TÜSKA
TÜRKİYE HEALTH CARE QUALITY AND ACCREDITATION INSTITUTE

Standards of Accreditation in Health Oral and Dental Health Services (ODHS)

ODHS Set – v3.0/2022

ISQuaEEA International Society for Quality in Health Care External Evaluation Association

IEEA ISQua External Evaluation Association Health and Social Care Standards

Standards of Accreditation in Health

ODHS Kit v.3.0/2022

ISBN: 978-975-590-503-7

Communication

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- Ünal BAYDAR
- Volkan SOZAN, DMD.
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Acknowledgement

In process of preparing and developing standards for Standards of Accreditation in Health Oral and Dental Health Services (SAS ODHS), opinions of institutions and organizations that provide oral and dental health services in public, private and university status, specialty associations, professional organizations, health managers, health workers, academics, patient rights workers, patients and their relatives were asked. Feedback and suggestions obtained through opinion- suggestion platforms prepared to receive opinions and suggestions during studies were evaluated.

We would like to thank all public institutions and organizations, non-governmental organizations, universities and all our stake holders who contributed individually to the SAS ODHS Set (v3.0/2022) studies.

Türkiye Health Care Quality and Accreditation Institute

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Prologue

Introduction

Nowadays, rapid advances in medical technology and applications have brought significant changes in physical and functional construction of the health services.

Emerging success rates of diagnosis and treatment applications, corresponding increases in number of patients and patient beds turnover, people being more careful about health of themselves and their families can be listed as the cause of the physical and functional changes.

These changes affect structural, administrative and designative practices of hospitals and emphasize the need to provide quality health care for patients who need medical care as soon as possible.

So far, a few patient and organizational structure focused accreditation systems have been established for the purpose of development of patient care in the world at an optimal level of quality, creation of a safe patient care environment, minimizing risks concerning patients and employees, a number of quality improvement and patient safety, and performance of healthcare institutions started to be evaluated within these systems.

In Republic of Türkiye, foundations of accreditation have been laid Ministry of Health in 2005 with the quality of healthcare evaluations and service standards of evaluations have been determined. These standards which are developed over time in the terms of number and structure have been implemented in four different versions. By 2013, standards got restructured in the terms of four basic principles of accreditation and ten goals, and the fifth version has been finalized with the name of "Standards of Accreditation in Health ODHS Kit".

This set prepared for Oral and Dental Health Services have two sections and consists of Standards, Assessment Criteria and Guides.

In the first part, historical development process and general information about the accreditation standards have been demonstrated.

The second part includes guides which consists of Standard Requirements that will help understanding and implementing standards and assessment criteria.

SAS-ODHS Kit which contains basic information about accreditation process and requirements for becoming accredited is presented for the benefit of ODHS and all stakeholders to improve the quality of health care.

With the establishment of national accreditation structure in the axis of Standards of Accreditation in Health, three main elements of Transformation of Health Program has been completed. The structure of quality in health consists of two parts:

» Türkiye Health Quality System

» Türkiye Health Accreditation System

Türkiye Health Quality System: The system is created by the Ministry of Health to raise the quality of health services in our country to the highest level within the scope of Health Transformation Program and to ensure patient and employee safety and patient and employee satisfaction.

The system is mandatory for all public and private healthcare organizations in the 1st, 2nd and 3rd level in our country.

Türkiye Health Accreditation System: It is a system based on SAS, which health care organizations will apply on a voluntary basis and become accredited according to their success. Accreditation of Health System is a program that will be applied to, for organizations that want to go beyond the current national quality state and put forth the difference in their quality level. It's organized as incentive for domestic and overseas health tourism because of including a document approved internationally.

In Türkiye, this structure which is established in the field of health quality by Ministry of Health has significant importance for rising on a sturdy foundation in the framework of an awareness of a service that continuously improves and is sustainable.

Standards of Accreditation in Health-ODHS aim to set success goals that will make sure the standards are met firstly in oral and dental health services. Within this context, the standard set has been prepared according to all oral and dental health centers, clinics, policlinics, oral and dental hospitals and university dental hospitals. The statement as "oral and dental health centers" written in the set includes all of these institutions.

Standards of Accreditation in Health ODHS Set (SAS ODHS)

Development of Standards

Work on accreditation in health conducted within the Ministry in Türkiye stretches back to the year 2003 and concepts of quality and accreditation have been among the priorities of the health policy with the principles determined within the scope of Health Transformation Program.

In the Health Transformation Program, emphasis is put on the planning and supervising roles of the Ministry of Health, that is on a Ministry structure and practice that determine the standards of service, set rules, and supervise the framework of practices and the level of implementation of these standards. The accreditation system is established with the principle of "quality and accreditation for quality and effective health services" contained in the sixth component of the program.

Quality and accreditation studies in health services in Türkiye started with the Health Transformation Program in 2003, and effective studies have been carried out within Ministry of Health for about ten years, with the principle of "quality and accreditation for qualified and effective health care" included in the sixth component of the program. The first steps for establishment of national accreditation system in health in Türkiye started with official cooperation process established by Ministry of Health with ISQua in 2012, and as a result of the studies carried out between 2012 and 2014, the first accreditation standard set "Health Accreditation Standards" was prepared.

Within the scope of these studies; One of standard sets prepared is SAS ODHS Set. SAS ODHS Set was accredited by ISQua for the first time on November 26, 2014, and studies are carried out to re-accredit the set every four years.

As of 2015, all works and transactions carried out with all kinds of information and documents within the scope of accreditation activities have been transferred to TÜSEB Türkiye Health Services Quality and Accreditation Institute (TÜSKA) with the approval of the Ministry Authority dated

18.10.2015 and numbered 26325996. In addition, all documents related to responsibility and process for international accreditation of standards with Standards of Accreditation in Health sets prepared by the Ministry of Health, with the approval of the Ministry Authority dated 05.10.2021 and numbered E-26325996-804.01-194, have been transferred to the TÜSEB Türkiye Health Services Quality and Accreditation Institute (TÜSKA). TÜSKA is the first and only national accreditation institution established and recognized by government to carry out accreditation activities in health services, with internationally accepted standards and surveyor training program about health care.

ODHS Kit of Standards of Accreditation in Health is prepared considering international and national quality studies, principles of World Health Organization and ISQua. This kit has been created taking into account international developments, coverage of all service sections and compability for teleological interpretation. Also, properties such as service and outcome-oriented approach, encouraging innovation in organizations, highlighting of applicability, being easy to use and inclusive were considered.

Standards of Accreditation in Health have been structured in line with minimum risk, optimum quality and maximum safety principles within the frame work of the principles of World Health Organization and ISQua which are patient safety, quality improvement, patient and service user-oriented, institutional planning and performance in the field of quality in health.

Standards of Accreditation in Health-ODHS aim to set success goals that will make sure the standards are met firstly in oral and dental health services. Within this context, the standard set has been prepared according to all oral and dental health centers clinics, policlinics, oral and dental hospitals and university dental hospitals. The statement as "oral and dental health centers" written in the set includes all of these institutions.

Goals of Standards of Accreditation in Health ODHS

Standards of Accreditation in Health ODHS Set has been developed by taking into account patient safety goals of WHO, principles of ISQua, accreditation programs conducted across the world and needs and priorities of our country with a view to ensuring quality in oral and dental health centers and in order to achieve quality goals contained in the figure below.

In order to be able to say that service provided in oral and dental health centers is of quality, these centers must achieve the above mentioned goals.

These goals can be handled in two categories in general. The goals in the first category are organizational goals that relate to service delivery mode of the institution in other words how the institution puts forwards its services. (Effectiveness, Efficiency, Productivity and Healthy Work Life).

The goals contained in the second category concern those that get service from the institution directly. (Patient Safety, Equity, Patient-Orientedness, Suitability, Timeliness, Continuity).

The categorization is aimed at putting forth the goals in a clear manner. For example, in an institution where there is no healthy work environment, it will not be possible to ensure patient-oriented. There is no priority relationship between the goals that have been mentioned and the fact that these goals are achieved in compliance with one another is a point that is emphasized by Standards of Accreditation in Health.

The definitions of SAS goals can be found below:

- **Effectiveness**: The criterion used to achieve the planned goal.
- **Efficiency:** The ability to do the work in a proper manner.
- **Productivity:** The relation between the amount of service that is gen- erated and the input used to generate these services. It means achiev- ing the goals by using the least amount of resources.
- **Healthy Work Life**: Ensuring an ideal and safe work environment and infrastructure for health professionals.
- **Patient Safety:** Measures and improvement activities undertaken to keep all the foreseeable dangers that may cause harm to the stake- holders that get service on an acceptable risk level.
- **Equity:** All of the service units of the institutions ensuring that those getting service benefit from equal rights based only on their care and treatment needs regardless of any other difference.
- **Patient-Oriented:** Ensuring active participation of the patient in the services related to diagnosis, treatment and care by taking their wishes, needs, expectations and values into consideration.

- **Suitability:** The health of the person benefiting from the medical procedures and processes to be conducted rather than being harmed.
- **Timeliness:** Providing the services regarding diagnosis, treatment and care in the most appropriate and acceptable time interval in line with the needs of the patient.
- **Continuity:** Ensuring the continuity of medical services in a chrono- logical and interdisciplinary manner after the treatment is completed.

Structure of Standards of Accreditation in Health ODHS Set

Standards of Accreditation in Health consist of 7 aspects, 29 Chapters, 49 Standards, 205 assessment criteria.

SAS ODHS Set is composed of Standards, Assessment Criteria and the guidelines related to them. In the guidelines there are the objectives, goals and Standard requirements of the Standards. Standards, assessment criteria and the relevant guidelines must be handled as a whole and implemented as such.

Aspects of Standards of Accreditation in Health ODHS

7 aspects that are contained in Standards of Accreditation in Health ODHS Set are as follows:

- Management and Organization
- Performance Measurement and Quality Improvement
- Healthy Work Life
- Patient Experience
- Healthcare Services
- Support Services
- Emergency Management

General Objectives and Scope of the Aspects

Aspects contained in Standards of Accreditation ODHS were determined based on the service provided at ODHS, executive activities and people involved in the service process in such a way as to encompass all the units of the institution.

Management and Organization

Aspects contained in Standards of Accreditation ODHS were determined based on the service provided at ODHS, executive activities and people involved in the service process in such a way as to encompass all the units of the institution.

To attain this goal, an organization structure must be established in the institution, main policies and values must be determined, quality management structure must be created, document management must be ensured, an adverse Event Reporting System must be established, risk management and training management must be ensured, work must be undertaken to promote and develop health and institutional communication must be ensured.

» Performance Measurement and Quality Improvement

It is aimed to determine and address the potential problems regarding service delivery especially administrative, financial and medical processes and take actions to improve quality. It is planned to achieve these goals by making use of indicators determined by the institution and SAS indicators.

» Healthy Work Life

Under this aspect it is aimed to make sure that the personnel lead a healthy life for quality service delivery and to look at the organizations of ODHS through the perspective of the personnel.

In line with this goal, a structure aimed at human resources management must be established, measures must be taken against factors that threaten the health and safety of the personnel and requirements to improve the work life must be determined.

» Patient Experience

Under this aspect it is aimed to look at the services through the perspective of the patient in order to ensure basic patient rights, patient safety and patient satisfaction.

To attain this goal, the services that are provided must be organized in such a way as to protect the patient and care rights, to make sure that patients access the services on time and to ensure patient safety.

» Healthcare Services

It is aimed to provide all the medical service processes provided at ODHS within the scope of SAS goals. To that end, work must be undertaken in prevention of infections, sterilization services, drug management, radiation safety, patient care, prosthesis laboratory services and safe surgery.

» Support Services

Under this dimension it is aimed to establish the infrastructure necessary to ensure the safety and continuity of medical service processes. To attain this goal, work must focus on hospitality; facility management, waste management, information management and material and device management must be ensured; activities aimed at outsourcing must be planned.

» Emergency Management

Under this aspect it is aimed to intervene in the fastest and most efficient manner to prevent dangerous situations and harm at ODHS that may be caused by natural disasters such as earthquake, flood or emergencies like fire, explosion etc., respiratory or cardiac arrest cases and in cases where the personnel is exposed to violence.

Coding of Standards of Accreditation in Health

The coding system was developed with a view to giving the standards an identity and thereby ensuring their monitorability.

Coding System

- The code of the Standard is composed of 4 parts.
- The first two parts are composed of letters and the last two parts of figures.
- The parts where the letters are used are composed of two letters and these two letters are the acronyms of the relevant aspect and chapter.
- The figures in the last two parts (3rd and 4th Parts) constitute a two-digit number.
  - The third part signifies the number of the Standard in the chapter.
  - The fourth part signifies the number of the assessment criterion of the Standard.

Standards of Accreditation in Health - ODHS Kit

- "00" in the fourth part signifies the Standard itself, the numbers starting with "01" signifies the ordering of assessment criteria.

The codes for the aspects are as follows:

Aspects	Codes
Management and Organization	YO
Performance Measurement and Quality Improvement	PÖ
Healthy Work Life	SÇ
Patient Experience	HD
Healthcare Services	SH
Support Services	DH
Emergency Management	AD

The codes for each chapter can be found below:

SECTION CODE	SECTION NAME
YO.OY	Organizational Structure
YO.PD	Core Policies and Values
YO.KY	Quality Management Structure
YO.DY	Document Management
YO.GR	Adverse Event Reporting System
YO.RY	Risk Management
YO.EY	Training Management
YO.Kİ	Institutional Communication
PÖ.Gİ	Monitoring of Indicators
SÇ.İK	Human Resources Management
SÇ.ÇG	Employee Health and Safety
HD.HH	Basic Patient Rights
HD.HG	Patient Safety
HD.GB	Patient Feedback
HD.HE	Access to Service
SH.EK	Prevention and Control of Infections
SH.SY	Sterilization Management
SH.İY	Drug Management
SH.HB	Patient Care
SH.RG	Radiation Safety
SH.PL	Prosthesis Laboratory Services
SH.GC	Safe Surgery
DH.OH	Hospitality Services
DH.TY	Facility Management
DH.AY	Waste Management

The codes for each chapter can be found below:

SECTION CODE	SECTION NAME
DH.BY	Information Management
DH.MC	Material and Device Management
DH.DK	Outsourcing
AD.AD	Emergency Management

An example of coding for a Standard can be found below:

STANDARD CODE	STANDARD	EC CODE	Assesment Criteria (AC)
YO.OY.01.00	An organizational structure to cover all ODHS activities must be established.	YO.OY.01.01	Organizational structure must be defined with all vertical and horizontal relations from top management level to the lowest unit, including corporate, financial and clinical management responsibilities
		YO.OY.01.02	Duties of all units in the organizational structure must be defined.
		YO.OY.01.03	Responsible personnel must be determined for all units defined in organizational structure.
		YO.OY.01.04	Institutional plan must be prepared for all activities carried out in line with organization's goals and objectives.
		YO.OY.01.05	In all units in organizational structure; ODHS policies, procedures, processes and plans must be implemented

Determining Met Level of Standards

Processes for implementation of standards using a holistic perspective and with a notion that develops and promotes a culture of quality, carried out in accordance with following standard application criteria:

1. Scope and Implementation: It is definition of plans, policies and processes related to Standard/Assessment Criteria, and met level of the works and procedures for realizing purpose of standard in all relevant departments of institution.

2. Traceability and Continuity: It is retrospective and simultaneous tracking of works and procedures involved in process and information generated during process related to Standard/Assessment Criteria and also continuity of implementations related to Standard/Assessment Criteria - not only in certain periods or time frames

3. Leadership and Participation: It is level of awareness, adoption, and realization of implementations related to orientation of employees of organization at all levels of management and participation of employees of organization in order to realize objective of Standard/Assessment Criteria.

Outputs/Evidence

As a result of studies carried out in line with above-mentioned principles and criteria, outputs related to standards are obtained. These outputs are evidence of any kind of information and documentation determining fulfilment level of standard in self-assessment process.

Deciding on Level Met of Standards

Met level of standards is determined in accordance with the following principles;

- Met level is judged for standard itself.
- Standard, evaluation criteria, objectives and goals of standard, and its requirements are considered as a whole when judging met level.
- Met Level of standard is judged on conformance/nonconformance status of practices that concern standard.
- Conformance/nonconformance judgment concerning a standard is determined,

  In line with standard implementation criteria,

» While focusing on evidence prepared using evidence collection principles and evidence collection methods,

» In compliance with met level criteria.

- Met level for each standard is judged to belong in one of three categories; "met", "partially met", "not met".

Categories for met level of standards/evaluation criteria are as described below;

- **Met (M):** If there is no nonconformity or even if it exists, it may be decided that it is met as a result of evaluation made within scope of Nonconformity Definition Criteria. When there is a nonconformity, de- cision of met level can be made in cases where frequency of existing nonconformity is low, area of influence is individual and low risk level according to definitions specified in Matrix.
- **Partially Met (PM):** As a result of evaluation made within scope of Nonconformity Definition Criteria, Partially Met decision can be given. When there is a nonconformity, decision to partially met can be made in cases where frequency of existing nonconformity is middle or high, area of influence is sometimes individual sometimes systematic and low or middle risk level according to definitions specified in Matrix.
- **Not Met (NM):** As a result of evaluation made within scope of Non- conformity Definition Criteria, decision of Not Met can be given. When there is a nonconformity, decision of Not Met can be made in cases where frequency of existing nonconformity is middle or high, area of influence is generally systematic and middle or high risk level accord- ing to definitions specified in Matrix.

A determination of met level is based on evidence that has been collected in sufficient quality and on purpose and objectives of standard. At this stage, standard must be handled as a whole, together with evaluation criteria, standard purposes and objectives, and requirements.

After ensuring that evidence provided/obtained represent standard and evaluation criterion in such a way as to be evaluated in terms of "Standard Implementation Criteria" and constitute a basis for met

level judgment; natures of Standard, Evaluation Criterion, Purpose and Objectives, and Standard Requirements must be considered while an evaluation is performed based on following criteria, where appropriate and relevant;

- Scope and implementation level of standard and evaluation criterion

- Traceability and continuity of standard and the evaluation criterion in implementation
- Leadership of administrators and level of involvement of employees in matters regarding standard and evaluation criterion

In event that a nonconformance (incompleteness & error) regarding standard or evaluation criterion is identified via evidence obtained, nonconformance must be handled according to the "Met Level Criteria".

The most important point that must be remembered is that "Met Level Criteria" must be regarded as fundamental parameters to be used to arrive at a correct judgment regarding fulfillment level of standard in event that a nonconformance concerning standard is identified.

Met level criteria are;

- Frequency Level
- Severity Level
- Risk Level

Frequency Level :

When examined within scope of sample being evaluated, this is frequency, within sample, of nonconformance concerning standard /evaluation criterion.

If frequency of nonconformance in sample being evaluated is;

- No or rare nonconformances (5% or lower in the selected sample): LOW
- Infrequent (Between 6-15% in the selected sample): MEDIUM
- Very frequent (16% or higher in the selected sample): HIGH

Severity Level :

Means determination of whether identified nonconformances concerning standard are individual or confined to a limited area, or are influential at an institutional and systemic level.

- If nonconformance is individual or occurs in a considerably limited area: It is identified to be INDIVIDUAL. Individual nonconformances usually occur due to the employees' inattention, negligence, failure to comply with the requirements of their occupations, or other causes that stem from another external factor. They usually include issues originating from employees or other external factors, which are not covered under the system designed and implemented by institution or organization, and additionally, for which institution or organization can not be held responsible.

- If nonconformance is influential at an institutional or systemic level: It is identified to be SYSTEMIC. Nonconformances concerning organization, execution, supervision of system designed by institution or organization fall within this scope.

Risk Level:

Expresses relation, to patient and employee safety, of identified nonconformances concerning standard. Nonconformances considered in this context are those directly related to safety, however highest potential of adversity is taken into consideration.

- If there are no/very few adversities with regard to patient and employee safety (outpatient treatable adversities at the most): LOW
- If nonconformance is partially adverse with regard to patient and employee safety (adversities that are not lethal or serious, and will not cause chronic adversities): MEDIUM
- If nonconformance is very adverse with regard to patient and employee safety (adversities that may be chronic, leave sequelae, be serious, or lethal): HIGH

Each nonconformance is defined in accordance with Met Level Criteria and intersection zones of these judgments are identified in matrix below concerning met level for the evaluation criterion. Zones identified direct opinion of self assessment team, and under light of unary and binary judgments in the matrix, a judgment on met level is made while taking into consideration levels of met for standard, relevant section of standard set, and even those other sections that are relevant; that is, from a holistic point of view.

