CGP 147

CLINICAL QUALITY ASSURANCE POLICY, PROCESSES AND PROCEDURES

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1. POLICY INTRODUCTION

National Ambulance (NA) strives to deliver clinical services in accordance with international evidence based best practices, and with the appropriate adopted/adapted policies, procedures, protocols guidelines and training as approved and/or published by National Ambulance.

National Ambulance provides its employees with quality assured processes, systems and content to produce quality clinical services activity and outcomes including training and ongoing fitness to practice to ensure quality and safe best clinical practice are maintained by NA staff.

This policy is developed and implemented to ensure that the services that NA delivers meets a set standard of quality in to support the aims of the organization and to meet the requirements set by regulatory and accrediting bodies associated with National Ambulance.
The Clinical Quality Assurance Plan Policy applies to all staff and administrators at National Ambulance and will be held accountable through routine evaluations and audit processes. Measures may include but is not limited to peer reviews, performance appraisals, audits, client feedback including complaints and investigations.

This policy is related to management components of leadership and commitment and Continuous Improvement.

2. SCOPE

This Clinical Quality Assurance Policy includes all necessary elements and activities to provide Clinical Quality Assurance for National Ambulance under the umbrella of CGP 150 Clinical Governance Policy and in accordance with the Clinical Services Strategy, Framework and Implementation plan.

This policy includes all details necessary to plan and deliver quality assurance including reporting duties to providers of external accredited courses, to regulatory bodies and to other accrediting bodies such as JCIA, ISO and AHA. It will also contribute to compliance with Legal and Regulatory requirements.

This policy includes the roles and responsibilities of clinical services personnel, the procedures implemented to maintain the quality of all resources including staff, students, documentation, training programmes, training materials and education sites.

3. ROLES AND RESPONSIBILITIES

The Medical Director / Medical Delegate is responsible for:

- Ownership, oversight and approval of the Policy, its revision and any procedures detailed herein
- Related clinical or ethical issues that may arise
- Oversight of all key performance indicators detailed in this policy as well as others that are agreed for inclusion to ensure clinical quality is improved.

The Education Manager is responsible for:

- Leading the implementation and monitoring of the Education part of this Policy and Procedure to ensure that quality is maintained, with aim for continuous improvement
- Ensuring that relevant partnerships and accreditations are in place, remain current and are fit for purpose
- Review and update of this policy
- Ensuring that the Education department is capable of conducting quality courses.
- Course monitoring - The clinical education manager (or their designee) shall at least once a month monitor the standard of the delivery of courses by instructors
- Use the Clinical Audit, Mentorship Scheme and Clinical Incident Reporting data to enhance content of the courses
- Ensuring staff receive clinical updates for both internal and externally validated courses
- Oversight of the Learning Management System (LMS) with regards to availability and timings of courses
- Evaluating Clinical Educators and Instructors who provide training for NA staff
- Providing recommendations on clinician who can be privileged for various activities
- Rostering of available instructors
- Ensuring student: Staff ratios are maintained
- Ensuring Course bookings are managed
- Protection of Examination material and course completion documents (physical and electronic)
- Review student's feedback forms and complaints regarding the department

Clinical Governance and Audit Officer is responsible for:

- Supporting the Medical Director/Medical Delegate and other clinicians in achieving clinical governance excellence against all elements of the Clinical Governance Strategy Framework and Implementation policy
- Support the Medical Director/Medical Delegate with clinical performance to ensure that all NA health professionals are aware of their responsibilities and appropriate accountabilities
- Provide advice on clinical accreditation requirements (JCIA, ISO, OSHAD, DOH & Partner Organizations) with regard to facilities and professionals
- Oversight of all clinical and patient related policy and procedure development and review using an agreed policy framework
- Facilitate the process to ensure that clinical guidelines are current and appropriate to the model and level of care delivered and will improve patient safety and quality of care
- Management of staff in the Clinical Governance Team
- Evaluating the clinical audit program to ensure that clinical audit occurs at all levels of service; that an open disclosure and learning attitude is maintained.
- Working with QHSE manager and necessary data analysts to integrate incident monitoring data into clinical governance systems
- Managing systems for collating and analyzing clinical data and identifying clinical trends
- Assist with the production of agreed clinical performance KPIs

- Develop recommendations from clinical governance reviews, clinical audit and clinical incidents; evaluate, implement, monitor and report on these clinical improvement strategies/processes.
- Establishing and managing systems for collection and dissemination of clinical performance information including reporting against agreed clinical measures and agreed performance indicators

Administrative Coordinator Clinical Services is responsible for:

