Vision

King Khalid University Hospital, Ambulatory care Department will Work to achieve:

Optimum standards of care by practicing Evidenced Based Medicine.

Full respect to human dignity

An Innovative Center for Medicine and Nursing with respect to Patients Care that meets International Standard.

Best quality of life of our clients.
Mission

Ambulatory Care clinics will continuously provide individualized Treatment and care to all with highest quality standards that reflects the values of compassion, integrity and dignity. Utilizes the resources Of King Khalid University Hospital in the most prudent manner and within the scope of Out Patient Department.
Values

All Out patient’s staff and personnel will:

Improve and maintain Health and well being of every patient/client by providing high Standards and quality medical care following standardized protocols and guidelines of King Khalid University Hospital culturally appropriate and evidence based.
The Out Patients Department operates in 6 Cs....

Committed and competent: 
Staff to deliver quality care

Compassionate and caring:
To all patients/clients

Collaborate and coordinate:
To all team members and Department/clinics for early diagnosis and treatment.
General goals:

To provide comprehensive medical services under standardized Protocol and guidelines in accordance with the provisions of Saudi legislation in all areas in the Out patient Care.
Goals of Out patient Department

1. Maintain the momentum of services delivery and implementation of established policies, health programs and projects.

2. Continue to focus on the different programs and activities of All Out Patients Clinics.

3. Acquisition of additional medical equipments and supplies for the improvement of existing health medical facilities and expansion of health services.
4. Conduct training and continue education to all health Personnel to improve knowledge and skills for more Effective service delivery.

5. Continuous health education to all patients especially those Who lack information on health care, importance of exercise, Diet and maintaining healthy lifestyle to live a Productive life.

6. Serve as a training centre for King Saud University medical students to make them skillful and knowledgeable individuals.

7. Provide a safe environment for all Health providers and recipients.
8. Encourage Ambulatory care staff to participate and be involved in any Research programs and activities which will help staff to improve their skills, for Professional growth and development to meet the changing need.

9. Maintain and sustain the referral system with the different specialty Clinic for early diagnosis and Treatment of referred patients.

10. Actively involved in all educational activities, programs and projects provided by the hospital to increase staff knowledge and improve their skills to make them more qualified in the areas which they are assigned.
11. Be supportive with all the innovation project implemented by the Hospital like the accreditation projects to meet the optimum Standards of care.

12. Regularly maintain all equipments and apparatuses to avoid any breakdown during procedure or treatment of patients.

13. To expand the number of clinics in an out patient setting to meet the increase number of patients and to decrease waiting time of patients.

14. To hire more staff to meet the pressing need of increasing number of patients.
Areas of coverage by the staff and their categories:

1. Primary Care Clinics are located in ground floor blocked 30 and 31, New Building. For those above 12 years of age both for male and female.

   This clinic has 3 sub-clinics:
   a. Refill clinic
   b. Triage Clinic
   c. Follow-up Clinic
2. **Employee Health Clinic**
is situated in the ENT clinic 2nd blocked 30. This clinic provides quality care services to all KKUH employees and staff, Faculty members of Medicine Department, dependents of KSU staff. (housemaids and Drivers for Processing only.)

3. **University Health Clinic**
is situated within King Saud building 17 level 5 and provides optimum health care services to all male university students.
4. **Student housing clinic** is a walk in clinic and open 24 hours a day and 7 days a week. This is located at Dirriyah student housing no. 25.

**Time of operation:**
- 7:30 am - 12:00 am
- 1:00 pm - 4:00 pm

From Saturday to Wednesday and Selected staff works half day on Thursday to do Physical examination of medical and nursing students.
Staff schedule:

Physicians

According to Rota issued by the Associate Medical Director of outpatient clinics, the staffs are distributed in clinics, to cover 10 sessions am and pm per week. Those who are included in teaching of undergraduate medical students, the number of sessions will be less according to their teaching load.
Staff schedule:

Nurses
Working Days start from Saturday to Wednesday for 9.5 hours daily and additional 2 days duty depending on the calendar days. Nurses are deployed in the Department of Emergency Medicine.

Dressing duty on Thursday on rotation basis. Receives referral from Pediatric clinic and Academic Staff Clinic.
Weekend coverage:

The staff covers the Thursday morning duty in such areas:

1. Direyah clinic “King Saud Campus” for staff families living in the Campus.

2. Primary Care Clinic in KKUH, for Medical checkup of:
   a. Undergraduate Medical students
   b. Dental College Students
   c. Nursing College Students

3. Supervising the dressing to patients referred from different clinic (Department of Emergency Medicine, Academic Staff Clinic and Pediatric clinic).

4. Students Housing Clinic
Holiday Schedules

Eid Holidays:

The Saudi and non-Saudi doctors are given their holidays according to Hospital Personnel Regulations (4 days in Eid Al-Feter and 5 days in Eid Al-Adha for non-Saudi)
Where the outpatient clinics in KKUH (two clinics male and female) are active from 8:00 am up to 12:00 midnight to reduce the load of patients on Accident and Emergency Room.
Ramadan and Eid schedules depend on the arrangement of duties by the Medical and Nursing administration. Primary Care Clinic are open during the days of Eid and Ramadan holidays with 2 physicians assigned from 8:00 am up to 12 midnight to reduce the load of patients in the Emergency Medicine Department.

Primary health Care staff nurses are schedule during the said holiday to assist the physicians on duty.
Annual leave:

Physicians:

Annual leave of physicians is according of number of booked patients and active clinics, the physicians are scheduled 6 months ahead of each summer.

Nurses are entitled to 45 days annual vacation and scheduled according to unit situation and staffing. Nurses are can apply additional days for their vacation like Eid and Ramadan holidays too.

They are also entitling to split and emergency leave.
Sick leave coverage: Physicians

Any colleague subjected to illness necessitate a sick leave, the Associate Director will reschedule the distribution of doctors in all areas and the following could be done:

1. The booked patients will be distributed among physicians.

2. To call some doctor from the peripheral areas or sending someone from outpatient clinic if possible.

3. To ask some academic staff to help if possible.
Sick leave coverage

Nurses:

1. All staff must report 1 hour before duty to be able to notify the supervisor on duty of their sickness.

2. Head nurse/designee must give referral to their staff to allow them to be seen in Employee Health Clinic. Any staff given sick leave must report back at their area before leaving the hospital.

3. All staff are entitled for 15 days sick leave.
How the Rota is Developed:

The Rota for outpatient clinics is done monthly by the Associate Director of the clinics with the approval of the Medical Director of Primary care Clinic. Physicians Rota are sent through their respective E-mail address.

For peripheral clinics the schedule is done and planned for 6 months.

Head nurse is responsible to make the Rota for the staff nurses and it is one month before the next schedule.
How the shortage is covered:

**Physicians:**
First the Rota will be revised by Associate and Medical directors, taking in consideration the number of booked patients and active clinics.

The following could be done:

1. The booked patients will be distributed among physicians.

2. To call some doctor from the peripheral areas or sending someone from outpatient clinics if possible.
Nurses

1. Only 3 nurses are allowed to go for annual vacation to avoid any shortage in the clinic.

2. If one staff is on sick leave, the head nurse will make special arrangement to cover her/his absence as not to compromised the delivery of any services that the clinic renders.

3. The Associate Director of Nursing will be informed if any shortage of staff occurs in the clinic.
Communication and Reporting:

Physicians:

Twice weekly meeting between the Medical Director and Associate Director from 7:30 am with fixed agenda and recommendations at end of meeting. Sometimes the meetings could be on daily basis if needed.

The Family Medicine Unit “Members from Academic and selected Hospital Staff of family medicine” meets every two weeks with agenda and recommendations on Monday, from 10:00 – 12:00 noon.

Monthly meeting with all staff members on Monday from 12:30 pm with agenda done by Associate director.
The reports of any recommendations or any memos coming through Director and Associate Director are E-mailed to all staff members through the Primary Care Secretary and if necessary by hard copies and everyone has to sign that he received a copy.

All recommendations and memos are kept and arranged in a labeled file by the Primary Care Secretary.

The Continuing Medical Education Meeting is held on Monday from 12:30 – 4:00 pm every two weeks.
All nurses are required to do yearly mandatory assessment for the following Programs:

1. Infection control
2. Fire
3. Medication Calculation
4. Cardio Pulmonary Resuscitation

Ambulatory Care Professional Development Programs are scheduled every Tuesday twice a month by the Nursing Education Department.

Sub-unit PDP are scheduled once a month and nurses are rotated to do lectures on medicine and nursing updates.
Staff Meeting

All staff nurse attend the monthly meeting with the head nurse every 2nd Monday at 3:30 pm.

Quarterly meeting is scheduled to meet with the Associate Director for Ambulatory clinics at the Seminar room at 3:30 pm every 3rd Monday.

Emergency meeting is scheduled any time as the need arises.
The Primary Care Clinic is responsible to provide complete Spectrum of services in an Outpatient setting to all 12 years and above from diagnosis to treatment.

The clinic gives also referral to specialty clinics and Department of Emergency if medical care and treatment needs beyond Primary care or needs further investigations.

We refer patients to do any laboratory Procedure and examination too.
The Services include:

1. Assess, diagnose, plan and treat cases from common to Chronic diseases.

2. Receives referral from Department of Emergency, wards, clinics and Outside referral from any Health center in the Kingdom.

3. Patients who are discharged from the ward and require follow up are seen in the clinic.

4. Patient who has seen in Department of Emergency for any minor Procedure will be followed up for dressing is in our clinic.
5. Refilling of medication.

6. Refer patients to specialty clinic for further management and care.

7. Administer drug injections prescribed by the clinic Physicians or completion of vaccination started from Department of Emergency like anti-rabies, hepatitis vaccines.

8. Administers therapeutic care to patients like Nebulization of asthmatic patients from the clinic or Employee health Clinic.
9. Health Education to all Diabetic patients every Sunday and Tuesday from 9:00 -10:00 am.

10. Serves as a training clinic for Medical Students and Interns.

11. Coordinate with other clinics or department on research or any studies render in our area.

12. Examines medical students and nursing students yearly.

13. Assist in the pre-employment procedure of all staff in KKUH and KSU.
Client/Customers

Patients from the whole kingdom
Hospital Staff and personnel
Medical Students
Nursing students

Supplier

Medical Supply
Information Technology
Other Departments/Specialty Clinics
Clinic support services (Laboratory, Radiology, Pharmacy others).
Staffing Plan:

Primary Care Clinic is staffed by:

Primary Care Clinic
Consultants: 18
Senior Registrars: 6
Registrars: 5
Residents: 7
Head Nurse: 2
Staff Nurses: 37
Secretary: 1
Porter: 3
Receptionists: 6
Number of patients seen and examined yearly (Data 1429)

<table>
<thead>
<tr>
<th>Name clinic</th>
<th>Total seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Clinic 1</td>
<td>25,775</td>
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<tr>
<td>Primary Care Clinic-2</td>
<td>32,769</td>
</tr>
<tr>
<td>Employee health Clinic</td>
<td>12,495</td>
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<tr>
<td>University Health Clinic</td>
<td>4,243</td>
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<tr>
<td>Student Housing Clinic</td>
<td>14,680</td>
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<tr>
<td>Diriyah Health Clinic</td>
<td>5,885</td>
</tr>
<tr>
<td>PCC1 (Gynecology Clinic)</td>
<td>3,589</td>
</tr>
</tbody>
</table>
1.0 Organizational Relationship:

1.1. **Reports to**: Consultants and General Registrars in patient care clinical matters and to the Chairman of the Unit in administrative matters.