Evaluation Criteria Coverage Level Criteria Matrix

FACTOR	SEVERITY LEVEL	MEETING LEVEL	
RISK LEVEL	*HIGH*	NM	NM
	MEDIUM	NM/PM	NM
	LOW	M/PM	NM/PM
	HIGH	PM/NM	NM
	MEDIUM	M/PM	NM/PM
	LOW	M	NM/PM
	HIGH	M/ PM	NM
	MEDIUM	M	NM/PM
	LOW	M	M/PM
FACTOR	SEVERITY LEVEL	*INDIVIDUAL*	*SYSTEMIC*
	IMPACT LEVEL		

NM: Not Met, PM: rtially Met, M:Met Pa

Possibilities for the Judgment on the Fulfillment level of Standard with 5 Evaluation Criteria					
Judgment on the Fulfillment Level of the Evaluation Criteria					Judgment on the Fulfillment Level of the Standard
1	2	3	4	5	
F	F	F	F	F	F
F	F	F	F	PF	F
F	F	F	PF	PF	F/PF
F	F	PF	PF	PF	PF/F
F	PF	PF	PF	PF	PF
PF	PF	PF	PF	PF	PF
F	F	F	F	U	U
PF	PF	PF	PF	U	U
F	PF	F	PF	U	U

Accreditation Decision

* Accreditation decision for standards; All other aspects of survey process, including application and self-assessment, are carried out in line with TÜSKA ODHS Accreditation Program Guide.

Possibilities for the Judgment on the Fulfillment level of Standard with 4 Evaluation Criteria				
Judgment on the Fulfillment Level of the Evaluation Criteria				Judgment on the Fulfillment Level of the Standard
1	2	3	4	
F	F	F	F	K
F	F	F	PF	K/KK
F	F	PF	PF	F/PF or vice versa
F	PF	PF	PF	PF
PF	PF	PF	PF	PF
F	F	F	U	U
PF	PF	PF	U	U
F	PF	F	U	U

Standards and Guides

Aspects and Chapters

Management and Organization

- Organizational Structure
- Core Policies and Ethical Values
- Quality Management Structure
- Document Management
- Adverse Event Reporting System
- Risk Management
- Training Management
- Institutional Communication

Performance Measurement and Quality Improvement

- Monitoring of Indicators

Healthy Work Life

- Human Resources Management
- Employee Health and Safety

Patient Experience

- Basic Patient Rights
- Patient Safety
- Patient Feedback
- Access to Service

Health Services

- Prevention and Control of Infections
- Sterilization Management
- Drug Management
- Patient Care
- Radiation Safety
- Prosthesis Laboratory Services
- Surgical Safety

Support Services

- Hospitality Services
- Facility Management
- Waste Management
- Information Management
- Material and Device Management
- Outsourcing

Emergency Management

- Emergency Management

SAS ODHS

ACCREDITATION STANDARDS OF HEALTHCARE SET ODHS							
ASPECT CODE	**ASPECT**	**CHAPTER CODE**	**CHAPTER**	**STANDARD CODE**	**STANDARD**	**AC CODE**	**ASSESSMENT CRITERIA (AC)**
YO	Management and Organization	YO.OY	Organizational Structure	YO.OY.01.00	An organizational structure to cover all ODHS activities must be established.	YO.OY.01.01	Organizational structure must be defined with all vertical and horizontal relations from top management level to the lowest unit, including corporate, financial and clinical management responsibilities
						YO.OY.01.02	Duties of all units in the organizational structure must be defined.
						YO.OY.01.03	Responsible personnel must be determined for all units defined in organizational structure
						YO.OY.01.04	Institutional plan must be prepared for all activities carried out in line with organization's goals and objectives
						YO.OY.01.05	In all units in organizational structure; ODHS policies, procedures, processes and plans must be implemented.
				YO.OY.02.00	ODHS must have all necessary authorization and permits for all its activities	YO.OY.02.02	ODHS must have all necessary authorization and permits related to institutional services and staff working status for all its activities.
						YO.OY.02.02	The current and valid status of the necessary authorization and authorization documents for all services and personnel must be reviewed at least once a year and regularly when necessary
		YO.PD	Core Policies and Ethical Values	YO.PD.01.00	Core policies and ethical values of ODHS must be	YO.PD.01.01	Mission, vision and ethical values of ODHS must be defined in a clear and understandable manner.
						YO.PD.01.02	ODHS must share its mission, vision and ethical values with the public.
						YO.PD.01.03	Corporate goals and objectives must be determined in accordance with mission, vision and values, the objectives of the medical and ODSH.
						YO.PD.01.04	Service planning towards the achievement of institutional goals and objectives in ODHS must be made taking environmental and financial factors into account as well.
						YO.PD.01.05	An efficient budgeting must be in place in order to attain goals and objectives set.
						YO.PD.01.06	ODHS must review and assess its institutional resources once a year intervals by taking into consideration plans prepared and budgets drafted with the aim of realizing such plans.

ACCREDITATION STANDARDS OF HEALTHCARE SET ODHS							
ASPECT CODE	**ASPECT**	**CHAPTER CODE**	**CHAPTER**	**STANDARD CODE**	**STANDARD**	**AC CODE**	**ASSESSMENT CRITERIA (AC)**
YO.PD	YO.PD	YO.PD	Organizational Structure	YO.PD.02.00	ODHS must organize programs related to health promotion according to public health structure and general health problems.	YO.PD.02.01	ODHS must organize programs to improve and promote health by taking it according to health structure of region and population it serves, within the scope of national and global health problems, according to its service capacity.
						YO.PD.02.02	Results of implemented programs related to health promotion and improvement must be evaluated by ODHS, effectiveness of implementation and degree of reaching planned targets must be determined.

ACCREDITATION STANDARDS OF HEALTHCARE SET ODHS							
ASPECT CODE	**ASPECT**	**CHAPTER CODE**	**CHAPTER**	**STANDARD CODE**	**STANDARD**	**AC CODE**	**ASSESSMENT CRITERIA (AC)**
YO	Management and Organization	YO.KY	Quality Management Structure	YO.KY.01.00	Planning, implementation, coordination and continuity of quality improvement activities must be ensured.	YO.KY.01.01	A management structure must be established in order to ensure the planning, implementation, coordination and continuity of quality
						YO.KY.01.02	The duties, powers and responsibilities of those involved in the management structure must be defined.
						YO.KY.01.03	The managerial structure should ensure the planning, execution and coordination of quality improvement activities.
						YO.KY.01.04	Committees must be established concerned with at least the following topics: •Employee safety •Patient safety •Training •Facility management •Prevention and control of infections •Infections •Radiation
		YO.DY	Document Management	YO.DY.01.00	Management of documents at ODHS must be ensured.	YO.DY.01.01	Policies, procedures, processes and plans related to all main functions covered by the SAS ODHS set should be documented.
						YO.DY.01.02	Format of documents must be determined.
						YO.DY.01.03	Preparation, check, approval, up-to-datedness and maintenance of documents must be ensured.
						YO.DY.01.04	Rules to communicate documents to relevant people must be set
						YO.DY.01.05	Process related to monitoring of external documents to be followed by ODHS must be defined.
		YO.OB	Adverse Event Reporting System	YO.OB.01.00	Reporting of adverse events that may or does affect the safety of patients and staff negatively must be ensured, and necessary measures must be taken.	YO.OB.01.01	A system must be established in order to report adverse events.
						YO.OB.01.02	Case specific analysis must be conducted, and actions must be taken if necessary.
						YO.OB.01.03	Notifications made to the system must be analyzed, reported and evaluated.

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YO	Management and Organization	YO.RY	Risk Management	YO.RY.01.00	Risk related to ODHS and services provided must be managed.	YO.RY.01.01	There must be a regulation related to managing the risks that may occur in an ODHS.
						YO.RY.01.02	A risk management plan must be prepared in order to manage risks related to ODHS and services provided.
						YO.RY.01.03	Risk management plan must entail patients, carers, visitors, staff, facility safety and environmental safety and administrative and financial processes.
						YO.RY.01.04	Risk management plan must entail the following issues: •Patients • Relatives •Carers • Visitors •Staff • Facility safety •Environmental safety • Administrative and financial processes. •Strategic risks • Communication processes with stakeholders
						YO.RY.01.05	"Necessary measures must be adopted in line with the according to the risk level identified, and actions must be taken for improvement."
						YO.RY.01.06	Risk management plan must entail the following issues: Risks identified and effectiveness of improvement actions must be reviewed periodically.
						YO.RY.01.07	"Indicators for monitoring the effectiveness of risk management must be determined and monitored."
		YO.EY	Training Management	YO.EY.01.00	In accordance with quality improvement activities, training needs of patients, carers and staff must be determined, and it must be ensured that necessary training is conducted effectively.	YO.EY.01.01	A committee in charge of the planning and coordination of training activities must be established.
						YO.EY.01.02	Training needs must be identified on the basis of patients, carers and staff.
						YO.EY.01.03	Training plans must be prepared and implemented in line with training.
						YO.EY.01.04	Effectiveness of training plans and trainings carried out must be monitored and necessary improvement actions must be taken.
		YO.Kİ	Institutional Communication	YO.Kİ.01.00	Institutional communication activities must be carried out effectively.	YO.Kİ.01.01	Under the scope of institutional communication, target audience must be identified by taking ODHS structure, core policies and values into account and communication strategies for target audience must be determined.
						YO.Kİ.01.02	Target audience must be informed about ODHS activities and their organization.
						YO.Kİ.01.03	Necessary actions must be taken to create a positive opinion among target audience.

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ASPECT CODE	**ASPECT**	**CHAPTER CODE**	**CHAPTER**	**STANDARD CODE**	**STANDARD**	**AC CODE**	**ASSESSMENT CRITERIA (AC)**
PÖ	Performance Measurement and Quality Improvement	PÖ.Gİ	Monitoring of Indicators	PÖ.Gİ.01.00	Institutional indicators must be monitored and evaluated in order to continuously improve processes related to service delivery, led by administrative, financial and medical steps.	PÖ.Gİ.01.01	Process for monitoring indicators must be defined.
						PÖ.Gİ.01.02	Indicators must be determined to include processes concerning service delivery, primarily administrative, financial and medical steps.
						PÖ.Gİ.01.03	Indicator cards must be created to cover issues related determination, collection, evaluation and monitoring of data to be used for indicators.
						PÖ.Gİ.01.04	Arrangements must be made for monitoring, evaluation and reporting of indicators
						PÖ.Gİ.01.05	Necessary improvements must be made taking into consideration the analysis results for the indicators.
						PÖ.Gİ.01.06	The results of the SAS indicators must be submitted to the SAS Indicator Data System.

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ASPECT CODE	**ASPECT**	**CHAPTER CODE**	**CHAPTER**	**STANDARD CODE**	**STANDARD**	**AC CODE**	**ASSESSMENT CRITERIA (AC)**
SÇ	Healthy Work Life	SÇ.İK	Human Resources Management	SÇ.İK.01.00	A management structure that will fulfill the requirements concerning planning of human resources, improvement of work life and the personnel must be established.	SÇ.İK.01.01	The relation of the management structure with other management levels must be identified.
						SÇ.İK.01.02	Duties, authorities and responsibilities of those in the management structure and the qualifications they must have must be identified.
						SÇ.İK.01.03	Annual goals and work plans must be developed.
						SÇ.İK.01.04	Feedback processes aimed at determining satisfaction levels and comments and suggestions of the personnel regarding their work life must be identified.
				SÇ.İK.02.00	The requirements necessary to constantly improve recruitment and compliance processes of the personnel and their work life must be determined and fulfilled.	SÇ.İK.02.01	A personnel recruitment plan must be developed in line with human resources needs of ODHS.
						SÇ.İK.02.02	Personnel recruitment processes must be identified.
						SÇ.İK.02.03	Processes regarding ensuring the adaptation of the newly recruited personnel to ODHS must be identified.
						SÇ.İK.02.04	Duties, authorities, responsibilities of the personnel and the qualifications they should have and the performance criteria their job requires must be determined.
						SÇ.İK.02.05	Performance of the personnel must be measured, training needs must be determined to enhance the performance and necessary trainings must be provided.
						SÇ.İK.02.06	How and to what extent the current standards, protocols and evidence- based clinical guidelines accepted by ODHS are used by the personnel must be monitored and trainings aimed at ensuring the use of these standards and guidelines efficiently must be identified.

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ASPECT CODE	**ASPECT**	**CHAPTER CODE**	**CHAPTER**	**STANDARD CODE**	**STANDARD**	**AC CODE**	**ASSESSMENT CRITERIA (AC)**
SÇ	Healthy Work Life	SÇ.ÇG	Employee Health and Safety	SÇ.ÇG.01.00	Factors threatening the health and safety of employees should be identified and necessary precautions should be taken to establish a healthy and safe working environment.	SÇ.ÇG.01.01	Committee aimed at management of the factors that threaten employee health and safety must be established..
						SÇ.ÇG.01.02	Risk analyses must be conducted on the factors that threaten employee health and safety and measures must be taken to eliminate or decrease the risks that threaten the safety.
						SÇ.ÇG.01.03	It must be ensured that employees use the personal protective equipment against the risks.
						SÇ.ÇG.01.04	Quality improvement activities that aim to ensure the continuity of employee safety must be planned.
						SÇ.ÇG.01.05	Physical and social opportunities that are necessary to improve the work environments and the work life must be provided and personal needs of the employee regarding work life must be met.

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HD	Patient Experience	HD.HH	Basic Patient Rights	HD.HH.01.00	The services provided in ODHS must be organized in such a way as to protect patient and carer rights.	HD.HH.01.01	An executive structure aimed at protecting, exercising and improving the rights of patients and carers must be established.
						HD.HH.01.02	ODHS must declare information about all the services that are provided and access to these services and the quality of the services.
						HD.HH.01.03	Patient and/or carers must be informed about the services related to diagnosis, treatment, care and patient responsibilities.
						HD.HH.01.04	During the health care process, consideration must be given to the choices and preferences of the patient.
						HD.HH.01.05	Activities must be planned in all service processes for the patient to be respected and to receive meticulous service.
						HD.HH.01.06	Consent of patient must be obtained for diagnosis and treatment procedures to be applied
						HD.HH.01.07	Patients must be able to examine the medical documents about themselves and receive a copy if requested.
						HD.HH.01.08	Arrangements must be made for the spiritual and cultural needs of the patient.
						HD.HH.01.09	All measures necessary must be taken to ensure patient privacy
						HD.HH.01.10	Arrangements must be made for receiving, investigating and resolving complaints of patients and their relatives.
						HD.HH.01.11	Patient's consent must be obtained if the patient is to take part in a research or experiment, or if the information, data or materials about the patient are to be used in any way.
						HD.HH.01.12	Ethical issues related to care, such as no treatment, withdrawal or discontinuation of treatment, must be discussed and resolved in a timely manner.
						HD.HH.01.13	Processes aimed at informing the patient or carer if unintended events that negatively affect the patient safety occur must be identified

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HD	Patient Experience	HD.HG	Patient Safety	HD.HG.01.00	The services provided at ODHS must be organized in such a way as to protect the safety of patients and their carers	HD.HG.01.01	A committee must be established to ensure patient safety.
						HD.HG.01.02	Risk analyses must be conducted on the factors that threaten patient safety and measures must be taken to eliminate or decrease the risks that threaten safety.
						HD.HG.01.03	Quality improvement activities must be planned to ensure the continuity of patient safety.
		HD.HG	Patient Safety	HD.HG.02	In patient care process, it must be ensured that right procedure is applied to right patient	HD.HG.02.01	Patient identity must be verified in all procedures to be performed during patient care process.
						HD.HG.02.02	For authentication application, identifier must be used.
						HD.HG.02.03	Training must be given to patients and healthcare professionals about patient identity verification.

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HD	Patient Experience	HD.HG	Patient Safety	HD.HG.03.00	Preventions must be taken to prevent patient falls.	HD.HG.03.01	Process for prevention of falls must be planned.
						HD.HG.03.01	Patients must be considered in terms of risk of falling.
						HD.HG.03.03	Preventions must be taken regarding risk level of patients.
						HD.HG.03.04	Falling events that occur must be followed up for investigation.
		HD.HG	Patient Safety	HD.HG.04.00	Effective communication must be ensured in exchange of medical information among healthcare professionals.	HD.HG.04.01	Process for employee handovers must be defined.
						HD.HG.04.02	Process of reporting panic values related to diagnostic tests must be defined.
						HD.HG.04.03	Arrangements must be made for application of verbal requests.
						HD.HG.04.04	Arrangements must be made for abbreviations, symbols and dose amounts that must not be used.

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HD	Patient Experience	HD.HG	Patient Safety	HD.HG.04.00	Effective communication must be ensured in exchange of medical information among healthcare professionals.	HD.HG.04.05	In patient transfer between departments, accurate and complete transfer of patient information must be made
						HD.HG.04.06	Process regarding implementation of ODSH in and out of ODSH consultations must be planned

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HD	Patient Experience	HD.HG	Patient Safety	HD.HG.05.00	Patient must be transferred safely.	HD.HG.05.01	Process for safe transfer of patient must be defined.
						HD.HG.05.02	Preventations must be taken for the safe transfer of patients.
		HD.GB	Patient Feedback	HD.GB.01.00	A system must be established to receive feedback (opinions, suggestions and complaints, etc.) of patients and their relatives about services provided	HD.GB.01.01	Scope, methods and tools must be defined in system, including the acceptance, investigation and resolution of complaints and all feedback.
						HD.GB.01.02	Patients and their relatives must be informed about how they can give feedback.
						HD.GB.01.03	All feedback must be taken into consideration.
						HD.GB.01.04	Necessary improvement activities must be planned for results obtained from feedbacks.

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HD	Patient Experience	HD.HF	Access to Service	HD.HE.01.00	Necessary measures must be taken to ensure that patient reaches the services in time.	HD.HE.01.01	During patient's application to ODSH, any kind of need, in a way that can access information and facilitate application process, welcome, orientation and consultation services must be provided.
						HD.HE.01.02	In outpatient clinic process of the patients, aimed at minimizing waiting times, necessary measures must be planned and patients must be informed about how long they will wait and when they will be examined.
						HD.HE.01.03	According to age, disease and disability, facilitating measures must be taken in accessing services and waiting areas.
						HD.HE.01.04	Service delivery processes must be arranged in a way that ensures timely diagnosis and treatment of patient without delay.
						HD.HE.01.05	Arrangements must be made in ODSH to facilitate patient's access to emergency services outside of working hours.

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SH	Health Services	SH.EÖ	Prevention and Control of Infections	SH.EÖ.01.00	Necessary measures must be taken for the prevention and control of infections.	SH.EÖ.01.01	A committee must be formed for infection control and prevention, and responsibilities must be determined.
						SH.EÖ.01.02	A program must be created for the control and prevention of infections.
						SH.EÖ.01.03	Efficiency of the practices aimed at ensuring control and prevention of infections must be monitored.
		SH.SY	Sterilization Management	SH.SY.01.00	Processes concerning sterilization services must be identified and taken under control.	SH.SY.01.01	Physical areas and conditions in sterilization unit must be planned according to the process steps.
						SH.SY.01.02	All processes for re-use, sterilization, storage and transfer of reusable medical devices and materials must be regulated and taken under control
						SH.SY.01.03	Traceability of the evidence regarding time, device, method, implementer and control parameters must be ensured in each stage of the sterilization.

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SH	Health Services	SH.İY	Management	SH.İY.01.00	Efficient and safe drug management must be ensured in the institution.	SH.İY.01.01	Drug management structure that will provide an effective implementation of drug administration and coordination must be created.
						SH.İY.01.02	Main and critical stages of all the medicine processes in the institution
						SH.İY.01.03	The right medicine must be provided at the right time and effective stock management of the medicines must be ensured.
						SH.İY.01.04	Drug must be kept under proper conditions.
						SH.İY.01.05	Measures must be taken to ensure the safety of the patient and the personnel when the medicines are being prepared and administered
						SH.İY.01.06	At all stages of drug administration, measures must be taken for patient and employee safety.
						SH.İY.01.07	Traceability of medicine processes must be ensured by making use of feedback infrastructures and indicators and the necessary improvement work must be undertaken.
		SH.HB	Patient Care	SH.HB.01.00	Patient care processes must be conducted in line with the needs of the patient and so as to ensure patient safety.	SH.HB.01.01	The process for patient care practices must be planned with a multidisciplinary approach and to ensure participation of all health professionals in care process
						SH.HB.01.02	Patients must be evaluated in terms of their care needs.
						SH.HB.01.03	A care plan for patients must be developed according to the results of the evaluation.
						SH.HB.01.04	Care plan must be reviewed and updated continuously according to clinical results of patient.
						SH.HB.01.05	Patients/carers must be involved in the care processes.
						SH.HB.01.06	Processes regarding referral of patient or completion of treatment must be planned so as to ensure continuity of care.
						SH.HB.01.07	Records of patient's care process must be complete and accurate and contain necessary warnings for clinical follow-up of patient.