- Supporting the Medical Director/Medical Delegate and the Clinical Services team with day to day administrative services.
- Coordinating administrative services in the department including the duties of the administrative staff.
- Ensuring all administrative processes comply with policies and procedures.
- Overseeing the administration of the Continued Medical Education Learning Management System.
- Coordinating health professionals' CME credits reporting.
- Coordinating and recording of certifications and feedbacks for clinical practice purposes.
- Issuing accurate course AHA completion cards and certificates.
- Supporting Occupational Health staff where necessary.
- Supporting all clinical service leads as necessary

Clinical Educators are responsible for:

- Delivery of education in accordance with the approved curriculum, using equipment that is safe and best quality against the relevant standards approved for use by National Ambulance
- Engage in peer reviews
- Participate in Clinical Investigations as required
- Initiating remediation plans and assisting in independent training plans
- Accurate use of the Learning Management System (LMS).
- Availability of pre course materials such as student materials and information regarding pre course testing.
- Protection of Examination material and course completion documents (physical and electronic).
- Maintain document control as per accredited bodies recommendations and/or internal policy on document control guidelines.
- Issuing accurate course certificates and PHTLS completion cards.

Clinical educators must have attained a minimum level of qualifications and experiences to be able to fulfill this role which includes:

- Licensed with DOH / MOH
- Experience in administering the skills that they are teaching
- Instructor qualification valid and current for the courses they are teaching
- Evidence of performance appraisals, any clinical updates and any necessary remediation

Clinical Mentors are responsible for:

- Mentoring/Educating/Supporting/Assessment of staff engaged in the process within the Mentorship Program
- Completing **Daily Observation Report** forms when mentoring/supporting operational clinical staff in the field and record the outcomes and any consequent actions

Clinical Mentors must be evaluated by the Mentorship Coordinator/Clinical Educator. This may be performed via simulation cases and field evaluation by the Mentorship Coordinator/Clinical Educator at least once a year or more frequently as required to assess and guide the mentor's clinical and educational supportive and assessment capabilities.

Clinical Services staff must adhere to this policy and must notify the identified line manager if they are unable to comply, or if there are any concerns with the process or procedure.

All Clinical staff must comply with all relevant elements of external organizations' requirements, and in accordance with their roles and responsibilities as detailed below and must notify their line manager.

4. POLICY STATEMENT

This policy details the Quality Assurance strategies and activities of the Clinical Services department which permit 'Continuous Improvements' to all elements of the department's services. The Quality Assurance activities are monitored, analyzed and revised to enable robust quality assurance aligned with National Ambulance vision, mission and strategic plan.

Quality Assurance is specified for the following areas:

- Clinical Governance.
- Compliance and Accreditation.
- Education.
- Research and Development.
- Medication Management.
- Occupational Health.

This policy is related to the following NA Policies and Procedures:

- Other Policies of Clinical Departments need to be included, eg Medication Management, Clinical Governance etc. CGP 134 Patient Care Protocols; Clinical Practice Guidelines 2016
- CGP 146 Continuing Medical Education Policy
- CGP 150 Clinical Governance Policy
- CGP 203 Fitness to Practice Policy & Procedure
- CGP 207 Clinical Ethics Internal Working Group
- CGP109 Policy and Procedure on Clinical Ethics
- CGP148 Clinical Audit Policy and Procedure

Clinical services staff will report against the key performance indicators including, but not limited to those detailed below in accordance with their roles and responsibilities:

- Licensure of facilities and professionals
- Follow up on regulatory circulars and standards

- Review and revision of Policies and Procedures against set time frames
- Resolution of clinical incidents within set time frames
- Staff influenza vaccination rates / Immunization Programmes
- Research and development reports
- Performance monitoring of staff
- CME reflecting current clinical practice documents e.g. protocols, clinical practice guidelines
- Staff completion rates of CME
- Review of student feedback
- Drug pack inventory
- Pharmacy stock check
- Drug storage compliant with regulations
- Clinician access to in-date medications
- NA Newsletter

4.1. CLINICAL GOVERNANCE QUALITY ASSURANCE

Patient Safety remains centric to all clinical care provided thus to ensure no harm is done to patients the team works to ensure:

