualifications:

8.2.5.3.1. Bachelor of Medicine from a recognized university

8.2.5.3.2. Saudi Council Certification

8.2.6. Locum Tenens**:** -Clinicians who are employed for a limited period and who practice within the scope of delineated privileges. Major functions and qualifications are specified according to the post.

8.2.7. Part-Time Physician: - Clinicians who are employed in this type of contract are renewed every 3 months, and most of them are on continuous duty without any gap.

8.2.8. Full-time Physician: -Physicians who have completed and passed the trial period, the first three months of the contract.

8.3. General Qualifications (Only Physicians And Dentists):

8.3.1. Adequate experience, education, and training,

8.3.2. Current licensure (Saudi Commission for Health Specialties),

8.3.3. Curriculum vitae, continuing medical education meeting the licensure requirements,

8.3.4. Current professional competence, good judgment, character

8.3.5. Adequate physical and mental health status

8.3.6. Training in Life Support (BLS/ACLS/PALS/ATLS/ALSO) according to specialty

8.3.7. The ability to perform the clinical privileges requested, so as to demonstrate to the satisfaction of the Hospital that they are professionally competent and that patients treated by them can reasonably expect quality medical care; and are determined

8.3.8. To adhere to the ethics of their respective professions,

8.3.9. To be able to work cooperatively with others so as not to adversely affect patient care or disrupt Hospital operations

8.3.10. To be willing to participate in and properly discharge those responsibilities determined by the Hospital

8.3.11. To have read and agreed to abide by these by-laws and the policies and procedures of the medical staff

8.3.12. All members of the medical staff shall maintain active professional practice and provide evidence of continuous professional liability insurance from an acceptable insurance company and at not less than the minimum amount, if any, as requested by the Saudi Commission for Health Specialties.

9. ACCOUNTABILITY AND RESPONSIBILITY

9.1. Accountability: The Medical Executive Committee of the hospital maintains the corporate responsibility for the quality of medical care as defined by Medical Staff By-laws. In exercising this responsibility, the Medical Executive Committee delegates the fulfillment of the medical staff's purpose and functions to medical staff officers and holds them accountable.

9.2. Responsibility of The Medical Staff

9.2.1. General Responsibilities

9.2.1.1. Review and evaluate the quality of patient care provided through valid and reliable patient care evaluation procedures.

9.2.1.2. Participates in planning and implementation of integrated multi-disciplinary medical care programs.

9.2.1.3. Establish a mechanism that allows ongoing monitoring of patient care practices.

9.2.1.4. Participate in hospital-wide and departmental continuing education programs based on educational and training needs assessment.

9.2.1.5. Provide a framework for cooperation with other community health facilities and/or educational institutions.

9.2.1.6. Show compliance with laws and regulations governing the privacy and confidentiality of data and information.

9.2.1.7. Show compliance with standards of ethical conduct.

9.2.1.8. Participate in the implementation of National (CBAHI) and International (JCI) Accreditation Standards for Hospitals

9.2.2. Specific Responsibilities

9.2.2.1. Medical Director: - Is generally appointed by the Hospital Director or the Directorate of the Riyadh First Health Cluster, upon the Hospital Director's recommendation, and is accountable for ensuring the quality of medical care within the hospital. This role involves advising the Medical Executive Committee and the Hospital Director on medical services and overseeing the execution of all medical staff functions as outlined in the Medical Bylaws. Responsibilities include:

9.2.2.1.1. To ensure that an appropriate system for the ongoing review and analysis of care provided by all the physicians is effective, be aware of the results of all review activities and ensure that corrective actions are taken.

9.2.2.1.2. To regularly report to the hospital director and the medical board regarding such matters.

9.2.2.1.3. To call, preside at, and be responsible for the agenda of all general meetings of the medical staff.

9.2.2.1.4. Is responsible and accountable for the clinical performance of the medical staff, the quality of care they provide, as well as their professional conduct.

9.2.2.1.5. Recommends to the hospital director the appointment of the heads of clinical departments.

9.2.2.1.6. To represent the views, policies, and needs of the medical staff committees.

10. APPOINTMENT OF THE MEDICAL STAFF

10.1. Procedures for processing of Medical Staff Application for Appointment:

10.1.1. Inside the Kingdom of Saudi Arabia

10.1.1.1. Any physician or dentist applying for a job as a medical staff member shall complete a written application including the following:

10.1.1.1.1. Professional qualifications of the applicant.

10.1.1.1.2. His/her past practice and hospital staff affiliations.

10.1.1.1.3. Clinical privileges desired.

10.1.1.1.4. Personal and Professional references.

10.1.1.1.5. An interview and verification of the paper will be done by the recruitment committee.

10.1.1.1.6. In case of acceptance, will submit recommendations to the hospital director.

10.1.1.1.7. If the hospital director agrees, an appointment letter will be issued to the physician, and he has to fill out all of the required information and complete his personal file.

10.1.1.1.8. A complete set of appointment letters will be sent to the general directorate for final approval and registration.

10.1.1.1.9. Once approved, the staff member will sign a statement that he/she has received and read a copy of the Medical Staff By-laws, and agrees to read them and be bound by the terms therein. A copy of this signed statement will be kept in the medical staff personnel file.

10.2. Probationary period: Medical Staff members shall be subjected to a probationary period of ninety (90) consecutive days. The position will be reviewed and documented by the head of the department and sent to the Medical Director, after the results of the performance appraisal conducted during this period, for final disposition. The applicant staff member will be notified in writing in case the job position is revoked.

10.3. Duration of appointment: Appointment and re-appointment to the medical staff shall be for a period of one year, based on the contract renewal, unless otherwise specified.

10.4. The re-appointment and rehire process

10.4.1. Each re-appointment/rehire of a medical staff member will be processed as follows:

10.4.1.1. Annually, ninety (90) consecutive days prior to the expiration of the member's current appointment.

10.4.1.2. The Physician's Evaluation form will be forwarded to the department for completion by the head of the department regarding the individual's performance, and his/her recommendation regarding re-appointment and clinical privileges.

10.4.1.3. The medical director will review the report and, based on the evaluation, make a recommendation regarding further employment.

10.4.1.4. Annual evaluation of department heads will be coordinated by the Hospital Director through the Medical Director.

10.5. Retirement: Retirement shall be considered mandatory at the age of 60, but may be extended in certain circumstances at the discretion of the Hospital Director.

10.6. Guidelines for appointment of Department Heads

10.6.1. Medical Director appoints or recommends the appointment of department heads to the hospital director.

10.6.2. There are certain guidelines for the appointment of department heads, which include:

10.6.2.1. The head of department should be a consultant with 5 years' experience or a specialist with 10 years' experience in his/her specialty in a recognized hospital.

10.6.2.2. He / She has a Saudi Board, equivalent, or higher qualifications in his/her specialty, if any.

10.6.2.3. He / She has a Registration and Accreditation in the Saudi Medical Council.

10.6.2.4. He / She has a certificate of BLS and ACLS / PALS / NRP/ ATLS as required by his/her department.

10.6.2.5. Ability to evaluate, monitor, assess, and implement changes and re-evaluate the changes to improve the quality of patient care provided by the department.

10.6.2.6. Demonstrates administrative and leadership skills and experience, if any.

10.6.2.7. Fluent in verbal and written English.

10.6.2.8. Exhibits professionalism and excellent communication skills.

10.6.2.9. His / Her annual evaluation for the last 2-3 years shows a good standing manner.

10.6.2.10. Knowledgeable of the Medical By-law.

10.6.2.11. Ability to manage Educational programs.

10.6.2.12. Knowledgeable in computer applications.

10.6.2.13. The head of departments must have their appointment letter in his/her personnel file.

10.6.2.14. He / She must receive the job description (as Head of the Department and as Consultant or specialist) from the Medical Director.

10.7. Verification of Medical Staff Credentials

10.7.1. Verification of Application: Verification by the original source of a specific credential to determine the accuracy of the qualification reported by an individual health care practitioner. Examples of Primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and Data Flow Verification (Saudi Commission of Health Specialties), and reports from university database and credential verification organizations.

10.7.2. Each Application Form for appointment for medical staff membership and privileges shall be filled out and submitted to the Human Resource Department.

10.7.3. If there is any information that the applicant fails to provide, he/she will be advised to correct the deficiency within 90 days or shall be deemed to voluntarily withdraw his / her application.

10.7.4. Information regarding the applicant's qualifications, professional training, and experience, current licensure/registration, or registration in the Saudi Commission for Health Specialties shall be forwarded to the Credentialing and Privileging Coordinator.

10.7.5. Upon completion of the collection and verification procedure, personnel shall submit the application forms and supporting documents to the Credentialing and Privileging Committee for final approval before being considered by the Hospital Director.

10.8. Promotion of the Medical Staff

10.8.1. Promotion of the medical staff will take the following steps:

10.8.1.1. The physician should write the request to the medical director through his/her head of the unit (if any) and head of the department with his or her complete CV, certificates, Saudi Council registration, and current license.

10.8.1.2. The Medical Director will add the request to the agenda of the credentialing and privileging committee.

10.8.1.3. The secretary of the committee will present the physician’s complete file to the committee.

10.8.1.4. If the committee agrees on the promotion, a letter of promotion will be issued to the employee's affairs and the Saudi council as a recommendation letter to the applying physician in order to move forward with his promotion.