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SH	Health Services	SH.HB	Patient Care	SH.HB.02.00	Patients who are at risk of harming themselves or others must be take under control	SH.HB.02.01	Patients must be evaluated for the risk of harming themselves or others.
						SH.HB.02.02	Necessary measures must be taken for patients who are at risk of harming themselves or others.
				SH.HB.03.00	Standardization of care practices for specific patient groups must be ensured	SH.HB.03.01	Processes for specific patient groups and care practices must be defined
						SH.HB.03.02	Specific care practices and all procedures for specific patient groups must be

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SH	Health Services	SH.RG.	Radiation Safety	SH.RG.01.00	Measures must be taken to ensure radiation safety for patient/carers and the personnel.	SH.RG.01.01	A committee must be established to ensure radiation safety.
						SH.RG.01.02	The areas where there are devices that emit radiation must be identified and protective measures must be taken in these areas.
						SH.RG.01.03	Rules must be determined for procedures that entail the use of radiation.
		SH.PL	Prosthesis Laboratory Services	SH.PL.01.00	The physical environment of the prosthesis laboratory must be created to ensure prosthesis safety and employee safety.	SH.PL.01.01	The areas that have been determined for the admission of prosthetic materials into the prosthesis laboratory, the preparation of the material for the procedure, its being processed and for the delivery must be arranged so as to ensure the safety of the prosthesis.
						SH.PL.01.02	A healthy work environment must be ensured in all areas in the prosthesis laboratory.
				SH.PL.02.00	The processes that precede the fabrication of prosthesis must be checked.	SH.PL.02.01	The methods and rules for transfer of prosthetic material to the prosthesis laboratory, its admission into the laboratory and its preparation before the procedure must be identified.
						SH.PL.02.02	Rules on the renewal of impression when necessary must be determined and relevant dentists must be provided with information.
						SH.PL.02.03	The relevant health personnel must be provided with general information on the procedures conducted in prosthesis laboratory and with training on safe transfer of prosthetic material, its admission into prosthesis laboratory and its preparation before the procedure
				SH.PL.03.00	The processes regarding the fabrication of prosthesis must be checked.	SH.PL.03.01	The methods and rules about the processes regarding fabrication of prosthesis in prosthesis laboratories must be identified.
						SH.PL.03.02	Rules regarding effective and safe use of the prosthetic material in prosthesis laboratories and other materials and devices must be identified.
						SH.PL.03.03	Quality control procedures regarding the suitability of the prosthesis must be identified and implemented.

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SH	Health Services			SH.PL.04.00	The processes that follow the fabrication of prosthesis must be checked.	SH.PL.04.01	The prosthesis that has been completed must be delivered with Prosthesis Delivery Report.
						SH.PL.04.02	The prosthesis must be inserted within the set time of delivery.
						SH.PL.04.03	Patients must be informed about the rules regarding the use of prosthesis.
		SH.PL	Prosthesis Laboratory Services	SH.PL.05.00	Traceability of the processes regarding prosthesis laboratory must be ensured.	SH.PL.05.01	Records must be kept to ensure traceability of the impression and the prosthesis in all the processes.
		SH.GC	Surgical Safety	SH.GC.01.00	Patient safety must be ensured in surgical procedures	SH.GC.01.01	All procedure steps and rules regarding safe surgical procedures must be defined.
						SH.GC.01.02	Before surgery, measures must be taken to ensure patient safety.
						SH.GC.01.03	During surgery, measures must be taken to ensure patient safety.
						SH.GC.01.04	Precautions regarding patient safety after the surgical intervention must be taken.

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SH	Health Services	SH.PL	Surgical Safety	SH.GC.02.00	Conditions of the operating room must be appropriate to ensure safe surgery.	SH.GC.02.01	Rules regarding operating rooms must be determined.
						SH.GC.02.02	Operating areas must be arranged so as to ensure patient and employee safety.

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DH	Support Services	DH.OH	Hospitality Services	DH.OH.01.00	Processes regarding catering for inpatient/ carer and the personnel must be identified.	DH.OH.01.01	Safe supply and storage of the food must be ensured.
						DH.OH.01.02	Processes regarding preparation of the food under the set conditions must be identified
						DH.OH.01.03	Food must be distributed according to the set rules.
						DH.OH.01.04	Health screening of the personnel distributing the food must be conducted.
				DH.OH.02.00	Laundry services must be provided in a safe and efficient manner to ensure patient and personnel health at ODSH.	DH.OH.02.01	Processes regarding the delivery of laundry services must be identified.
						DH.OH.02.02	The laundry room must be arranged so as to ensure efficient conduct of service processes.
						DH.OH.02.03	Rules regarding the use of laundry equipment must be determined.
				DH.OH.03.00	Patient/examination rooms and the areas used by patients/carers must be safe and ergonomic.	DH.OH.03.01	All departments providing service must be designed in a way that ensures comfort of the patient.
						DH.OH.03.02	Action must be taken to ensure easy access of the patient to the relevant health personnel.
				DH.OH.04.00	Safety/security services must be provided in ODHS to ensure safety of life and property of patient/carer and the personnel.	DH.OH.04.01	Processes regarding the delivery of Safety/Security services must be identified.
						DH.OH.04.02	Safety of life and property of the patient/carer in ODHS must be ensured.

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DH	Support Services	DH.TY	Facility Management	DH.TY.01.00	A quality facility management structure and process must be established to ensure the quality and safety of healthcare services.	DH.TY.01.01	A committee responsible for planning and coordinating activities related to facility management must be formed.
						DH.TY.01.02	Risks originating from the facility must be detected and necessary measures must be taken.
						DH.TY.01.03	Continuity and safety of core facility resources must be ensured.
						DH.TY.01.04	Issues related to physical conditions and operations must be reviewed periodically.
						DH.TY.01.05	Measures must be taken to facilitate access to services by patients who are disabled, old or in need of help due to illness.
						DH.TY.01.06	Physical arrangements must be made to ensure the comfort of service users
		DH.AY	Waste Management	DH.AY.01.00	Safe and effective management of waste produced at ODHS must be ensured to protect human and environmental health.	DH.AY.01.01	Waste Management Plan must be prepared.
						DH.AY.01.02	Waste must be sorted at the source.
						DH.AY.01.03	Necessary steps must be taken to ensure that waste is transported, temporarily stored and disposed in appropriate conditions.
						DH.AY.01.04	Personnel involved in waste management must be trained.

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DH	Support Services	DH.BY	Information Management	DH.BY.01.00	A safe and effective information management system must be present at ODHS.	DH.BY.01.01	Those in charge of carrying out and coordinating activities related to information management must be identified.
						DH.BY.01.02	The necessary technical and supporting infrastructure must be established for the efficiency of information management.
						DH.BY.01.03	Measures must be taken for the security of medical records that are physically stored.
						DH.BY.01.04	Necessary measures must be taken to ensure information security and confidentiality.
						DH.BY.01.05	It must be ensured that the information is timely and continual.
						DH.BY.01.06	Personnel must be trained for effective use of information management.
		DH.MC	Material and Device Management	DH.MC.01.00	Efficient, effective and safe use of materials and devices must be ensured.	DH.MC.01.01	Those in charge of management of materials and devices must be determined.
						DH.MC.01.02	Materials and devices must be determined and supplied in accordance with the needs of the institution.
						DH.MC.01.03	Materials must be conserved in proper conditions.
						DH.MC.01.04	Necessary physical conditions must be met to ensure that the devices work in proper working conditions.
						DH.MC.01.05	Personnel must be trained in material and device management.
						DH.MC.01.06	Traceability of medical devices must be provided.
						DH.MC.01.07	Necessary maintenance, calibration, adjustments and tests of the devices needed must be conducted.
						DH.MC.01.08	Rules must be set to ensure safe and effective use of materials and devices, the necessary protective material and information concerning the devices must be available.
						DH.MC.01.09	Arrangements must be made for management of dangerous substances
		DH.DK	Outsourcing	DH.DK.01.00	The services provided through outsourcing must be in line with the core policies and values of ODHS and Standards of Accreditation in Health.	DH.DK.01.01	The services to be outsourced must be determined in line with the core policies and values of ODHS.
						DH.DK.01.02	Scope and process of the outsourced services must be defined.
						DH.DK.01.03	It must be ensured that outsourced services will comply with Health Accreditation Standards.

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AD	Emergency Management	AD.AD	Emergency Management	AD.AD.01.00	Measures must be taken for the natural disasters or events which require emergency response, striving, first aid or evacuation.	AD.AD.01.01	Necessary measures must be determined by risk analysis for the events that require extraordinary response, striving, first aid or evacuation.
						AD.AD.01.02	Planning must be done for preventive measures determined and possible emergencies.
						AD.AD.01.03	Trainings must be provided on emergency management and drills must be conducted.
				AD.AD.02.00	Timely interventions must be performed in the case of respiratory or cardiac arrest.	AD.AD.02.01	An emergency alert system must be formed by ODHS for timely intervention in cases of respiratory arrest and/or cardiac arrest.
						AD.AD.02.02	Those in charge of management of the emergency alert system must be determined.
						AD.AD.02.03	Intervention team/teams must be determined.
						AD.AD.02.04	Medicines and equipment to be used in the procedures must be specified.
						AD.AD.02.05	Records must be kept about interventions performed.
						AD.AD.02.06	Emergency alert system trainings must be provided and drills must be conducted.
				AD.AD.03.00	Timely intervention must be ensured in cases where the health professional is exposed to a risk of violence, or an act of violence is directed towards him/her.	AD.AD.03.01	An emergency alert system defined with Emergency alert system must be in place for intervention in cases where there is a risk or and actual act of violence towards health professionals.
						AD.AD.03.02	Those in charge of the management of the emergency alert system must be determined.
						AD.AD.03.03	Intervention team/teams must be determined.
						AD.AD.03.04	Emergency alert system trainings must be provided and drills must be conducted.
				AD.AD.04.00	There must be an arrangement in place to ensure timely response to fire.	AD.AD.04.01	There must be a fire detection system.
						AD.AD.04.02	Emergency alert system defined with Emergency alert system must be established to respond in time in the case of fire.
						AD.AD.04.03	Those in charge of management of the emergency alert system must be determined.
						AD.AD.04.04	The equipment to be used while responding to fire, rules regarding safe use of this equipment, signs and instructions to be taken into account in the case of fire must be identified.
						AD.AD.04.05	Trainings must be provided on Emergency alert system and drills must be conducted.

Management and Organization

Organizational Structure

Standard 1

Code	Standard	Code	Assessment Criteria
YO.OY.01.00	An organizational structure to cover all ODHS activities must be established	YO.OY.01.01	Organizational structure must be defined in a way that covers responsibilities related to governance, financial stewardship.
		YO.OY.01.02	Duties of all units in the organizational structure must be defined.
		YO.OY.01.03	Responsible personnel must be determined for all units defined in organizational structure.
		YO.OY.01.04	Institutional plan must be prepared for all activities carried out in line with organization's goals and objectives.
		YO.OY.01.05	In all units in organizational structure; ODHS policies, procedures, processes and plans must be implemented.

Goal

To identify duties, authorities, responsibilities, liabilities and communication and approval mechanisms in order to attain institutional goals, to ensure sustainability in ODHS functioning, to ensure performance and inspection of the workflow of ODHS in a defined organizational structure.

Objectives

- Effectiveness
- Efficiency
- Productivity
- Continuity

Standard Requirements

Establishment of Organizational Structure

Organizational structure of ODHS must be designed in a way that it will lead to the goals and targets defined on the basis of main policy and values. While designing organizational structure in this context, one or several of structure types such as Functional, Sectional or Matrix must be approached by evaluating main elements such as size of ODHS, service type, target group, other related institutions and their positions, internal and external necessities.

The organizational chart must be defined in one or more documents, showing horizontal and vertical relationships from the top unit to the bottom unit. At a minimum, the following must be covered in the document:

In the organizational scheme, at least topics below must be issued:

- Specialty and division of services
- Responsibilities and relations
- Ways to delegate authority
- Coordination and integration points
- Duties and positions of staff

Governance

Responsibilities related to governance must be defined including the basic factors listed below:

- Transparency
- Accountability
- Participation
- Responsiveness

- Rule of law
- Efficiency
- Equality
- Strategic vision

Responsibilities related to clinical governance must be defined including the basic factors listed below:

- Clinical efficiency
- Clinical assessment
- Clinical Risk management
- Patient and public participation
- Staff and human resources management
- Education and training
- Use of information

Responsibilities related to financial stewardship must be defined including at least the basic factors listed below:

- Defining budget by institution and unit basis
- Ensuring efficient, economical and efficient use of the budget
- Control and monitoring of expenditures and income / outcome balance

For successful implementation of governance, financial stewardship and clinical governance, an efficient leadership, team work and communication must be ensured in political and clinical processes.

Defining Duties, Powers and Responsibilities of Units and Staff

Duties of units and staff included in the organizational scheme must be defined, and their powers and responsibilities must be clarified. Terms of reference must include relations between units as well and must be prepared in such a way as to avoid uncertainty and confusion. Authorities and responsibilities assigned to units and individuals must be consistent.

Determining Unit Supervisors

Supervisors must be determined for the positions from the senior management to subunits.

Establishment of the Institutional Plans

An institutional plan should be established for the activities carried out in line with the organization's aims and objectives.

Management and Organization

Standard 2

Code	Standard	Code	Assessment Criteria
YO.OY.02.00	ODHS must have all necessary authorization and permits for all its activities	YO.OY.02.01	ODHS must have all necessary authorization and permits related to institutional services and staff working status for all its activities.
		YO.OY.02.02	The current and valid status of the necessary authorization and authorization documents for all services and personnel must be reviewed at least once a year and regularly when necessary.

Goal

To ensure effective check and monitoring of health care services and support services provided at ODHS by making sure that these services are delivered only by people and institutions authorized under related the national legislation.

Objectives

» Efficiency

» Efficiency

» Productivity

Standard Requirements

All required authorization and permits described by the national legislation must be determined for all service activities performed by ODHS.

Within this scope;

» ODHS must obtain the required activity permits, licenses, etc. at ODHS level and/or service area level;

» All activities consisting of traditional, complementary, alternative medicine practices and all other services provided apart from healthcare services (administrative, technical, etc.)

must be performed by people authorized (diploma, certificate, specialty certificates, etc.) in the framework of all related national health policies, legislation and other legal regulations. This authorization requirement applies to all staff including permanent, temporary, voluntary and casual employees. Authorization documents for working areas of employees must be verified, validity period of documents must be followed and updated.

Core Policies and Ethical Values

Code	Standard	Code	Assessment Criteria
YO.PD.01.00	Core policies and ethical values of ODHS must be defined.	YO.PD.01.01	Mission, vision and ethical values of ODHS must be defined in a clear and understandable manner.
		YO.PD.01.02	ODHS must share its mission, vision and ethical values with the public.
		YO.PD.01.03	Corporate goals and objectives must be determined in accordance with mission, vision and values, the objectives of the medical and administrative departments should be compatible with the basic policies and values of the ODHS.
		YO.PD.01.04	Service planning towards the achievement of institutional goals and objectives in ODHS must be made taking environmental and financial factors into account as well.
		YO.PD.01.05	An efficient budgeting (income/ expense budget) must be in place in order to attain goals and objectives set.
		YO.PD.01.06	ODHS must review and assess its institutional resources at regular intervals by taking into consideration plans prepared and budgets drafted with the aim of realizing such plans.

Goal

To define principles to guide executives and staff in relation to institution's activities and strategic decisions by determining core policies and ethical values of ODHS.

Objectives

- Efficiency
- Effectiveness
- Productivity

Standard Requirements

Determining Mission, Vision and Ethical Values

- Mission and vision of institution must be determined based on information obtained with analysis of internal and external environmental conditions, and conditions that ODHS intends to attain.
- ODHS must determine ethical values which include principles and rules that will lead all its activities. Issues such as ethical principles and rules of conduct, principles which highlight the focus on patient and staff, can be addressed within the scope of ODHS ethical values.
- ODHS must pay attention to ensure that its core policies and ethical values are compatible with minimum ethical values of its staff and service receivers.
- Strategic plan must be reviewed annually and revised as necessary.

Sharing Core policies and ethical values with the Public

- Mission, vision and ethical values of ODHS must be shared by the institution with the public periodically by using various communication tools (website, boards, promotion activities, etc.).

Determining Goals and Objectives

- ODHS must determine its goals and objectives by institution and unit on the basis of core policies and ethical values.
- The objectives of the medical and administrative departments should be in line with the objectives of the institution.
- Activities of ODHS must be planned and implemented on the basis of goals and objectives set by the institution and units.

Service Planning

Goals and objectives determined by the institution and units must be taken as basis for planning ODHS activities.

During planning, internal factors (human resources, financial status, size, diversity of services, structural conditions, etc.), external factors (legal environment, corporate relations, public health structure, suppliers, competitors, etc.), features and feedbacks of service users, employees and society must be taken into account.

Code	Standard	Code	Assessment Criteria
YO.PD.02.00	ODHS must organize programs related to health promotion according to public health structure and general health problems. structure and general health problems.	YO.PD.02.01	ODHS must organize programs to improve and promote health by taking it according to health structure of region and population it serves, within the scope of national and global health problems, according to its service capacity.
		YO.PD.02.02	Results of implemented programs related to health promotion and improvement must be evaluated by ODHS, effectiveness of implementation and degree of reaching planned targets must be determined.

Goals

To ensure that ODSH provides health-promoting and improving services for social responsibility towards public and to improve health level of public it serves.

Objectives

» Patient Oriented
» Suitability
» Equity
» Effectiveness
» Continuity

Standard Requirements

» ODSH must investigate health texture/structure of region and public it serves, and national and global health problems. In this context, a situation analysis must be made by evaluating the following:

- Demographic data such as population, age, gender, education level
- Demographic data such as population, age, gender, education level

» Based on situation analysis, health promoting and improving activities for target public must be planned within a program. ODSH must create at least two programs within this scope.

» Results of program must be evaluated by ODSH, and effectiveness of implementation and degree of reaching the planned goals must be determined.

» Evaluation and effectiveness of program must be made by analyzing change in main data and information over time, depending on whether it is short, medium or long term.

» According to evaluation results, improvements must be made in program activities and continuity must be ensured in order to achieve program objectives.

Programs to be developed within the scope of the standard can be created on following topics or similar topics:

» Fight against smoking
» Increasing awareness and knowledge level of public about dental health
» Educational and preventive activities developed to combat chronic diseases
» Healthy nutrition for a healthy life
» Encouraging young public about sports activities for a healthy life
» Promotion of breastfeeding
» Educational activities for pregnant patients
» Cooperation with local governments within the scope of combating regional factors that threaten public health
» Detection and information about oral cancers
» Oral and dental health practices of elderly and disabled patients
» Oral and dental health practices of patients receiving chemotherapy and radiotherapy.
» etc.

Quality Management Structure

Code	Standard	Code	Assessment Criteria
YO.KY.01.00	Planning, implementation, coordination and continuity of quality improvement activities must be ensured.	YO.KY.01.01	A management structure must be established in order to ensure the planning, implementation, coordination and continuity of quality improvement activities
		YO.KY.01.02	The duties, powers and responsibilities of those involved in the management structure must be defined.
		YO.KY.01.03	The managerial structure should ensure the planning, execution and coordination of quality improvement activities.
		YO.KY.01.04	Committees must be established concerned with at least the following topics: » Employee safety » Patient safety » Training » Facility management » Prevention and control of infections » Radiation safety

Goal

To establish a quality management structure by defining the roles and responsibilities of all the staff from senior management to unit employees at ODHS in quality improvement activities; to ensure that quality is continuously improved through the planning, implementation and coordination of quality improvement activities within this structure.

Objectives

» Efficiency
» Effectiveness
» Productivity
» Continuity

Standard Requirements

Management Structure Related to Quality

» Management structure must be established within ODHS to ensure planning, implementation, coordination and continuity of quality improvement activities.

» The duties, authorities and responsibilities of people involved in the management structure, and the vertical and horizontal relations of this structure must be defined.

» Quality supervisors to work in coordination with this management structure must be determined on the basis of units and/or processes.

» ODSH must establish a plan for quality improvement activities. Activities must be regularly monitored, updated and shared with relevant stakeholders through this plan.