1.2. **Coordinates with**: Registrars, Residents and Interns.

1.3. **Liaises with**: Other medical, nursing, technical and secretarial staff.

2.0 **Job Summary**: 

2.1. Exercise the highest possible standards of patient care according to clinical privileges and available resources.

2.2. Participate in the training and teaching program of the hospital.

3.0 **Duties and Responsibilities**: 

3.1. Abide by the Medical Staff Bylaws, Code of Medical Ethics, Rules and Regulations of the Medical Staff and those specific to the department.

3.2. Provide the highest attainable standard of medical care for his/her patients.

3.3. Carry out full range of inpatient and outpatient clinical duties as assigned by the Chairman of the department in accordance with individually approved clinical privileges.

3.4. Participate in the on-call duties as required by the department.

3.5. Teach staff assigned for training purposes

3.6. Participate in the improvement of quality of patient care (Total Quality Management Program, Quality Assessment Improvement Program) as applicable.

3.7. Fulfill the requirements of the Saudi Council for Health Specialties with regard to continuing medical education.

3.8. Participate in and actively supports approved research projects.

3.9. Deputize for his/her superior as required and share workload in his/her specialty during the absence of colleagues.
3.10. Strive to improve his/her clinical expertise as well as standard of practice with regard to morbidity and cost effectiveness.

3.11. Participate in the forward planning, and further development of the department.

3.12. Serve on hospital committees as requested.

3.13. Participate in the Major Disaster Plan of the hospital, as indicated.

3.14. Perform other applicable tasks and duties assigned within the realm of his/her knowledge, skills and abilities, within the hospital and/or affiliated medical facilities.

4.0 **Education/ Licensure:**

4.1. Graduate from a recognized medical school.

4.2. Master degree of equivalent in the desired specialty.

5.0 **Professional Experience:**

5.1. Essential:
   Specialized professional post qualification experience in the desired specialty in a recognized centre for at least 2 years

5.2. Desirable:
   Participated and preferably led original research.

6.0 **Specialized Knowledge and skills:**

6.1. Self-motivated and with awareness of current trends in the field.

6.2. Ability to work in a multi-cultural environment.

6.3. Ability to speak, write and read Arabic and English.

7.0 **Condition**

7.1. This job description will become effective on the date signed by the Dean of College.

7.2. This job description is subject to periodic review and should not be changed without approval Dean of College.
1.0 Organizational Relationship:

1.1. Reports to : Chairman of the unit

1.2. Coordinates with : Senior Registrars, Registrars, Residents and Interns.

1.3. Liaises with : Other medical, nursing, technical and secretarial staff.

2.0 Job Summary:

2.1. Exercise the highest possible standards of patient care according to clinical privileges and available resources.

2.2. Participate in the training and teaching program of the hospital.

3.0 Duties and Responsibilities:

3.1. Abide by the Medical Staff Bylaws, Code of Medical Ethics, Rules and Regulations of the Medical Staff and those specific to the department.

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3.14. Perform other applicable tasks and duties assigned within the realm of his/her knowledge, skills and abilities, within the hospital and/or affiliated medical facilities.

4.0 Education/ Licensure:

4.1. Graduate from a recognized medical school.

4.2. Saudi Board or equivalent qualification in the desired specialty.

5.0 Professional Experience:

5.1. Essential:

   Specialized professional post qualification experience in the desired specialty in a recognized centre for at least 3 years.

5.2. Desirable:

   Participated and preferably led original research.

6.0 Specialized Knowledge and skills:

6.1. Self-motivated and with awareness of current trends in the field.

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1.0 Organizational Relationship:

1.1. Reports to: Consultants in patient care matters and to the chairman of the unit in administrative matters.

1.2. Coordinates with: Senior registrars, Registrars, Residents and Interns.

1.3. Liaises with: Other medical, nursing, technical and secretarial staff.

2.0 Job Summary:

2.1. Exercise the highest possible standards of patient care according to clinical privileges and available resources.

2.2. Participate in the training and teaching program of the hospital.

3.0 Duties and Responsibilities:

3.1. Abide by the Medical Staff Bylaws, Code of Medical Ethics, Rules and Regulations of the Medical Staff and those specific to the department.

3.2. Provide the highest attainable standard of medical care for his/her patients.

3.3. Carry out full range of inpatient and outpatient clinical duties as assigned by the Chairman of the department in accordance with individually approved clinical privileges.

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3.14. Perform other applicable tasks and duties assigned within the realm of his/her knowledge, skills and abilities, within the hospital and/or affiliated medical facilities.

4.0 **Education/ Licensure:**

4.1. Graduate from a recognized medical school.

4.2. Saudi Board or equivalent qualification in the desired specialty.

5.0 **Professional Experience:**

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   Specialized professional post qualification experience in the desired specialty in a recognized centre for at least 2 years.

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   Participated and preferably led original research.

6.0 **Specialized Knowledge and skills:**

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6.3. Ability to speak, write and read Arabic and English.

7.0 **Condition**

7.1. This job description will become effective on the date signed by the Dean of College.

7.2. This job description is subject to periodic review and should not be changed without approval Dean of College.
1.0 CONDITIONS:
All family physicians must fill up the forms for new patient attending in Primary Care Clinic.

2.0 PURPOSE:
To provide Medical based line information and improve management and follow-up of patients seen in Primary Care Clinic.

3.0 DEFINITIONS:

3.1 Primary Health care: Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and community.

3.2 Assessment:

3.2.1 In clinical medicine, evaluation of the patient for the purposes of forming a diagnosis and plan of treatment.

3.2.2 In research, evaluation of a treatment or diagnostic test through experiment and measurement.

4.0 POLICY:
The new Primary Health Care assessment form is complete with more detail information about patient status.

5.0 PROCEDURE:
All physicians must fill up the require information using new assessment form for new patients seen in the Primary Care Clinic.

6.0 FORMS AND ATTACHMENTS:
New Primary Care Assessment Form
### 7.0 REFERENCE:

- **7.1** Old Primary Care Assessment form
- **7.2** Lowell General Hospital Adult Outpatient Initial Assessment Form
- **7.3** St Lukes Medical Clinic, Patient History and Physical Assessment Form
- **7.4** Gateway Community Health center Inc.
- **7.5** The American Academy of Family Physicians and the National Academy of Science Institute of Medicine
1.0 CONDITIONS:
Conducted by Diabetic Educator and applies to all Diabetic Patient new to Insulin.

2.0 PURPOSE:
To educate Diabetic patient new to Insulin.

3.0 DEFINITIONS:

3.1 Diabetes - Diabetes is a disease in which the body does not produce or properly use insulin. Insulin is a hormone that is needed to convert sugar, starches and other food into energy needed for daily life.

3.2 Insulin medication - Insulin injection is used to control blood sugar in people who have type 1 diabetes (condition in which the body does not make insulin and therefore cannot control the amount of sugar in the blood) or in people who have type 2 diabetes (condition in which the blood sugar is too high because the body does not produce or use insulin normally) that cannot be controlled with oral medications alone.

3.3 Hypoglycemia or low blood sugar is the medical term for a state produced by a lower than normal level of blood glucose (< 70 mg/dl).

3.4 Hyperglycemia or high blood sugar is a condition in which an excessive amount of glucose circulates in the blood plasma.

4.0 POLICY:
Diabetic patient who needs insulin should be started right after an agreement is made with the patient by his physician.

5.0 PROCEDURE:

5.1 Diabetic patient who needs insulin is referred to the Diabetic Educator for Education for the following:

5.1.1 A Proper administration of insulin medication.
5.1.2 Awareness of the signs and symptoms of hypoglycemia/hyperglycemia
5.1.3 Home monitoring of Blood glucose
5.1.4 Diet control
5.1.5 Exercise

5.2 Meeting the Diabetic Educator:

5.2.1 Monthly a diabetic educator is covering one area.

5.2.2 The nurse will bleep the educator when there is a patient for education.

5.2.3 The patient consultation will be done by the diabetic educator at the same day in a separate room for education.

5.2.4 Group education are held once or twice a week at the Primary Care Clinic, Seminar room for one hour. Patients need to be registered before the day of the group education.

6.0 Reference:


6.2 http://www.diabetes.org/about-diabetes.jsp
1.0 CONDITIONS:
Conducted by the Primary Care Physician and applies to all Patient who need refill of Medication.

2.0 PURPOSE:
To provide high-quality patient care to those who require refills on the medications.

3.0 DEFINITIONS:
3.1 Refill: Prescribing the medication for chronic Illnesses’ like Diabetes Mellitus, Hypertension and others before their next appointment date.

3.2 Booked Patient: Patient with Refill appointment.

3.3 Controlled medication: Drugs like Narcotics which be written special prescription form (Red Prescription)

4.0 POLICY:
Helps decrease undue burden from regular clinics by providing better patient compliance minimizing drug abuse and maintaining medication documents.

5.0 PROCEDURE:
5.1 Only patients (regularly attending the follow-up clinic appointments) are booked for the refill clinic appointment.

5.2 Patients coming for refill must have their future appointments’ booked with their regular clinic.

5.3 Patients will be prescribed only those medications that are documented in their file by their regular clinic.

5.4 Patient with a history of missing/cancelling appointment for more than 2 times or without seen by a doctor for the previous 12 months shall not be booked for refill appointments.

5.5 Patients shall not be booked for refill appointment if they have their last visit from A/E only.
5.6 The Refill Physician Task:
5.7 The refill physician only prescribe medication required until the next appointment.
5.8 The refill physician will not write any medication that is not documented in his/her File.
5.9 Refill physician may not change frequency, dose or strength of any medications.
5.10 Refill physician is responsible to write all medications prescribe by him on the Drug List paper.
5.11 Patients from Academic Staff Clinic must be served for refill at the same clinic.
5.12 Patients with psychiatric illnesses must get refill (controlled medication) from relevant clinic.
5.13 No refill for any controlled medication.
5.14 Patients will not be accepted for refill if he/she has a pharmacy sticker (even 14 days old).
5.15 Maximum number of patients seen per day will be 25 in the morning and 15 in the Afternoon.
5.16 Receptionist will process refill request from 8:00 am to 11:00 am and 1:00 pm to 3:00 pm.