10.8.1.5. Appointment letter with the new post will be issued, and the physician will have the new privileges of the new post.

11. CLINICAL PRIVILEGING

11.1. Each member of the medical staff, by virtue of medical staff membership, shall, in performance of such practice, be entitled to exercise only clinical privileges specifically granted to him/ her. Such privileges shall be based on education, training, experience, demonstrated competence, references, and other relevant information, including an appraisal by the head of the clinical department in which privileges are to be granted.

11.2. The delineation of an individual's clinical privileges includes the limitation, if any, on an individual's privileges to admit and treat patients or direct the course of treatment for the conditions for which they are admitted. The physician is responsible for obtaining a consultation when necessary for patient safety or when required by hospital policy. Special consultation requirements may be made a condition of any assignment of privileges.

11.3. There must be evidence at the department level of continuing physician evaluation and/or departmental reviews to support the clinical privileges extended. The applicant may be required to submit any reasonable evidence of current ability to perform privileges that may be requested.

11.4. Types of Privileges

11.4.1. **Temporary (probationary) Privileges**: May be granted by the Medical Director (or designee) after consultation with the department head. Candidates for such privileges include visiting or working medical staff during or after the probationary period. Privileges granted shall not exceed a period of ninety (90) days, unless approved by the Hospital Director.

11.4.2. **Emergency Privilege**: - An emergency is hereby defined as a condition in which serious or permanent harm would result to a patient if medical treatment were not rendered immediately, or in which the life of a patient is in immediate danger. It is granted by the Medical Director/Hospital Director to a qualified physician with special skills useful during certain emergencies, which applies to a single occurrence / can be used for one time only once (per case).

11.5. Visiting / Locum / Part Time / Volunteer:

11.5.1. IAFH part-time contracts are renewed every 3 months, and most of them are in continuous duty without a gap. In such a case, after the completion of the temporary privilege period (90 days), permanent privilege will be granted according to the process mentioned in this policy.

11.5.2. If the gap between the end of the part-timer contract and its renewal is within the time period of permanent privilege and the part-time physician keeps the same credentials, the hospital will allow the practitioner to continue the same granted permanent privilege.

11.6. Monitoring of Clinical Privileges: It shall be the responsibility of both the medical director and the relevant department head to jointly monitor the implementation of, and adherence to, granted clinical privileges and be responsible and accountable to the hospital director.

11.7. Request for Modification of Privileges: Medical staff members have the right to request modification of their granted privileges. They must have the required privileges supported by documentation of appropriate training and experience. The staff member shall have the burden of establishing his/her qualifications and competency in the specific clinical privileges being requested.

11.8. To follow APP.IAFH.095 CREDENTIALING AND PRIVILEGING POLICY in requesting an update/modification of privileges.

12. MEDICAL STAFF DISCIPLINE

12.1. Disciplinary Procedure. Disciplinary actions will depend upon the nature and severity of the offense and the extent of any previous offenses.

12.2. Counseling/Verbal Warning. The employee involved shall be counseled by the employee's immediate supervisor, who should point out the nature of the employee's shortcomings and offer in advance how to correct these shortcomings.

12.3. Written Warning. This is used to document serious or repeated infractions of hospital or departmental rules, policies, and regulations. Written warning will be prepared in English and, when appropriate, in Arabic. When a written warning is issued, it must be discussed with the employee at the same time, and corrective action will be recommended by the employee's supervisor.

12.4. Content. A written warning must describe the nature and repetition of the offense(s) for which the employee is being accused. It also must present corrective actions as well as state the consequences for the repetition of the same offense

12.5. Acknowledgment of Warning. The employee will be required to acknowledge the written warning by signing one copy of the warning. If the employee refuses to sign, it must be signed by the department head of the employee in the presence of the employee and a witness. The witness will sign the warning to attest to the fact that it was presented to the employee.

12.6. Signatory Level. All written warnings must be signed by the employee's department head. A second written warning within the period of twelve months must be signed by the administrative director or his deputy.

12.7. Final Warning. Based on the severity of the offense, any warning may constitute a final warning. A final warning must clearly state that it is a "FINAL WARNING" and must be signed by the appropriate administrator. The final warning must state the consequence, if any, for repetition of the same offense.

12.8. Salary Deduction. Based on the severity of the offense, an employee may go on duty without pay. This sanction must be documented by a written warning, but it is not required prior to serving the sanction. Prior to any sanction, the employees' affairs must be notified.

12.9. No Allowance and Annual Salary Increase. Based on the severity of the offense, an employee may not receive her/his annual salary increase. This sanction must be documented by a written warning, but it is not required to serve the sanction. Prior to any sanction, the employees' affairs must be notified.

12.10. Termination of Employment. Should it become necessary to terminate the service of an employee, the approved policies for employment termination will apply.

12.11. Automatic Suspension. The following shall result in automatic suspension or revocation of staff membership and/or clinical privileges:

12.11.1. Whenever a medical staff member's license is revoked or suspended, staff membership and clinical privileges shall be immediately and automatically revoked or suspended.

12.11.2. Whenever a member of the medical staff is convicted of a felony with a penalty of imprisonment, the medical staff's membership and clinical privileges shall be automatically revoked.

12.11.3. All such automatic suspensions/revocations shall be subsequently reviewed by the medical director to determine whether additional corrective action is necessary.

12.11.4. Interview – When a corrective action is being considered, the affected staff member shall be given Special Notice and afforded an interview with the Hospital Director or Medical Director. He / She shall be informed of the specific nature of the allegations and may present information relevant to the issues. The medical staff member is obliged to sign a receipt of acknowledgment of any special notice issued by the administration. In case of reluctance, two witnesses will attest to his refusal.

12.11.5. Request for Hearing – A staff member may request, through his / her department head, a hearing by an Ad Hoc committee, if any of the following occur:

12.11.5.1. Denial of requested advancement in medical staff membership.

12.11.5.2. Downgrading to a lower medical staff category.

12.11.5.3. Suspension of medical staff membership

12.11.5.4. Exclusion from medical staff membership

12.11.5.5. Denial of requested privileges

12.11.5.6. Reduction of privileges

12.11.5.7. Suspension of privileges

12.11.5.8. Termination of privileges in the above-mentioned cases, the staff member shall have fourteen (14) consecutive days following the date of receipt of a notice to request a hearing. Failure to request a hearing within this period shall constitute a waiver of the medical staff's right to a hearing. The Medical Director shall then form an Ad Hoc Judicial Review Committee, which shall consist of five (5) members. None of the Committee Members shall have actively participated in the conflict under review.

12.12. Time and Place for Hearing: Within ten (10) consecutive days after receipt of the hearing request, the Ad Hoc Review Committee shall be scheduled, and notice of the time, place, and date of the hearing shall be given to the requester and committee members

12.13. Appeals: All the provisions of these by-laws concerned with hearings and appeals shall apply to the Physicians who are proposed for recall or removal. Hearings and appeals can be made to the Medical Board, whose decision shall be considered final when approved by the Hospital Director.

13. COMMITTEES

13.1. Appointment of standing committees shall be made by the Hospital Board. These Committees may be established to manage the internal administrative business of the Hospital and Medical Boards. All committees should have an appropriate representation of the Medical Staff. The membership of each committee, together with its full terms of reference, shall be incorporated in the permanent records of the Medical Board, and a copy shall be distributed to the members of the Committee.

13.2. The Hospital Board may also create sub-committees that report to the Standing Committees. All hospital committees shall report to the Hospital Executive Committee appointed by the hospital director. Administrative and logistic issues shall be the responsibility of the Committee Coordinator, who reports to the Hospital Executive Committee.

13.3. Committee Terms of Reference: Each standing or ad hoc committee shall have a charter or terms of reference that is approved by the Hospital Board. The terms of reference document shall include the reporting of the committee, main functions, responsibilities, the meeting venue, frequency, the quorum, the call to order, the attendance, and the periodic as well as the annual reporting.

13.4. Committee Meeting: Meetings shall be not less than 10 times per year or as required by the national and international standards. Meeting minutes shall be documented in the approved format, distributed to all members, and kept secure and confidential. Recommendations of committee meetings shall be followed, achievements recorded, and obstacles mentioned, if any.

13.5. Committee Policies: Policies developed by committees shall be consistent with the provisions of the By-laws and Rules and Regulations. Upon approval by the Hospital Board, Committee Policies shall be effective and binding on all members of the Staff.

13.6. Additional Authority of Committees: Committees shall exercise such additional authority as may be specifically provided by other provisions of these By-laws, Rules and Regulations, or as may be authorized by the Hospital Board.

13.7. Committees Objectives: The Following Standing Committees are hereby established for the purpose of:

13.7.1. Evaluating and improving the quality of health care rendered.

13.7.2. Reducing morbidity or mortality from any cause or condition.

13.7.3. Establishing and enforcing guidelines designed to keep the cost of health care within reasonable bounds.

13.7.4. Reviewing the professional qualifications or activities of the Medical Staff and Affiliated Health Care Professionals or applicants for admission.

13.7.5. Reporting variances to accepted standards of clinical performance by, and in some cases to, individual practitioners.

13.7.6. For such additional purposes as may be set forth in the charges to each committee

13.8. LIST OF IAFH COMMITTEES

13.8.1. There are 24 standing committees in the hospital. Another committee or team can be organized according to the hospital's needs.