- Patient rights and patient confidentiality are maintained
- Appropriate Clinical Standards, Policies, Protocols, Guidelines and Procedures are created and monitored for effectiveness. They are reviewed regularly to ensure they remain fit for purpose and lead to best patient outcomes, benchmarked against international best-practice
- Clinical audit is undertaken regularly to provide the organization with data to formulate clinical enhancements, mitigate risk and achieve market excellence
- Patients and staff are exposed to clean and safe environments
- Minimization of avoidable harm such as drug errors or healthcare associated infections
- There is active management of any clinical risks identified in the organization
- Action is taken to prevent recurrence of any patient safety related incidents
- All processes are adhered to ensure that all clinical resources are fit for purpose
- Ensuring all processes ultimately lead to beneficial outcomes for the patients and the community as a whole

4.1.1. Clinical Audit

As part of effective service development, international gold standard benchmarks are used to develop the Key Performance Indicators (KPI's), the results of clinical audit are measured against these and utilised as a key area of research potential. This can assist in service development and improving patient outcomes, ensuring appropriate care bundles are delivered to all patients. To achieve improvements in patient outcomes, it is imperative that KPIs are appropriately determined. NA clinicians work collaboratively to develop and report on appropriate bench marking KPIs. Key areas benefitting from identifying KPI priorities include, but are not limited to:

- STEMI.
- Trauma

- Paediatrics
- Burns
- CVA (Stroke)
- Sepsis
- Seizures
- Hypoglycaemia

The areas are aligned with the DOH Public Health Strategic priorities; information from the DOH clinical stakeholder working groups feeds into NA quality assurance decisions and activities. Data management including extraction and verification is carried out in accordance with the clinical audit policy and procedures. Timely analysis of data is carried out to ensure immediate areas of concern can be evaluated and where necessary action plans developed and implemented.

Results, trends and issues identified at audit are fed back to relevant line managers, education team, individuals or other relevant staff to ensure compliance with expected standards and policies including Policy on Fitness to practice. Feedback is delivered in a timely, evidence based manner. Positive outcomes and issues and trends requiring action can be summarised in NA Communications and ultimately influence review and revision of policies, procedures, protocols and educational courses and materials.

4.1.2. COMPLIANCE AND ACCREDITATION

4.1.2.1. Compliance

National Ambulance ensure quality through demonstrating compliance and by working with and in accordance with DOH, Ministry of Health and any other legislated standards to ensure Legal and Regulatory compliance. The specific elements are managed using internal and external systems, processes, policies, procedures and forms including but not limited to the following compliance measures:

- Healthcare Facility Licensing
- Professional Licensing
- Notification of Suspected or Confirmed Communicable Diseases
- Notification of Sentinel Events
- Influenza Immunization data
- Clinical incident management
- Quality performance indicators

Proactive strategies and operations such as regular scheduled review of laws and regulations are used as well as external legal review to maintain continuous improvement including a detailed scheduled review of applicable Federal and Emirate laws, regulations and circulars that inform internal policies and procedures.

Maintaining the quality of NA licensed professionals is essential, this is comprehensively detailed in section 7.2 and refers specifically to CGP 203 Fitness to Practice Policy and Procedure to ensure Professional licensing compliance.

Maintaining appropriate healthcare facility licensure is a necessary and continuous quality assurance activity following the DOH and MOH process, systems and requirements and identifying any issues or risks in a timely manner. Support is given by other departments for corporate elements such as Financial, Human Resources and QHSE.

4.1.2.2. accreditation

External Gold standard accrediting bodies such as Joint Commission International (JCI), International Organisational Standards (ISO) and American Heart Association (AHA) are used by NA to maintain accreditation against international standards and to benchmark quality measures throughout all systems and processes in the organisation.

NA will meet the requirements of those external bodies giving full access to the clinical services department, any designated training sites, personnel and any documentation and teaching materials. NA, will also ensure access to clinical services staff records of training to be externally monitored and verified by course accrediting bodies.

To demonstrate NA's commitment to the provision of quality and safe services and education using the latest relevant standards it shall also prepare for and accommodate all audit and review of its department's policies and procedures, by external accreditation bodies. Responses to the findings or auditors or surveyors is the catalyst for action planning, progression and closure of any compliance issues.

4.2. EDUCATION

4.2.1. QUALITY ASSURANCE OF EDUCATIONAL STAFF

4.2.1.1. INTERNAL REVIEW

Instructors and mentors within the education department are monitored through peer and / or management evaluation when delivering educational activities. This is evidenced by provision of constructive feedback. These reviews are monitored by the Education Manager for trends and issues, and addresses individual needs where necessary through, staff appraisal, or the production and progression of remediation and individual training action plans.

Student feedback is obtained on completion of all face to face courses offered by NA, students are offered feedback forms either from the accrediting / awarding body responsible for the course (E.G. AHA) or an NA internal feedback form – **QHF411 – Clinical Education Evaluation Survey**. These forms specifically

monitor the perceived quality of the learning experience, the capability of the instructor delivering the training and the relevance of the training to their clinical practice.