6.0 FORMS AND ATTACHMENTS:
   6.1 Drug List Form/Refill Form
   6.2 Out patient Prescription
   6.3 Control Medication Prescription

7.0 REFERENCE:
1.0 CONDITIONS:

1.1 Conducted by the assigned Primary Care Physician and applies to:

1.1.1 King Khalid University Hospital Employees.
1.1.2 Medical students of King Saud University.
1.1.3 Faculty of College of Medicine.
1.1.4 Dependents of KSU staff (House maid /Drivers for Iqama process only).

2.0 PURPOSE:

To provide pre-employment physical check-ups, preventive and curative services during the day for all types of Acute, chronic and urgent cases.

3.0 DEFINITIONS:

3.1 Preventive: The prevention of disease and methods for increasing the power of the patient and community to resist disease and prolong life.

3.2 Curative: Curative services refer to treatment and therapies provided to a patient with intent to improve symptoms and cure the patient's medical problem.

3.3 Acute Cases: Is a disease with either or both of a rapid onset and a short course (as opposed to a chronic course).

3.4 Chronic cases: Is a disease that is long-lasting or recurrent persists for a long period of time, usually with a duration greater than three months.

3.5 Urgent Cases: An urgent situation calling for prompt action.

3.6 EHC: Employee Health Clinic
3.7 ICD: Infection Control Department
3.8 MOH: Ministry of Health
3.9 HCW: Health care worker
4.0 **POLICY:**

King University Hospital strongly committed to provide the highest safety standards for all employees by preventing controlling the spread of infectious diseases, creating and maintaining injury-free workplace, promote safe work practices and good environment for all. In pursuit of this endeavor all employees must have satisfactory Pre-employment health evaluation, properly immunized, supports positive and healthy lifestyle.

5.0 **PROCEDURE:**

5.1 Only employees of KKUH and KSU Medical students are eligible for consultation and treatment in Employee health Clinic.

5.2 All KKUH and KSU staff for pre-employment examination must obtain the pre-medical form from the Personnel Department duly signed by the Department head.

5.3 All new hired staff must open their medical records file duly approved by the Out Patient Director.

5.4 All new employees must complete the pre-employment medical screening prior to the first day of work. Any person who fails to comply with this pre-employment process will not be permitted to work. Clearance to work consists of a written verification that the Employee is able to perform his/her assigned duties and fit for work.

5.5 KSU staff and their housemaids and drivers are eligible for Iqama processing only.

5.6 Follow-up consultation and treatment will be done in Primary Care Clinic.

5.7 **The New Hire Screening Procedure:**

5.7.1 Upon offer of employment, all applicants are required to complete the following steps prior to beginning the first day of work:

5.7.1.1 **Mantoux test:**

A. Mantoux test 5 tuberculin units (TU, 0.1 ml) of Purified Protein Derivative standard **PPD** is injected intradermally on the inner aspect of the forearm.

B. Mantoux test is read 48-72 hours after initial testing. At the time of testing the applicants will be given an appointment to return for a reading of the test. Any applicant who fails to return for this reading may not begin employment duties.

C. All applicants will be given 3 copies of the test results. Original copy will be required to be place in the applicant's Medical file. The second copy is for Personnel Department and the last copy is for the employee.

D. Any applicants with 10 mm or more if indurations' not erythematic is considered positive test results, the physician will have to check his/her chest- X-ray results for further evaluation.

E. All positive PPD skin test, chest x-ray, smear and exhibiting symptoms of TB. Diagnosed as Open Case
of Pulmonary Tuberculosis must be treated appropriately based on the current standards treatment in King Saud Chest Hospital until becoming non-infectious before sending back home.

F. If PPD skin test result is 0-9 mm of indurations, a second test is given one week and no more than three weeks after the first. The result of the test is used as the base line test in determining Treatment and follow-up of these personnel.

G. Complete Physical Examination should be done within 10 days before signing of contract.

5.8 Routine Laboratory examinations:

5.8.1 This include: CBC, U/E, Chest-x-ray, VDRL (venereal- diseases), TPHA, HIV confirmatory test, HCV, HBsag (hepatitis B), Blood group, Urinalysis, stool analysis, LFT, Varicella antibodies, pregnancy test and malaria film.

5.8.1.1 In the event of unsatisfactory report, The EHC physician may require such Employee to undergo additional test if necessary.

5.8.1.2 Applicants will fail the pre-employment examination if the EHC physician have confirmed that the duly hired staff is HIV carrier. He will be referred to the International Recruitment Department and subject to the recruitment policy of KKUH.

5.8.2 Those with negative hepatitis B virus (HBsAg-ve) will receive first dose of hepatitis Vaccine before iqama application.

5.8.3 Any Staff with positive hepatitis B surface antigen with viral load of < 100,000 has no work restriction but however staff with viral load of > 100,000 copy/ml is restricted from performing exposure-prone invasive procedure. (According to MOH Regulation dated 18/02/1427).

5.8.4 Employees with positive HCV antibody diagnosed with confirmed PCR is restricted from performing exposure-prone invasive procedure. (According to MOH Regulation dated 18/02/1427).

5.8.5 Staff found to be hepatitis A carrier is restricted from patient contact, contact with Patient environment and food handling.

5.8.6 Staff with Iqama and diagnosed with tuberculosis are referred to the Infection Control Department their Iqama will be renewed.

5.8.7 Saudi Students applying for medical college and diagnosed with HBV, HCV, HIV must be referred to the Infection Control Department along with the student Referral form for Positive Hepatitis Cases.(See attached table A regarding the Summary of Important regulations Protocol to control transmission of infectious diseases for Health Care Workers)
5.9 Consultation/ Sick Leave for Employees:

5.9.1 Employees must obtain a referral form duly signed by the department head or designee authorizing him/her to visit the EHC.

5.9.2 The referral form is a reference for medical evaluation and refill of medication.

5.9.3 For booking appointment, all staff must register at the EHC reception at the 2nd floor of the new building or by telephone Female (9-0898) Male (9-0878) From 7:30-12:00 Am and 1:00 – 4:00 Pm.

5.9.4 When an employee is sent off for sick leave, the employee will be given a referral form, duly signed by the EHC physician, which should be taken to his/her department before leaving the hospital.

5.9.5 When EHC is not open, Department of Emergency may be used, in all cases of work-related injuries, illness and infection.

5.9.5.1 The Employee shall report to or contact the EHC if follow-up is needed.

5.9.5.2 For nurses, the nursing supervisor must inform the Associate of nursing designee respectively if sick leave was given to the staff.

5.9.5.3 A maximum of 2 days sick leave is given to all staff except for cases which are infectious/contagious in nature. (See attached table A regarding the Summary of Important regulations protocol to control transmission of infectious diseases for HCW).

5.10 Sharp Injury Incident

5.10.1 When an employee sustains a sharp injury on the job, the staff should notify his/her Department head immediately.

5.10.2 Full information about the sharp injury and related incident report should be provided to the Infection Control Department.

5.10.3 Sharp injury and Fluid Exposure Notification form is completed and staff is treated without delay at EHC.

5.11 Immunization Services:

5.11.1 Varicella vaccine: Staff with doubtful or no history of varicella infection should receive varicella vaccine.

5.11.2 Hepatitis B vaccine: This is offered to all employees and medical students who are considered at risk for the exposure to Hepatitis decease.

5.11.3 Influenza Vaccine: is administers in a timely manner to all staff prior to flu season.

5.11.4 Meningococcal vaccine serves as a prophylactic measure during hajj period to conduct from the month of Shawwal until the end of Dhu-Al hajj.

5.11.5 Other Vaccines are provided only when the physician deems it necessary.
5.11.6 Immunization Certificate is issued for every one receiving any Vaccine.

5.12 **Renewal of Igama:**

5.12.1 HIV screening is required to all staff every 2 years from Ethiopia, Erytria, Kenya, Somalia, Jebuty, Thailand, Nigeria, Sudan, Nepal and Vietnam according to the MOH circular no. 8896 on 07.06.2009.

5.12.2 Children below 6 years old, they only need to do blood grouping examination.

5.12.3 Follow up of results should be done one week after the procedure is being made at the EHC.

5.12.4 Certificate is signed by the EHC physician and stamped and signed by the Out patient Clinics Director

5.13 **Staff age 60 with Extension of Contract:**

5.13.1 The staff will be examined by EHC Physician.

5.13.2 Investigations are requested according to Health state of the staff.

5.13.3 The certificate will be issued once the clinical examination and required investigations, if any, are within normal limits and he/her is fit to continue.

5.13.4 This medical check-up will be repeated yearly if necessary.

5.13.5 In cases when staff is found un-fit. The concerned Department /College will be notified for proper action.

5.14 **Forms and Attachments:**

5.14.1 MOH Regulation for Health care Employee

5.14.2 Summary if Important Regulations and Protocol to control transmission of infectious diseases for Health Care Workers (HCW).

5.14.3 Employee illness/Injury Form

5.14.4 Incident report

5.14.5 New Employee Assessment form

5.14.6 Igamma form

5.14.7 Housemaid/Driver certificate

5.14.8 EHC fit to work certificate

5.14.9 Vaccination Certificate

5.14.10 Physical Examination Form


6.0 **REFERENCE:**

University, Baltimore, MD for the Robert Wood Johnson Foundation (September 2004 Update). "Chronic Conditions Making the Case for Ongoing Care"

6.2 en.wikipedia.org/wiki/Acute_disease/emergency
6.3 Pennsylvania Hospital and Surgery Center of Pennsylvania Hospital Administrative Policy Manual series of 2008
6.4 Nursing Department Broad Policy and Procedure series of 1430
6.5 Summary of Important Regulations and Protocol to control transmission of infectious diseases for Health Care Workers (HCW).
6.6 MOH Regulation for Health care Employee
Title: Provision of Financial Assistance of Referred Patients Seen in Primary Care Clinic or Speciality Clinics

1.0 CONDITIONS:
Provision of financial assistance conducted by Out patient physicians with coordination with Social worker department and applies to all patient who need financial assistance.

2.0 PURPOSE:
For better quality life.

3.0 POLICY:
Any referred patients from primary care or specialty clinics may get financial assistance from the hospital administration or from the appropriate community resources. The social worker will assess the financial needs of the patient and refer them accordingly.

4.0 PROCEDURE:
4.1 All referred patients have a referral form from the physician directed to the assigned social worker.

4.2 The social worker will interview the patient to assess his/her financial status. Patients are considered poor if his/her income level falls below 5000 S.R monthly salary, with 4 and more of family members, living in a rented house, and have debts.

4.3 The patient has to demonstrate his identification and personal documents (house rental contract, social security card) as evidences to prove his eligibility.

4.4 The social worker will perform a social report determining the financial assistance amount that the patient needs.

4.5 The social report sent to the hospital executive director for immediate help, or together with the patients documents the social report sent to the appropriate agencies for financial assistance.