SN:	COMMITTEE NAME	COMMITTEE NUMBER
1.	Hospital Executive Committee	**02**
2.	Antimicrobial Stewardship Committee	**03**
3.	Quality& Patient Safety Committee	**04**
4.	OR Committee	**05**

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SN:	COMMITTEE NAME	COMMITTEE NUMBER
5.	Medical Executive Committee	**06**
6.	Cardio Pulmonary Resuscitation Committee	**07**
7.	Infection Prevention & Control Committee	**08**
8.	Hospital Safety Committee	**09**
9.	Credentialing, Privileging, and Promotion Committee	**10**
10.	Pharmacy& Therapeutics Committee	**11**
11.	Patient and Family Rights and Education Committee	**12**
12.	Violence and Abuse Protection Committee	**13**
13.	Utilization Management Committee	**14**
14.	Mortality and Morbidity Committee	**15**
15.	Blood Utilization/Tissue Review Committee	**16**
16.	Medical Record Review Committee	**17**
17.	Breastfeeding Support Committee	**18**
18.	Clinical Audit Physician productivity Review committee	**19**
19.	Occupational Health Committee	**20**
20.	Venous Thromboembolism Prevention Committee	**21**
21.	Consultative Council for Patients and their Families	**22**
22.	Research Committee	**23**
23.	CLABSI Committee	**24**

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SN:	COMMITTEE NAME	COMMITTEE NUMBER
24.	Nursing Executive Committee	**25**

13.9. AD HOC: Exist to accomplish a specific task and then cease to exist (e.g., Plans and supports audit of major functions, e.g., finance, programs, or organization).

13.10. Task Force: A small number of defined experts who cooperate together to achieve a timeline, specific task, goal, or perform definite tasks (e.g., implementation and advisory) under clear boundaries to benefit from their diverse skills and based on mutual accountability. Reports its findings to a large committee or department(s). Task force discussions and findings are made available to the mother committee/ department.

13.11. Accreditation Team: The accreditation team is an interdisciplinary team involving all levels of staff; care providers, support services, and management, others can be invited (i.e., Patient or family member). The main role for these teams is the preparation for the Survey (Documentation and training), which is overseen and supported by a Steering committee, which meets monthly. The Accreditation Team consists of:

13.11.1. Core Team Leader

13.11.2. Chapter File Holder

13.11.3. Coordinators

13.12. Meetings of the Medical Staff. The meetings of the Medical Staff may be called by:

13.12.1. The Hospital Executive Committee

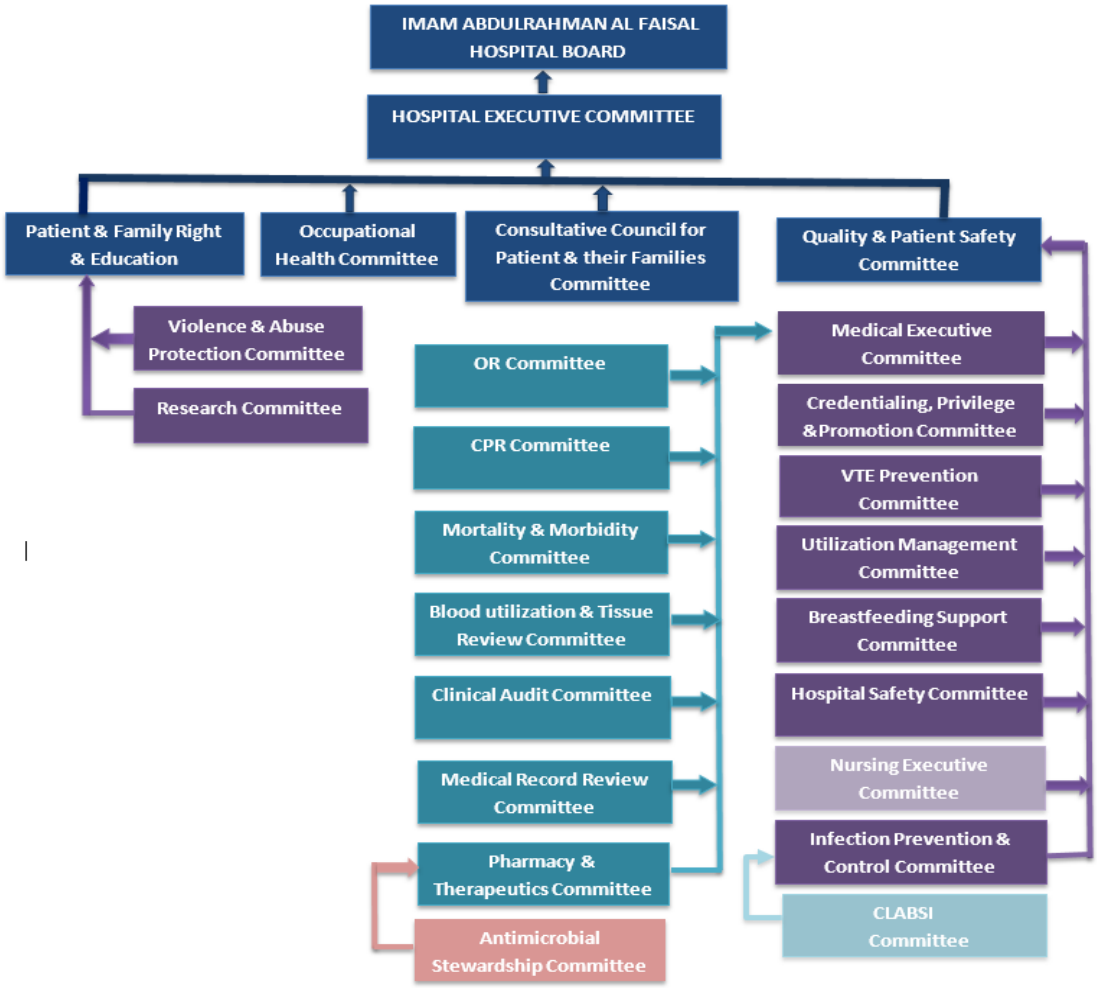
13.12.2. The Medical Director.

13.13. Regular Departmental Meetings. Each clinical department in the Hospital shall schedule and hold departmental meetings on a monthly basis as may be required to maintain an adequate review of the medical practice, medical records, mortality and morbidity case reviews, and other issues related to

patient care and staff affairs. Members of the Staff must adhere to the departmental meeting requirements.

13.14. Standing Committee. A Permanent committee with members from all the relevant departments that makes recommendations to the higher authorized committee for final decision-making.

13.15. COMMITTEES ORGANIZATIONAL CHART



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14. STAFF DEVELOPMENT

14.1. Continuous Medical Education (CME) Activities

14.1.1. It is IAFH policy to help staff develop their capabilities, update their knowledge, and build the required skills that enable them to carry out their responsibilities in offering a safe service.

14.1.2. Continuous Medical Education (CME) activities include journal clubs, workshops, special seminars, lectures, conferences, special demonstrations and presentations, etc.

14.1.3. Medical Staff members shall actively pursue continuing medical education in their field. Medical Staff members are responsible for attending CME activities to the degree required to maintain their licenses and professional status in the Kingdom of Saudi Arabia and the required CME hours by the Saudi Council for Health Specialties. Medical Staff members shall participate in local events that have educational value, whether in the role of instructor or trainee. Medical Staff members shall take full advantage of the IAFH medical library.

14.1.4. Participation in CME activities is encouraged and regarded as a measure of the level of interest of the Medical Staff member. Such participation will be taken into account when annual performance appraisals are being done.

14.2. CPR Training

14.2.1. All Medical Staff members shall regularly attend Cardiopulmonary Resuscitation (CPR) refresher courses as required. A record of attendance at CPR courses shall be maintained by the department heads in the personnel files. Medical Staff members shall be certified at least every 2 years. Medical Staff members shall be prepared to put their knowledge of CPR to use in an emergency situation.

14.2.2. BLS is a must for all medical and paramedical staff. ACLS is a must for all Medical physicians, PALS/NRP is a must for pediatricians and neonatologists, and ATLS for all surgeons.

14.2.3. Categories of the Medical Staff are required to attain and maintain specific advanced levels of life support knowledge and skills as per the CBAHI standard requirements, depending on the population they serve and related specialties. It is the hospital's policy to facilitate their enrollment in these programs.

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14.3. Performance Evaluation and Appraisal

14.3.1. In IAFH, there are several methods for evaluating the hospital staff, including Probationary Evaluation, Regular/Annual Performance Evaluation, Unplanned Evaluation, Peer Review, and Regular monitoring of staff competencies (nursing, other allied health staff).

14.3.2. All employees shall be evaluated only within the scope of their job descriptions, privileges, and credentials, while ensuring their adherence to hospital protocols, employee code of conduct, policies, procedures, infection control practices, and guidelines.

14.3.3. To follow APP.HR.008 PERFORMANCE EVALUATION AND APPRAISALS Policy for staff performance evaluation and appraisal.

14.3.4. Head of department, supervisor, or preceptor appointed to monitor the employee performance must rate the employee performance, including both job-specific competencies as well as core behavioral competencies (i.e., interactions with others/communication; customer service; expertise/continuous learning; resourcefulness/results and personal accountability, person-centered care).