Forms are collated by administration staff and the results documented and data is produced, There is regular monitoring and analysis by the Education Manager, and where necessary the Clinical Governance and Audit Officer and MD.

If trends or issues are identified appropriate actions are initiated from any findings to ensure quality and continuous improvement is maintained within the department. This involves the monitoring of the abilities of educational staff using **the CGF 411 – Clinical Education Evaluation Survey**.

4.2.1.2. EXTERNAL REVIEW

External agencies with whom NA has educational partnerships regularly inspect educational staff's documentation and delivery of courses content as well as interaction with students. This provides quality assurance to NA of an individual educator's proficiency and the overall quality of training delivered by the departments using fully developed systems and processes and tools and in accordance with the requirements of each organisation.

4.2.1.3. COMPLAINTS AND APPEALS

Students are clearly informed that if they have any cause for concern, or with to appeal decisions made by the education staff they can initially discuss their concerns with the educator involved, or the education manager. If a resolution is not achieved students can complete a complaints and appeals form (**CGF 102- Education Complaints and Appeals form)**.

These forms are reviewed by the clinical education manager; should staff not agree with the findings made by the education manager, students may request their case be reviewed by the MD.

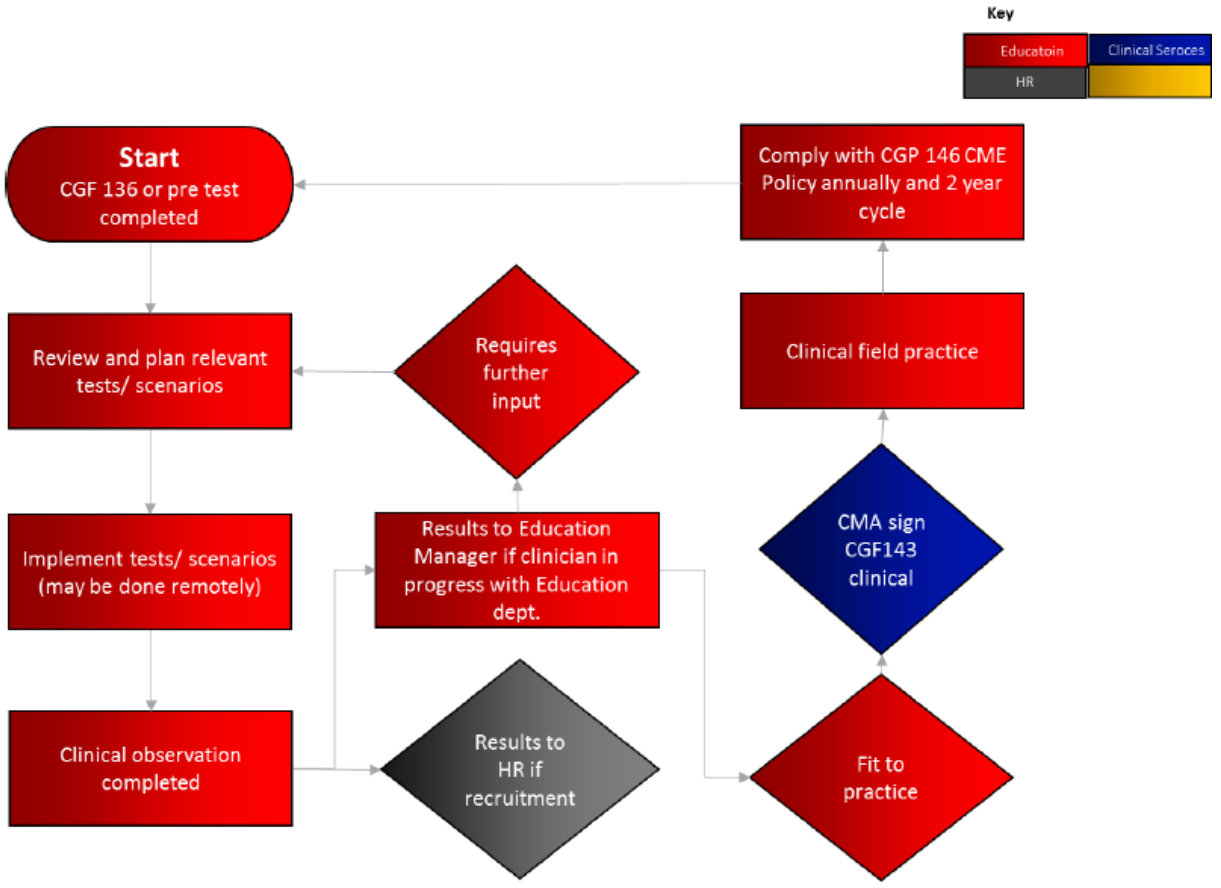
4.2.2. QUALITY ASSURANCE OF CLINICAL STAFF