The Planning, Execution and Coordination of Quality Improvement Activities

» Within the framework of Standards of Accreditation in Health, at least the following activities must be carried out to ensure planning, implementation and coordination of quality improvement activities:

- Ensuring planning and implementation of measurement, assessment, improvement and monitoring activities

√ Defining and implementing processes related to self- assessment (at least twice a year to cover all processes and sections)

√ Defining and implementing the scope and processes concern

Patient/employee satisfaction surveys [at least twice a year and in a way to cover different service areas (outpatient, inpatient, etc.) of ODHS and, to reflect specific expectations from and perception of the specific service area]

√ Defining and implementing processes with the aim of obtaining patients'/staff's opinions and suggestions

√ Monitoring performance related to quality improvement activities through indicators; planning and monitoring of activities aiming at the use of results obtained from such study for the purpose of improvement

» Periodic sharing of performance and quality improvement data with senior management

√ Monitoring the results of the external evaluations carried out within ODHS and defining and implementing processes so that the results can be used for the benefit of the institution

- Monitoring the activities of the committee and coordinating relevant committees
- Defining documentation processes related to quality activities, setting a documentation system, and ensuring its implementation within the rules required by the system
- Monitoring and coordinating unit- and/or process-based quality activities performed in cooperation with unit and/or process quality supervisors.

Forming Quality Committees

» Within the scope of SAS ODHS, committees must be established in relation to at least following issues (committees can be merged in line with ODHS size and conditions):
  - Employee Safety
  - Patient Safety
  - Training
  - Facility Management
  - Prevention and control of Infections
  - Radiation Safety

  » Processes must be defined in order to ensure the cooperation and coordination of committees with other committees.

Document Management

Code	Standard	Code	Assessment Criteria
YO.DY.01.00	Management of documents at ODHS must be ensured.	YO.DY.01.01	Policies, procedures, processes and plans related to all main functions covered by the ODHS set should be documented.
		YO.DY.01.02	Format of documents must be determined.
		YO.DY.01.03	Preparation, check, approval, up-to-datedness and maintenance of documents must be ensured.
		YO.DY.01.04	Rules to communicate documents to relevant people must be set.
		YO.DY.01.05	Process related to monitoring of external documents to be followed by ODHS must be defined.

Goal

In ODSHs; planning and writing down the processes of the applications, performing the application in accordance with the written rules and effectively managing the quality studies.

Objectives

» Efficiency
» Effectiveness

Standard Requirements

Establishment of Document Management System

» Processes related to management of documents and rules related to operation of these processes must be defined:
» Definition must entail at least following processes:

- Determining the documents to be prepared
- Determining the format of the document
  - √ Document Preparation
  - √ Check and approval of documents
  - √ Communication of documents to relevant people
  - √ Document Storage
  - √ Document Revision
  - √ Archiving and disposal of documents
- External document tracking

Determining documents to be prepared

» Documents to be prepared must be determined taking into consideration Standards of Accreditation in Health, ODHS size, areas of service provision and processes.
» Policies, procedures, processes and plans related to all main functions of ODHS must be documented.
» All prepared documents must be reviewed periodically and revision date must be recorded.
» Types of documents which can be prepared in line with SAS ODHS are as follows:

- Procedure
- Instruction
- Guideline
- Form
- Plan
- Consent
- List
- Support documents
  - √ Policy
  - √ Protocol
  - √ Objectives
  - √ Duty-Authority-Responsibility
  - √ Clinical Guidelines
  - √ Work flow
  - √ Report of Medicine Disposal
  - √ Meeting Minutes

Determining the Format of the Document

» All documents must include at least the following information:

- Document
  - √ Name
  - √ Code
  - √ Publication date
  - √ Revision date
  - √ Revision number
  - √ Page number/number of pages
  - √ Prepared By – Checked By – Approved By details

» In original copy of documents, position and title of individual(s) must be indicated in the section Prepared by – Checked by – Approved by.

Preparing Documents

» Documents must be prepared in accordance with the SAS ODHS form.

» Document must be prepared by relevant unit/committee/team members.

» Documents must be easy to understand, include concise information and must be clear.

Check and Approval of Documents

» Documents must be checked by the quality management unit and must be approved by the senior management.

Communicating Documents to Relevant People

» It must be ensured that the up-to-date versions of the documents are shared with relevant staff effectively.

» Necessary training must be provided for relevant staff on the documents prepared.

» Posting rules must be determined. It must be defined how and by whom approval for documents to be hung on the boards will be given, how long documents will be hung on board and how process of removing them from board will be managed.

» Responsibilities for follow-up of documents must be determined, and posted documents must be up-to-date.

» Boards and documents hanging on boards must be visually arranged.

» To be hung outside designated boards and areas; rules for informative announcements, announcements and explanations must be determined.

Storage of Documents

» With physical or electronic signatured original documents with wet signs must be stored by the quality management unit. Original physical documents must be stored in line with a systematic filing plan and necessary measures must be taken to keep contents of documents readable.

Rules must be defined for electronic preservation of electronically signed documents, and necessary precautions must be taken for security of documents.

» Documents in the form of records related to actions taken in line with SAS ODHS (Corrective and Preventive Action Forms, Meeting Minutes, Self-Assessments, maintenance, repair and calibration (measurement) records, temperature and humidity follow-ups, must also be kept. And these documents include how long these documents will be kept, and they should be kept accordingly.

Revision of Documents

» Whenever there is a change in any of the processes of ODHS, revision must be made immediately.

» During revision, all rules to be followed in the initial preparation of the document must be observed. Following the management approval, the revised document must be published, it must be communicated to relevant people, and the revised document must be explained to relevant people within the scope of a training.

» Revision date and revision number must be indicated on the document revised. In the first publication of the document, revision number must be (0) and revision date must be kept blank. Old versions of documents must be archived by the Quality Management Unit in order to track revisions.

» A list of all documents used in ODHS must be kept and the list must enable the tracking of revisions as well. Document list must include following information:

- Document Name
- Document Code
- Publication Date
- Revision Dates
- Revision Number

External Document Tracking

Tracking and up-to-datedness of external documents must be ensured through a method determined by ODHS. ODHS must identify supervisors in charge of the tracking of external documents.

Archiving and Disposal of Documents

Rules for archiving and destruction of documents should be specified.

Adverse Event Reporting System

Code	Standard	Code	Assessment Criteria
YO.OB.01.00	Reporting of adverse events that may or does affect the safety of patients and staff negatively must be ensured, and necessary measures must be taken.	YO.OB.01.01	A system must be established in order to report adverse events that may or does affect the safety of patients and staff negatively.
		YO.OB.01.02	Case specific analysis must be conducted, and actions must be taken if necessary.
		YO.OB.01.03	Notifications made to the system must be analyzed, reported and evaluated.

Goal

To ensure that adverse events related to patient and staff safety with a potential to occur (near misses) or occur in ODHS are reported; to monitor them and to take necessary measures against events as a result of reports.

Objectives

- Patient safety
- Healthy Working Life

Standard Requirements

Adverse Event Reporting System

» A reporting system must be established in order to analyze events to take necessary measures and to prevent the repetition of errors by ensuring the reporting of events that may or does harm employees and patients at ODHS or have been noticed before the occurrence of harm.

» System must be web-based, available on the intranet, electronically or in printed forms

» System must be confidential

» Under the scope of the adverse event reporting system, notification, analysis and reporting processes must be defined and supervisors in charge of these processes must be identified.

» Adverse Event Reporting System must consist of two modules:

- Patient Safety Module (Issues threatening the safety of carers and visitors must be notified in this model as well)
- Staff Safety Module

» For the purpose of increasing efficiency and use of the system, cultivating a reporting culture at ODHS, learning lessons from events, developing learning process and devising solutions and encouraging the implementation of solutions; the system must be:

- Designed confidential in a way that makes the staff feel safe, provide information such as name and location when needed
- Based on voluntary reporting
- Accessible
- Easy to use
- Simple and easy to understand

» Module must be based on privacy. This module must be designed to collect at least the following information:

- Subject of the event
- Narration of the event
- Comments and suggestions related to event

Analysis and Improvements

» Notifications to the Adverse Event Reporting System must be analyzed on a case-by-case basis, improvement activities must be planned and implemented after analysis.

» General analysis of notifications to the system must be repeated regularly, reported and evaluated. According to evaluation as a result of general analysis, necessity of unit- or process-based improvement activities must be determined.

» All staff members must be informed about the importance of notification for patient and staff safety, how to do it and improvement activities carried out as a result of notifications.

Risk Management

Code	Standard	Code	Assessment Criteria
YO.RY.01.00	Risks related to ODHS and services provided must be managed.	YO.RY.01.01	There must be a regulation related to managing the risks that may occur in an ODHS.
		YO.RY.01.02	A risk management plan must be prepared in order to manage risks related to ODHS and services provided.
		YO.RY.01.03	Risk management plan must entail patients, carers, visitors, staff, facility safety and environmental safety and administrative and financial processes.
		YO.RY.01.04	Risk management plan must entail the following issues: • Patients • Relatives • Carers • Visitors • Staff • Facility safety • Environmental safety • Administrative and financial processes. • Strategic risks •Comminucation processes with stakeholders
		YO.RY.01.05	Necessary measures must be adopted in line with the according to the risk level identified, and actions must be taken for improvement.
		YO.RY.01.06	Risks identified and effectiveness of improvement actions must be reviewed periodically.
		YO.RY.01.07	Indicators for monitoring the effectiveness of risk management must be determined and monitored.

Goal

To prevent or minimize risks related to ODHSODHS and services provided within the scope of patient, staff, facility safety and environmental safety and administrative/financial processes.

Objectives

- Patient Safety
- Healthy Working Life
- Efficiency
- Effectiveness

Standard Requirementsi

Scope of the Risk Management

Risk management should cover the following processes.

- Clinical processes
- Administrative processes
- Processes related to information management system
- Patient
- Relatives of patient
- Visitor
- Employee
- Facility management
- Financial processes
- Environmental safety
- Strategic risks
- Communication processes with stakeholders

Risk management must include all physical, chemical, biological, ergonomic, psychosocial factor and service based risks that may be faced in an ODHS.

Policies, processes and methods regarding risk management must be defined in relevant documents.

In risk management procedure, at least the following terms must be defined:

- Goals and objectives
- Scope
- Risk management method
- Obtaining opinions of the relevant employees
- Reporting of the defined risks
- Analysis of the defined risks, risk level detection and keeping records
- Management of processes regarding required improvement actions
- Personnel Trainings

Risk Management Plan

Risk management plan aims reviewing and observation of the risks. The plan must cover at least the following topics:

- Process, action or factor in which the risk is evaluated
- Detected risks relevant to processes, actions or factors mentioned at the previous article
- Designated risk levels
- Precautions against the risks
- Responsible staff
- Designated time period for precautions

All defined risks must be registered in scope of the risk management plan. Risk analyzes must be performed at least once every two years and updated when necessary.

Identification and Analysis of Risks

- Taking into consideration the risk management scope, risks must be identified on the basis of unit, person and/or process.
- Clinical risk evaluations must be conducted to protect patients against adverse results (risk of allergy, fall risks, risks arising from devices etc.).
- Risks must be analyzed in line with the method determined by the institution.

» Risk analysis method must be simple and easy to understand and implement.

» Risk levels must be rated in at least three categories (Low, medium, high) considering the possibility to occur and potential effects.

Improvement Actions

» According to identified risk levels, measures must be adopted on the basis of unit, person and/or process, and improvement actions must be taken.

Monitoring the Effectiveness of Risk Management

» Risks identified within the framework of risk management and effectiveness of improvement actions must be reviewed periodically.

» Indicators for monitoring the effectiveness of risk management must be determined and monitored.

» Sustainability of measures taken must be ensured to achieve effectiveness in risk management effectiveness.

» Risk analysis must be updated periodically. Risk analyzes must be performed at least once every two years and updated when necessary

Training Management

Code	Standard	Code	Assessment Criteria
YO.EY.01.00	In accordance with quality improvement activities, training needs of patients, carers and staff must be determined, and it must be ensured that necessary training is conducted effectively.	YO.EY.01.01	A committee in charge of the planning and coordination of training activities must be established.
		YO.EY.01.02	Training plans must be prepared and implemented in line with training needs.
		YO.EY.01.03	Training plans must be prepared and implemented in line with training needs.
		YO.EY.01.04	Effectiveness of training plans and trainings carried out must be monitored and necessary improvement actions must be taken.

Goal

To deliver necessary trainings to patient/carer and staff efficiently and effectively in line with quality improvement activities of ODHS.

Objectives

- » Efficiency
- » Relevance
- » Continuity
- » Effectiveness
- » Continuity
- » Productivity

Standard Requirements

Training Management

» A committee must be formed in order to manage the decision, planning, coordination, communication and evaluation procedures so as to implement effectively and efficiently the necessary trainings which must be provided for quality improvement at ODHS.

» The Committee must determine processes related to trainings and rules concerning the operation of procedures. Within this scope, the minimum processes which must be handled are as follows:

- Identifying training needs
- Preparing training plans
- Implementing the training activities planned
- Monitoring the effectiveness of training plan and trainings conducted and improving them

» Training committee must collaborate with other units and committees which operate under the scope of quality management.

Identifying Training Needs

» In line with quality improvement objectives; Who needs training on which subjects, at what level and to what extent, must be determined once a year and when necessary. While identifying subjects and scope for training needs, the following must be assessed:

- The results of performance evaluation within the scope of quality improvement within ODHS (self-evaluation, data derived from the indicators, etc.)
- Efficiency evaluation results of previous trainings
- Feedback, requests and observations related to training activities.

» Training subjects must be categorized at least by hierarchical level, occupational group, specific to department and general. It must be identified which training will be delivered to which occupational group and through use of which content. Training subjects must be given in 2 categories, patient and employee-based, at least under the following general headings.

- Employee Trainings
- Quality management
- Patient rights
- Patient and employee safety
- Patient oriented care process and philosophy
- Risk management
- Staff compliance
- Device usage and security
- Unit-based professional trainings
- Trainings including new scientific developments
- Social trainings
- Personal development trainings
- Patient and Relatives Trainings
- Trainings for development and promotion of health
- Trainings deemed necessary within the scope of the patient's care needs
- Discharge trainings
- Use of drugs and medical devices
- Trainings for patient relatives

Planning and Implementation of Trainings

» Training plans must be developed to regulate processes of preparing content for trainings, determining methods and implementation and evaluation procedures in a systematic manner.

» Training plans must be developed as short-, medium- and long-term plans considering the nature of training need, priority of objectives to be achieved through training, time needed to achieve objectives, institutional policy of ODHS and targets and objectives of change process.

» Training plans must include at least the following:

- Training goals and objectives
- When, to whom and by whom the training will be delivered
- Training method
- Training stages if any (basic training, advanced training, theoretical and practical training, etc.)
- Training location
- Duration of training
- General headings concerning the content of training
- Materials needed for training
- Methods to evaluate training

» Trainings must be implemented in line with plans.

» Guidelines for general and department orientation training must be prepared and it must be ensured that orientation training is delivered right after a new recruitment is made.

» During the training period, in cases where training needs to be organized outside plan, process must be managed by taking into account issues included in training plan.

» In cases where training is organized outside plan or changes are made in matters such as training, training content, training method, plan must be revised in a way that can be traced back. Arrangements must be made for relevant employees to access training materials and source documents that are deemed appropriate to be shared by training committee.

Evaluation of Training

» Compliance with training plan prepared must be monitored, and measures must be taken to enhance compliance with the plan.

» Efficacy and effectiveness of training programs implemented must be evaluated on the basis of goals and objectives set.

» Evaluation must also cover trainer's performance.

» Some of the methods that can be used to evaluate the effectiveness and efficiency of training programs implemented are listed below:

- Pre- and post-test
- Self-assessments
- Observations
- Interviews with participants
- Evaluations with unit supervisors
- Questionnaires
- Measurement methods to measure training-induced change in behavior (such as accepted scales)

Institutional Communication

Code	Standard	Code	Değerlendirme Ölçütleri
YO.Kİ.01.00	Institutional communication activities must be carried out effectively.	YO.Kİ.01.01	Under the scope of institutional communication, target audience must be identified by taking ODHS structure, core policies and values into account and communication strategies for target audience must be determined.
		YO.Kİ.01.02	Target audience must be informed about ODHS activities and their organization.
		YO.Kİ.01.03	Necessary actions must be taken to create a positive opinion among target audience.

Goal

To create public opinion based on positive attitude, behavior towards and trust in ODHS and its activities, to ensure that policies and activities of ODHS are adopted by establishing permanent good relations with its target audience and to improve the effectiveness and quality of services through the feedbacks of target audience.

Objectives

- » Patient-oriented
- » Effectiveness
- » Equity
- » Continuity

Standard Requirements

Identifying Target Audience and Communication Strategy

» Under the scope of institutional communication, target audience must be identified by taking institution type, size, patient profile, regional features, people and institutions communicated and main policies and values, and communication strategies for target audience must be defined.

» Target audience must be identified by taking internal and external communication stakeholders into account.

» Within the framework of communication strategy, communication rules must be established for target audience within ODHS. Within this scope at least the following issues must be addressed:

- Information and decision flow among units and elements of ODHS
- Information and decision flow in evaluation and inspection functions
- Communication during training and information activities
- Communication during activities aiming at enhancing motivation and taking ownership of institutional identity

Informing Target Audience

» Information activities specific to target audience identified must be conducted

» Activities must be done regarding on-line representation and promotion of the institution. Institutional website must be managed effectively, The website should include adequate and actual information, also should be made easy to use, accessible and available.

Management and Organization

» Target audience must be informed about at least the following issues:

- Core policies and values
- Organizational structure
- Service areas
- Activities carried out under the scope of social responsibility
- Human resources
- Public relations activities
- How to make an appointment
- Communication and travel
- Access to service within ODHS

» Since the staff at ODHS are important representatives for institutional communication they must be trained about the subject.

Creating Positive Public Opinion

In order to create positive public opinion in the target audience, first of all, information activities towards society about services provided and activities carried out must be conducted in line with needs and expectations of target audience.

While these activities can be conducted through information tools (poster, brochure, web-based, etc.), it must be ensured that staff communicates effectively with patients and carers during service provision and senior management represents ODHS effectively outside and establishes good relations.

Monitoring Institutional Communication and Perception

Questionnaires about performance of institutional communication activities and in order to measure perception of current identity and image of ODHS in the target audience must be conducted regularly, the results must be evaluated, and necessary actions must be taken to improve institutional communication strategies.

Performance Measurement and Quality Improvement

Monitoring of Indicators

Code	Standard	Code	Assessment Criteria
PÖ.Gİ.01.00	Institutional indicators must be monitored and evaluated in order to continuously improve processes related to service delivery, led by administrative, financial and medical steps.	PÖ.Gİ.01.01	Process for monitoring indicators must be defined.
		PÖ.Gİ.01.02	Indicators must be determined to include processes concerning service delivery, primarily administrative, financial and medical steps.
		PÖ.Gİ.01.03	Indicator cards must be created to cover issues related determination, collection, evaluation and monitoring of data to be used for indicators.
		PÖ.Gİ.01.04	Arrangements must be made for monitoring, evaluation and reporting of indicators.
		PÖ.Gİ.01.05	Necessary improvements must be made taking into consideration the analysis results for the indicators.
		PÖ.Gİ.01.06	Results of indicators must be shared with relevant stakeholders and public.
		PÖ.Gİ.01.07	The results of the SAS indicators must be submitted to the SAS Indicator Data System.

Goal

To detect and correct potential problems related to service delivery, primarily administrative, financial and medical processes, and ensure that interventions are carried out to improve quality.

Objectives

Objectives vary according to features of indicators.

Standard Requirements

Definition of Indicator Monitoring Process

» Indicators to be monitored within the scope of performance measurement and quality improvement studies; data collection process, data analysis, post-analysis improvement studies must be documented.

» Responsible personnel for monitoring indicators must be determined and their responsibilities must be defined.

» Processes for monitoring indicators must be coordinated by quality management unit.

» Training must be given to relevant personnel about monitoring of indicators.

Identifying Indicators

» Institutional indicators must be monitored and evaluated in ODHS concerning processes related to service delivery in order to improve quality continuously, primarily administrative, financial and medical steps.

» In order to continually improve the processes for service delivery, the SAS indicators which has to be monitored according to the type of institution service and patient profile should be determined.

» Institution must carry out quality improvement studies to be carried out for any critical process within the scope of patient and employee safety, by determining new indicators other than those in the SAS ODSH set when necessary. Monitoring process of these indicators, which are included in measurement systematic, must be carried out in a way that includes results of implementation and improvement activities. Institution must evaluate indicators it has determined in terms of contributing to improvement studies, how often it will continue to monitor, when monitoring will be terminated, etc. must define its rules.