14.3.5. Unplanned and ongoing professional performance evaluations are conducted in situations that the employee requires continuous additional monitoring as a result of:

14.3.5.1. A peer review evaluation with unaccepted and not accepted variance in the standard practice

14.3.5.2. An involvement in any patient safety events that resulted in serious patient harm

14.3.5.3. Unsatisfactory competency evaluations for full time regular employees

14.3.5.4. A request to upgrade physician privilege

14.3.5.5. Unplanned and ongoing professional performance Competencies: Criteria for conducting Unplanned/Ongoing Performance Evaluation are as follows:

14.3.5.5.1. Patient Care

14.3.5.5.2. Medical and Clinical Knowledge

14.3.5.5.3. Practice-Based Learning and Improvement

14.3.5.5.4. Interpersonal and Communication Skills

14.3.5.5.5. Professionalism

14.3.5.5.6. Systems-based practice

14.3.5.5.7. Peer Review Report

14.3.5.6. Unplanned evaluation done by the head of department and can be requested by the Medical Director, Hospital Director, and Quality Director if there are any patient safety events or reports of unsatisfactory performance.

15. GENERAL RULES AND REGULATIONS

15.1. PATIENT CARE DELIVERY

15.1.1. **Patient Admission**

15.1.1.1. Patients may be admitted to the Hospital as an inpatient only by a qualified member of the Medical Staff who has been granted the privilege to admit patients to IAFH.

15.1.1.2. All patients requiring admission will be assessed by the admitting physician to determine the urgency, appropriate bed category (ICU or Ward), and the necessary investigations to establish a provisional diagnosis or confirm the need for admission, in line with the scope of services.

15.1.1.3. In an emergency, a screening for the patient's triage will be carried out.

15.1.1.4. Admissions are accepted 24 hours a day, 7 days a week, irrespective of any holidays, via the Emergency Room, and from the OPD, only during working hours/ working days.

15.1.1.5. The hospital may get patients for admission from other hospitals according to the policy.

15.1.1.6. The history and physical examination are completed according to the approved hospital format, and any special history or examination requirements will be determined by the department heads according to the needs.

15.1.1.7. If the patient is being admitted to the ICU, the most responsible physician, with the intensivist, jointly makes the decision to admit the patient. Only those patients who are likely to benefit from intensive care will be transferred to the ICU/PICU (Refer to the policies governing admission criteria for critical care units.)

15.1.2. **Patient Discharge**

15.1.2.1. Discharge - means to move a patient from one level of care to another within or outside the current health care facility.

15.1.2.2. Discharge process – a process that involves the development and implementation of a plan facilitating the release of an individual from the hospital.

15.1.2.3. Discharge planning begins at the time of admission. The plan for discharge from service should be developed with input from the physician, attending nurse, family, social worker, other ancillary staff, and other health care workers.

15.1.2.4. An order from the attending physician should be secured before a patient can leave the hospital; otherwise, it is considered as DAMA or Absconded.

15.1.2.5. Patients and their families need to know the expectations of the healthcare team in terms of anticipated length of stay, the patient's expected condition at discharge, and the potential need for aftercare services.

15.1.2.6. It is most important that the patient and family are aware of the need to make arrangements for continued care in a timely fashion and are assisted with accessing appropriate community resources and institutions.

15.1.2.7. It is most important that the physician and nursing and ancillary staff maintain a current knowledge base with respect to community resources, particularly new programs which periodically become available. An awareness of this information.

15.1.2.8. The Multidisciplinary Discharge Planning Checklist shall be filled out for selected cases by each discipline according to the patients' needs upon admission.

15.1.3. **Patient Transfer**

15.1.3.1. External Transfer – is the act of moving a patient from IAFH to another healthcare facility as ordered by the treating physician for the purpose of clinical care and treatment needs.

15.1.3.1.1. For any patient transfers externally to follow - APP.IAFH.039 TRANSFER OF PATIENT TO ANOTHER FACILITY Policy

15.1.3.1.2. If the patient/family requests to be referred to another hospital for a medical service that can be provided by IAFH, the family of the patient will be responsible for getting the acceptance of the other hospital. After acceptance by the other hospital, the patient will be discharged and provided with a medical report reflecting the medical care given, with a notice that the patient's discharge is according to the patient/family's request. The transport of the patient to the other hospital will be properly coordinated to ensure patient safety.

15.1.3.1.3. The examining physician and/or treating physician shall use his/her best judgment with regard to the condition of the patient when determining the timing of transfer, mode of transportation, and level of care provided during transfer.

15.1.3.1.4. Qualified personnel and transportation equipment shall be a requirement, including the use of necessary and medically appropriate life support measures during transfer.

15.1.3.1.5. The medical summary report and other pertinent records and laboratory/ diagnostic results (if available) will be sent with the patient to the receiving facility or be electronically transferred as soon as practical.

15.1.3.1.6. The Medical Coordination Office should be working 24 hours, equipped with necessary communication facilities (e.g., computers, internet connection, telephones, fax machines, etc.), to manage all transfers and referrals of cases.

15.1.3.1.7. Internal transfer – this refers to the transfer of a patient within the facility based on the patient’s condition as ordered by the treating physician. For any intra-facility transfer of a patient to follow – APP.IAFH.038 INTRA FACILITY TRANSFER OF PATIENTS policy.

15.1.3.1.8. The most responsible physician shall assess the need for transfer based on the condition of the patient, with admission criteria of the unit.

15.1.3.1.9. A Physician Order shall be required prior to any intra-facility patient transfer. There should be a verbal or written agreement received from the receiving unit, and it is

documented in the patient's medical record, including the name of the receiving physician.

15.1.4. **Plan of Care**

15.1.4.1. IAFH policy – APP.IAFH.047 PLAN OF CARE

15.1.4.2. Patient Care Plan - A treatment plan especially designed for each patient, based on individual strengths and needs. The caregiver(s) develop 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 special needs of the patient. Planning is an interdisciplinary process.

15.1.4.3. The responsible physician, nurse, and other healthcare practitioners must develop an individualized plan of care for each inpatient within 24 hours of admission, based on the patient's initial assessment and identified needs.

15.1.4.3.1. The patient care plan must be stated clearly

15.1.4.3.2. Expected length of stay

15.1.4.3.3. Possible diagnosis and differential diagnoses

15.1.4.3.4. Possible diagnostic tests

15.1.4.3.5. Possible therapeutic interventions

15.1.4.3.6. Any surgical procedure that the patient might go through

15.1.4.3.7. Any special care needed

15.1.4.3.8. Transfer/ Referral possibilities

15.1.4.3.9. Consultation

15.1.4.3.10. Second opinion

15.1.4.4. The plan of care must be communicated to the patient/ family by the admitting physician in an understandable language for their participation in the process and decision-making. This discussion must be documented in the patient's medical record.

15.1.4.5. The information must include the proposed care/alternate care, benefits, and risks of the proposed treatment.

15.1.4.6. The patient and family must be informed of the likelihood of success of the treatment and the possible problems related to recovery.

15.1.4.7. The admitting physician will be the responsible one to explain the rights for refusal of the treatment and the consequences of that.

15.1.4.8. The plan should be written in detail with special emphasis on an interdisciplinary team approach.

15.1.4.9. The plan of care has to be revised, updated, and adjusted by the treating team according to any change in the patient's condition, and it has to be documented. The change of the plan is based on daily rounds, morning meeting discussions, or a second opinion.

15.1.4.10. The patient care plan must be reviewed after a surgical procedure.

15.1.5. **Responsibility of Care**

15.1.5.1. Each patient is assigned to a single physician referred to as the treating physician or the most responsible physician (MRP) who is granted clinical privileges to admit and treat a patient.

15.1.5.2. To follow the IAFH policy APP.IAFH.048 RESPONSIBILITY OF CARE

15.1.5.3. All services provided to the patients in all settings will be under the direction of a single physician who is a member of the medical staff (referred to as the Primary Physician / Most Responsible Physician (MRP).

15.1.5.4. For an admission, the Primary Physician is the physician who gives the order to admit the patient to the hospital under his / her name.

15.1.5.5. The Primary Physician is responsible for overseeing patient care during hospital admissions or clinic visits, including providing medical treatment, coordinating care, ensuring the accuracy and completeness of the medical record, and educating the patient and their family.

15.1.5.6. The transfer of a patient between services within the facility must be determined and initiated by a physician following a thorough assessment and evaluation to ensure optimal and effective management.

15.1.5.7. Patient transfers must be documented in the medical record with the reason and receiving physician's name, occur only with mutual physician agreement and a primary physician's order

in accordance with hospital rules, involve notifying the patient and all healthcare providers involved in their care, and, in cases of vacation, be documented according to departmental policies, with any disputes referred to the Medical Director for resolution.

15.1.6. **Patient Assessment & Re-assessment**

15.1.6.1. IAFH Policy – APP.IAFH.034 PATIENT ASSESSMENT AND REASSESSMENT

15.1.6.2. Initial Patient Assessment - initial medical patient assessment to determine patient treatment needs for emergency, elective, or planned care on admission. The initial patient assessment should be documented in the patient's medical record in accordance with the time frame specified in this policy.