4.2.2.1. Scope of practice

To ensure continual provision of clinical staff capable of delivering comparable standards of care in accordance with the CGP 203 Fitness to Practice Policy, and to serve patients and clients, the Clinical Services department take an active role in recruitment and ongoing training of suitable clinical staff including but not limited to:

- Review of clinical credentials;
- Clinical skills testing – face to face and through electronic functions;
- Approval of applicants in conjunction with corporate services team;
- Review of completed Clinical Competency and Skills Inventory Form CGF136 and subsequent action planning for appropriate level of training and assessment required for the staff member;
- Education of clinical staff to ensure they meet the relevant level of clinical privileges and meet the regulator's license requirements
- Recommendation and approval of clinical privileges as well as review at least annually.

FITNESS TO PRACTICE PROCEDURE CGP 203



Where gaps in practice or skills are identified, the education department will provide appropriate training or re-categorisation of the level of privileges recommended to the MD. This ensures that all staff act within their scope of practice and ability, and provides a mechanism of internal regulation of expected scopes of practice for all clinical grades.

4.2.3. TRAINING MATERIALS

4.2.3.1. Student materials

To enhance students learning experience, all current clinical materials are available to staff through the Learning Management system and through the NA e. Library. Materials include but are not limited to:

- Policies & Procedures
- Clinical Practice Guidelines
- Patient Care Protocols
- Medication Formulary

For specific courses relevant training materials are made available to learners at least two weeks prior to commencement of the course. Students must utilize all such learning material prior to attending the course, and complete any required pre-course testing. This material may be kept by the student for future reference after completion of the course to assist in their continual development and education.

Students have made available (and utilize), on-line educational resources designed by the clinical services and education department to complement training and educational activities and provide more variety of learner methods available to staff. In the event of the students not being able to complete online pre-learning, or access educational programmes contained on the education department's Learning Management System (LMS), these are made available to students in hard copy two weeks prior to the course commencement, to ensure all staff have access to full body of educational material offered by NA.

4.2.3.2. Course materials

Courses offered by NA, and the material of existing courses are regularly reviewed by the department to ensure they are up to date with current best practices and in line with recommendations made by external accrediting bodies. They shall also be developed as required, to address clinical concerns, identified organisational risks, gaps in clinical skills or practices or to meet organisational growth strategies.

The necessity to review learning material may be initiated from external course providers, when new international guidelines are introduced, from student feedback forms, complaints, investigations, to meet expected or projected organisational growth or staff development. Periodically (at least once a year), the educational manager will ensure that all course contents are evaluated by educational staff to ensure they meet current best practices and organisational policies, protocols and procedures.

The completion of the learning and assessment strategies review form must be completed when courses are reviewed, and when in-house courses are developed; to establish the programme's ability to address identified gaps in practice, knowledge or ability to disseminate new corporate directives and to test knowledge and competency in accordance with any revised materials.

4.2.3.3. Security of materials

All written examination papers are protected by storage in a locked cabinet in an office which is also secured when unattended. Access to the written examination papers is restricted to the Clinical Educators, the Administrative Coordinator and Faculty only. All training records are held securely and are reviewed by relevant management as required.

Examination papers are circulated to educators immediately prior to the examination taking place, for the time interval between, the distribution of papers to educators and the commencement of the exam, instructors must keep all papers about their person and not leave them unattended at any time.

Course completion cards are ordered only by the Clinical Education Designated Coordinator, the Administrative Coordinator and a designated Faculty who have access to the security code, which is not to be disclosed to anyone. When cards are received, they must be kept in a secure, locked location. The course administrators are the only persons who have access to the course completion cards. Cards are not held anywhere outside the NA Head office location prior to being completed and distributed to learners upon their signature for receipt.

4.2.4. CONTINUING MEDICAL EDUCATION (CME)

Courses are delivered with the ultimate aim of imparting current knowledge and assessing the skills and competencies of the staff members to enable clinical privileges to be recommended and approved. Tools and processes used to measure the achievements such as scenario assessment and simulation activity meet international best practice standards and have oversight from the Medical Director and help with ensuring staff competency.