Indicator Cards

Indicator cards must be prepared for indicators identified. Indicator cards should include at least the following information:

» A short description of the indicator

» Reason for monitoring

» Linked process

» Calculation method/formula

» Target value

» Data source

» Data collection period

» Data analysis period

» Supervisors for collecting, monitoring, evaluating and analyzing data related to indicator

» People to share the results with

» Points of attention concerning indicator

Monitoring and Evaluation of Indicators

Information management system infrastructures or existing national/international data systems must be used for indicators needed within ODSH in order to collect, monitor and evaluate data related to indicators.

Measures must be taken to obtain accurate and high quality data. It must be ensured that relevant staff members be involved in the data collection and analysis processes.

Based on analysis concerning indicators, required corrective and preventive actions must be planned and implemented. Results of indicators must be shared with senior management, relevant employees, relevant stakeholders and public.

SAS Indicator Data System

Results of determined indicators at SAS Indicators List must be Submitted to the SAS Indicator Data System.

Healthy Work Life

Human Resources Management

Standard 1

Code	Standard	Code	Assessment Criteria
SÇ.İK.01.00	A management structure that will fulfill the requirements concerning planning of human resources, improvement of work life and the personnel must be established.	SÇ.İK.01.01	The relation of the management structure with other management levels must be identified.
		SÇ.İK.01.02	Duties, authorities and responsibilities of those in the management structure and the qualifications they must have must be identified.
		SÇ.İK.01.03	Annual goals and work plans must be developed.
		SÇ.İK.01.04	Feedback processes aimed at determining satisfaction levels and comments and suggestions of the personnel regarding their work life must be identified.

Goal

To define a management structure that will perform activities such as assignment, coordination and assessment regarding necessary processes for the establishment of a healthy working life

Objectives

- Healthy Work Life
- Efficacy
- Efficiency
- Productivity

Standard Requirements

Management Structure and Its Relation with Senior Management

» A management structure that will perform all activity planning and coordination such as employment, orientation, improvement of and support to the personnel, providing the personnel with physical and social opportunities, minimizing safety risks that threaten employees and increasing motivation must be established at ODHS.

» Management relations such as where the new management structure will be in the hierarchy of ODHS management or to whom it will be responsible, which powers it will have, who will be in this structure and who will be responsible to this structure must be defined.

Duties, Authorities and Responsibilities

» Terms of reference must be prepared for people to be involved in management structure, and their responsibilities and authorities must be identified.

» Which qualifications employees involved in the structure must have must be defined in order to carry out all necessary duties and responsibilities.

Targets and Planning

Newly formed management structure must define annual targets in order to ensure a healthy work life. Key factors such as which activities will be carried out, which measures will be taken and how much budget will be needed in order to reach the targets must be planned.

Healthy Work Life

Comments and Suggestions from the Staff

» A system identifying in which scope and through which mechanisms feedback will be received from the staff in order to detect the needs and expectations of the staff and to ensure that they participate in the decision mechanisms.

» Activities towards identifying the needs and expectations of the staff must meet at least the following requirements:

- Regularly conducted satisfaction questionnaires
- Personal and face-to-face interviews with the staff
- Taking comments and suggestions from the staff

Standard 2

Code	Standard	Code	Assessment Criteria
SÇ.İK.02.00	The requirements necessary to constantly improve recruitment and compliance processes of the personnel and their work life must be determined and fulfilled.	SÇ.İK.02.01	A personnel recruitment plan must be developed in line with human resources needs of ODHS.
		SÇ.İK.02.02	Personnel recruitment processes must be identified.
		SÇ.İK.02.03	Processes regarding ensuring the adaptation of the newly recruited personnel to ODHS must be identified.
		SÇ.İK.02.04	Duties, authorities, responsibilities of the personnel and the qualifications they should have and the performance criteria their job requires must be determined.
		SÇ.İK.02.05	Performance of the personnel must be measured, training needs must be determined to enhance the performance and necessary trainings must be provided.
		SÇ.İK.02.06	How and to what extent the current standards, protocols and evidence-based clinical guidelines accepted by ODHS are used by the personnel must be monitored and trainings aimed at ensuring the use of these standards and guidelines efficiently must be identified.

Goal

To ensure that needs regarding continuous improving of work life and the processes of recruitment and adaptation of staff are identified and met.

Objectives

- Healthy Work Life
- Efficiency
- Efficacy
- Productivity

Standard Requirements

Recruitment of Staff

- ODHS must define in which service area and staff with which qualifications is needed, must determine the feasibility of recruitment and must plan main processes such as recruitment and training in advance.
- In recruitment plan, legal regulations, taking into account different disciplines and professional groups, number and the quality of staff needed (training, knowledge, skills, etc.) must be included considering different disciplines and professional groups that will be able to meet needs concerning services to be provided.
- Need for staff must be regularly reviewed by preparing terms of references on the basis of departments and processes, and human resources must be planned by taking legal regulations into account. Measures must be taken regarding how recruitment will be made and which qualifications new staff must have and how many people will be recruited.
- Which necessary documents and information is needed in the process of application and recruitment and steps regarding evaluation and approval process must be defined.
- ODHS must inform new recruits about from which facilities of the ODHS they can benefit, opportunities provided and employee rights.

Recruitment Processes

Recruitment processes in ODHS must be described, and how staff planned to be recruited for previously defined tasks in the departments in need must be defined. Principles and processes regarding recruitment processes must be announced.

Adaptation of Staff

- ODHS must define the processes that will enable new staff, recruited for the position opened in line with the needs, to adapt to the new working environment quickly and accurately. All kind of information such as main and professional rules, basic working principles, elements that may threaten personnel health and safety, hierarchical order and all facilities that may be used by the personnel must be provided to the personnel during recruitment and later regularly.
- Adaptation of staff to job and work environment must be assessed, and if needed, activities towards adaptation must be repeated.

Duties, Powers, Responsibilities and Performance Criteria

- Duties, powers and responsibilities of staff that is working or planned to be recruited must be identified in line with service processes in a way that they will encompass previously defined duties and responsibilities.
- Performance criteria defined as the performance of the duties by staff successfully must be identified, and staff should be informed about the criteria.
- Performance of staff must be measured on the basis of performance criteria set by ODHS. Performance measurements should be planned at least once a year.
- In order to increase the employee performance, it must be determined which trainings will be provided and what their scope will be in line with the qualifications and needs of staff and required planning in relation to training must be done. Objectives of the trainings that will be provided within this scope must be defined in advance and it must be assessed after trainings whether the objectives set have been attained.
- Only trained and authorized staff must use specific and medical devices and in the training plans, the need for training on such issues must be taken into account.
- How and to what extent the current standards, protocols and evidence based clinic guidelines accepted by ODHS are used must be monitored and trainings must be planned in order to ensure effective utilization of the standard and guidelines.

Employee Health and Safety

Code	Standard	Code	Assessment Criteria
SÇ.ÇG.01.00	Factors threatening the health and safety of employees should be identified and necessary precautions should be taken to establish a healthy and safe working environment.	SÇ.ÇG.01.01	A committee aimed at management of the factors that threaten employee health and safety must be established.
		SÇ.ÇG.01.02	Risk analyses must be conducted on the factors that threaten employee health and safety and measures must be taken to eliminate or decrease the risks that threaten the safety.
		SÇ.ÇG.01.03	It must be ensured that employees use the personal protective equipment against the risks.
		SÇ.ÇG.01.04	Quality improvement activities that aim to ensure the continuity of employee safety must be planned.
		SÇ.ÇG.01.05	Physical and social opportunities that are necessary to improve the work environments and the work life must be provided and personal needs of the employee regarding work life must be met.

Goal

To establish healthy work life environment in ODHS by removing or minimizing the elements that threaten the safety of staff.

Objectives

» Healthy working life
» Safety

Standards Requirements

Committee on Personnel Health and Safety

A committee must be established to detect threats that exist or may exist against the ODHS personnel and to take measures against those threats. Committee structure must be shaped in line with the size of ODHS and risks posed by safety threats with the aim of ensuring the performance of activities effectively, continuously and systematically and achieving coordination.

Risk Analyses

» First of all, assessment must be performed by identifying the risk factors that threaten the safety in terms of employee safety within ODHS and again by identifying their risk levels. After identifying risk factors, necessary action must be undertaken in order to remove or minimize the detected threats according to their priorities

» In order to secure personnel health and safety at ODHS, at least the following issues must be addressed:

Healthy Work Life

- Developing management policies in relation to health and safety of personnel
- Preventing infections
- Planning and implementation of health screenings
- Chemicals and radiation safety
- Food safety
- Noise
- Lighting
- Falls prevention
- Managing facility-borne risks
- Reducing needle stick injuries.
- Ergonomic factors
- Preventing violence against healthcare staff and responding to violence as soon as possible
- Preventing mobbing among staff
- Managing wastes threatening the safety of personnel
- Immunization
- Reducing unnecessary workload
- Stress management

» At ODHS, action must be taken in order to ensure that medical, psychological and other counseling and support services are always available for the staff.

» It must be ensured that near misses and adverse events which threaten employee safety are reported in order to treat staff with occupational disease and injuries.

Personal Protective Equipment

» Which personal safety equipment will be used in which departments must be defined and measures must be taken in order to ensure the use of these equipment's.

» It is required that sufficient number of personal safety equipment having protective qualities is made available in designated working areas and trainings are organized for the employees about the operation of such equipment.

Quality Improvement

» In order to secure personnel health and safety, ODHSs must plan and implement quality improvement activities in order to remove or avoid the elements that pose risks.

Improving Working Environment

» Improvement plans on issues such as physical environments of the personnel, materials and devices they use, chemical, physical and biological materials and working methods must be planned by taking personnel expectations into account.

» Achieving harmony between duties and employees' physical and mental capacities

» In order to reach an adequate level of health and safety; activities and trainings in order to encourage employees' professional improvement or motivation, to achieve communication of employees between units and departments and to ensure collaboration and dialogue effectively must be planned and implemented

» Activities to improve working life such as resting, reading and sports areas that personnel may benefit from, kindergartens and children clubs, individual improvement trainings must be organized by ODHS.

» Arrangements must be made at ODHS for disabled and sick staff.

» It must be ensured that facilities offered to staff are easily accessible, practical and employee-oriented.

Patient Experience

Code	Standard	Code	Assessment Criteria
HD.HH.01.01	The services provided in ODHS must be organized in such a way as to protect patient and carer rights.	HD.HH.01.01	An executive structure aimed at protecting, exercising and improving the rights of patients and carers must be established.
		HD.HH.01.02	ODHS must declare information about all the services that are provided and access to these services and the quality of the services.
		HD.HH.01.03	Patient and/or carers must be informed about the diagnosis, treatment, care services, patient rights, patient responsibilities and other services.
		HD.HH.01.04	During the health care process, consideration must be given to the choices and preferences of the patient.
		HD.HH.01.05	Activities must be planned in all service processes for the patient to be respected and to receive meticulous service.
		HD.HH.01.06	Consent of patient must be obtained for diagnosis and treatment procedures to be applied.
		HD.HH.01.07	Patients must be able to examine the medical documents about themselves and receive a copy if requested.

Code	Standard	Code	Assessment Criteria
HD.HH.01.00	The services provided in ODHS must be organized in such a way as to protect patient and carer.	HD.HH.01.08	Arrangements must be made for the spiritual and cultural needs of the patient
		HD.HH.01.09	All measures necessary must be taken to ensure patient privacy.
		HD.HH.01.10	Arrangements must be made for receiving, investigating and resolving complaints of patients and their relatives.
		HD.HH.01.11	Patient's consent must be obtained if the patient is to take part in a research or experiment, or if the information, data or materials about the patient are to be used in any way.
		HD.HH.01.12	Processes aimed at informing the patient or carer if unintended events that negatively affect the patient safety occur must be identified.
		HD.HH.01.13	Processes aimed at informing the patient or carer if unintended events that negatively affect the patient safety occur must be identified.

Goal

To ensure that the rights of patients and carers are under guarantee in the delivery of services provided by the ODHS and that services are processes are arranged with this target in mind

Objectives

» Ptatien-oriented
» Equity
» Relevance
» Timeliness

Standard Requirements

Management Structure

» A management structure must be established for the protection, exercise and improvement of the rights of patients and carers.

Information about Services and Patient Rights

» ODHS should declare information about all services it provides and access to and quality of these services.

» Patients and/or carers should be informed about diagnosis, treatment, care services which can be provided, responsibilities of the patient and additional services.

» Patient and/or caretaker must be informed about patient rights during the application. This information must include the following topics:

- Privacy
- Esteem and being respected
- Confidentiality of patient information
- Patient safety and security
- Informative actions about health services which will be provided and consent of the patient
- Right to decline the treatment

» In case adverse events that affect patient's safety negatively occur, processes in relation to informing the patient or his/her carer must be defined.

Choices and Preferences of Patients

» During the health care process, consideration must be given to the choices and preferences of the patient, such as selecting the physician and accepting treatment or refusing treatment.

» Patients must be informed about care during medical treatment, their preferences and demands must be taken into account, and their participation in care process should be ensured.

» In case patients refuses medical treatment or refuses therapeutic procedures while receiving treatment; If available, they must be informed about alternative treatments and their preferences must be evaluated. They must be informed about risks that may arise from refusing or not continuing treatment and their consent must be obtained.

Patient's Consent

» Patient must be informed verbally by using a simple and understandable language before any planned interventional treatment.

» Patient who is admitted to ODSH for inpatient treatment or applied for first time as an outpatient; Consent must be obtained by being informed about procedures that can be performed during diagnosis and treatment process.

» Before all procedures performed under anesthesia, including surgical or interventional procedures, use of blood and blood products, moderate and deep sedation, and other high-risk procedures; Patients must be informed about procedure by person who will perform procedure and his written consent must be obtained. This written consent must contain at least following information.

- Name of the person to perform the procedure
- Expected benefits of the procedure
- Results likely to be encountered if the procedure is not performed
- If any, alternatives to the procedure
- Risks and complications of the procedure
- Estimated length of the procedure
- Name, surname and signature of the patient (regulatory agencies for Patients who do not have the competence to make decision making for diagnosis and treatment, such as child patients, and emergency situations must be determined)

» Required measures must be taken to inform the disabled and to take their consent considering their condition (Patient's Rights Regulation).

Access to Medical Documents

It must be ensured that patients have access to and take a copy of applied procedures, analyses or all the documents entailing private information about themselves both while receiving and after receiving the service. A policy needs to be determined for sharing of above-mentioned patient records with nonpatients.

Access to Medical Documents

ODHS must ensure that patients receive service in accordance with their cultural and spiritual values.

Spiritual/Cultural Needs

» ODHS must ensure that patients receive service in accordance with their cultural and spiritual values.

» Patients and their relatives, complaints, opinions, suggestions, etc. They must be informed and guided about where and how to apply for their requests and all processes related to the application.

» Health institutions make these information processes open to public, transparently, on information screens, boards, websites, etc. through systems.

» Complaints of patients and their relatives must be received, examined and resolved in a timely and fair manner.

» Applications received must be resolved on the same day, if possible in accordance with legislation, and within 15 days at latest in cases that require examination, and the applicant must be informed.

» Complaints evaluation commission must be established.

Resolving Ethical Dilemmas

» In case of ethical dilemmas related to care, such as no treatment, withdrawal or discontinuation of treatment decided by the physician, how the process must be managed and must be defined in advance.

» In order to resolve ethical dilemmas, an ethics committee must be established, including patient and physician.

» In cases of ethical dilemmas, an ethics committee must be convened and a solution must be sought as soon as possible by prioritizing patient safety.

» In case of patients who leave ODHS without permission of physician or do not accept treatment, necessary procedures must also be determined.

Patient Safety

Code	Standard	Code	Assessment Criteria
HD.HG.01.00	The services provided at ODHS must be organized in such a way as to protect the safety of patient and their carers.	HD.HG.01.01	A committee must be established to ensure patient safety.
		HD.HG.01.02	Risk analyses must be conducted on the factors that threaten patient safety and measures must be taken to eliminate or decrease the risks that threaten safety.
		HD.HG.01.03	Quality improvement activities must be planned to ensure the continuity of patient safety.

Goal

To ensure the safety of patients and carers in services provided by ODHS, and to organize provided services and processes in line with safety of patients and the carers by determining in advance the elements that could threaten their safety.

Objective

Patient safety

Standard Requirements

Patient Safety Committee

» A committee must be established to work regularly and systematically in this field in order to be to identify existing or possible safety threats at ODHS and to take measures.

» The structure and the composition of the committee must be described considering the size of the institution and types of services to ensure effectiveness, continuity and systematic structure of activity.

Quality Improvement

» The risks for patient safety must be analyzed and evaluated on a clinical and patient basis; levels of risk must be determined and necessary improvement actions must be taken on the basis of the results of the analysis. Effectiveness of activities must be monitored.

» In this context, ODHS must address following issues related to patient safety, which is mentioned in various sections of Standards of Accreditation in Health:

- Prevention of infections
- Medication safety
- Radiation safety
- Falls prevention
- Safe surgery
- Safe injection practices
- Identity verification
- Information safety
- Emergency management
- Facility safety
- Medical device safety
- Adverse Event reporting system
- Waste management

Standard 2

Code	Standard	Code	Assessment Criteria
HD.HG.02.00	In patient care process, it must be ensured that right procedure is applied to right patient.	HD.HG.02.01	Patient identity must be verified in all procedures to be performed during patient care process.
		HD.HG.02.02	For authentication application, identifier must be used.
		HD.HG.02.03	Training must be given to patients and healthcare professionals about patient identity verification.

Goal

In the field of patient care applications, while giving medicine to the patient, all kinds of examinations, treatments, operations etc. is to apply the procedure to right patient in applications.

Objective

» Patient safety
» Efficiency
» Effectiveness
» Suitability

Standard Requirements

Authentication Tools

An identifier must be used for authentication. For this purpose;

» In outpatients;
  • Picture and official documents containing identity information of patient
» Inpatients;
  • Armbands/wristbands
  • Barcoding Systems
  • Biometric systems (Retinal scan, fingerprint scan, palm authentication system, etc.)

Other methods that can identify patient identity determined by ODSH.

In case of using armbands/wristbands as an identifier, following points should be considered.

» White armbands/wristbands must be used inpatients and red inpatients with allergies.

» At least patient's name/surname, date of birth, and protocol number information must be on armbands/wristbands.
» Information on armbands/wristbands must contain a maximum of 4 descriptive parameters.
» Information on the armband/wristband must be legible and not erasable.
» Persons whose identity is unknown, who are inpatient in same service but with a similar name, who have a physical or medical disability for use of armbands/wristbands, etc. processes for identification and authentication must be defined for patients.

Trainings

Practices must be carried out to increase awareness of healthcare professionals about sources of error related to identity verification, and healthcare professionals must be given training on authentication.

Patients must be informed about the use of identifiers and the importance of authentication.

Confirmation of Patient Identity

Authentication can be defined as a set of practices that reliably determine that patient receiving care in ODHS is the right person.

» In all processes from the moment patients apply to ODHS until he leaves ODHS (transfer of the patient's measurements, models and prostheses to laboratory, before any test or procedure, before applying drugs, etc., during patient transfer, etc.) patient identity must be verified through identification parameters. Identification parameters can consist of the following information:
  • Patient name-surname
  • Date of birth (day/month/year)
  • Father name
  • Protocol number
» The identifier must contain information for a maximum of four parameters.

  Below are examples of methods to be used during the authentication process:

» For Inpatients;
- Verbally asking patient and confirming identification parameters in patient records
- Comparing patient records with identification parameters on patient armband
- Verbally asking and confirming identification parameters written on patient's armband.

» For Inpatients;
- Verify patient identity with photo ID check
- In communication with prosthesis and orthodontic laboratories, descriptive parameters such as barcodes, labels, etc. that will confirm patient's identity must be added to the measure, model, prosthesis and appliances.
- Verbally asking and confirming patient identification parameters on test and radiography request form.
- Comparing identification parameters on label for laboratory test sample container with patient records or verbally asking patient

Standard 3

Code	Standard	Code	Assessment Criteria
HD.HG.03.00	Preventions must be taken to prevent patient falls.	HD.HG.03.01	Process for prevention of falls must be planned.
		HD.HG.03.02	Patients must be considered in terms of risk of falling.
		HD.HG.03.03	Preventions must be taken regarding risk level of patients.

Goal

In ODHS, it is prevention of patient falls and minimizing risk of injury from falls.

Objective

» Patient safety
» Efficiency
» Suitability

Standard Requirements

ODHS management must ensure participation of all employees to activities in order to prevent patient falls and must plan system for fall prevention strategies in all units in ODHS. This plan must include following information;

» How to determine risks (determining fall risks of patients, determining fall risks caused by ODHS)

» How to evaluate risk levels of patients (to which patients risk evaluation will be conducted, which scale will be used for fall risk evaluation, how to define risk levels, etc.)