4.6 The hospital help can be repeated twice a year with the exception of patients who have lack of income for whom it can be repeated more than twice. Whereas the community resources assistance repeated once a year.
5.0 **FORMS AND ATTACHMENTS:**

5.1 Referral inside the hospital

6.0 **REFERENCE:**

6.1 Standing policy and procedure of Social Worker Department. KKUH.
1.0 **CONDITIONS:**
To be conducted by all Ambulatory Care physicians and applies to all patients with asthma and all Respiratory Health Educators.

2.0 **PURPOSE:**
2.1 To regularly monitor lung function and response to therapy
2.2 To determine the severity of an asthma attack
2.3 To assess the response of the patient to treatment administered

3.0 **DEFINITIONS:**
3.1 A peak flow meter is a small, hand held device used to monitor a person’s ability to breathe out air. It measures the airflow through the bronchi and thus the degree of obstruction in the airways.
3.2 Peak expiratory flow rate – PEFR provides a numerical value of how ell the airways in the lung are open, and thus, provide physicians with an idea of how effective the medication is and corollary the severity of the disease.

4.0 **POLICY:**
4.1 To enable the physician in managing and controlling asthmatic patient. better options of care can be implemented

5.0 **PROCEDURE:**
5.1 The peak flow meter should read zero or its lowest reading when not in use. Use the peak flow meter while standing up straight. Take in as deep of a breath as possible.
5.2 Place the peak flow meter in the mouth, with the tongue under the mouthpiece. Close the lips tightly around the mouthpiece.
5.3 Blow out as hard and fast as possible; do not throw the head forward while blowing out. Breathe a few normal breaths and then repeat the process two more times. Write down the highest number obtained. Do not average.
5.4 For the most accurate readings, it’s important to keep your peak flow meter clean. follow the manufacturer's instructions on how to take care of your peak flow meter.
## Peak Flow Meter Reading Chart

<table>
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<tr>
<th>Zone</th>
<th>Reading</th>
<th>Description</th>
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<tbody>
<tr>
<td>Green Zone</td>
<td>80 to 100 percent of the usual or normal peak flow readings</td>
<td>A peak flow reading in the green zone indicates that the asthma is under good control.</td>
</tr>
<tr>
<td>Yellow Zone</td>
<td>50 to 80 percent of the usual or normal peak flow readings</td>
<td>Indicates caution. It may mean respiratory airways are narrowing and additional medication may be required.</td>
</tr>
<tr>
<td>Red Zone</td>
<td>Less than 50 percent of the usual or normal peak flow readings</td>
<td>Indicates a medical emergency. Severe airway narrowing may be occurring and immediate action needs to be taken. This would usually involve contacting a doctor or hospital.</td>
</tr>
</tbody>
</table>

### 6.0 REFERENCE:

6.1 Dr. Alan Greene, Department of Pediatrics, Packard Children's Hospital Stanford University School of Medicine. 5/16/2007.

6.2 http:www.ehow.com

6.3 http:www.mayoclinic.com

6.4 http: www.Wikipedia.com

6.5 National Asthma Education and prevention program Expert Panel Report, Guidelines for the Diagnosis and Management of Asthma. Rockvill, M.D.
1.0 CONDITIONS:

This policy conducted by all Staff nurses assigned in Treatment room and does skin test to client and applied to all client who needs Tuberculin skin test.

2.0 PURPOSE:

To properly screen patients particularly for newly hired employees as part of their physical examination routine to provide treatment if the result indicates its necessity.

3.0 DEFINITIONS:

3.1 PPD-The purified protein derivative is an antigen (a substance that stimulates the immune system to eliminate or fight foreign substances in the body), which is injected intradermally in the forearm.

3.2 Tuberculosis infection-TB is an infectious disease caused by the bacteria.

3.3 Induration - Palpable raised hardened area.

3.4 Erythema - Redness

4.0 POLICY:

To ensure correct procedure of Purified protein derivative test for accurate reading and to have early diagnosis and treatment of Tuberculosis cases in King Khalid University Hospital.

5.0 PROCEDURE:

5.1 This skin test helps determine if a person has ever been infected by the microorganism that causes tuberculosis.

5.2 The Mantoux Tuberculin skin test is also known as the Purified Protein Derivative (PPD) Test. 5 units of PPD is injected into the skin of forearm, with the needle bevel facing upward. (intra-dermal).

5.3 After administering the protein, the individual must return within 48-72 hours for a reading of the injection site and be evaluated by a physician.
5.4 The reaction should be measured in millimeters of the induration. The diameter of the induration should be measured across the forearm (perpendicular to the long axis).

5.5 A positive reading corresponds to the formation of a raised indurated area at the injection site which is greater than 10mm. A person who has been exposed to the bacteria is expected to mount an immune response in the skin containing the bacterial proteins.

5.6 If there is no induration, the result should be recorded as "0 mm". Erythema (redness) should not be measured.

5.7 If the client does not return within 48-72 hours for a tuberculin skin test reading, a second test can be placed as soon as possible. There is no contraindication to repeating the skin testing unless a previous Tuberculin skin test was associated with severe reaction.

5.8. The physician will document the Tuberculin skin test reading in the patients file.

6.0 FORMS AND ATTACHMENTS:

6.1 Vaccination/Injection form

7.0 REFERENCE:

7.1 Reviewed By: David C. Dugdale, III, MD, Professor of Medicine, Division of General Medicine, Department of Medicine, University of Washington School of Medicine; and Jatin M. Vyas, PhD, MD, Instructor in Medicine, Harvard Medical School, Assistant in Medicine, Division of Infectious Disease, Massachusetts General Hospital. Also reviewed by David Zieve, MD, MHA, Medical Director, A.D.A.M., Inc. 9/28/2008.


7.4 Tuberculosis Treatment: Positive Reading of PPD Test Image.


1.0 CONDITIONS:
Conducted by Family Physician and applied to outpatients in Primary Health Clinics.

2.0 PURPOSE:
Assessment of patients for reasons of referral and to be given appropriate appointment according to their health condition.

3.0 DEFINITIONS:
Triage-clinic: Walk in and Sorting clinic

4.0 POLICY:
Patients with referral from Specialty clinic, Department of Emergency Medicine, Health Centers and other Hospitals will be seen in Primary Care Triage Clinic to assess their referral and to give them Medical care and appropriate appointment.

5.0 PROCEDURE:
5.1 Only patients with referral from Department of Emergency Medicine, Specialty Clinic and other health sectors are seen in Triage Clinic.
5.2 Patients must present their referral slip to the receptionist so they can be issued Triage Appointment.
5.3 Triage physician is responsible for screening and assessing the health needs of all triage Patients.
5.4 The Triage physician to provide appropriate management and do necessary referral to specialty if needed.
5.5 Patient will be given appropriate Appointment according to their medical condition.
5.6 All patients are booked through the computer in the Reception.

6.0 FORMS AND ATTACHMENTS:
Out Patient Referral form approved by the Out Patient Department Director.
7.0 REFERENCE:

Existing Policy of Primary Care Clinics.
1.0 CONDITIONS:

Conducted by Family Medicine Residents and applies to all Primary Care Clinics, under the supervision of attending Family Physicians /post-graduate trainers.

2.0 PURPOSE:

To attain the specific objectives of becoming a trained family physician by acquiring necessary knowledge, skills and attitudes as defined by the Saudi commission for health specialties.

3.0 DEFINITIONS:

3.1 **Attending Family Physician**: The senior Family Physician on duty to supervise.

3.2 **Post-graduate**: Any level of expertise a physicians gain after the basic Medical qualification.

3.3 **Residents**: The trainee undergoing particular specialty training program

4.0 POLICY:

To attain the specific objectives of becoming a trained family physician by acquiring necessary knowledge, skills and attitudes as defined by the Saudi commission for health specialties.

5.0 PROCEDURE:

5.1 Family Medicine Residents will be working in Primary Care Clinics for the period of four months for Residents year - 1 and eleven months for Resident year 4 , under the supervision of attending Family Physicians post-graduate trainers.

5.1.1 Directions:

5.1.1.1 Residents are directed from the director of the post-graduate program in Family Medicine to Director of PCC.

5.1.1.2 Director of PCC will direct residents to the assistant directors of residency program in Family Medicine in PCC1 & PCC2.
5.1.2 Number of residents to be accepted for training:
5.1.2.1 Maximum of six residents would be accepted at a time.
5.1.2.2 Number of the residents may be changed according to the availability of training places and the number of the family physicians trainers available during that period.
5.1.2.3 Maximum of 2 residents will be attached with one trainer per session.

5.1.3 Time & Duration of training:
5.1.3.1 Four months for R1 and 11 months for R4 as already decided by the post-graduate program in family medicine by Saudi Commission regulation.
5.1.3.2 First session starts from 8 am to 12 mid day and second from 1pm to 4:30 pm daily from Saturday till Wednesday.
5.1.3.3 Maximum of six clinics per week as the residents will be having other academic activities in the department.

5.1.4 Place of training:
5.1.4.1 PCC offer a full range of primary health care services with number of experienced trainers to supervise the residents.
5.1.4.2 Residents will be rotated through different trainers in the department of primary care. Trainers preferably would be senior registrar, consultant or faculty staff in the department of family medicine.
5.1.4.3 Residents may be rotated to staff housing clinic in Dereiyah, as well as other hospitals e.g KFSH, Military hospital and KFNGH as the regulation of the joint program by Saudi Commission.

5.1.5 Timing and conditions for PCC rotation:
5.1.5.1 Residents will work according to the university residents’ regulations.
5.1.5.2 Residents will sign the attendance sheet and will report to the assigned supervisor for the particular session.

5.1.6 Assistant directors of the residents at PCC level will
5.1.6.1 Will be responsible for the orientation of the residents.
5.1.6.2 Will be responsible for the Duty rota of the residents.
5.1.6.3 Will be coordinating between supervisors at PCC and residents.
5.1.6.4 Will be coordinating between Director PCC and residents.
5.1.6.5 Will be responsible to solve technical problems during rotation.
5.1.6.6 Will be responsible to discuss residents or/and supervisors in case of any difficulty or problem during rotation.
5.1.6.7 Will be evaluating residents at the end of rotation
5.1.6.8 Will be handing over the final evaluation of individual residents to the director of the post-graduate program. May discuss and suggest any disciplinary action against any residents.
5.1.7 ORIENTATION:

5.1.7.1 Every resident will be given a Primary care clinics orientation by the Assistant directors on the first morning of the rotation.

5.1.7.2 Residents will receive orientation regarding logbook containing a checklist of required skills as well as their assessment like Mini-CEX and other evaluation / general assessment forms to be completed at the end of the rotation.

5.1.7.3 Introduction to the working team

5.1.7.4 Explanation of the system (e.g appointments, referrals, social workers help etc).

5.1.7.5 Importance of regularity, punctuality, ethical practices and adherence with roster, departmental policies procedures will be explained.