15.1.6.3. Reassessment - reassessment of patients by all clinical services is essential to determine response to treatment and to revise the care plan when indicated. The patients are reassessed at intervals appropriate to their condition. Plan of care and individual needs reassessment should be documented in the patient's medical record.

15.1.6.4. All patients receiving inpatient, outpatient, or emergency services at the facility will receive a complete head-to-toe assessment by a qualified individual to allow development and implementation of a plan of care that will best meet the individualized health care needs of the patient. The assessment of the care or treatment needs of the patient will be continuous throughout the patient’s hospitalization.

15.1.6.5. All disciplines deemed necessary upon initial or ongoing assessment by nursing services or by physician order will participate in the assessment process in an effort to provide a comprehensive, collaborative approach to patient care.

15.1.6.6. The assessment should include the patient’s social and psychological needs.

15.1.6.7. The MRP (Most Responsible Physician) (i.e., specialist /consultant) must attend patients within 24 hours for routine admissions, and within 30 minutes for emergencies/urgent cases.

15.1.6.8. Consultants/Specialist must attend their patients for reassessment at least daily for routine patient needs; and anytime if there is a significant change (deterioration) in the patient's condition.

15.1.6.9. The contents of the history and physical examination are determined by the department heads according to the needs.

15.1.7. **Physician Order**

15.1.7.1. IAFH Policy – APP.IAFH.045 PHYSICIAN ORDER

15.1.7.2. Physician Orders are written documentation for the treatment plan and care of the patient.

15.1.7.3. All entries of the physician order in the Watheeq Hospital Information System must be legible and complete through the Physician Progress Notes

15.1.7.4. Any abbreviation used on the medication orders must be on the hospital's approved list (Refer to LIST.IAFH.001 LIST OF APPROVED ABBREVIATIONS Policy). If an abbreviation is used that is not on the list, the order must be verified before carryout.

15.1.7.5. Any correction, change, or addition to the physician order after it is sent to Pharmacy is not allowed. The order must be rewritten to reflect the change.

15.1.7.6. The physician should alert the nurse of all STAT orders when possible. The physician should review all orders with the patient's nurse.

15.1.7.7. Medication orders must comply with the prescribing guidelines of the Hospital Formulary Drug Policy and Regulations. i.e.

15.1.7.7.1. Order should be written in the Metric System / SI units.

15.1.7.7.2. Use of a decimal or a leading decimal point in writing doses is discouraged. Write order as: Kefzol 1gm, not 1.0 gm..: Sucralfate 500mg, not 0.5 gm.

15.1.7.7.3. When ordering PRN medication, the physician should indicate the reason for ordering a PRN drug, such as: Prochlorperazine 5mg q 6 hours PRN for nausea.

15.1.7.7.4. Consultant/Specialist must order and sign narcotic/controlled substance.

15.1.7.7.5. Order should be written using the generic drug name

15.1.7.7.6. Telephone orders will be accepted when immediate patient care intervention is required. The telephone order must be documented by the physician at the earliest possible time, but not later than twenty-four (24) hours.

15.1.7.7.7. A verbal order is given to a staff nurse by a physician who is physically present. These are reserved for code/emergency situations only. The physician must document as soon as the emergency is over.

15.1.8. **Patients' Affairs**

15.1.8.1. Patient Rights & Responsibilities

15.1.8.1.1. Patient Rights/Responsibilities Statement – is a document that outlines the patient's rights and responsibilities and is given when he/she enters the hospital.

15.1.8.1.2. Rights are ethico-legal principles and privileges, which patients are entitled to, and these should be upheld and observed by the health care professionals.

15.1.8.1.3. Responsibilities – these are the duties/tasks that the patients are obliged to perform.

15.1.8.1.4. All members of the health care team should uphold the patient's rights and responsibilities and promote trust and respect as part of the dimension of patient care.

15.1.9. **Patient Rights**

15.1.9.1. The right to be informed about his/her rights and responsibilities in a manner he/she can understand.

15.1.9.2. The right to obtain a copy of the Patient's Rights and Responsibilities Statement.

15.1.9.3. The right to a considerate care, with full respect to the patient's dignity, regardless of nationality, color, age, sex, cultural and religious values and beliefs, and disability (if any).

15.1.9.4. The right of provision of a safe environment for care in accordance with approved policies and procedures.

15.1.9.5. The right to know the names of the physician, nurses, and staff members involved in the treatment.

15.1.9.6. The right to participate in health care decisions pertaining to his/her care to the extent he/she wishes to before signing the General Consent Form.

15.1.9.7. The right to information about his/her condition, including the diagnosis, procedures that should be, any alternatives, and complications. In cases where communicating this information may adversely affect the patient's health and is deemed inappropriate, such information must be relayed to the family.

15.1.9.8. The right to be seen by the consultant within twenty-four hours from admission and on a regular basis throughout the whole duration of hospital stay.

15.1.9.9. The right to privacy and confidentiality.

15.1.9.10. Conducting medical examination in designated areas only, out of the view and hearing of others.

15.1.9.11. Provision of a convenient atmosphere where the patient can discuss openly and in full confidentiality his/her illness.

15.1.9.12. All communications and other patient records should be kept confidential.

15.1.9.13. No unauthorized access to the medical record.

15.1.9.14. No talking about patients in inappropriate areas.

15.1.9.15. No public postings of patients' personal information.

15.1.9.16. Closing the patient's database program on the computer after each use.

15.1.9.17. The right to obtain information or documents, such as medical reports, sick leave, etc., as documented in the medical chart.

15.1.9.18. The right to request consultation or a second opinion from another physician(s) through the treating consultant, guided by the hospital-approved policy.

15.1.9.19. The right to request a change of physician and/or transfer to any external facility as desired at his/her own expense.

15.1.9.20. The right to be informed about the necessary directives and procedures, in case he/she needs to be transferred to an external facility for treatment completion in accordance with the Institution's policies and procedures on eligibility.

15.1.9.21. The right to refuse to participate in Medical Training Program and Research Projects, and he/she has also the right to withdraw at any stage from an ongoing research project in which the patient has been participating, without any consequences that may affect the care given to him/her.

15.1.9.22. The right to refuse or discontinue treatment after a thorough explanation by his/her physician about the consequences and/or outcomes of his/her decision.

15.1.9.23. When discharged from the hospital, the patient has the right to have medicine prescriptions, follow-up appointments, and all the information and the training needed to be able to take care of themselves at home (if the case requires).

15.1.9.24. The right to choose the person who will represent him/her in signing the hospital documents, including the release of information when he/she won't be able to do so.

15.1.9.25. The right to have his/her valuables collected and secured according to hospital procedures.

15.1.10. **Patient Responsibilities:**

15.1.10.1. To know and follow the law of the Kingdom of Saudi Arabia and the hospital rules and regulations as explained by the hospital staff.

15.1.10.2. To provide accurate and complete information that concerns the present complaints, past illnesses and hospitalizations, and other matters relating to his / her illness.

15.1.10.3. To make it known whether he/she clearly comprehends the course of the medical treatment.

15.1.10.4. To follow the treatment plan established by the health care team.

15.1.10.5. Take full responsibility when he/she decides to refuse treatment or not follow the physician's order.

15.1.10.6. To notify the physician, the head nurse, or the social worker representative of any dissatisfaction regarding his/her care in the hospital.

15.1.10.7. Assist in the control of noise, smoking, and other possible sources of unnecessary disturbance and/or discomfort.

15.1.10.8. Show respect and consideration for other patients, visitors, and hospital authorities.

15.1.10.9. Sign the informed consent for surgery, medical, or interventional procedures that may be needed in his/her care.

15.1.10.10. Obliged to sign the Discharge against Medical Advice Form (DAMA) whenever he/she refuses or discontinues treatment and/or insists on being discharged.

15.1.10.11. Be aware that the hospital is committed to high standards of care and hospitality for patients and their families.

15.1.10.12. Parents or Guardians Responsibilities: In addition to the responsibilities of adult patients, the parents/guardians of the pediatric/ handicapped patient shall have the following responsibilities:

15.1.10.12.1. To sign the informed consent for admission, surgery, medical, or interventional procedures that may be needed in the care of his/her child.

15.1.10.12.2. To sign the discharge Against Medical Advice Form (DAMA) whenever he/she refuses or discontinues any treatment for his/ her child.

15.1.11. **Ethical Considerations**

15.1.11.1. The service takes into account that vulnerable dependent patients are unable to make a decision for themselves.

15.1.11.2. All decisions taken must be in the best interest of the patient.

15.1.11.3. Clinical ethics should be strictly adhered to while taking all such decisions.

15.1.11.4. The patient's family should be involved in all decision-making. If they are not available, a medical committee, with three Doctors (Consultant/ Specialist) and Patient Experience, can make a decision, and it must be documented in the medical record of the patient by the MRP (Most Responsible Physician) and countersigned by other committee members.

15.1.11.5. Only lifesaving surgical interventions should be undertaken in situations where the patient is suffering from a condition that temporarily makes him unable to make a decision.

15.1.11.6. All decisions taken are documented in the file with medical reasons for which they are taken and countersigned by Patient Experience.

15.1.11.7. In clinical situations involving brain-dead and potentially brain-dead patients on ventilators, the service identifies important relevant ethical issues for the clinicians

15.1.11.8. The service facilitates both the family and clinicians in such situations.

15.1.11.9. The medical and ethical guidelines are strictly adhered to, and no hasty decisions are taken.

15.1.11.10. Anybody having doubt about a case where the ethical issues are not properly handled must be reported to the Quality and Patient Safety Director either verbally or in writing (OVR).