Staff within NA are expected to achieve CMEs each year to achieve and maintain their Department of Health (DOH) Licensure and fulfil NA requirements, this is included in CGP **146 Continuing Medical Education (CME)** policy.

The education department facilitates CME by the provision of in-house developed courses and internationally approved and accredited training courses. Category one CMEs are DOH approved and have varying levels of CMEs credited to them **in accordance with CGP 146.** These courses are recorded on the Learning Management System (LMS) and reports are run on at least a monthly basis and may be externally monitored by DOH and other accrediting bodies to ensure the quality and consistency of education to all NA staff and external clients.

In accordance with CGP 146 and CGP 203 courses are delivered to ensure that staff can meet the licensing and clinical competency requirements, courses are normally booked through the Learning Management System or if the system is not available through contact with Education Co-ordinators and administrators.

4.2.5. MAINTAINING LICENSURE OR REGISTRATION

To ensure staff from other countries maintain their professional registrations, the education department provides continuous training. This ensures NA staff are recognised both nationally and internationally by

NA supplies all its staff with certificates of completion for CME courses attended, these may be utilised by staff to maintain clinical registration in other countries, as well as supporting and maintaining DOH licensure in the UAE.

4.2.6. PROGRAMME GROWTH AND DEVELOPMENT

National Ambulance offers international, evidence based relevant courses with clearly identified learning outcomes as required for its employees to ensure best quality clinical care can be delivered. Liaison with Corporate Services, the COO and Managers ensures planning for increased numbers of students and their relevant education needs. To achieve these objectives a ratio of 1 Clinical Educator to every 60 clinical staff members is to be maintained.

Provision of education for external customers is managed according to their needs and the ability of NA to accommodate them within any specified timeframe.

Recruitment of suitable education staff is an ongoing process managed by the Education Manager in conjunction with the Recruitment team.

Several growth opportunities exist in education and will be managed through the Education Manager in collaboration with the Medical Director as resources allow.

4.2.7. REMEDIATION AND INDIVIDUAL TRAINING PLANS

Where students fail to meet required expectations during CME courses or other educational activities, a remediation plan may be initiated by the instructor. Students shall be considered for remediation when they have fallen short of course expectations/ standards in accordance with, **CGP 128 – Remediation and ITP Policy and Procedure**. The policy and its procedures ensure that any identified issues are managed in a routine and comprehensive manner.

Failure to successfully complete a remediation in a particular subject or CME may result in the student being placed onto an Independent Training Plan (ITP) in accordance with CGP 128.

4.2.8. EQUIPMENT

4.2.8.1. Equipment evaluation within department

NA shall utilize education staff in collaboration with supply chain to evaluate all new clinical equipment which are to be considered for future purchase. This shall be reviewed in accordance with policies and procedures disseminated corporately. Involvement of the education department in this process has been included to ensure the clinical product options are safe and effective for patient use.

4.2.8.2. Equipment maintenance

To provide assurances that the equipment used during training sessions meet the international best practice standards (and in accordance with the instructor manuals for the relevant course), equipment is regularly maintained and serviced according to the manufacturer's instructions.

The equipment must be cleaned and stored in accordance with the Infection Control Policy to prevent and control cross contamination as per approved policies and procedures and with the manufacturer's instructions to prevent damage. Where necessary equipment is disposed of after use in the appropriate clinical waste container and in accordance with Hazardous Materials Policy and Procedure

4.2.9. TRAINING SITES

Education and training held at all National Ambulance sites, must only utilize instructors, equipment and materials approved by the headquarters site; they must conform to the same standards, policies and procedures detailed in this and other NA directives and accrediting organizations' standards.

External sites providing training under NA such as satellite AHA sites, if implementing any additional policies and procedures regarding staffing and equipment maintenance. However, they must demonstrate full compliance with policies and procedures of the accrediting organization for which they are delivering the training on behalf of.

4.3. RESEARCH AND DEVELOPMENT

National Ambulance plays a key role in the furthering of prehospital research in the Middle East region to confirm that the patient assessment and care undertaken by our staff is evidence based and produces optimum patient outcomes and to ensure that new clinical practices are safe and effective. Through a process of reviewing the international best-practice and contemporary medical literature, clinical developments that have the potential to positively impact on patients are regularly identified and integrated into the high-quality care options that staff can provide.

Working with partner organisations, including, but not limited to academic organisations as well as undertaking internal research activities within the organisation or through external commission, the overall goal of the research and development programme is to contribute to improvement of quality and safety of care.

Findings from research activities are marketed as poster presentations at conferences nationally and internationally, and finally, as published articles in prestigious international peer-reviewed clinical journals, professional publications and online repositories. In addition, any local trends or issues identified are analysed and action plan developed to inform any review or revision of policies and procedures, educational activities or materials and any operational issues.