5.1.7.6 Disciplinary action against poor compliant will also be highlighted during that session.

5.1.7.7 Brief job description of residents:

5.1.7.7.1 In order to meet the family medicine (primary care) objectives as lay out by the family medicine program guidelines by Saudi Commission, following job description is suggested by the Department of family medicine:

A. All residents will work under supervision. All actions taken should be discussed with supervisor initially.

B. Will work as a part of PCC team. There must be attempts to integrate the experience, knowledge and skills gained in all other domains.

C. Consultation of patients in the PCC (history, examination, diagnose, management plan, refer or follow up appointment). Will involve in acute, chronic, and preventive as well as rehabilitative care.

D. Perform Minor surgical procedures e.g dressing, wound management.

E. Cost effective approach to the use of resources including use laboratory investigations, radiology and appropriate referrals.

F. Emphasis on non pharmacological care and opportunistic health promotion advices e.g dietary counseling, exercise, quit smoking explanation, compliance with medicine for chronic problems etc.

5.1.8 Proposed schedule of rotation at PCC:

5.1.8.1 1st week: The individual resident will have opportunity for direct observation of consultations, patient record reviews,
case discussions and a learning conversation from his/her supervisor, in order to be oriented to the flow and content of the work as Sit-In clinic.

5.1.8.2 **Subsequent weeks:**

5.1.8.2.1 Residents will start independent consultation.

5.1.8.2.2 Discuss the case with supervisor/trainers

5.1.8.2.3 Carry out the agreed plan that is approved by the supervisor.

5.1.9 **EVALUATION:**

5.1.9.1 Day to day evaluation by the supervisor should take the form of direct observation of consultations, patient record reviews, and case discussions.

5.1.9.2 Each resident must undergone 3 Mini-Cex evaluation and feedback by each trainer/supervisor from the department.

5.1.9.3 At the end of each rotation residents will be evaluated by their respective supervisors using the evaluation form of the Saudi Commission.

5.1.9.4 Both Trainer and supervisor will handover the evaluation forms to assistant directors.

5.1.9.5 Assistant directors will be responsible to write a final evaluation of individual resident in the light of evaluations made by supervisors/trainers. Assistant directors may advice the disciplinary action in the final evaluation form, if needed.

5.1.9.6 Assistant directors will be responsible to handover the final draft of resident evaluation to the Director of the Post-graduate Family Medicine program in the department.

6.0 **REFERENCE:**


6.2 This document was modified from the Interns’ Rotation Guidline for King Khalid University Hospital ,King Saud University ,Riyadh,SA on 15.3.2009 and reviewed by:

6.2.1 Dr. Hamza Abdulghani, Post-Graduate Program Director

6.2.2 Dr. Syed Irfan karim, Assistant Post-Graduate Program Director

6.2.3 Dr. Kamala Sati, Assistant Post-Graduate Program Director
1.0 CONDITIONS:
Conducted by primary care physicians and applied to patients in need for emergency intervention or admission.

2.0 PURPOSE:
Safe transport of patients to accident and emergency.

3.0 DEFINITIONS:
3.1 Emergency: A sudden, urgent, usually unexpected occurrence or occasion requiring immediate action.
3.2 Critically ill: Patients who are medically unstable need a comprehensive and continuous care (an intensive level of care)
3.3 Admission: Patients admission into hospital for investigation and management, not possible on out-patient basis.

4.0 POLICY:
Patients attending primary care clinic and are in need for emergency intervention and admission should be transported safely to accident and emergency by the assigned nurse.

5.0 PROCEDURE:
5.1 Patients assessed by the practicing physician and in need for urgent investigation and management which are not accessible through primary care clinic or need for admission have to be referred to accident and emergency department.
5.2 The physician has to call the accident and emergency supervisor before transferring the patient.
5.3 After acceptance of the accident and emergency, the physician has to document this in the patient file, mentioning the name of supervisor and his bleep.
5.4 It is the responsibility of the Head nurse to arrange and assign a nurse to transport the patient with the file to A/E.

5.5 All ill patients have to be transported by a wheelchair.

5.6 The nurse will endorse the patient to assigned physician in A/E.

5.7 In case of critically ill patients like acute chest pain, seizure. The physician will accompany the patient to A/E.

6.0 REFERENCE:


6.2 en.wikipedia.org/wiki/Acute disease/emergency
INTERNAL POLICIES AND PROCEDURES
CONCURRENCE / NON-CONCURRENCE FORM

To be completed by initiating department/person.

From: ___________________________(department/person) Tel. Extension No.:_____
Date: _____________

Name of Policy and Procedure: _____________________________________ Number: ______________

☐ New Document  ☐ Revised Document  Reviewed Document (no changes done)

Comments: (a brief summary of purpose of the document or changes made)
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

To be completed by the reviewers (affected departments).

You are requested to review the attached document(s) as there could be an effect or impact upon your department if the action is initiated. Please sign if you concur (agree) with the document, date and forward to the next person on the list. If you do not agree with the document, please provide an explanation and send your written comments to the sender (initiating) department.

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*Non-concurrence must forward written comments to the originating department/person.
1.0 CONDITIONS:

1.1 Conducted by the Dean of Hospital Affairs applies to:

1.1.1 KKUH staff
1.1.2 Patient

2.0 PURPOSE:

To establish a safer, effective communication for all employees and Patients.

3.0 DEFINITIONS:

3.1 Communication is a process of transferring information from one entity to another. Communication process are sign-mediated interaction between a least two agents which share a repertoire of signs and semiotic rules. Communication is commonly defined as "the imparting or interchange of thoughts, opinions, or information by speech, writing, or signs". Although there is such a thing as one-way communication, communication can be perceived better as a two-way process in which there is an exchange and progression of thoughts, feelings or ideas (energy) towards a mutually accepted goal or direction (information).

4.0 POLICY:

4.1 Communication is a vital link for effective, efficient and safe facility operations. Mechanisms must be in place to facilitate communication between all levels of facility personnel, the medical staff, administration, the Governing Body, and patients and families.

4.2 Effective communication fosters the coordination and integration of patient care between healthcare workers, departments and patients/families.
5.0 PROCEDURE:

5.1 Provided to all staff at orientation, annually and as needed, on an ongoing basis.

5.2 Effective communication and interdisciplinary and interdepartmental relationships improve patient care and safety in the organization.

5.2.1 Employees communicate and receive information by way of staff meetings, storyboards, newsletters, committee meetings and posted flyers and memorandums.

5.2.2 Medical staff communicates and receive information by way of medical staff committees newsletters, voice mail, e-mails and memorandums.

5.2.3 Administration and the medical staff forward appropriate information to the Governing Body by way of appropriate committees or by formal address to individual board members by acceptable mechanisms, i.e., personal appointment or by letter with copy to the Chief Executive Officer.

5.3 Effective communication between facility staff and patients and families foster a culture of safety. Patients and families should feel comfortable asking questions and reporting concerns about their care.

5.3.1 Patients and their families shall be encouraged to participate in their own care as a patient safety strategy.

5.3.2 Information regarding the reporting of concerns about patient safety and patient care shall be posted throughout the organization. This information will also be posted on KSU-KSUH’s web site.

5.3.3 Patient and families may also report concerns about patient safety and patient care anonymously using the hotline number:

6.0 REFERENCES:

6.1 www.K.12.wa.us/curriculumInstruct/communication/default.aspx-Cached


6.3 From Wikipedia, the free encyclopedia

6.4 http://www.communicology.org/content/definition-communicology
1.0 CONDITIONS:
This policy is implemented by all Pathologists, Medical Technologists, Physicians, Nurses, and Clinicians.

2.0 PURPOSE:
To provide a protocol for notification of all critical test and critical results and values reporting.

3.0 DEFINITIONS:
3.1 Critical Tests: Tests which will always require communication of the results, even if normal, i.e., STAT exams.

3.2 Critical Results: Findings (even if from routine tests) which always require rapid communication of the results, i.e., panic values or red-line values.

4.0 POLICY:
4.1 It is the policy of King Khalid University Hospital to communicate critical test results and critical results and values to the licensed practitioner (LIP) and/or clinician and approved by this institution to take clinical action pursuant to the results of critical test results and critical results and values.

4.2 Generally, critical results or “panic” values are defined by the medical staff, with input from nursing services for specific tests.

4.3 However, critical results are understood to be any resultant test values/levels/interpretations where delays in reporting have the potential for causing serious adverse outcomes for patients.

4.4 Critical test results and critical results and values can occur for Clinical Laboratory, Imaging/Radiology, Cardiology and other diagnostic tests in any setting in this organization.
4.5 Critical tests are defined as those tests that are STAT exams which demand the rapid reporting of results, whether normal or abnormal.

5.0 PROCEDURE:

5.1 A list of prioritized critical tests and critical results and values (panic values) specific to the individual department will be kept in the Clinical Laboratory, Imaging/Radiology Department, Cardiopulmonary Department, Cardiology Department, Neurology Department, Pathology Department, other departments and all patient care units.

5.2 Lists of critical tests and critical results and values will be developed in conjunction with nursing services and approved by the medical staff.

5.3 Lists of critical tests and critical results and values will include, at a minimum, the name of the test, the critical value, the time frame for performing the test and obtaining the result.

5.4 It is understood that results of critical tests and critical results and values are to be immediately reported by the department performing the test and determining the result.

5.5 Critical Tests and Critical Results and Values:

5.5.1 Include tests and results ordered on a STAT, Emergent and/or Urgent basis

5.5.2 Include results from tests reaching the pre-established critical or “panic” level as determined by nursing services and the medical staff and approved by the appropriate medical staff committee

5.5.3 Include results where it is clinically evident that delays in reporting have the potential for causing serious adverse outcomes for patients

5.5.4 Include results from critical tests whether normal or abnormal

5.6 Critical tests and critical results and values will be reviewed and verified at least on an annual basis by the director of the department and the medical staff committee governing the department, to allow for additions and deletions from the list.

5.6.1 New tests may be added to the list as needed at any time, with the approval from the medical staff committee governing the department.

5.7 Critical test results and critical results and values will be called by the individual performing the test immediately upon determination that the value of the test is at critical limits.

5.8 All departments reporting critical test results and critical results and values will contact the licensed healthcare provider responsible for providing direct care to the patient for whom the test has been ordered (i.e., Physicians and report the result. Only patient care providers approved by the organization to receive diagnostic test results and
proven competent in the interpretation (general clinical interpretation) of those results may receive and report critical test results and critical results and values.

5.8.1 In the instance the specific patient’s licensed care provider is unavailable to receive the result, the supervisor of the patient care unit (which may include charge or lead nurse) where the patient is located will be notified of the critical test results or critical results and values.

5.9 The individual receiving the result will write down and read the result back to the individual reporting the result to verify accuracy.

5.10 Critical test results and critical results and values will be reported to the individual ordering the test and/or the licensed independent practitioner responsible for the patient, as appropriate, by the patient’s licensed care provider or that provider’s supervisor immediately upon receipt of the test result.

5.11 Critical test results and critical results and values must be reported directly to a LIP that is licensed to take appropriate clinical action, not an intermediary.