15.1.11.11. All such consultations are kept strictly confidential.

15.1.11.12. The care of patient who are in a persistent vegetative state and their management has to consider code status.

15.1.11.13. Resuscitation

15.1.11.13.1. Attending physician has to decide on resuscitation.

15.1.11.13.2. For patients who do not require a resuscitation to follow the APP.IAFH.030 DO NOT RESUSCITATE (DNR) Policy.

15.1.11.13.3. Family has to be informed about the code status.

15.1.12. **Consent**

15.1.12.1. Informed consent – a voluntary granting of permission made by a well-advised and mentally competent individual to be treated or a procedure to be performed by a healthcare provider or institution.

15.1.12.1.1. Informed consent must be obtained for all procedures that require it, using the designated forms available in the Watheeq Hospital Information System.

15.1.12.1.2. The informed consent must include the following elements:

1. Informing the patient of the nature of the treatment

a. Possible alternative treatments
b. Complications
c. Potential risks
d. Benefits of the treatment, and the likelihood of success

2. The form itself is not an informed consent; rather, it serves as evidence of the hospital and the treating physician that an informed consent has been obtained prior to medical, surgical, or any other special, invasive procedures and treatments.
3. The consent shall be considered valid only when it is given voluntarily and the patient is competent and of legal age (18 years old and above).
4. Every patient (male or female) that are of legal age and mentally sound shall be given the opportunity to enter into an agreement prior to his/her admission.
5. All patients who are capable and of legal age can sign the informed consent. Except for:
    a. Minors (below 18 years of age), the legal guardian shall sign the informed consent.
    b. If the patient is incapable or lacks the capacity to give consent, the legal guardian shall sign the informed consent.
    c. A married woman who will undergo procedures relating to reproduction that may lead to infertility, such as hysterectomy and tubal ligation, the consent must be obtained from the patient and her husband only.
    d. A pregnant woman in labor but not married, the consent must be obtained from the father and brother of legal age only.
    e. A Residence Identification Card (Family Card/Iqama) is necessary prior to the patient/legal guardian signing the informed consent to verify his/her identity.
    f. All consent forms must be filled out completely (with the date and time the signature was obtained), correctly and legibly; misspelled words and abbreviations are unacceptable.

g. The consent form has two (2) witnesses, which is in accordance with the custom and law of the Ministry of Health (MOH). The person who will sign as the 1st witness is a close relative of the patient who is of legal age. The nurse on duty (NOD) or other allied health practitioner will sign as the second witness.

h. When a person other than the patient signed the consent form, the relationship to the patient should be written.

15.2. Legal Guardian – a close relative (father, mother, spouse, son, daughter, sister, and brother) of legal age (18 years old and above) that assumes full responsibility for an individual who is presumed to be incompetent and unable to care for him/herself

15.3. Witness – is an individual who signs the informed consent form to ensure the authenticity of another signature and that the procedure, including the risks and costs involved in the treatment, was explained thoroughly by the physician to the patient/legal guardian.

15.4. Medical Records:-It is the policy of IAFH to create a medical record, including history and physical examination of each inpatient within twenty-four hours after admission. The Most Responsible Physician (Consultant/Specialist) shall review and countersign the history and physical examination, document his own examination, opinion, and recommended treatment.

15.5. Progress notes shall be documented in the medical record by the attending physician, as well as by every other practitioner who examines the patient. Such progress notes shall be recorded with sufficient detail to document the patient's status, give a pertinent chronological report of the patient's course in the hospital, and reflect the results of the treatment.

15.6. All diagnostic and therapeutic orders must be documented in the Physician Progress Notes in the Watheeq Hospital Information System to include the complete name, designation, and date and time of the ordering physician.

15.7. All Medical Staff categories shall complete admissions, including history collection, physical examination, orders, progress notes, and consultations with date and time.

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15.8. A discharge summary, including the presence of any reportable disease, shall be completed on every patient. This summary, which may be completed by a member of the Resident Staff, shall be reviewed and signed by the attending physician as part of the discharge procedure.

15.9. A warning of delinquency shall be issued on a weekly basis to responsible physicians, indicating that failure to complete medical records in accordance with medical record completion policies may result in suspension. A physician is considered to be delinquent if any medical record for which he is responsible remains incomplete for longer than thirty (30) days.

15.10. Disregard of the rules concerning medical record availability or completion will be referred to the appropriate Head of Department and Medical Director.

15.11. Medical Records Department personnel shall review the medical records of all discharged patients to be certain that the medical records are complete and that the diagnosis in each case is properly recorded in a prominent place in the medical record and shows proper authentication.

15.12. All medical records are the property of the Hospital and shall not be removed from the Hospital except as otherwise required by court order, subpoena, or applicable law.

15.13. Late entries may be made and are placed after the last documentation. It is noted as a late entry with the current time and date, and reference is made to the original time and date. Late entries must be made before the end of twenty-four (24) hours after the occurrence. Reasons for late entries must be included.

15.14. To ensure the quality of documentation in the medical record, all physicians should write in a clear font and make sure to cover the following points:

15.14.1. Name of Most Responsible Physician (MRP)

15.14.2. Medical History must include:

15.14.2.1. Patient's chief complaint

15.14.2.2. Reason for admission

15.14.2.3. Present illness

15.14.2.4. Past illnesses

15.14.2.5. Relevant past social and family history

15.14.2.6. Current list of medications

15.14.2.7. Allergies

15.14.2.8. Other requirements may apply to specific patient populations. The physical examination must reflect a comprehensive review of systems.

15.14.2.9. The history and physical examination must include the planned course of action.

15.14.2.10. Patients admitted for dental care, the dentist shall be responsible for describing the oral pathology of the patient.

15.14.3. The patient care plan must state clearly

15.14.3.1. Expected length of stay

15.14.3.2. Possible diagnosis and differential diagnoses

15.14.3.3. Possible diagnostic tests

15.14.3.4. Possible therapeutic interventions

15.14.3.5. Any surgical procedure that the patient might undergo

15.14.3.6. Any special care needed

15.14.3.7. Transfer/ Referral possibilities

15.14.3.8. Consultation

15.14.3.9. Physician Progress Notes must include:

15.14.3.9.1. Patient condition has to be described by one of the styles of clinical documentation, e.g., “SOAP” (S – Subjective, O – Objective, A – Assessment, P – Planning) by the attending physician.

15.14.3.9.2. All the findings must be documented in the patient's progress notes.

15.14.3.9.3. All physician orders.

15.14.3.9.4. Entries must be dated and timed.

15.14.3.9.5. All entries must be dated, timed, legible, and documented in English

15.14.3.9.6. In the outpatient areas, this may be either electronic or on a designated physician order sheet.

15.14.4. Medical assessment for patients who are admitted for surgery.

15.14.4.1. Preoperative investigation and results documented for all patients admitted for surgery.

15.14.4.2. Preoperative assessment for surgery should include:

15.14.4.2.1. History

15.14.4.2.2. Physical examination

15.14.4.2.3. Preoperative diagnosis

15.14.4.2.4. Lab and radiology results

15.14.4.2.5. Signed consent

15.14.4.3. Pre-operative anesthesia assessment must be completed.

15.14.4.4. Pre-anesthesia assessment, maximum 30 days, includes:

15.14.4.4.1. Risk category

15.14.4.4.2. Any consultation

15.14.4.4.3. Anesthesia plan

15.14.4.5. Complete anesthesia form, make sure to record:

15.14.4.5.1. Agent

15.14.4.5.2. Dose

15.14.4.5.3. Technique

15.14.4.5.4. Blood administration

15.14.4.5.5. Investigations

15.14.4.5.6. Unusual events

15.14.4.5.7. State of the patient at the end of the procedure

15.14.4.5.8. I.V. fluid given

15.14.4.6. Monitor patient during and after surgery and document:

15.14.4.6.1. Oxygen saturation

15.14.4.6.2. Time of admission

15.14.4.6.3. Vital signs

15.14.4.6.4. Level of consciousness

15.14.4.6.5. Unusual events

15.14.4.6.6. ECG

15.14.4.6.7. Time of discharge

15.14.4.7. Post-procedure patient status

15.14.4.7.1. Vital signs

15.14.4.7.2. Level of consciousness

15.14.4.7.3. ECG

16. PROFESSIONAL AFFAIRS

16.1. Consultation

16.1.1. Consultations - A type of service provided by a physician whose opinion or advice regarding the evaluation or management of a specific problem is requested by another physician.

16.1.2. Patient welfare shall be the first priority and consideration. A consultation initiated by a consultant or specialist shall not be refused by the consulting service if proper procedure was followed.

16.1.3. Judgment regarding the nature of an illness and questions concerning prognosis or management rest with the attending physician responsible for the care of the patient. Good medical practice requires proper and timely consultation with individuals qualified to give opinions in the field in which the advice is sought.

16.1.4. A consultation shall not be initiated unless approved by the treating consultant or specialist.

16.1.5. Urgent /Emergency Consultations – Serious medical conditions where the life or well-being of the patient is in immediate danger.