For final research outcomes NA works with other stakeholders including hospitals to develop and implement mechanisms to make improvements in the continuum of care process and systems and to demonstrate outcome improvements such as the Disability Adjusted Life Year (DALY) for the UAE in accordance with the Federal initiative. Continuous improvements are also achieved by working with local,

national and international organizations and external research groups (PAROS, PATOS, and ADTSI) to establish a robust research programme.

4.3.1. QUALITY ASSURANCE FOR RESEARCH AND DEVELOPMENT STAFF

The research and development teamwork under the direction of the Medical Director and ensure, collaborative working with other clinical services and operational staff in accordance with the clinical research and development plan. The staff have relevant credentials and continuing medical education to ensure efficient and effective working practices. In addition, there is systematic use of an ethical approval system and documentation to ensure that best practice and quality clinical ethics are applied to any research and development related activity. Outcomes are measured through research articles and publications produced by the research and development team.

4.4. MEDICATION MANAGEMENT

Medication Management strives to deliver top quality pre-hospital services to customers in the UAE with the aim of improving patients' outcomes. Medication Management covers the whole lifecycle of any medication in the organization; from the clinically sound selection of medication, to its procurement, storage, dispensing, administration and subsequent monitoring of its effectiveness. Integrated within the lifecycle to ensure quality assurance is the education and training for the staff, audit, documentation and importantly compliance to regulations.

The Medication Management team is dedicated to adhere to all UAE regulatory body policies and standards to ensure safe control and management of medications used by the organization as well as the delivery of high standard medication services to patients.

As part of the department quality assurance commitment, Medication Management regularly reviews the Medication Formulary to formally control what medications are to be included using latest publications in evidence based practice, quality assurance activities (e.g., drug utilization review/evaluation and updating drug monographs), adverse drug reactions/medication errors, determining availability of drugs via DOH approved vendors, dealing with drug shortages and recommending alternatives and education in drug use.

Inventory control and continual supply of medication play an important role in optimizing patient care.
A vital part of Medication Management quality assurance priority is to ensure continuous supply of high quality emergency medications that is stored and supplied in a timely manner. The department constantly warrants continual supply of medications for all NA contracts through the Procurement and Tendering committee. The idea of the tendering provides consistency and maintains efficient supply of medications.

Quality Assurance is achieved by the following activities:

- Ensure adherence with all regulatory bodies regulations and requirements.
- Continuous improvement of all course material to include up-to-date information and guidance.
- Promote and apply clinical audits in and outside of pharmacy to ensure pharmacy standards are met appropriately.

- Controlled medication formulary in which the selection is based on clinical effectiveness and safety rather than cost.
- Procurement of medication through tendering process to guarantee supplies, quality and prices.

4.4.1. Medication Safety Assurance and Audits

In order to deliver top quality pre-hospital services to all customers in the UAE, the Medication Management places large emphasis on patient safety. The USA Institute of Safe Medication Practices (ISMP), UK National Patient Safety Agency (NPSA), and UAE government bodies such as DOH guide this department to reduce the risk of medication related errors. In combination, these agencies/authorities provide a variety of tools and up-to-date safety alerts to improve practice in an emergency/ambulatory healthcare setting.

The focuses of the department to ensure continuous improvements to quality assured processes are:

1. Optimization of control and storage of medications according to manufacturers', ISMP, and DOH/MOH regulations through regular review of guidance and implementation into policies and procedures as well as clinical practice.
2. Continuous temperature and humidity monitoring to keep all medication within the range recommended by manufacturers and DOH recommendations to optimize therapeutic effectiveness.
3. A continuous effort to enhance the accessibility to medication-related information to clinicians across the organization by issuing monthly medication related alerts. The alerts are dependent on analysis gained from Operative IQ audits and are issued in the form of Quick Reference Dosing Cards, and/or LMS educational courses through Education department.
4. Early error detection and reporting through regular clinical audits in and outside of pharmacy as well as continuous liaison with the QHSE department of National Ambulance.

Real time clinical audit utilizing ePCR / BI integration as used by clinical audit team is the key to ensuring patient medication safety. Not only does it measure the effectiveness and performance of healthcare against an agreed standard, but it also provides assurance of quality to service users, clinicians and the Medication Management Team. The incorporation of the web-based system Operative IQ within the Medication Management, which was launched November 2015, is a valuable, accurate tool for audit.