5.11.1 In the event that the healthcare provider responsible for the patient and/or the ordering LIP is not immediately available to receive the result of the critical test or critical result, his/her alternate LIP will be notified.

5.11.1.1 Each credentialed, privileged and licensed LIP member of the medical staff has the responsibility to provide the name of an alternate care provider, who is an approved member of the medical staff, and who has agreed to his/her alternate status, as a condition of initial and reappointment to the medical staff.

5.11.1.2 Each department and patient care unit will maintain a current list of LIPs and their alternates with contact information.

5.11.2 In the event the ordering LIP or LIP responsible for the patient is not available and that LIP’s alternate cannot be reached or is unavailable, the medical director, service chief or department chief of the service under which the LIP is privileged will be notified of the critical test result or critical result and value. In any instance, notification from the patient’s licensed healthcare provider will be made to the licensed independent practitioner that is able to take appropriate clinical action in relationship to the test.

5.11.3 The licensed healthcare provider reporting the critical test result or critical results and values to the patient’s LIP, will request that the LIP read back the test result to verify accuracy.

5.11.4 The licensed healthcare provider reporting the critical test result or critical results to the patient’s LIP will not terminate the
conversation until verification of the critical test result or critical results has been obtained via the read-back process.

5.12 Documentation:

5.12.1 The department performing the test and determining the critical result will document the date and time of notification and to whom the result was reported (i.e., the name of the person receiving the report and performing the read-back of the result) on the hardcopy test result or on the electronic test result entry screen, both of which become a component of the patient’s hardcopy and/or electronic medical record.

5.12.2 The patient’s licensed healthcare provider or his/her supervisor receiving the critical test result or critical result and conducting the read-back process to the individual reporting the result, will document the critical test result or critical result, the date and time the result was received and the name of the individual reporting the result (and to whom the read-back process was conducted), in the physician’s progress notes.

5.12.3 The patient’s licensed healthcare provider or his/her supervisor reporting the critical test result or critical results to the patient’s responsible LIP, and conducting the read-back verification process with the LIP, will document the critical result, the date and time the result was reported and the name of the LIP receiving the result and conducting the read-back process on the physician’s progress notes.

5.12.4 When face-to-face critical test result or critical result reporting is conducted, the individual reporting the information must document the information listed above on either the hardcopy/electronic copy test result or physician’s progress notes, as appropriate to the circumstances.

5.12.5 The physician (or his/her alternate) ordering the critical test will initial or sign each result when the hardcopy or electronic copy is reviewed.

5.12.5.1 The physician may review and initial the result before the copy has been filed in the medical record; however, regardless of where the review is performed, the physician must initial his/her review directly on the test result once the review has been performed.

5.13 Compliance Monitoring:

5.13.1 Periodic monitoring of the critical test communication process will be conducted on a departmental and organization wide basis.

5.13.1.1 Turn-around-times from order entry of critical tests to notification of the critical test result or critical results and values to the patient’s licensed healthcare
provider will be evaluated. Time from the identification of a critical test result or critical result to the time of report will also be evaluated.

5.13.1.1 Evaluation will be conducted in a parallel study format with a random sampling of records identified with critical test results reviewed by the department performing the test and reporting the result. The patient care unit, where the patient’s whose record is reviewed by the department, will review the same records to determine the turn-around-time from order entry to receipt of test result by the patient’s care provider to:

5.13.1.1.1 Verify that turn-around-times from critical test order entry to critical test result reported are equal

5.13.1.1.2 Identify any communication process breakdown issues at the departmental or patient care unit level

5.13.1.2 During the record review, the patient care unit will review documentation in the physician’s progress notes and written test results to:

5.13.1.2.1 Verify notification of critical test results or critical results to the patient’s LIP in a timely fashion

5.13.1.2.2 Determine if written test results have been reviewed and initialed by the patient’s LIP, as per policy

5.13.1.2.3 Identify any communication process breakdown issues at the patient care unit or medical staff level

6.0 REFERENCES:

6.1 Laboratory Critical Value Notification Policy.
1.0 CONDITIONS:

Conducted by Primary care physician and applied to patients seen by Primary Care Clinic Physicians and need early appointment.

2.0 PURPOSE:

Booking for patients who need appointment within 3 months time period.

3.0 DEFINITIONS:

3.1 Stable Patient: A patient for whom no in flight medical intervention is expected but the potential for medical intervention exists and/or controlled on medications.

3.2 Appointment: Booking time for patients to be seen by their physician.

4.0 POLICY:

Patient seen in triage clinic or regular clinic and needs to be seen early by Primary Care physicians will be registered in Follow-up Clinic, if there is no slot in regular appointment system.

5.0 PROCEDURE:

5.1 Only patients seen and examined by Primary care physician can be given follow-up Clinic appointment.

5.2 Selected patients seen in triage clinic will be seen in follow-up clinic to quickly assess and evaluate different laboratory results and procedure done to the patient:

5.3 Patients who are stable can be given routine appointment under the name of the consultant.

5.4 Patients assessed by the Primary care physician and needs early appointment can be issued follow-up appointment.

5.5 Patient is given appointment slip signed by the physician and instructed to go to the Reception for appointment as stated in the appointment slip.

5.6 "Appointment slip" issued by the physician and "Booking appointment slip" should be attached together. Both papers should be submitted to the receptionist upon arrival.

5.7 Receptionist is responsible for distributing file equally to all physicians on duty:
5.8 Follow-up appointment is given to the same physician who have seen and examined the patient.

5.9 In cases where the physician in unavailable the file will be distributed to other physicians on duty.

5.10 All patients are booked through the computer in the reception as follows:

5.10.1 PCC-1 (Female) 25-15 patients in the morning and 10 patients in the afternoon.

5.10.2 PCC-2 (Male) 10-20 patients in the morning and 16 patients in the afternoon.

5.10.3 Every two weeks the Associate Director together with the computer Department evaluate the follow-up appointment system to check for any misuse of appointment.

5.10.4 The policy on follow-up appointment and the protocol for the number of patients to be booked must be strictly adhered at all times.

6.0 **REFERENCE:**

Newly opened clinic for near appointments.
## 1.0 CONDITIONS:

Conducted by the Unit manager and applies to all Out patient Department patients

## 2.0 PURPOSE:

To outline the mechanism by which Ambulatory Care Services are directed and integrated.

## 3.0 DEFINITIONS:

1. **Ambulatory care** is a type of medical care which is provided to patients who do not need to be admitted to a hospital for treatment. The types of procedures and treatments offered in ambulatory care are sometimes referred to as “outpatient care”. As the "ambulatory " in ambulatory care would seem to suggest, classically the patient can get into a medical facility for treatment under his or her power.

2. **It** is any medical care delivered on the outpatient basis. Many medical conditions do not require hospital admission and can be managed without admission to a hospital. Many medical investigation can be performed on an outpatient setting.

## 4.0 POLICY:

1. Managers of the facility shall expedite delivery of patient services through communication and problem solving within the facility and between interfacing facility departments.

2. Policy formulation shall be the result of joint effort of the facility managers.

3. In all situations the desired goal of the facility shall be patient safety and satisfaction through easy outpatient access to care, treatment and services with early, safe discharge and follow-up at home.
5.0 **PROCEDURE:**

5.1 Formulated policy to be available in all the unit

5.2 Patient safety and satisfaction can be attain through:

5.2.1 Early appointment in OPD

5.2.2 Receiving immediate care and treatment to patient with underlying illness.

6.0 **REFERENCES:**

6.1 www.wisegeek.com/what-is-ambulatory-care.htm

6.2 www.med.nyu.edu/hjd/programs/ambulatory.html
1.0 CONDITION:

Conducted by each Department Head and applies to all KKUH Patients and clients. Referral letter is an effective link between primary health care and secondary/tertiary health care level.

2.0 PURPOSE:

Referral system comprises of three integrated and inter-related components; the referring physician, referred consultants and the consultee. Notably, the salient characteristics of each component determine the success of referral system. Physician should effectively and meaningfully communicate to the patient the significance of referral/clinical correspondence. He should also note down patient's adequate data-administrative and clinical—in the referral letters. The patients should comply and consult the referred specialist who after interviewing the patient should write a comprehensive feedback detailing diagnostic and treatment steps.

2.0 DEFINITIONS:

Patient referral letters are a rich sources of medical diversities and provide multiples opportunities to the referring physicians, the referred consultants and also the patients of mutual education, updating knowledge and research.

3.0 POLICY:

It is the policy of this facility to accept those individuals who meet established criteria and require services that are within the facility’s capacity to provide. When services are not available at this facility, efforts are made to refer the patient to the appropriate agency or facility.

4.0 PROCEDURE:

4.1 Utilize the patient assessment procedure and the preoperative assessment criteria for the facility to evaluate the patient.
4.2 If the outcome of the assessment determines that the preoperative assessment criteria are not met and services could be better provided by another provider, the patient shall be given referrals.

5.0 FORMS AND ATTACHMENTS:

5.1 Referral Inside and Outside the hospital.
1.0 CONDITIONS:
Conducted by the Medical Record Department and applies to all staff in KKUH

2.0 PURPOSE:
Medical Records contains information of the patient which can be use in sharing information to all health practitioners and are able to treat their patient more efficiently and effectively.

3.0 DEFINITIONS:
Medical health records can be defined as data which is stored and filed in one folder in relation to the treatment of patients by healthcare professionals

4.0 POLICY:
4.1 The following forms are required to be present on all outpatient medical records:
4.1.1 Date
4.1.2 Face sheet containing patient’s demographic information
4.1.3 Preoperative diagnosis
4.1.4 Surgical consent; sterilization form required for voluntary sterilizations (see appropriate policy)
4.1.5 Clinical Laboratory sheet with lab results as ordered
4.1.6 X-ray and EKG reports, if ordered
4.1.7 Surgical checklist, completed
4.1.8 Nursing assessment and Nurses’ Notes
4.1.9 Medication Reconciliation/Verification Form
4.1.10 Medication sheet
4.1.11 Intake and output sheet
4.1.12 History and physical form or typed history and physical from Medical Records
4.1.13 Physician’s order sheet
4.1.14 Completed operative report dictated or written immediately after procedure, which shall include surgeon and assistants names, findings, technical procedures, specimens removed and postoperative diagnosis
4.1.15 Anesthesia evaluation sheet
4.1.16 Belongings sheet
4.1.17 Postoperative documentation of patient's status, including vital signs, level of consciousness, medications and blood administered, unusual events or postoperative complications and the management of such events and the name of the licensed independent practitioner responsible for the patient’s discharge
4.1.18 Patient Discharge Summary Instructions.

4.2 Responsibility:

4.2.1 The Ambulatory Care Services nurse is responsible for preparation of the patient medical record and completion of all necessary lab work and paperwork.

5.0 PROCEDURE:

5.1 This record shall contain all information necessary for documentation of procedures, permits and services rendered to the patient from admission to discharge.

5.2 All patient information on the medical record shall be strictly confidential.

5.3 Upon discharge, the medical record shall be sent to the Medical Records Department. Release of information from Medical Records can be authorized by the patient and given by Medical Records.