16.1.6. Not Urgent / Routine Consultations – The patient's life or well-being is not in immediate danger in these consultations.

16.1.7. For any consultations, follow the APP.IAFH.044 CONSULTATION IN PATIENT CARE Policy.

16.2. Handover Communication

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16.2.1. To follow IAFH policy for handover – APP.IAFH.049 HANDOVER COMMUNICATION POLICY

16.2.2. Patient information is communicated between physicians, nurses, and technicians during shift changes; when a patient is received from the intensive care unit to the medical unit or from the emergency department to the operating theater; and from the inpatient unit to diagnostic or other treatment departments, such as radiology, to assure continuity of care.

16.2.3. The SBAR worksheet will be used for all care handovers, retained as a permanent part of the patient record, and the handover information should be clear, concise, and communicated using easily understood language with minimal approved abbreviations.

16.2.4. **Purpose:** To provide accurate information about a patient's care, treatment or service, and their current conditions with any recent or "anticipated changes when responsibilities are "hand over" from one care provider to another, in permanent and/or temporary situations. When a patient leaves one department/unit to go to another. Also, ensure consistent communication between staff ("handover"), including the opportunity to ask and respond to questions.

16.2.5. **Hand-over Communication** - the patient hand-over is a process in which the passing of patient-specific information occurs from one caregiver to another or from one department to another. Caregivers include physicians, nurses, and technicians. There are two types of Hand-over Communication, written and verbal. Both are important, and each has a different purpose. Written handover can provide detailed information that serves as a reference for the receiving provider. Verbal handovers allow discussion and cross-checking with the receiving provider to be certain that he/she has understood the information being provided.

16.2.6. **ISBAR**-it is an acronym that stands for Identification-Situation-Background-Assessment Recommendation. It is an evidence-based communication model that assists the provider by providing a framework to organize and convey information.

16.2.7. **Clinical Handover**- transfer of professional responsibility and accountability for some or all aspects of care for 'patient or group of patients, to another person /family on a temporary or

permanent basis. It is the exchange of information between healthy professionals that accompanies the transfer of patient care.

16.2.8. **Short Break** - anytime away from the patient for 10 — 15 minutes, e.g., transferring of patients from another area, picking up patients from another area, bathroom break occurs between the nurse for the patient and the nurse who is assuming responsibility of the patient. Comprises a short verbal handover focusing on the greatest risk for the patient.

16.2.9. **Long break**- any time away from the patient that is greater than 15 minutes, e.g., meal breaks, education sessions, head nurses' meetings. Occurs between the nurse responsible for the patient and the nurse who is assuming responsibility for the patient, comprises a verbal handover in ISBAR format — identification of patient, current situation, and any risk or recommendation for break interval.

16.2.10. **Transferring physician**: Complete the SBAR form and participate in verbal handover for clarity of transfer of information.

16.2.11. **Receiving physician**: Review the handover form or receive verbal handover, and resolve any questions with the transferring physician.

17. PEER REVIEW

17.1. Peer**:** A "peer" is defined as practitioners from the same department or from another, but_related departments, with similar clinical privileges, in reference to an external or internal expert.

17.2. Medical Staff Peer Review**:** The medical staff uses an effective mechanism designed to involve medical staff members in activities to measure, assess, and improve performance on an organizational basis. This mechanism is designed to:

17.2.1. Collect data on processes and outcomes to assess performance in relation to design specifications of processes, determine the level of functioning of processes, identify opportunities for improvement, and review outcomes in relation to expectations.

17.2.2. Communicate to appropriate medical staff members the findings, conclusions, recommendations, and actions taken to improve organizational performance.

17.2.3. If relevant, identify individual performance as a result of the assessment process. When a determination has been made, steps for further review, final recommendations, any actions taken, and follow-up are required.

17.2.4. When the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review and/or the periodic evaluations of a licensed independent practitioner's competence, in accordance with the by-law requirements on renewing or revising clinical privileges.

17.3. For Medical Staff Peer Review, to follow the APP.HR.009 CLINICAL PEER REVIEW Policy.

18. REFUSAL OF TREATMENT

18.1. The patient's physician determines whether the patient has the capacity to make an informed decision to refuse treatment and documents the factors relied upon in making such a determination.

18.2. The patient's physician also explains to the patient or the patient's representative and documents all information necessary for him/her to make an informed decision, including the risks, benefits, and alternatives to treatment and consequences of no treatment.

18.3. When an adult patient with capacity refuses treatment and the physician decides he/she is unable to comply with the patient's decision to refuse treatment, then it is the physician's responsibility to explain this to the patient, document the patient's decision and explanation in the medical record, and to offer or attempt to refer the patient to another physician who is able to comply with the request.

18.4. If the physician is unable to refer the patient to another physician with privileges at the hospital who is able to serve as an attending physician to the patient and accommodate the decision to refuse treatment, the patient will have to arrange to transfer to another provider.

18.5. For any patients refusing treatment, to follow the APP.IAFH.068 REFUSAL OF CARE AGAINST MEDICAL ADVICE Policy.

19. DO NOT RESUSCITATE (DNR)

19.1. Do not Resuscitate (DNR) – No CPR "status" is a medical order to provide no resuscitation to individuals for whom resuscitation is not warranted. It means that all procedures for resuscitation are not initiated

(i.e., in the event of cardiopulmonary arrest, do not call CPR/code team or initiate chest compression, defibrillation, cardioversion, intubation, or administer advanced cardiac life support medications). Other supportive measures to maintain the patient's comfort that have been given before the event of cardiopulmonary arrest may continue at the discretion of the Most Responsible Physician (MRP) as indicated in the order sheet.

19.2. The DNR order is appropriately recommended when the patient is terminally ill and when resuscitation measures, in the best judgment of the attending consultant, would be ineffective at saving the patient's life.

19.3. For patients who are already admitted to a critical care unit, and have no response to aggressive life support interventions, and who are assigned a DNR order, the attending consultant may consider withholding any further life support measures; withdrawing current life support measures; or de-escalating, setting no further escalation, or setting limited escalation to the life-sustaining measures only when the burden on the patient overly outweighs the expected benefit according to the physician's best judgment.

19.4. For any DNR patients, follow the APP.IAFH.030 DO NOT RESUSCITATE (DNR) Policy.

20. CONFIDENTIALITY

20.1. All medical records and patient-specific information, records of peer review and other committee proceedings, quality assurance and risk management materials including incident reports, medical staff credentialing records and files, minutes of medical staff and hospital meetings, and other confidential hospital and medical staff personnel files data, and information, may not be used for purpose other than patient care, peer review, risk management, and other proper Hospital and medical staff functions.

20.2. Such confidential materials (whether maintained in hard copy, in computer memory or diskette, or in any other format) may not be removed from the hospital, duplicated, transmitted, or otherwise disclosed to parties outside of the hospital without proper authorization in accordance with the hospital and medical staff policies. Compliance with this confidentiality policy shall constitute a condition of continuing staff membership.

20.3. A confidentiality statement shall be signed by all medical staff members and those in contact with the above-mentioned information and kept in the personnel file.

21. CODE OF ETHICAL CONDUCT

21.1. Conduct - is the responsible manner that which an individual acts or behaves properly.

21.2. Code of Conduct - A set of principles and expected behaviors that are expectations of staff performance within a healthcare setting or as defined by the leadership group. Code of conduct defines how staff should act on a day-to-day basis. It reflects the organization's daily operations, core values, and overall company culture.

21.3. Ethics - a set of moral principles of practice or values governing an individual or a group that should be consistently applied and followed accordingly. Moral principles that govern a person's behavior or the conducting of an activity.

21.4. Conflict of interest - a situation in which a person is in a position to derive personal benefit from actions or decisions made in their official capacity.

21.5. **Purpose**: The code of conduct provides guidance to ensure that the hospital's business is conducted in an ethical and legal manner. Its purpose is to ensure the hospital's commitment to the Islamic ethics, Saudi rules and regulations, and cultural obligations, and the responsible conduct of IAFH employees.

21.6. **The Code**: The code is the foundation of the values upheld and practiced by all personnel at the hospital. All employees without exception shall adhere to the highest ethical standards of conduct in all professional and business activities and shall act in a manner that enhances the hospital's standing as a vigorous and ethical contributor within the health care professions and the community. Failure to comply with any provisions under the code will result in the management taking disciplinary action.

21.7. **Code of Conduct**: The code has been formulated based on our values as follows:

21.7.1. The IAFH Code of Conduct (APP.IAFH.016 CODE OF CONDUCT Policy)

21.7.1.1. The code of conduct outlines expected behaviors and communication with the employees.

21.7.1.2. The hospital expects that every employee conduct business fairly, impartially, in an ethical and proper manner, and in full compliance with all applicable laws and regulations and the highest standards of ethical business code of conduct.

21.7.1.3. All employees shall deal fairly and honestly with those who are affected by our actions and shall treat them as we would expect them to treat us if the situation were reversed.

21.7.1.4. Every employee will promptly report any illegal or unethical conduct to management or other appropriate authorities (i.e., Ethics, Law, and Security)

21.7.1.5. All employees are committed to maintaining an environment in which every individual can work and live without being harassed.

21.7.1.6. Harassment includes conduct that affects dignity or shows hostility toward another because of the person's gender, which can be the basis for a hostile, offensive, or intimidating environment claim. Gender-based conduct can take the form of abusive written or graphic material; a nickname; negative stereotyping; jokes; or threatening, intimidating, or hostile acts.