» What precautions will be taken in accordance with determined risks (patient/disease-based precautions, environmental precautions, etc.)

» Monitoring process for fall events (when, how and to whom the falls will be reported, how the results will be evaluated, etc.)

Evaluation of Fall Risk

» Risk evaluation must be done to determine fall risk level of inpatients and outpatient groups determined by institution. Necessary measures must be taken by institution for directly accepting certain patients as high risk, even without risk evaluation.

» Fall risk evaluation of patients must be made by nurse of relevant department or relevant physician, following admission of patient to department where they will receive service. Risk evaluation must be repeated in transfer of patient between departments, in postoperative period, in case of a change in patient's condition and in event of a fall.

» Fall risk scoring scales must be used for risk assessment of patients. National and international scales such as Morse, Hendrich II, İtaki Fall Risk Scale, Harizmi Fall Risk Scale (for pediatric patients) can be given as examples of these scales. Measures to be taken according to the determined risk levels must be planned.

Precautions to be Taken According to the Risk of Falling

» At least following precautions must be taken for risks in determined ODHS environment in order not to cause falls:

- Outpatient clinics and patient rooms must be made simple, unnecessary tools, materials and items must not be kept in place, and adequate lighting must be provided in the place.
- Units and patient beds must be positioned to prevent patient falls.
- Walking areas must be kept dry to prevent patients from falling, there must be a warning sign on slippery floors, and there must be no objects or objects that prevent movement in walking area.
- Where necessary, grab bars must be available for patients.

» For some specialty patients (patients who will undergo minor surgery, disabled patients, pediatric patients) who receive outpatient services by ODHS, they should be considered as high risk directly without risk evaluation and for these patients necessary additional precautions must be taken.

In order to prevent inpatients from falling, patient-based measures must be taken according to determined risk levels.

Patient-based precautions can be defined as general precautions to be taken in regard to patients risk levels, specific precautions for patient, and ones defined as specific to risk factors as a result of the risk evaluation.

» Minimum general precautions to be taken for high-risk patients are as follows:

- High-risk patients must be identified by a symbol determined by ODHS. Symbol must be used as controlled by ODHS to warn employees in every area where patient is present or transferred. Units and patient beds must be positioned to prevent patient falls.
- Care of high-risk patients must be planned and preventive measures must be followed.
- High-risk patients' observation frequency must be determined. Patient/patient relative must be informed about risk of falling.

Monitoring for Falls

» Fall events in ODSH must be monitored, statistical analyzes must be done and according to results of analysis, necessary improvement activities must be conducted

» » Employees' submission of fall events to adverse event reporting system must be implemented.

Standard 4

Code	Standard	Code	Assessment Criteria
HD.HG.04.00	Effective communication must be ensured in exchange of medical information among healthcare professionals.	HD.HG.04.01	Process for employee handovers must be defined.
		HD.HG.04.02	Process of reporting panic values related to diagnostic tests must be defined.
		HD.HG.04.03	Arrangements must be made for application of verbal requests.
		HD.HG.04.04	Arrangements must be made for abbreviations, symbols and dose amounts that must not be used.
		HD.HG.04.05	In patient transfer between departments, accurate and complete transfer of patient information must be made.
		HD.HG.04.06	Process regarding implementation of ODSH in and out of ODSH consultations must be planned.

Goal

To prevent patient safety threats that come from communication problems between health employees.

Objective

- » Patient Safety
- » Efficacy
- » Efficiency
- » Convenience
- » Timeliness
- » Productivity

Standard Requirements

Shift changes between employees, verbal-telephone orders, use of abbreviations, symbols and symbols that should not be used, patient transfer between departments, external referrals and consultations within and outside of ODHS are important processes that affect the flow of information among healthcare professionals in terms of patient safety. Shift turnover processes must be defined in ODHS. Terms mentioned below must be taken into account for turnover processes:

» Turnovers must be practiced between at least two people as one for turnover and other for takeover.

» During turnovers, patient must be handed over by both information transfer via records and patient visit.

» During turnovers, all information in regard to patient care (drugs used, clinical course, special conditions related to patient care, etc.) must be conveyed.

Verbal Request Application

Verbal request is defined as the doctor's conveyance of the request to the nurse in a verbal way in the obligatory cases which the physician can not give a written request.

» Verbal request application must be avoided as much as possible and its application must be limited except of necessary conditions

» In the event that there is no chance for written request and if verbal request is inevitable, verbal request must be taken within the framework of the following factors:

- ODSH must determine clear rules about verbal requests.
- It must be defined in which conditions verbal request can be used.
- A mechanism for ensuring validity of prescribing, authorization must be provided,
- While receiving verbal request, drug name, dosage, application type and frequency must be stated clearly.
- Verbal requests must be verified immediately after they are taken.

Validation must be done as following:

√ During taking verbal request, request is listened first.

√ Given request is recorded.

√ Then written request is reread and its accuracy is confirmed by the person who gave the request. The one taking request can read back for confirmation of request by following ways:

– Spelling out drug name

– Using both generic and trade names of drug names

– Specify what purpose it can be used for

– Not to use the numbers that can be mixed up during speaking

– Avoiding drug names that can be confused in terms of prefix and suffix aspects. For these, a method can be developed to help separative spelling (such as Bursa to B)

– If necessary, asking for a spelled repetition of drug name with drug (such as Bursa to B)

- If there is any correction, request is recorded again.
- All verbal request, must be rendered to written state as soon as possible, ODHS medical records must be updated and request must be signed by the one giving request.
- In verbal request records it should be stated how (verbally, telephone, etc.) the request was taken.
- In verbal request records, patient's name and surname, age, weight, drug name, dosage form (tablet, capsule, inhalant etc.), dose, way of administration, amount and or time, name and phone number of the one giving the request must be included.
- High risk drugs determined by ODSH must be avoided at verbal requests application.

Abbreviations that Should Not Be Used

» Abbreviations, symbols and tokens that should not be used must be determined by ODSH and listed.

» None of the Abbreviations, symbols and tokens in determined list must be used at any stage of the processes.

» Rules for use of abbreviations outside list must be defined.

Communication at Patient Transfer

» Inter-unit patient transfer must be implemented by convenient transportation management (stretcher, wheel chair etc.)

» A health care employee must accompany patient during transfer.

» During transfer, required personal and care process related information must be conveyed by involved health employees right and completely in an understandable way and through practical technics (Handover communication technics etc.)

Contact of Consultation Process

Process related to Intra- and extra-department consultation implementation must be planned in ODSH. Minimum topics mentioned below must be addressed on the issue:

- How necessary consultation services for diagnosis and treatment is going to be provided must be determined.
- How records related to consultation will be collected must be determined.
- Intraoperatively pathology consultations related process must be defined.
- External diagnosis material consultation related process must be defined. (sample transfer, how to report the outcome of consultation, how to convey consultation report to patient and/or physician, etc.)
- Consultation process must be checked by relevant primary physician and patient care process must be re-evaluated in accordance with consultation.

Standard 5

Code	Standard	Code	Assessment Criteria
HD.HG.05.00	Patient must be transferred safely.	HD.HG.05.01	Process for safe transfer of patient must be defined.
		HD.HG.05.02	Preventations must be taken for the safe transfer of patients.

Standard Requirements

Description of Processes

Processes must be defined for safe transfer of patients. Definition must cover at least following points;

» Transfer of inpatients

» Transfer of special patients (such as patients receiving radiation therapy/ chemotherapy, geriatric patients, pregnant women and psychiatric patients)

» Processes to be considered in transfer of patients

» Suitability and use of vehicles to be used in transfer

» Identification of employee to be involved in transfer

Precautions for Safe Transfer of Patients

- Appropriate equipment (such as stretchers, wheelchairs) must be found and used for transfer.
- Equipment used must be checked and maintained.
- Necessary precautions must be taken and implemented to prevent patient falls during transfer.
- Transfer of patient must be carried out in accompaniment of a health worker.

Patient Experience

- Healthcare worker must convey necessary personal information of patient and information regarding care process accurately and completely during transfer.
- Healthcare workers should be trained for the safe transfer of patients.

Patient Feedback

Code	Standard	Code	Assessment Criteria
HD.GB.01.00	A system must be established to receive feedback (opinions, suggestions and complaints, etc.) of patients and their relatives about services provided.	HD.GB.01.01	Scope, methods and tools must be defined in system, including the acceptance, investigation and resolution of complaints and all feedback.
		HD.GB.01.02	Patients and their relatives must be informed about how they can give feedback.
		HD.GB.01.03	All feedback must be taken into consideration.
		HD.GB.01.04	Necessary improvement activities must be planned for results obtained from feedbacks.

Goal

To make sure that necessary improvement is made by receiving systematic feedback from those who are provided with service in the institution.

Objective

» Patient-oriented

Standard Requirements

Feedback system

A feedback system must be established to receive all kinds of feedback (comments, suggestion, complaints etc.) from those who are provided with service at ODHS. Within this system; methods such as satisfaction surveys conducted regularly to receive comments and suggestions from patients and carers, one-on-one interviews or face-to-face meetings held when necessary, assessment of expectations and satisfaction levels before and after the service must be used.

Information on Feedback System

» Patients and their caretakers should be informed about how they can give feedback about services which they are offered, problems they face during service processes or issues related to ODHS and ODHS staff employees.

Assessment of Feedback

» Feedback received from patients and carers must be analyzed in a systematic manner, and the findings must be assessed.

» The findings obtained through data analyses must be shared with the top management and relevant units and benefit must be derived from feedback in an efficient manner.

Quality Improvement

As a result of the findings obtained from the feedback, what kind of improvements are necessary must be determined and how these improvements will be made must be planned according to the order of importance and these plans must be put into practice.

Access to Service

Code	Standard	Code	Assessment Criteria
HD.HE.01.00	Necessary measures must be taken to ensure that patient reaches the services in time.	HD.HE.01.01	During patient's application to ODSH, any kind of need, in a way that can access information and facilitate application process, welcome, orientation and consultation services must be provided.
		HD.HE.01.02	In outpatient clinic process of the patients, aimed at minimizing waiting times, necessary measures must be planned and patients must be informed about how long they will wait and when they will be examined.
		HD.HE.01.03	Facilitating measures concerning access to services and waiting periods must be taken based on age, disease and disability.
		HD.HE.01.04	Service delivery processes must be arranged in a way that ensures timely diagnosis and treatment of patient without delay.
		HD.HE.01.05	Arrangements must be made in ODSH to facilitate patient's access to emergency services outside of working hours.

Goal

To put forward the measures that must be taken by the institution and to ensure the access to service to make sure that patients access the services provided by ODHS in a timely, efficient, effective and sufficient manner.

Objective

- Patient-oriented
- Suitability
- Continuity
- Equity
- Timeliness

Standard Requirements

Reception, Orientation, Consultation

From beginning to end of application process for patient and patient's relatives, in order to facilitate their access to service, how and in what way all Reception, Orientation, Consultation services are provided must be planned and implemented.

Considering patient population served by ODSH, access to service must be facilitated for all patients (including foreign nationals) receiving service from ODSH. Arrangements must be made to procure foreign language and sign language personnel when necessary.

ODHS must be able to provide to patients with detailed information about services (ODHS information guide, introductory brochure, telephone, computer, etc.)

Facilitating Measures in Accessing Service

Necessary arrangements must be made in order to carry out patient registration procedures effectively and accurately. Physicians list must be up-to-date, appropriate time interval, appointment and time to show results must be determined by ODHS. Patients or their relatives must be informed about appointment and results.

Arrangements must be made in all service areas (priority seating areas, priority in diagnosis and treatment procedures, wheelchair services, etc.) to facilitate access to healthcare services for elderly, disabled and patients in need of priority.

Arrangements must be made to prioritize service processes for elderly, disabled, and those who need help based on their illness, receiving service from ODHS.

Providing the Service on Time

- Procedures and steps of procedures must be examined in detail to detect system-related problems that might pose a risk for patient safety by prolonging diagnosis and treatment and measures must be taken to shorten the procedure time in an optimal manner and to increase efficiency.
- ODHS must assess its service processes within this framework and document its work and plans aimed at increasing efficiency, productivity and safety.
- Action must be taken to facilitate access of the patient with an emergency to the service in ODHS out of working hours. Emergency shift services and the treatments to be administered must be managed by the institution.

Health Services

Prevention and Control of Infections

Code	Standard	Code	Assessment Criteria
SH.EÖ.01.00	Necessary measures must be taken for the prevention and control of infections	SH.EÖ.01.01	A committee must be formed for infection control and prevention, and responsibilities must be determined.
		SH.EÖ.01.02	A program must be created for the control and prevention of infections.
		SH.EÖ.01.03	Efficiency of the practices aimed at ensuring control and prevention of infections must be monitored.

Goal

To identify and prevent risks of health services-related infections threatening the employees and patients.

Objectives

- Patient Safety
- Healthy Work Life

Standard Requirements

Establishment of the Committee for Infection Prevention and Control

A committee responsible for the process of infection and control prevention at ODHS must be established. Members of this committee must be determined by taking the legislation of the country, personnel capacity of ODHS, patient profile and needs of ODHS into consideration.

The responsibilities of the committee for infection prevention and control are as stated below:

- To determine an infection control program in accordance with the features and conditions of ODHS within the scope of scientific principles
- To ensure the coordination of infection control activities at ODHS
- To monitor the efficiency of activities specified and implemented in the program for infection prevention and control, to make decisions on the necessary improvement activities, and to make suggestions to the administration

Creation of a Program for Infection Preventing and Control

Scope of work for infection control and prevention and the program to be established also covers the assigned position of the committee, and must be analyzed according to following subjects at least:

- Assessment of health care processes in terms of infection risk
- Hand hygiene
- Isolation measures
- Infection control in special areas available in ODHS (operating room, isolation rooms, etc.)
- Rational use of antibiotics
- Cleaning, disinfection, sterilization, asepsis, antisepsis
- Identification of health checks and immunization procedures to protect employees from occupational infections

Air, water and food infection control measures

Prevention of infections in renovation, repair and construction works in ODHS

Prophylaxis after exposure

Making emergency plans for extraordinary situations such as epidemics or rare infections and making appropriate arrangements and monitoring effectiveness of implementation

Prevention of infections in support services such as laundry, food services, waste management and ventilation systems

Assessment of Health Care Processes in Terms of Infection Risk

Health care delivery must be assessed in terms of the patient and employee safety in all areas and processes. Measures must be taken and maintained against the risks determined.

For a detailed risk assessment, see Management and Organization Aspect- Risk Management Section

Hand Hygiene

Improvement activities of hand hygiene quality must cover the following subjects at least:

- Determination of Hand Hygiene Rules
- Assessment of Hand Hygiene Compliance
- Activities for Hand Hygiene Compliance

Setting Hand Hygiene Rules

WHO's "5 Indication Rules" describes when the healthcare professional needs to apply hand hygiene.

1. Before contact with the patient,
2. Before aseptic procedures,
3. After contact with bodily fluids,
4. After contact with the patient,
5. After contact with the patient's surroundings, hand hygiene must be applied.

On the other hand, ODHS has various areas without patient care where the healthcare services are indirectly provided to the patient. Laboratories, pharmacies, sterilization units, units allocated for medication preparation etc. can exemplify these areas. Rules regarding hand hygiene in all healthcare delivery areas, including the ones mentioned above, must be set and the application thereof must be realized within the frame of these rules, to ensure both patient and employee safety.

Assessment of Hand Hygiene Compliance

Hand hygiene compliance refers to the application of hand hygiene at the right time, using the appropriate method, in the correct way and for the right duration. Hand hygiene compliance means not only washing and rubbing the hand, but also practicing it in the **correct** way.

Hand hygiene compliance must be measured by such methods as monitoring of hand hygiene materials, surveys (for the awareness, level of knowledge and compliance of health care professionals) as well as the informed prospective observations. In accordance with the data obtained as a result of the assessments, necessary improvement must be planned. Feedback on hand hygiene compliance rate must be reported to relevant units.

Actions for Improving Hand Hygiene Compliance

Following actions must be taken to improve hand hygiene compliance:

» Establishing hand hygiene policy
» Determining hand hygiene responsibilities
» Supporting skincare of healthcare professionals
» Trainings
» Reminder and warning messages
» Facilitating material access

Some points are stated below in detail:

Establishing a hand hygiene policy and identifying responsible employees:

» ODHS hand hygiene policy must be defined. ODHS hand hygiene policy must cover at least the following:
  - Definition and scope of hand hygiene
  - Importance of hand hygiene for ODHS
  - General ODHS goals for hand hygiene

  - Basic responsibilities of managers and employees regarding hand hygiene
  - Continuous improvement strategy
  - References to hand hygiene procedures

» ODHS hand hygiene policy must be traceable to strategic targets and ODHS practices.

Supporting skincare of healthcare professionals

It must be ensured that hand hygiene materials (liquid soap, hand antiseptic, etc.) and gloves are not cause skin irritation.

Trainings

All employees must receive training on hand hygiene. Contents and periods of the trainings must be determined by ODHS according to the occupational groups and needs detected through the measuring results. Trainings must cover at least:

» Importance of hand hygiene
» Hand hygiene methods and indications
» Simulations of "5 Indications" approach to hand hygiene
» General information about use of gloves and hand antiseptics
» Safety precautions to be taken regarding alcohol-based hand sanitizers

Facilitating material access

Materials for hand hygiene must be available in all areas of health care. ODHS must prepare plans for access to materials such as liquid soap, single-use towel in the hand washing areas/ lavatories.

Within the framework of recommendations in WHO guidelines, alcohol-based hand antiseptic must be available at **patient point of care.** Patient point of care is the place where three elements come together:

1. Patient
2. Healthcare professional
3. Care or treatment procedure including contact with the patient or his/her surroundings (within the patient's area)

This term precisely covers the setting of care and, thus, the need of hand hygiene in this setting. Alcohol-based antiseptic must be easily accessible in patient point of care.

All areas where patients are provided care and treatment must be regarded within this scope. The aim here is to organize the bedside products in such a way that the patient can reach them without leaving his/her area.

Access to alcohol-based antiseptics is provided through health professionals' pocket bottles, dispensers fixed on the walls, containers fixed to the patient bed and through bottles on the bedside table or in the medication trolleys.

Isolation Measures

The committee responsible for the prevention and control of infections ODHS must determine the conditions in which isolation measures must be implemented; the implementing rules and the required physical conditions (separate room/unit, adequate distance between beds/units, adequate numbers of personnel etc.) and Isolation cards with symbols must be defined. Healthcare professionals must be provided with training, sufficient personal protective equipment must be supplied and this equipment must be used in compliance with isolation measures.

Rational Use of Antibiotics

For the ideal use of antibiotics; correct antibiotics must be administered in the most suitable way, in effective doses, at optimum intervals and for a suitable duration after the correct diagnosis.

The minimum actions needed to be taken at ODHS regarding Rational Use of Antibiotics are as follows:

» Policies on antibiotic use at ODHS must be determined; the required practices must be applied and monitored.

» A team responsible for creating awareness on rational use of antibiotics and planning and conducting the required studies on this subject must be set up. Duties, authorities and responsibilities of the team must be determined.

» Guidelines on the principles of rational use of antibiotics and proper antibiotic prophylaxis must be drawn up. In order to ensure that practices are applied in line with the guidelines, training and informing activities must be organized. Clinical practices of the implementations must be monitored (To illustrate; rate of proper use of antibiotics in surgical prophylaxis)

» International and national and/or local guidelines (if available) must be benefited from when determining policies on antibiotic use, local resistance data should also be considered.

» The status of antibiotics use in line with guidelines must be monitored.

Cleaning, Disinfection, Sterilization, Asepsis, Antisepsis

Rules of cleaning, disinfection, sterilization, asepsis and antisepsis processes must be determined.

Following issues must be determined within these periods:

» Duration of application

» Range of application

» Method of application and material to be used

» Process for monitoring efficiency of implementation

Cleaning

» Policies for ODHS cleaning must be determined, plans must be drawn, specific areas for infection must be determined, supervising staff must be identified. It must also be determined who will use which cleaning materials in which area, and who would check how the materials would be applied and the effectiveness of the application must be determined.

Disinfection

» The medical equipment's used in patient care should be classified as critical, semi-critical and non-critical in the framework of internationally accepted guidelines used to determine the need for disinfection and sterilization methods.

» Disinfected surface, material, equipment and waste must be determined.

» Disinfection type, disinfectant to be used and rules on how to use it (duration, quantity, controls or measures for ensuring efficient concentration, points to take into consideration in terms of patient and employee safety etc.) must be determined according to the material used during disinfection procedures.