5.4 If a portion of the patient's medical record is requested at the time of discharge for continuous care of the patient, the patient's signature for release of medical record information is required and must be signed for release of medical record information.
1.0 CONDITION:

Applies to all for primary care physicians.

2.0 PURPOSE:

To improve and update the knowledge and skills of Family physicians which will be held as Half Day Release Activity every fortnightly in PCC and to be organized by Primary Care Physicians CME Committee.

3.0 PROCEDURES:

3.1 The CME committee of PCC is responsible for organizing the CME activities.

3.2 It is scheduled every two weeks as Half Day Release Activity on Monday from 12:30 – 4:00 pm.

3.3 The schedule is planned over one Academic year and will be ready at the beginning of each academic year.

3.4 A form will be distributed to be filled by every physician to write the topics of interest, according to their learning needs and common health problems.

3.5 The selected topics will be prioritized by the committee according to PHC physicians needs. Every physician will be assigned a topic and date for presentation.

3.6 The CME activity has to be presented in two parts if possible:

3.6.1 Part I: An update and evidence based for the topic selected.

3.6.2 Part II: Problem solving cases for discussion if possible.

3.7 Every physician has to be competent to present the assigned topic.

3.8 If any presenter has a commitment or in cases of unexpected circumstances, he/she has to inform the committee two weeks before presentation if possible.

3.9 The Secretary of Ambulatory care services will remind the presenter two weeks earlier to take his/her confirmation.

3.10 The communication regarding CME Activity will be mainly through e-mails.
3.11 Reminder will be issued by the Secretary 2 – 3 days prior to day of presentation.

3.12 Invitation of other specialties:

3.12.1 The Committee will invite other speakers/ specialties to participate in CME Activities according to needs of family physicians.

3.12.2 Any presenter can arrange with any specialist on the day of his presentation, but he / she has to inform the committee about the invitation.

3.13 Participation of Drug Companies:

3.13.1 Drug Companies will be scheduled according to the schedule of presentation over the academic year.

3.13.2 The Companies will be approved by the committee and have to submit their Materials (Hard or Soft copies) before the day of presentation.

3.13.3 The Drug companies will start their presentation at 12:30 pm (The time allocated for presentation will be 30 – 45 minutes including discussion)

3.14 Punctuality and Attendance of family physicians are compulsory for everyone and obligated to Sign in the attendance sheet.

3.14.1 If any physician has some regret to attend the CME Activity, he / she has to take permission from the associate director /medical director in PCC.

3.14.2 By the end of each academic year, a 10 hours CME credit will be given to every physician.

3.15 Evaluation form will be distributed for every presenter, to be collected by CME Committee at end of session and then given to the presenter as feedback.
1.0 CONDITIONS:
This policy applies to all patients of King Khalid University Hospital, Primary Care Clinic.

2.0 PURPOSE:
To ensure that only authorized staff handle the function of Processing of Appointments Check-in, Checkout, No-Show and Schedulable Order Completion for outpatient visits

3.0 DEFINITIONS:
3.1 Appointments
Scheduling and confirming an appointment, modifying/rescheduling an appointment, or cancelling an appointment.

3.2 Registration
Registering a patient for a scheduled/unscheduled appointment/procedure. Registration shall automatically create an encounter. Registration shall take place when the patient physically presents to the area of service.

3.3 Check-In
Check-in is considered to be when the patient begins consultation with the scheduled Health Care Provider. Responsibility for ‘check-in’ will be the Health Care Provider the patient is scheduled with; such as attending physician for physician appointments, dietician for dietician appointments, nurse for nurse clinic appointments. Check-in shall be done upon the same encounter created at the time of registration.

3.4 No-Show
If a patient is 60 minutes late for his/her appointment or at the discretion of the physician or if the patient arrives after the clinic session, the patient can be considered a ‘no-show’. At the end of the clinic session the authorized staff will process the patient as a ‘no-show’ through scheduling system or Power Chart.

3.5 Schedulable
Completion of the appointment order shall indicate that the
Order Completion

The patient was seen for his/her procedure/appointment. This step shall be completed before checking-out the patient through Power Chart.

3.6 Checkout

Checking the patient out of the service area when the appointment/procedure is completed; this shall be completed as soon as possible upon the patient leaving the area. The service area could include clinics. Checking out may or may not include discharging the outpatient encounter and giving next appointment.

4.0 POLICY:

4.1 Processing of Appointments

4.1.1 Staff designated to do scheduling shall only schedule and confirm an appointment in the Scheduling System or Power Chart when an authorized staff has placed the order.

4.1.1.1 Staff authorized to place, add, or modify a schedulable appointment includes Physicians, Nurses, and authorized Staff Clerks.

4.1.2 In Clinics/Service areas where a Scheduling Receptionist is present, the Scheduling Clerk shall handle Appointments.

4.2 Registration

4.2.1 In Clinics/Service areas where a Scheduling receptionist is present, the Scheduling Clerk shall be responsible for Check-in registration.

4.3 Check-in

4.3.1 The patient shall be ‘checked-in’ by the Primary Health Care Provider (Physician, Dietician, Nurse (Nurse Clinic appointments only) or scheduled resource as the patient begins consultation.

4.4 No-Show

4.4.1 Authorized personnel shall be responsible for handling the No-Show function. Authorized personnel are Nurse, Receptionist Clerks or Physician, if the location of service is a clinic; and Dietitian, if the location of service is a Dietitian Clinic.

4.5 Schedulable Order Completion

4.5.1 Authorized personnel shall be responsible for order completion. Authorized personnel are: Nurse, Receptionist Clerk or Physician, if the location of service is a clinic, and Dietitian, if the location of service is a Dietitian Clinic.

4.6 Checkout

4.6.1 Authorized personnel shall be responsible for handling the checkout function. Authorized personnel are Nurse, Receptionist Clerk or Physician if the location of service is a clinic; Dietitian, if the location of service is a Dietitian Clinic.

5.0 REFERENCES:

Appointment slip
1.0 CONDITIONS:

This policy applies to all patients/clients of King Khalid University Hospital.

2.0 PURPOSE:

To outline the process, whereby all the patients accepted for treatment in King Khalid University, shall complete the Patient Information Sheet in order to obtain full bio-data.

3.0 POLICY:

3.1 All patients must read and sign the consent form before opening Hospital file.

3.2 All patients must file up the Patient Information sheet completely and details must be updated yearly.

4.0 PROCEDURE:

4.1 Opening of Patient’s Hospital file is authorize only in Out-patients Directors office or with the approval of the Medication Administration.

4.2 The Pre-registration staff shall issue and request the patient to complete the Patient Information Sheet.

4.3 Pre-registration staff shall cross check the patient’s name in the Saudi National Identification Card/iqama/passport with the completed Patient Information Sheet.

4.4 The Opening File Receptionist staff shall ensure that all demographic information has been completed on the Patient Information Sheet.

4.5 The Opening file receptionist staff shall enter all Patients profile information in the Management Information System and be given Hospital medical number.
4.6 The Opening file staff shall file the Patient Information Sheet in the patient’s medical file.

5.0 **PROTOCOL PATIENTS:**

5.1 K1: all Saudi patients with referral

5.2 K2: Saudi staff of King Saud University, King Khalid University Hospital and their dependents

5.3 K3: Non-Saudi staff of King Saud University, King Khalid University Hospital and their dependents

5.4 K4: Arabian Gulf Countries Patients

5.5 K7: Non-Saudi patients for one time service only (Emergency cases)

5.6 K8: Drivers and Housemaids of King Saud University and King Khalid University Hospital staff

5.7 K11: King Saud University Students

5.8 K12: H1N1 patients

6.0 **REFERENCES:**

6.1 Patient Information Sheet

6.2 Patient ID Card (Saudi National Identification card, Iqama, Passport

6.3 Consent Form
1.0 CONDITIONS:

This policy applies to all staff in Ambulatory Care.

2.0 PURPOSE:

To outline the Department’s commitment to ensure the provision of adequate staffing during working hours and ensuring coverage when necessary in all appointment’s work station.

3.0 DEFINITIONS:

The policy and guidelines for scheduling monthly work roster, weekend coverage, leave time and schedule changes.

4.0 POLICY:

4.1 The Supervisor shall be responsible for preparing the employees Monthly Time Schedule.

4.2 The employee schedule equates to forty-four (44) working hours per week.

4.3 Changes to the Monthly Time Schedule shall be avoided once the schedule is posted.

4.4 Any approved changes shall be reflected and the Monthly Time Schedule revised.

4.5 In order to allow for minimal changes to the staffing schedule, the Department shall request staff to submit leave as far back as possible. Staff leaves shall be submitted, at least, two months ahead of the requested date.

4.6 Request for changes in the work schedule requires advance arrangement with the Team Leader and approved by the Supervisor.

4.7 Supervisor shall change an employee’s schedule to meet the Departmental need with approval from the Department Head.

4.8 Leave requests shall be approved on the “first come first serve basis”.
4.9 Unexpected staff leaves, such as emergency leave or resignation, may result in sudden schedule changes including cancellation of a scheduled staff leave.

4.10 Schedule changes may be made if staff does not return from leave as planned. Staff who is unable to return from leave as scheduled shall send a fax to the attention of the Appointment Supervisor, at least one week in advance of their expected return date. The fax must indicate a valid reason for the delay and must include such details:

4.11 Reason for delay
4.12 Expected date of return
4.13 Contact details.

4.14 The sixty-minute lunch period and prayer shall be taken between 12:00 noon. till 2:00 p.m.

4.15 The Employee Relations Manual shall be consulted regarding issues related to staff leaves and coverage

5.0 PROCEDURE:

5.1 Supervisor shall prepare the Monthly Working Schedule on a monthly basis indicating:

5.1.1 Department section
5.1.2 Name of employees
5.1.3 ID number and title
5.1.4 Pager number (where applicable)
5.1.5 Shift (beginning and ending time)
5.1.6 Reflection of employee’s leave
5.1.7 Any comments

5.1.1 Upon completion, the Supervisor shall sign the working schedule and submit it to the Head of Service for final approval.

5.2 Upon approval of the schedule, the Department secretary shall ensure distribution of schedule copies to concerned employees via the Supervisor.

5.3 Appointment employees shall report, on time, to their assigned work-station using the work schedule as guidelines.

5.3.1 The Team leader of each area shall coordinate the lunch break schedule with the employees, either on a daily or weekly basis.

5.3.1.1 If the Team Leader is not available, then it shall be the responsibility of the Supervisor to coordinate the lunch breaks

5.3.2 Employees shall coordinate with the Supervisor via the Team leader to obtain the Department Head’s approval and/or permission for any personal errands or business.

5.3.3 Employee shall call the Appointment Supervisor if suspecting to report late to duty or in case of emergency leave.
5.3.4 Employee shall obtain a Statement of Family Health Visit form from the Supervisor in case of Family Health or Clinical appointment.