21.7.2. Dress Code

21.7.2.1. All personnel are required to abide by the Dress code policy. This policy code should be carried out by all staff at all times while the employee is on the hospital's premises.

21.7.2.2. All staff are required to display on their upper dress/shirt their Identity Card at all times while on the hospital's premises

21.7.2.3. Conduct between Male and Female Employees: All members, male and female, should at all times practice the principle of modesty and respectable interaction and proper decorum during activities, gatherings, or when dealing with each other. According to the cultural rules, males should not start to shake hands with a female unless the lady starts.

21.8. Conflict of Interest

21.8.1. All employees shall abide by the conflict of interest policy, or activities that may raise questions about the hospital's values or otherwise cause embarrassment to the hospital, disclose any potential conflict of interest, and remove the conflict as required.

21.8.2. Employees will ensure that they do not engage in any activity that might create a conflict of interest for the hospital or for themselves individually.

21.8.3. All employees shall not take advantage of their position to seek personal gain through the inappropriate use of information or abuse of their position.

21.9. Disclosure of Information

21.9.1. All employees shall follow all restrictions in the use and disclosure of information. This includes following all requirements for protecting information and ensuring that non-hospital proprietary information is used and disclosed only as authorized by the owner of the information or as otherwise permitted by law.

21.9.2. All employees shall observe that fair dealing is the foundation for all of our transactions and interactions.

21.9.3. All employees are responsible for safeguarding the confidentiality of information related to the privacy of patients, hospital information, and information owned by others.

21.9.4. Gifts: No staff member shall accept any gift, favors, services, or other things of value under the circumstances from which it might be inferred that these were offered for influencing them in the discharge of their duties

21.9.5. Customer Satisfaction

21.9.5.1. Every employee shall promote relationships based on mutual trust and respect and shall provide an environment in which individuals may question a practice without fear of adverse consequences.

21.9.5.2. Problem solving is the process of taking corrective action in order to meet customer satisfaction as the ultimate goal of the hospital.

21.9.5.3. Problem solving follows the steps in the problem-solving process and is the responsibility of every employee in the hospital.

21.9.5.4. Every employee has to believe in the Customer Satisfaction concept and that the satisfied customers are essential to our success. This can be achieved by understanding what the customer requires and delivering it flawlessly.

21.9.5.5. Every employee has the responsibility to protect all customer and supplier assets and use them only for appropriate-approved activities.

21.10. Computer User Code of Ethics

21.10.1. Users are ultimately responsible for any and all use of their computing accounts.

21.10.2. Users should maintain secure passwords for all accounts assigned to them.

21.10.3. Users should take precautions against others obtaining unauthorized access to their computing resources. This obligation applies particularly to users who are responsible for confidential information.

21.10.4. Users must use computing facilities and services only for the purpose for which they were authorized. Specifically, accounts must not be: Used for private consulting or for any form of direct or indirect personal financial gain, for example, the stock Market. Provided as resources to other persons for unauthorized purposes.

21.10.5. Users should not willingly release passwords and other access control information for their personal accounts to any other person.

21.10.6. Users should not move or copy programs, and any other forms of software, from one computing system to another without proper authorization. This includes personal computer and personal workstation software.

21.10.7. Users must not attempt to interfere with the normal operation of a shared system.

21.10.8. Users must not attempt to invade on others' use of computing facilities or to deprive others of resources.

21.10.9. Telephones

21.10.9.1. Everyone is responsible for answering the phones as quickly as possible, after a maximum of three rings.

21.10.9.2. The telephone is one of the links that the hospital has to the public. It is therefore extremely important that each caller be treated with politeness and courtesy , regardless of the nature of the call.

21.10.9.3. The responsibility of the employee who answers the phone call, if he is not the required person, is to forward all calls or take messages for personnel out of the office.

21.10.9.4. Telephones are for business purposes only. Personal calls are permitted during working hours to a minimum, and any personal calls must be made from a pay telephone or cell phone.

21.10.9.5. Mobile phone: all unacceptable rings are forbidden to be used on the premises, and the ring should be on vibration or beep once only.

21.11. Visitors

21.11.1. A visitor is considered anyone who is not a current member of the hospital listed in the directory. All visitors must sign in at the Security Reception Area and are only allowed on the premises during working hours with permission.

21.11.2. No visitors are allowed on nights or weekends without prior permission from the Department Head.

21.11.3. If a problem arises, security will be contacted. Any violations of this policy may result in disciplinary action.

21.11.4. Building Access

21.11.4.1. To access the hospital building, the employee has to have his/ her ID visible to the security guard.

21.11.4.2. The security officer has the right to ask any employee about their ID if it is not visible.

21.11.4.3. During Working Hours: In case the employee is not wearing his/her ID, the security guard has the right to stop this employee for questioning.

21.11.4.4. After working hours: The security officer will stop any employee if the ID is not visible on them & will ask the employee to register their name, ID number, department, time, and reason for being in the hospital in the security log sheet.

21.11.4.5. Fire and Disaster Drills (FDD): During legitimate drills, the following procedure will take place: When the alarm signal sounds, all personnel will immediately evacuate the premises. Follow the FDD procedures.

21.11.4.6. Safety: All employees will comply with all laws and regulations governing the handling and disposal of hazardous materials, other pollutants, and infectious wastes

21.11.4.7. Traffic and Parking Regulations: The Hospital Authorizes the Department of Security to issue an internal traffic and parking citation within the boundaries of the hospital to employees if they violate the employee parking policy.

21.12. Enforcement of the Orders

21.12.1. Drug abuse is a serious offence. The mandatory punishment is death, so avoid getting involved with drugs.

21.12.2. No employee shall use, possess, distribute, or be under the influence of alcohol, narcotics, or other dangerous illegal drugs in or out of the hospital at any time.

21.12.3. The possession or use of illegal drugs or alcohol on the premises will result in immediate dismissal, and the matter will be referred to the governmental authorities for further action.

21.12.4. Law enforcement officials are not allowed to keep firearms, unless the use of these weapons is permitted by the Saudi Ministry of Interior.

21.13. Questions and How to Report Violations of the Standards:

21.13.1. Every employee has the responsibility to ask questions, seek guidance, and report suspected violations of this Code of Conduct. Revenge against employees who come forward to raise genuine concerns will not be tolerated.

21.13.2. It is also important that every employee has an effective way to get an answer to any question they may have about the best practice of this code of conduct.

21.13.3. In the event that an employee has a question or concern or believes that someone is conducting their business in an illegal, unethical, or otherwise questionable manner, or violating hospital policies, it is preferred that the employee first contact his or her supervisor to discuss the matter.

21.13.4. There are times, however, when either the response of the employee received may be inadequate or the employee may feel uncomfortable in discussing the matter with his or her supervisor. In those cases, the employee should contact the employee relations supervisor.

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22.24. Security Forces Hospital Medical By-laws

23. APPROVALS:

NO.	POSITION	NAME	SIGNATURE	DATE
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2	Head of Internal Medicine	Dr. Majed Khalifa		18/12/2024 10:33

مستشفى الإمام عبدالرحمن الفيصل
Imam Abdulrahman Alfaisal Hospital
Empowered by Riyadh First Health Cluster

IMAM ABDULRAHMAN AL FAISAL HOSPITAL BY-LAWS		
TITLE	**MEDICAL STAFF BY-LAWS**	
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APPLIES TO	**ALL IAFH STAFF**	

3	Head of Nursing Quality Improvement Unit	Ms. Amal Alhoilan		18/12/2024 11:09
4	Head of Obstetrics and Gynecology	Dr. Naeemah Abdulkader		18/12/2024 12:27
5	Head of General Surgery	Dr. Sarah Alharbi		18/12/2024 13:37
6	Head of the Emergency Department	Dr. Osama Bakheet		18/12/2024 14:40
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1	Hospital Director Assistant For Human Resource	Mr. Nabil Madkhali		01/01/2025 09:34
2	Hospital Director Assistant for patient services	Mr. Mohammed Alkhayat		01/01/2025 13:18
3	Hospital Director Assistant for Medical Affairs	Dr. Abdullah Alzayedi		01/01/2025 14:40
4	Hospital Director Assistant for Financial and Administrative Affairs	Mr. Thamer Al Thamir		02/01/2025 10:35
5	HDA for Nursing Affairs	Ms. Maryam Harthi		02/01/2025 13:17
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Effective Date : 20/01/2025				

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IAFH MEDICAL STAFF BY LAWS

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مستشفى الإمام عبدالرحمن الفيصل
Imam Abdulrahman Alfaisal Hospital
Empowered by Riyadh First Health Cluster

IMAM ABDULRAHMAN AL FAISAL HOSPITAL BY-LAWS						
TITLE	MEDICAL STAFF BY-LAWS					
DEPARTMENT	INDEX NUMBER		ISSUE DATE		REVIEW DATE	
IAFH	BYLAW.IAFH.001		18/12/2024		17/12/2027	
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POLICY HISTORY

Version	Title	Issued On	Review On	Effective On
BYLAW.IAFH.001 v.2	MEDICAL STAFF BY-LAWS	18/12/2024 00:00	17/12/2027 00:00	20/01/2025 00:00

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