» There must be a sufficient amount of equipment in order to effectively conduct disinfection procedures in the sufficient time, taking into consideration the patient circulation.

» In the areas where high-level disinfectant is used, ventilation must be configured in such a way as to provide employee safety.

» Technicians must be trained, and the status of application of disinfection must be monitored by the supervising staff under the rules of infections prevention and control.

Sterilization

» Materials and equipment used in patient care and needing disinfection must be determined.

» Rules and operations for sterilization processes must be determined. Authorities of infection prevention must monitor their implementation within the framework of rules determined.

» See Healthcare Services Aspect-Sterilization Section for detailed information.

Asepsis and Antisepsis

» Implementing rules must be determined within the framework of asepsis and antisepsis principles and the relevant healthcare professional must be trained.

Occupational Infection of Employees

Healthcare professionals are responsible for taking measures in order to protect both themselves and their patients against infectious agents. These measures are presented in three groups:

1. Measures to be taken before contact: Immunization against infections which can be immunized, routine screening.
2. Measures to be taken to prevent contact: Protective measures to be taken against the risks which might be encountered during healthcare delivery (standard measures, isolation measures).
3. Measures to be taken after contact: Procedures of immunization, prophylaxis, follow-up and treatment which must be conducted in case of contact with any infectious agent.

» ODHS must define all the processes on the above measures.

» Actions must be taken to improve the levels of knowledge and awareness on infection protection of employees at ODHS.

» Appropriate working environment and conditions must be provided for the employees to take necessary measures against infections. Necessary equipment must be supplied.

» Medical screening, which must be performed within the framework of risk analysis based upon the section at regular intervals, must be determined. A program must be created for the medical screenings.

» The procedures must be determined for the cases with positive scans.

» Efficiency of applications within the framework of the program must be monitored.

» Efficiency of applications within the framework of the program must be monitored.

Infection Control in Support Services such as Laundry, Kitchen, Waste Management and Ventilation Systems

» The following processes should be monitored in terms of prevention and control of infections, necessary measures should be taken and their continuity should be ensured.

» Cleaning of textile materials used in health services

» Processes of food supply, storage, preparation and distribution at ODSH

» Safe removal and disposal of medical wastes produced in the provision of health services

» End-of-life services, morgue area and its operation

» Ventilation and air filtration systems

Monitoring and Evaluation

» Actions for infections prevention and control at ODHS must be monitored on the basis of process and outcome. Necessary actions must be taken for continuous improvement. In monitoring and evaluations; routine observations and controls, process-based indicators determined for implementations must be used.

» Outcomes obtained from monitoring and evaluation must be analyzed. The compliance with targets that are set must be evaluated. They must be improved if necessary.

» Outcomes obtained must be shared with the management and relevant employees.

» Information and training must be provided for infection control and prevention of employees.

Sterilization Management

Code	Standard	Code	Assessment Criteria
SH.SY.01.00	Processes concerning sterilization services must be identified and taken under control.	SH.EÖ.01.01	Physical areas and conditions in sterilization unit must be planned according to the process steps.
		SH.EÖ.01.02	All processes for re-use, sterilization, storage and transfer of reusable medical devices and materials must be regulated and taken under control.
		SH.EÖ.01.03	Traceability of the evidence regarding time, device, method, implementer and control parameters must be ensured in each stage of the sterilization.

Goal

Sterilization processes, which are one of the important steps to prevent and control infectious diseases associated with health services, cover the issues of ensuring and controlling patient safety in the process of preparing reusable medical devices and materials for reuse.

Objectives

- » Patient safety
- » Effectiveness
- » Efficiency
- » Continuity

Standard Requirements

Measures Related to Physical Areas and Conditions in Sterilization Unit

Physical space in the sterilization unit should be arranged according to the process steps.

- Dirty area (receiving, washing (decontamination)
- Clean area, (inspection preparation and packaging area)
- Sterile material storage and distribution area
- Support areas (areas related to the infrastructure of the sterilization unit such as water, air, ventilation, rest room, administrative office room, personnel dressing room, WC, etc.)

» Surfaces in sterilization unit must be cleanable easily and disinfect.

» Appropriate temperature and humidity ranges must be determined for the areas and temperature and humidity rates must be followed up on a constant basis.

» Airflow must be from the from the sterile storage area to clean area and contaminated area. The air provided by the ventilation system must be filtered at least 10 times an hour. Any method that may cause turbulence must not be used. Ventilation system must work without interruption.

Positive rust must be provided in sterile storage. In order to ensure positive pressure, a veva corridor should be created at entrance of storage.

A controlled storage area must be established for equipment used in washing, chemicals and products.

» Systems like lighting, water, uninterrupted power supply must be planned and monitored so as to ensure sterilization safety.

» Storage conditions in sterile areas must not prevent air circulation and must ensure preservation of sterile material.

» Necessary equipment, working conditions and rules must be determined according to the physical areas in the unit and the services given in these areas.

Process Control in Sterilization Service

Process of sterilization service is composed of steps of procedure that proceed in a circular manner:

» Transfer from area of use to the contaminated area

» Dirty material acceptance

» Cleaning-Care

» Packaging

» Loading

» Sterilization

» Storage

» Distribution (Transfer to the area of use)

» Use of sterile material

Rules for all sterilization processes must be determined in accordance with national and international guidelines.

In all of the processes quality of material and medical device, sterilization management, working and control rules regarding the equipment used and area of use must be determined and the relevant personnel must be provided with training on the issue. Corrective and preventive action must be taken to address irregularities identified in the processes.

Mechanical installations in the sterilization unit, pressure vessels (autoclave, etc.), steam boiler, compressor, steam turbines must be maintained at regular intervals.

In ODHS, if there is instant sterilization, there must be definitions for this practice. Descriptions should include the following:

- In which cases the instant sterilization method can be used
- Which medical devices and materials are covered by the sterilization program
- What points must be considered before being used on the patient after leaving the sterilizer
- Informing employees about instant sterilization

- Monitoring of cycles with chemical and biological indicators suitable for instant sterilization program
- Recording whole process

Instant sterilization should be used in cases where there is not enough time to sterilize medical devices and materials with the standard pressurized saturated steam method, and should not be used as a routine sterilization method.

Washing, Disinfection and Packaging Processes

» Dirty materials should be counted from the material list and accepted into the sterilization unit and these are must be recorded.

Equipment used in washing, chemicals and physical parameters (such as temperature, concentration, cycle parameters if using a machine) must be compatible with the materials to be decontaminated, and the effectiveness of washing should be checked at regular intervals.

» The washing activity must be checked at regular intervals.

» Washing effectiveness control must also cover luminous appliances in use.

» The materials must be delivered to the clean area with the material list.

Package contents should be checked for cleanliness, integrity and damage and necessary maintenance must be done.

» Packing of materials and medical devices must be done in clean area.

» Textile materials should not be packed in a sterile area.

» Materials to be used in packaging must be compatible with the sterilization method to be applied and must ensure the effectiveness of sterilization and safe preservation of sterile packages.

» Rules for loading packages into the sterilization device must be defined,

» Excessive and cramped loading must not be done, which will reduce sterilization efficiency.

Quality Control Studies for Sterilization Process

» In order to monitor the sterilization efficiency, methods and processes to be followed by unit (such as parametric validation or biological validation, and routine control methods suitable for selected validation method, chemical and biological indicator use) must be defined and applied.

» Performance tests that measure washing and thermal disinfection efficiency must be applied.

» If sterilization efficiency is monitored with chemical and biological indicators, results of indicator control must be recorded and examined.

» Transaction indicator must be used on each package in order to distinguish between processed and unprocessed packages.

» After cycle, packages must be controlled in terms of humidity and exposure band.

» If biological validation is performed and biological indicator application is defined, it must be carried out within the framework of defined rules.

» Requirements and rules regarding recall of products delivered at the unit must be defined.

» All devices and equipment used in sterilization unit must be cleaned, maintained and checked with frequency and method determined.

» Storage of Sterile Material

» Sterile materials must be kept in a sterile storage area.

» Ventilation system must be designed in such a way that the air flows from sterile storage area to polluted area with positive pressure. There must be no direct contact with outside air.

» Necessary physical conditions (ceiling height, air circulation, heat, humidity, cleaning etc.) must be provided in sterile material storages.

» Materials leaving sterile storage must not be accepted into storage without being re-sterilized, even if package is not opened.

» Sterile materials must have an identifier, sterilization date and shelf life for sterilizing device and sterilizing worker.

» Shelf life of sterile material must be determined by considering factors such as packaging, number of layers, packaging tools, other protective factors (closed box, dust cover, transport cart), storage location.

Traceability of Sterilization Processes

» At every stage of sterilization processes; traceability must be ensured in terms of evidence regarding time, device, method, operator and control parameters.

» At least following records regarding sterilization processes must be accessible;

- Information on which date, which method, which device and in which cycle it was sterilized.
- Maintenance, repair and calibration records of the sterilization device
- Validation reports
- Device cycle records
- Device related tests (such as vacuum leak test, Bowie Dick test)
- Biological indicator result
- Information on who and when it is received and delivered
- Information on the stage and by whom the process is implemented.
- Records of quality control work performed at each stage

» Sterile material used must be associated with patient, and records in sterilization unit of medical device and material used for patient must be accessible retrospectively if necessary.

Drug management

Code	Standard	Code	Assessment Criteria
SH.İY.01.00	Efficient and safe drug management must be ensured in the institution	SH.İY.01.01	A drug management structure that will provide an effective implementation of drug administration and coordination must be created.
		SH.İY.01.02	Main and critical stages of all the medicine processes in the institution must be determined and the methods and rules regarding these stages must be identified.
		SH.İY.01.03	The right medicine must be provided at the right time and effective stock management of the medicines must be ensured.
		SH.İY.01.04	Medicines must be kept under proper conditions.
		SH.İY.01.05	Measures must be taken to ensure the safety of the patient and the personnel when the medicines are being prepared and administered.
		SH.İY.01.06	At all stages of drug administration, measures must be taken for patient and employee safety.
		SH.İY.01.07	Traceability of medicine processes must be ensured by making use of feedback infrastructures and indicators and the necessary improvement work must be undertaken.

Goal

To minimize the risks to the patient and the employees in all processes that involve the drug, ensure that the processes are carried out effectively and efficiently.

Objectives

- » Patient Safety
- » Efficiency
- » Productivity
- » Timeliness
- » Healthy Work Life
- » Patient-oriented
- » Suitability
- » Continuity

Standard Requirements

Management and Documentation

» In order to establish an efficient drug management system in ODHS, first of all an active management design that includes an adequate level of documentation must be created. Duties and responsibilities of people involved in this management design regarding medicine safety must be identified, necessary training opportunities must be provided in order to improve the competencies.

» Documents on drug management must be created by taking into account needs of ODHS and critical processes. The documents must address the following issues at minimum:

- Supply of medicines
- Duties and responsibilities of the personnel involved in drug management
- Conservation of medicines
- Medicine orders
- Transfer of medicines
- Preparation of medicines
- Administration of medicines

- Use and disposal of half-finished ampoules after treatment
- Control of drug-drug, drug-food interactions
- Adverse effect notifications
- Medication error notifications and indicators related to medication management
- Management and order process of high-risk drugs
- Hazardous drugs and intervention methods in all cases
- Disposal processes of drugs whose storage conditions are not suitable or whose storage period has expired after they have been reconstituted, opened or prepared
- Destruction processes of half-dose drugs and solutions with incompatibility after preparation
- Pharmaceutical waste management
- Tables of special quality drugs created to ensure drug safety

» Specific medicine groups must be determined by ODHS in line with legislation or relevant country and efficient use of these medicines must be ensured by making use of warning mechanisms (like colorful or audible warning signals) aimed at ensuring efficient and safe use of these medicines.

» Examples of specific medicine groups are as follows:

- Pediatric emergency medicines
- Medicines with a similar appearance
- Medicines with similar spelling and pronunciation
- Psychotropic medicines
- Narcotic medicines
- Medicines that should be protected from light
- High-risk medicines
- Medicines that require special technique/equipment/expertise to be prepared
- Concentrated electrolytes
- Medications that should not be used in pregnancy and lactation
- Cytotoxic drugs
- Drugs that require secondary follow-up

Communication in Drug management

Communication between patient and employee and between employee and employee in drug management is of great importance in terms of patient safety. Therefore, an efficient medicine methodology must be ensured for each stage of drug management at ODHS.

» Personnel must be trained to increase their awareness and knowledge levels about drug management.

» Patients must be informed about the medicines that are administered to them.

Supply of Medicines

» Rules and methods about demands for supply of medicine must be determined at ODHS. Within the scope of these rules, who can make a medicine request, the method of demand, who will evaluate the demands and how they will evaluate the requests are all points that must be identified.

» While determining types and amount of medicine to be supplied, evaluations made for a needs assessment, demands for supply and consumption analyses must be taken into account.

Conservation of Medicines

Storage areas for medicines encompass pharmacy warehouses and all the warehouses of the unit where medicines are kept for more than 24 hours (outpatient clinic, service, operating room etc.)

» Access of people except for the personnel in charge to the warehouses must be limited due to safety and security reasons.

» Medicines must be kept under appropriate conditions in line with their characteristics. To that end, action must be taken to ensure air- conditioning and lightning control and physical conditions must be monitored. Measures should be taken to protect the cold chain in extreme cases such as power failure.

» It is also important to prevent storage of any materials in the medicine warehouses and medicine refrigerators other than medicines and vaccines.

» Pillboxes must not be placed on direct ground level and the minimum height of the lowermost shelf must be determined so as to make sure the medicines are not affected in the case of flood.

» Pillboxes must not be placed on direct ground level and the minimum height of the lowermost shelf must be determined so as to make sure the medicines are not affected in the case of flood.

» Medicine arrangement plans of warehouses and refrigerators must be easy to use, accessible and the plans must be kept up-to-date.

- While the arrangement plan is being prepared, separate areas must be allocated for specific medicines and medicines with similar pronunciation/spelling/appearance must be stored far away from one another.

» Necessary storage measures must be taken in all the areas of ODHS to ensure safety of psychotropic medicines and narcotic medicines.

» Warning signals (labels etc.) must be used efficiently for high risk medicines.

Medicine Orders

ODHS must determine the authorities, methods and rules for all phases of order in line with the legislation. Abbreviations must not be used in the name of the medicine while ordering a medicine. Medicine orders are basically divided into three groups.

» Patient-based administration orders (verbal, written or electronic) that are made for treatment

» Storage orders that are made to the pharmacy by units having the medicine in stock

» Supply orders that are made for medicines with low levels of stock or which are out of stock

Administration orders that are transferred to the treatment plan prepared for the inpatients must include the following information at minimum:

» Full name of the medicine and pharmaceutical form

» Administration time

» Dosage

» Mode of administration

» Duration of administration

Transfer of Medicines

» Necessary measures must be taken to prevent breakage and spillage during the transfer of medicines.

» Equipment necessary for safe transfer of medicines (medicine boxes, tools like forklift etc.) must be provided. This equipment may change depending on the amount of the medicine to be transferred.

» The Health staff who will transfer the medicine must be trained on safe transfer of medicine and intervention in the case of breakage of hazardous medicine.

Preparation of Medicines

» People preparing medicines in the pharmacy must have enough information and experience about medicines.

» Measures must be taken to identify divided packages (blister tablet that have been cut etc.), expiry dates of all the medicines that have been prepared must be checked and the orders must be confirmed.

» The medicines that require special technique/equipment or expertise must be transferred to the relevant unit for the administration process after having been prepared by the specialist under proper conditions. Color directives must be taken into consideration during preparation of the medicines with colored label.

Administration of Medicines

» Medicines should be prepared specifically for each patient in the drug preparation environment before application, carefully applied in the framework of the specified rules, and the application should be recorded.

» Administration of the medicine must be conducted only by the personnel (dentist, nurse, intern under the supervision of the nurse etc.) authorized to administer the medicine. Patient identity must be verified before the administration and treatment information must be confirmed. Especially after administration of risky medicines patients must be monitored, it is necessary to be ready for any adverse effect that may occur.

Control of Medicines that Patients have with Them

» Processes for the management of the medicines brought by the patient must be defined.

» There must not be any medicine left near the patient, the medicines that patients have with them must be checked during admission to ODHS.

» Expiry dates and physical conditions of medicines that are taken from the patient must be checked.

» Medicines the expiry dates of which are over and the physical structure of which has changed must be disposed of after having informed the patient.

Traceability

Traceability and continuity of the data generated during entire drug management process must be ensured.

» Traceability and continuity of the data obtained during drug management process must be ensured within the scope of information management systems.

» An information infrastructure that will enable the personnel to report the problem that may arise in any phase must be established and it must be used efficiently.

» Problems about drug management that must be reported must encompass adverse effects and medication errors at minimum.

» Adverse reactions should be recorded and reported to the pharmacovigilance system. The pharmacovigilance officer must be defined.

» Inaccuracies in drug-related processes should be reported to the relevant experts and improvements should be made to the identified error sources.

Standard 1

Code	Standard	Code	Assessment Criteria
SH.HB.01.00	Patient care processes must be conducted in line with the needs of the patient and so as to ensure patient safety.	SH.HB.01.01	The process for patient care practices must be planned with a multidisciplinary approach and to ensure participation of all health professionals in care process.
		SH.HB.01.02	Patients must be evaluated in terms of their care needs.
		SH.HB.01.03	A care plan for patients must be developed according to the results of the evaluation
		SH.HB.01.04	Care plan must be reviewed and updated continuously according to clinical results of patient.
		SH.HB.01.05	Patients/carers must be involved in the care processes.
		SH.HB.01.06	Processes regarding referral of patient or completion of treatment must be planned so as to ensure continuity of care.
		SH.HB.01.07	Records of patient's care process must be complete and accurate and contain necessary warnings for clinical follow-up of patient.

Goal

All the patients getting service from ODHS must be provided with the same Standard of care in each stage of the patient care process.

Objectives

- » Patient Safety
- » Efficiency
- » Suitability
- » Continuity
- » Timeliness
- » Equity

Standard Requirements

» Patient care encompasses the whole health service processes starting from admission of the patient to ODHS to monitoring of the patient after discharge.

» It also includes service processes of all other relevant occupational groups beside diagnosis/treatment processes provided in policlinics for outpatients and in clinics for inpatients.

Identification of Patient Care Processes

» In order to ensure efficiency of services to be provided for patient care within this period of time, care processes must be identified. This identification must include the following issues at minimum:

- How, when and by whom the care needs of Outpatient/Inpatient will be evaluated
- Care planning after evaluation
- Providing patient with planned care service
- Putting care plan into practice
- Monitoring patient in order to understand results of care
- Making changes about care when needed.

» All stages of determining patient's care needs, planning, implementing and monitoring care must be carried out in a coordinated manner by

all members of care team with a multidisciplinary approach. These transactions must be recorded at the same time.

» Participation of patient/patient relative in the care processes must be ensured.

» It should be ensured that evaluation, care plan and follow-up results of inpatients must be monitored by all employees.

In prepared care plan, problems identified together with patient, targets for problems, measures taken and interventions and evaluations must be monitored.

Determining Patient Care Needs

» Care needs of patient must be evaluated by healthcare professionals who will care for patient when patient is admitted to department for inpatients, and in department where outpatient health services are received for outpatients.

» All members of care team must evaluate patient in relation to their service area and determine patient's care needs.

» While determining care needs of the patient; If there is a patient's history and physical examination, general condition of patient must be evaluated with a holistic approach in terms of physical, mental and social aspects, together with diagnostic test results. Patient/patient relative must also be included in this evaluation.

» Within the framework of identified care needs, measures must be taken to ensure patient safety in the procedures to be performed on the patient (filling, root canal therapy etc.) the right procedure must be performed on the right area.

Considering the Clinical Risks of the Patient in Care Planning

Within scope of clinical risk assessment, it must cover at least following topics according to clinic of patient:

- Allergic risk assessment
- Safe transfer of patients
- Pain assessment for inpatient and outpatient groups
- Consciousness level monitoring
- Evaluation of nutritional status
- Oral care and follow-up

- Evaluation of device-related risks

» Necessary precautions must be taken for risky patients.

Patient Care Plans

» Care plan is a document which includes treatment and care needs of the patient, goals with regard to these needs, implementation and evaluation of implementation.

» Continuity of treatment and care is essential to patient care. Care plans must be prepared in a way that also encompasses post-treatment checks.

» Any change or improvement (change of care needs, any intervention performed on the patient, change of medicines used by the patient etc.) must be reflected to the care plan concurrently and care plan must be updated when necessary. Relevant health personnel must be kept abreast of the updates in the care plan.