5.4 Supervisor and/or Team leaders shall be responsible in ensuring proper workstation coverage before releasing or excusing an employee from the workstation.

5.4.1 Supervisors and/or Team leaders shall monitor the employee’s daily attendance and ensure proper usage of the Daily Attendance Log, which shall be followed and submitted on weekly basis to the Department Head’s secretary.

6.0 REFERENCES:

6.1 Employee Relation Manual
6.2 Sick Leave
6.3 Regular Hospital Working Hours
6.4 Official Lunch Break Period
1.0 CONDITION:
   All KSU / KKUH staff staying in Diriyah Housing.

2.0 PURPOSE:
   To be familiarized with the protocols and guidelines implemented in the clinic by the Medical Director of Primary Care.

3.0 PROCEDURES:
   3.1 All KSU/KKUH staff and their immediate dependents, housemaid and drivers staying in the Staff Housing (Diriyah Compound) should be eligible to be seen in Diriyah Health Clinic.

   3.2 All residents seeking consultation in the clinic should fill up the form with the following information:

      3.2.1 Number of the Building / Villas and Flat

      3.2.2 Street where the resident stay

      3.2.3 Data of the official person designated to stay in the housing and members of the family including housemaid and driver.

   3.3 The forms should be submitted to the Housing Department of Diriyah Housing, a copy to be attached to the patient’s file and this need to be renewed every year.

   3.4 All visitors of the family are not entitled for consultation.

   3.5 All children below 13 years old should be accompanied by their parents. Without their parents the child will not be seen.

   3.6 Nurses should checked that the copy of the housing form and igama are attached to the patient’s file.

   3.7 All minor cases should be treated in the clinic while emergency cases are to be referred to Department of Emergency (Adult and Pediatric).
3.8 All patient seen in the clinic with medical record file are entitled for the dispense of their medication including the refill. Those files that are closed should be re activated to avail for the medication.

3.9 The physician will write a referral to patient needed to be seen in Primary Care, Specialty Clinic and King Abdulaziz University Hospital.

3.10 Minor injuries needed for dressing and removal of stitches can be done in the dressing room.

3.11 Patient receiving injection prescribed by the Specialty Clinic in KKUH needed precaution should not be given in the clinic, otherwise simple analgesics drugs can be given by the nurse after documented by the physician in patient’s file.

3.12 Those injectable medication that is prescribed from private hospital / clinic requesting to be given in the clinic should be approved by the physician in the clinic and to be documented in the patient’s files.

3.13 Prescription should not be accepted in the pharmacy if there is no stamp of the clinic.

3.14 Physicians and nurses should not allowed any patient to get medicine in the pharmacy if not seen in the clinic.

3.15 All residents should abide to the schedule time of the clinic (8am – 12:00 noon resumed at 1:30 pm – 4:00 pm). When there are many patients waiting inside and only 30 minutes left prior to the time that the clinic close, the physician will decide and inform the nurse to stop accepting patient. The nurse will close the entrance door of the clinic to give time for the physician to finish all those patients who are waiting inside.
1.0 CONDITION:
All physicians and diabetic educators.

2.0 PURPOSE:
To teach diabetic patients regarding the process of insulin medication administration.

3.0 POLICY:
Diabetic patient who needs insulin should be started right after an Agreement is made by the Attending Physician with the patient.

4.0 PROCEDURE:

4.1 All diabetic Patient who needs insulin is immediately referred to the Diabetic Educator for Health teaching regarding the process of Insulin medication administration.

4.2 Health teaching are held in the health teaching room by the Educator.

4.3 Health information are provided to increase patients awareness on the importance of controlling and preventing glucose increase, proper way to do home monitor ,diet, exercise and insulin medication administration.

4.4 In cases where the patient needs Glucometer set, the consulting physician must write a Referral slip to the Diabetic Educator/Social Worker to facilitate the release of glucometer set.

4.5 The Nurse must bleep the Social Worker and informed her/him that we are referring patient for Acquisition of Glucometer set.

4.6 The social worker must evaluation the financial status of the patient before any release of Glucometer set with the approval of the Endocrinology Consultant.

4.7 All diabetic patient with insulin are allow to collect syringes and alcohol swab with a prescription written by their attending physician.
4.8 In cases where patient do not have adequate supply He/she can take refill appointment in Primary Health Care clinic.
1.0 CONDITIONS:
Conducted by all physicians and nurses and applies to all patients in Ambulatory Care Clinics.

2.0 PURPOSE:
To ensure that all patients are properly identified prior to any care, treatment or services.

3.0 POLICY:
3.1 It is the policy of this facility to ensure that all patients are properly identified prior to any care, treatment or services provided.

Exception: Patients unable to provide identifying information, who experience conditions requiring emergency care, will receive treatment prior to identification if such care and treatment is necessary to stabilize the patient's condition.

4.0 PROCEDURE:
4.1 Principles of identification:

4.1.1 A system for positive identification of all facility patients fulfills four (4) basic functions:

4.1.1.1 Provides positive identification of patients from the time of admittance or acceptance for treatment.

A. This identification system shall apply to patients in all areas of the facility.

4.1.1.2 Provides a positive method of linking patients to their medical records and treatment.
4.1.3 Minimizes the possibility that identifying data can be lost or transferred from one patient to another.

4.1.4 Improves the accuracy of patient identification.

4.2 Patient Identification Policy:

4.2.1 Patients’ Hospital Card:

4.2.1.1 A tamperproof, nontransferable identification card shall be prepared and affixed to the Patient’s Medical File.

4.2.1.2 The identification Card will include the patient’s full name and medical record number.

4.2.1.3 Before any procedure is carried out, the identification card shall be on the patient and will be checked by the responsible care provider for the following two (2) identifiers to ensure that the right patient is involved:

   A. Patient name
   B. Patient file number

4.2.1.4 Whenever possible, staff should also verbally assess the patient to assure proper identification, asking the patient’s name and file no. and matching the verbal confirmation to the written information on the identification band.

4.2.1.5 Patient identification must be confirmed using the two (2) identifier system prior to conducting any healthcare procedures. Procedures may include, but are not limited to:

   A. Administration of medication
   B. Dressing wounds/Removal of sutures.
   C. Swabbing and nebulization.
      1. Specimen samples obtained from the patient will be labeled using the two (2) identifier system in the presence of the patient.
   D. Performing a treatment
   E. Sending patients to another department
      1. All referral and laboratory request must be double check before sending the patient.

4.2.1.6 Each healthcare provider conducting assessments on the patient shall include a check of the patient’s identification to assure that He is the right patient.
5.0 REFERENCES:

Hospital Wide Policy 002.
1.0 **CONDITIONS:**

This policy applies to all family physicians and nurses in primary care clinics and personnel in laboratory department.

2.0 **PURPOSE:**

To improve quality of care provided for patients with hepatitis B and C and to decrease the waiting time with hepatology clinics.

3.0 **DEFINITIONS:**

PCR - Polymerase Chain Reaction (Qualitative and Quantitative)

4.0 **POLICY:**

All patients with hepatitis B sAg positive and Anti HCV positive attending Primary Care Clinic will have PCR test before referring to Hepatology Clinic.

5.0 **PROCEDURE:**

5.1 Patients referred from Blood Bank or other health care sectors or discovered incidentally to be HBSAg positive and anti HCV antibody positive will be evaluated by Primary Care physicians.

5.2 The physician will arrange for PCR request and to be signed or counter signed by a Consultant.

5.3 PCR request will be included with a referral letter to the laboratory.

5.4 PCR will be requested once for the assigned patient and the physician has to be sure that PCR is not requested before for the same patient.

5.5 The laboratory also will check that PCR is not done before for the assigned patient.

5.6 PCR will be done through the laboratory. Where an assigned day will be selected "Wednesday AM of every week".

5.7 The physicians will refer hepatitis patients at the same visit to Hepatology clinic (as arranged with hepatology team).
5.8 The referral form should include:

5.8.1 Proper history of the patient

5.8.2 Notification about PCR request

5.8.3 LFT (before hepatology appointment)

5.8.4 Hepatitis B Markers (if patient is HbsAg positive)

5.8.5 Ultrasound Abdomen

6.0 FORMS AND ATTACHMENTS:

This is in concordance between Ambulatory care team with laboratory team and Hepatology clinic.

7.0 REFERENCE:

7.1 Old Primary Care Assessment form

7.2 Lowell General Hospital Adult Outpatient Initial Assessment Form

7.3 St Lukes Medical Clinic, Patient History and Physical Assessment Form

7.4 Gateway Community Health center Inc.

7.5 The American Academy of Family Physicians and the National Academy of Science Institute of Medicine

1.0 CONDITION:

All Physicians and Pharmacy staff.

2.0 PURPOSE:

To assure optimal patient care and safety through an efficient prescription and medication reconciliation by authorised practitioners and pharmacy staff.

3.0 PROCEDURE:

3.1 Only prescriptions written by a practitioners working in KKUH will be dispensed.

3.2 The patient must be eligible and should have an existing appointment in the clinic.

3.3 Interns prescriptions must be countersigned by an authorized practitioner.

3.4 The patient information shall be stamped on the prescription, **Routine Prescription**, by addressograph, which means all patients should have cards in their file.

3.5 The following should be followed:

3.5.1 Diagnosis must be written.

3.5.2 Patient age and sex should be mentioned.

3.5.3 The generic name shall be used except for combination drugs where common trademark name may be used.

3.5.4 No abbreviations of names of drugs are allowed.

3.5.5 Dose, dosage form, frequency, duration of treatment and any special instructions should be clearly written.

3.5.6 The prescriber name, ID and signature should be clearly written on the prescriptions.

3.5.7 The date of the prescription and the clinic stamp should be written on the prescription.
3.5.8 Clinic extension and prescriber bleep number should be written.

3.6 All controlled drugs should be written down in the **Controlled Prescription** form using the same colour pen and written by the same prescriber.

3.7 Some antibiotics need a **Restriction Form** according to regulations of infectious control beside the routine prescription.

3.8 The generic equivalent of brand product will be dispensed without contacting the prescriber.

3.9 If NO generic equivalent is available, the pharmacist need to call the prescriber for any suggestion for therapeutic alternative.

3.10 If the pharmacist need to contact the physician for medication reconciliation, the following steps will be followed:

3.10.1 Call the bleep number two times.

3.10.2 If NO answer call the clinic extension.

3.10.3 The original prescription may be modified by the pharmacist to reflect any authorized changes.

3.10.4 For control drugs, The patient should return to the physician with the prescription to be changed.

3.10.5 If the physician cannot be contacted, the original prescription will be returned to the patient with instructions to physician for alternative medicine or that the medication may be purchased from a private pharmacy.

4.0 **FORMS AND ATTACHMENTS:**

4.1 Routine Prescription

4.2 Controlled Prescription

4.3 Restricted Antibiotic Form

4.4 Outpatient Pharmacy communication (for PCC1 and PCC2)