4.4.2. Medication Quality Assurance Processes

The quality of Medication management services is assured by the following inputs, managed by relevant policies and procedures and continuously monitored to ensure improvements and issues are detected:

- Continue to comply with all JCI Accreditation patient safety and quality requirements
- Follow up on DOH circulars for medications alerts, recalls and updates and implement actions within the timeframe requested

- Regular assessment of all medication storage areas pan organization to comply with DOH requirements
- Ensure continuous education for the Medication Management Team through DOH approved CME courses to ensure highest level of medication management expertise.
- Medication Management Induction Program for clinical staff
-
- Assuring medication formulary remains up-to-date with current literature and data on all drugs with reference to clinical guidelines
- Design of quick reference cards to support with dosing error reduction.
- Continuous improvement of course material to include latest information and guidance on safety
- Closely work with the Procurement specialist to ensure all medications are accepted through tendering process.
- Advanced planning and predication of stock usage
- Supplier performance measurements on regular basis
- Regular audits and analysis of medication usage across all contracts using OpIQ reports and PCRs
- Optimization of the current medication safety practices and procedures
- Promotion of medication error reporting and assess errors using root-cause analysis
- Reduction of the risk of errors of high alert medications via ISMP recommendations

4.5. OCCUPATIONAL HEALTH

The Occupational Health Program and Policy overall aim is promotion and maintenance of the highest degree of physical, mental and social well- being of National Ambulance employees. This involves a collaborative work from OH and other departments including Operations, Human Resources and QHSE.

The Peer Support Network of Occupational Health program aims to support the general psychological and mental well-being of all National Ambulance employees. Peer supporters are trained by the program coordinators. The plan for this element of OH program and policy is to increase the number and quality of available support to all staff.

Occupational Health team facilitates clear and comprehensive identification of staff and organizational health needs. OH manages assessed needs using best practice policies, procedures and resources to achieve continuous improvement. General well- being of employees is checked and monitored by the following elements to ensure their fitness- to- work:

- Pre- employment screening
- Health surveillance including periodic screenings
- Health education and health promotion
- Immunization program
- Workplace factors which might affect worker's health such as Ergonomics, Manual handling and workplace violence.

- Identification of occupational health hazards and exposures and control of hazards. Monitoring and facilitating management of work-related injuries and illnesses.
- Use of approved systems, processes and databases for all elements of occupational health.
- Work with an external licensed health care facility to provide care and services for National Ambulance staff in accordance with best practices, laws and regulations and monitor the outputs.
- Monitoring of staff sickness cases and change in health status to identify trends and issues for management.
- Peer support activity using the Peer support wellness program.

5. RELEVANT LEGISLATION

International, federal or local legislation and circulars relevant to this Policy. Full detail on this legislation can be found in QHP109 Legal Register.

Code, Name of Legislation	Jurisdiction
Code, Name of Legislation, Year here	Jurisdiction here

6. RELATED POLICIES AND FORMS

List related policies and procedures to the created/updated policy.

Policy & Procedure /Form
CGP 150 Clinical Governance Policy
CGP 134 Patient Care Protocols
CGP 146 Continuing Medical Education Policy
CGP 203 Fitness to Practice Policy & Procedure
CGP 207 Clinical Ethics Internal Working Group
CGP109 Policy and Procedure on Clinical Ethics
CGP148 Clinical Audit Policy and Procedure
CGP 128 – Remediation and ITP Policy and Procedure

7. FEEDBACK

Any feedback or suggestions for improvement to this Policy, Processes or Procedures can be submitted to ghse@nationalambulance.ae

8. DOCUMENT CONTROL AND OWNERSHIP

A review and update of this document will take place as necessary, when changes occur that identify the need to revise this Policy such as changes in roles and responsibilities, release of new legislative or technical guidance, or identification of a new policy area.

This document ownership for editing is identified as:

- Medical Director

This controlled document is managed / overseen by Medical Director.

Version No.	Date	Changes
1	27 May 2014	First Version
2	12 September 2016	Clinical Educator Coordinator roles and responsibilities, frequency of evaluation of full time Clinical Educators and part time Instructors. Substantial revision to include other Clinical Services areas, previously only for Education Quality Assurance
3	28 October 2020	Policy Update due to expiry Title changes Medical Director (MD) & Department of Health (DOH) Education Department changes incorporated incl. Mentorship Incorporate Pharmacy Services Inputs Incorporate Clinical Governance Inputs Incorporate Changes as advised by Medical Director Update Occupational Health Remove RIB Changed GM to Clinical governance & Audit Officer Changed Performance Director to QHSE manager

CEO Approval

Board Member Verification