Involvement of Patient/Carer in the Care Process

Compliance of patient/patient relative to ODHS must be ensured. Rules that patients/patient relatives must comply with in ODHS, breakfast and meal times, phone usage, how they can reach healthcare workers, how they can get information about care services provided, etc. must be informed about issues.

» Relevant health employees who provide service must establish a communication with the patient in a way that take expectations, needs and values of patient/carers into account. The care team must establish a positive diaologue with patient/carers.

» Patient/patient relative must be informed about procedure by person who will perform procedure in all procedures to be applied to patient within the scope of care practices.

» Patient/patient relatives must be informed about process of care practices at frequency and time determined by institution.

» Training must be given to patients/patient relatives to ensure continuity of care (prosthesis care at home, correct tooth brushing, points to be considered after completion of treatment, rules to be followed in ODHS, access to service, etc.).

» In case of a risky procedure, patient must be informed about procedure by person who will perform procedure and written consent must be obtained.

Patient Trainings

» Training must be given to patient/patient relatives to ensure continuity of care. Training content; patient rights, use of drugs, important considerations during care practices, continuity of treatments, control stages of completed treatments, etc. topics must be covered.

Referral of Patient

Referral procedures of patients to be referred to ODHS in line with the identified care needs must be conducted in keeping with the current plan developed by ODHS.

» Involvement of patient and carer in referral procedures must be ensured and patient/carer must be informed.

» Prior to referral, coordination must be ensured with the institution to which the patient will be referred.

» During referral, information about patient care process such as patient's clinical condition, intervention (if any), diagnosis/treatment procedures must be conveyed accurately and completely.

Completion of Treatment of Patient

Procedures regarding completion of treatment of the patient must be planned.

» Patients whose treatment has been completed by the doctor must be informed about issues like points to pay attention to at home after treatment and how and when they must contact the health personnel for control.

» Records must be kept about completion of treatment.

Patient Records

There must be required regulations for keeping patient records complete and accurate.

Information about diagnostic practices done during patient care process with by who and when the practice is done must be included in the records. Also, these records must be accessible at future admissions of the patient.

» It must be ensured that information in patient files and records are complete and accurate.

» Date information must be in patient records.

» Patient records must be written in a readable and understandable manner.

» Alert notations, which have importance for patient's clinical trial must be included in the patient file.

Death of Patient

By ODHS, a plan must be prepared regarding services to be provided for cases when a patient dies.

Standard 2

Code	Standard	Code	Assessment Criteria
SH.HB.02.00	Patients who are at risk of harming themselves or others must be take under control	SH.HB.02.01	Identity verification methods and tools must be identified.
		SH.HB.02.02	Necessary measures must be taken for patients who are at risk of harming themselves or others.

Goal

Patients with agitation, confusion, aggression status and diagnosis of dementia, delirium or suicide attempt, some psychiatric patients are patient groups that have high risk of giving harm to self and others. To prevent patient giving harm to self and others in cases of similar situations.

Objectives

» Patient Safety
» Healthy work life
» Suitability
» Timeliness
» Continuity

Standard Requirements

Measures to Be Taken

Measures to be taken must be planned for patients with risk of giving harm to self and others. Minimum measures to be taken are as following:

» Patients with high risk of giving harm to self or others must be observed at a frequency determined by their care needs.

» Arrangements must be made to provide healthcare employees an easy access to patient when needed.

» Patient's room must be environmentally safe. (Proper lighting, furniture, prohibition of accessory usage, secure windows etc.)

» Necessary patient care applications must be determined with a psychiatric consultant.

» According to the decision of physician, when minimum precautions aren't enough, movement restriction or isolation can be implemented for uncontrollable patients.

Standard 3

Code	Standard	Code	Assessment Criteria
SH.HB.03.00	Standardization of care practices for specific patient groups must be ensured.	SH.HB.03.01	Processes for specific patient groups and care practices must be defined .
		SH.HB.03.02	Specific care practices and all procedures for specific patient groups must be defined.

Goal

Standardization of unit-based care practices for patient groups who have specific conditions in framework of scientific principles and recognized approaches.

Objectives

- » Patient Safety
- » Efficiency
- » Suitability
- » Timeliness
- » Equity

Standard Requirements

Specific Patient Groups and Determination Processes for Specific Group Oriented Practices

» Terms below can be given as examples for specific patient groups.

Hospital must determine its specific patient groups in accordance with following terms:

- Psychiatric patients
- Patients receiving radiation therapy/chemotherapy treatment
- Geriatric patients
- Patients with suppressed immune system
- Allergic patients
- Patients with neonatal anomalies
- Pregnant women
- Substance addicts
- Patient groups at risk of bacterial endocarditis
- Patients with orofacial severe traumatic wounds or maxillomandibular fractures
- Neglected/Abuse patients, etc.

» Processes for specific patient care applications must cover at least the following issues:

- Service delivery processes
- Environmental conditions to be served
- Necessary equipment

- Special maintenance practices and procedures

Determination of Special Applications and Procedures for Specialized Patient Groups

Special practices and procedures must be determined and applied according to the care needs of specific patient groups.

Radiation Safety

Code	Standard	Code	Assessment Criteria
SH.RG.01.00	Measures must be taken to ensure radiation safety for patient/ carers and the personnel.	SH.RG.01.01	A committee must be established to ensure radiation safety.
		SH.RG.01.02	The areas where there are devices that emit radiation must be identified and protective measures must be taken in these areas.
		SH.RG.01.03	Rules must be determined for procedures that entail the use of radiation.

Goal

To take measures in order to reduce exposure of patients and employees to radiation in radiation areas

Objectives

- Patient safety
- Healthy work life
- Efficiency
- Timeliness
- Compliance

Standard Requirements

Committee on Radiation Safety

A committee must be established in order to carry out radiation safety activities. The committee must carry out the activities below:

- To reduce the risks arising from medical irradiation practices at ODHS
- To plan the measures to be taken
- Decision making on the evaluation of radiation sources in terms of patient and employee safety by monitoring the said sources
- To monitor implementation of the decisions taken

Supervisors must be designated by committee in order to follow process or section-based actions to ensure radiation safety of patient and employees.

Radiation Areas

The area must be defined according to quality of radiation practice in radiation in ODHS. Radiation units must be classified in accordance with their radiation levels.

Preventive Measures and Rules of Procedure

Patient, carer and employee-oriented rules of procedure must be determined taking into consideration properties of radiation areas defined and processes of medical irradiation performed. Measures must be taken to reduce radiation exposure.

Physical Arrangements

- Authorized agencies and institutions must be licensed in accordance with the relevant legislation.
- There must be shielding in place in areas where there is a radiation source.
- There must be warning signs in radiation areas.
- Suitable ventilation conditions must be provided for radiation areas.

- Physical arrangements must be planned in such a way as to ensure that patients, carers and employees are away from the radiation source as far as possible. Waiting rooms must be outside the radiation zones.
- Measures to be taken in case of a probable accident which could jeopardize radiation safety, must be determined. Wastes arising from radioactive substance usage must be brought under control.

Arrangements for Patient and Carers

- It must be ensured that the patient uses the necessary radiation protective equipment.
- Only the area which will be imaged must be irradiated. The area necessary for the diagnosis in the panoramic radiography and cephalography must be determined, and only the area to be imaged must be irradiated.
- Within the framework of measures for reducing the exposure to radiation, only the patient to be imaged must be taken into the imaging room.
- Attention must be paid to the position errors in panoramic radiography
- Inquiries on the pregnancy and pregnancy suspicion must be carried out in the processes of request and implementation respectively.
- If medical irradiation is obligatory for pregnant women and the women with pregnancy suspicion, they must be informed about radiation safety and protective measures must be taken.
- Arrangements must be in place to ensure patient comfort and privacy at every stage of the medical irradiation process.
- Measures must be taken to reduce children's exposure to radiation during imaging. Repeated imagines must be kept to a minimum.
- Doors of imaging unit must be closed while the imaging is conducted.
- Carers must not be let into the imaging area unless it is not necessary. If they are let in, they must use protective equipment.
- Calibration and quality control tests must be periodically carried out in accordance with the utilization frequency of devices emitting radiation.

Arrangement for Employees

- It must be ensured that employees use protective equipment.
- Radiation protectors must be controlled (at least once a year and if necessary).
- It must be ensured that employees use their own personal dosimeter.
- Dosimeter results must be monitored and evaluated and the results must be shared with employees Results must be evaluated and improvements must be made when necessary.

Prosthesis Laboratory Services

Standard 1

Code	Standard	Code	Assessment Criteria
SH.PL.01.00	Physical environment of the prosthesis laboratory must be arranged so as to ensure safety of the prosthesis and the personnel.	SH.PL.01.01	The areas that have been determined for the admission of prosthetic materials into the prosthesis laboratory, the preparation of the material for the procedure, its being processed and for the delivery must be arranged so as to ensure the safety of the prosthesis.
		SH.PL.01.02	A healthy work environment must be ensured in all areas in the prosthesis laboratory.

Goal

To design physical conditions so that prosthetic material belonging to patient is admitted under appropriate conditions, it is prepared before process, it is processed and the prosthesis is delivered after process, and to create a healthy work environment for laboratory staff.

Objectives

- Patient Safety
- Healthy Work Life

Standard Requirements

» Prosthetic processes to be conducted within the institution must be defined, and physical infrastructure needed for such job description must be provided.

» In prosthesis laboratory, required areas for processes such as the admission of patient's material under appropriate conditions, its preparation before the process, delivery of the prosthesis after the process and rules regarding such areas must be determined.

» Rules concerning the entry and exit of staff to designated areas must be set.

» Physical conditions required in designated areas (its size, planning for efficient and safe use of the area, ambient temperature, ambient humidity, ventilation, rules concerning entry and exit, arrangements concerning emergency situations, etc.) must be determined and implemented.

» Maintenance of ventilation system must be performed regularly and filters must be replaced periodically.

Standard 2

Code	Standard	Code	Assessment Criteria
SH.PL.02.00	The processes that precede the fabrication of prosthesis must be checked.	SH.PL.02.01	The methods and rules for transfer of prosthetic material to the prosthesis laboratory, its admission into the laboratory and its preparation before the procedure must be identified.
		SH.PL.02.02	Rules on the renewal of impression when necessary must be determined and the relevant dentists must be provided with information.
		SH.PL.02.03	The relevant health personnel must be provided with general information on the procedures conducted in prosthesis laboratory and with training on safe transfer of prosthetic material, its admission into prosthesis laboratory and its preparation before the procedure.

Goal

To ensure the suitability and safety of the prosthesis by controlling all its related processes from impression taking to the transfer of the prosthetic material to the laboratory, its admission and preparation

Objectives

» Patient safety
» Efficiency
» Effectiveness
» Productivity
» Suitability

Standard Requirements

Impression Taking

» General rules concerning impression taking must be set, and relevant staff members must be trained.

» The time the impression is taken must be recorded correctly.

» Impression taking, its admission to or refusal by the laboratory must be recorded on the Information Management System (IMS) as separate stages, and they must be seen by authorized users.

Transfer of Prosthetic Material

» Relevant staff must be informed about such necessities as the transfer box to be used for the transfer of prosthetic material to laboratory, the method of transfer (manual methods, air system, etc.), suitable impression position, transfer temperature, etc.

» Maximum acceptable transfer periods for prosthetic material must be determined. Relevant training must be provided for staff members in

charge for the purposes of carrying out the transfer through correct method and within time set.

Admission of Prosthetic Material to Laboratory and Its Preparation for Procedure

- In order to ensure prosthesis safety, arrangements must be made with the aim of assessing the suitability of admitted prosthetic material to impression taken and admitting or refusing the material on the basis of this assessment.
- In the records concerning the admission or refusal of prosthetic material, date and time, department/physician sending the material, by whom it was admitted or refused, and if it was refused, reasons for refusal must be indicated.
- No action must be taken in relation to prosthetic material before its admission to laboratory.
- Admission or refusal of prosthetic material must be made through IMS.
- Relevant staff must be trained on how to run admission and refusal processes.
- Analyses must be made in relation to prosthetic material refused, and necessary corrective actions must be taken.

Standard 3

Code	Standard	Code	Assessment Criteria
SH.PL.03.00	The processes regarding the fabrication of prosthesis must be checked.	SH.PL.03.01	The methods and rules about the processes regarding fabrication of prosthesis in prosthesis laboratories must be identified.
		SH.PL.03.02	Rules regarding effective and safe use of the prosthetic material in prosthesis laboratories and other materials and devices must be identified.
		SH.PL.03.03	Quality control procedures regarding the suitability of the prosthesis must be identified and implemented.

Goal

To ensure patient safety through the continuity of quality improvement activities concerning prosthesis production processes

Objectives

- Patient safety
- Efficiency
- Effectiveness
- Productivity
- Continuity

Standard Requirements

Standard requirements concerning prosthesis production process include the followings:

Modeling

» Stages involved in modeling must be defined, and rules concerning the stages must be set.

» Training must be provided for relevant staff about the rules set.

Completion of Prosthesis

» After modeling, all stages until the completion of the prosthesis must be defined, and rules concerning these stages must be set.

» Training must be provided for relevant staff about the rules set

Material and Device Management

» Arrangements must be made concerning the control and safe use of all devices and materials used in prosthesis making in prosthesis laboratories.

» Plans must be developed for the management of devices and materials.

» An inventory of all devices must be available, and their maintenance and calibration must be made.

» Descriptive information about devices must be recorded. Such records must include at minimum the following information:

- Name of the device
- Brand and model of the device
- Date of production and launch
- Serial number
- Details of distributor

» A folder containing information about the operation of the device must be prepared, and attention should be paid to the fact that information included in the folder is current and it is easy to understand for staff. This folder should include at minimum the following information and documents:

- User manual or CD
- If any, calibration records and certificates of the device
- If any, quality control results

- Failure report form
- Contact details of firm

- User training certificates

» Training must be provided for users about operation of the device, maintenance and cleaning of the device, frequently encountered problems while operating the device and how to solve these problems.

» Failures, failure reporting and repair processes must be recorded. Rules must be set in order to ensure safe and economic use of materials.

Quality Control of Prosthesis

» Quality control actions concerning the suitability/unsuitability of the prosthesis must be defined and implemented.

» Data on quality control process of prosthesis must be traceable.

Standard 4

Code	Standard	Code	Assessment Criteria
SH.PL.04.00	The processes that follow the fabrication of prosthesis must be checked.	SH.PL.04.01	The prosthesis that has been completed must be delivered with Prosthesis Delivery Report.
		SH.PL.04.02	The prosthesis must be inserted within the set time of delivery.
		SH.PL.04.03	Patients must be informed about the rules regarding the use of prosthesis.

Goal

To take required measures to ensure patient safety in all processes from the completion of the prosthesis to its use to the benefit of patient

Objectives

- » Patient safety
- » Suitability
- » Continuity
- » Efficiency
- » Timeliness
- » Patient oriented

Objectives

Extra laboratory processes taking place after the completion of the prosthesis include reporting of the prosthesis' delivery and use of the prosthesis made for the benefit of the patient.

Prosthesis Delivery Reports

» Laboratory should determine at minimum what of kind information must be included in prosthesis delivery reports.

» Minimum time parameters to be included in delivery reports are as follows:

- Date and time when impression was taken
- Date and time when impression was admitted to laboratory
- Date and time when modeling started
- Date and time when prosthesis delivery report was recorded.

» Prosthesis delivery reports must have a dynamic structure to which comments, suggestions and opinions of relevant staff members can be added.

» Time of the prosthesis delivery and information to be provided in relation to them are as follows:

- Time of prosthesis delivery must be determined on the basis of ODHS conditions, its needs and scientific requirements.
- Relevant healthcare staff must be informed about the time of delivery determined.
- Patients must be informed about the time of the prosthesis delivery.
- If there is a delay in the delivery of the prosthesis due to any reason it should be determined how information will be provided.

Standard 5

Code	Standard	Code	Assessment Criteria
SH.PL.05.00	Traceability of the processes regarding prosthesis laboratory must be ensured.	SH.PL.05.01	Records must be kept to ensure traceability of the impression and the prosthesis in all the processes.

Goal

To ensure the traceability of processes related to prosthesis with the aim of collecting data to analyze and improve prosthesis laboratory processes.

Objectives

- » Efficiency
- » Timeliness
- » Patient safety
- » Effectiveness
- » Continuity

Standard Requirements

» In prosthesis laboratories, it must be ensured that each stage of prosthesis, from impression taking to prosthesis making, is traceable.

» In prosthesis laboratory information management system minimum following records must be available in relation to prosthesis making process:

- Name and surname of the patient
- Protocol number
- Date and time of examination
- Name, surname and specialty of the dentist examining the patient
- Material used for impression taking
- In relation to the impression taken
  - √ Date and time
  - √ Date and time on which it was admitted to laboratory and by whom it was admitted
- Date and time on which modeling started
- If there is, repetition of impression taking and its results
- Date and time on which prosthesis delivery report was recorded
- Name and surname of staff member and/or laboratory supervisor approving the report

Surgical Safety

Standard 1

Code	Standard	Code	Assessment Criteria
SH.GC.01.00	Patient safety must be ensured in surgical procedures.	SH.GC.01.01	All procedure steps and rules regarding safe surgical procedures must be defined.
		SH.GC.01.02	Before surgery, measures must be taken to ensure patient safety.
		SH.GC.01.03	During surgery, measures must be taken to ensure patient safety
		SH.GC.01.04	Precautions regarding patient safety after the surgical intervention must be taken.

Goal

To ensure that surgical practices are in conformity with the universal protocol and patient safety solutions determined by the World Health Organization in safe surgery, which occupies an important place in terms of preventing medical errors.

Objectives

» Patient Safety
» Patient-oriented
» Efficiency
» Effectiveness
» Equity

Standard Requirements

Documentation

ODHS must document the procedures, steps and rules on the processes of safe surgery. Documents cover:

» Rules on surgical processes
» Parameters on operating room environment
» Operating room entry and exit rules
» Management of medicine, material and devices in operating rooms
• Processes and rules for surgical applications outside operating room

Informing Patient and Receiving Consent

» The dentist and anesthesiologist must verbally inform the patient about the surgery and anesthesia. With this information, it is aimed that the patient knows about his/her problem and treatment, the procedure offered and its risks, who would do the operation when and where.

» After the patient is given the right to decide completely by his/her own free will, a consent form must be signed showing that s/he agrees the surgical operation and the anesthesia method to be carried out by her/his own free will.

Marking Surgical Area

Surgical area must be marked prior to surgical operation if the extraoral **area is subjected to intervention:**

» Marking must be done by the person who will carry out the surgical operation or a dentist from the team. Marking must be done before the patient is taken to operating room.
» Surgical area marking must be done within the period of time when the patient is awake and conscious, and the patient must confirm the marking area during the marking process.
» Marking must be done through a clear method which is determined before hand.
» The area to be operated must be marked. If there will be more than one operation, all the areas must be marked.
» Marking must be done in a way that is not erased easily. Marking must not be swept during surgical area cleaning.
» Marking must be done to the area or its surroundings, and it must be clear.
» Contraindications relevant to the surgical area marking must be determined by ODHS. If a contraindication is found, we must define how the confirmation processes will be conducted.

ODHS Safe Surgery Checklist

To ensure safety of surgical care; "Safe Surgery Checklist", which was put into practice by World Health Organization (WHO) (2009), must be applied for processes before anesthesia is given, before surgical incision and before patient exits surgery. Adjustments may be made to minimum requirements in WHO Safe Surgery Checklist within the framework of institutional requirements.

In order to evaluate the processes of patient before leaving clinic, necessary controls must be made, including at least following issues:

» Confirmation of patient identity

» Obtaining patient consent
» Completion of physical preparations of patient before operation (such as hunger, need for shaving, make-up, nail polish, prosthesis control)
» Special procedures required before surgery (enema, bladder catheterization, compression stockings, etc.)
» Special materials, implants, bone grafts, blood and blood products, etc. that may be required for the surgery.
» confirmation of readiness
» Control of necessary laboratory and radiology tests of patient
» Responsibilities for implementing checklist must be determined for each stage and effective implementation of Safe Surgery Checklist must be ensured.
» All steps must be verbally checked in order to ensure that key activities are implemented. The person who carries out the checklist must check whether or not they are implemented and allow to proceed the next step.
» ODHS Safe Surgery Checklist must be archived in the patient file.

Patient Transfer

» Safe transfer of patient from relevant department to operating room and from operating room to relevant department must be ensured.

Check and Safety of Personal Belongings and Prosthesis

» The process of delivering patient's removable prosthesis and valuable items must be defined before operation.
» Procedure for the protection of patient's belongings must be determined.
» Final check for non-removed belongings and prosthesis must be carried out by operating room staff.

Pre-operative Preparations

» Necessary preparations for pre-operative procedures before planned and emergency operations must be determined and planned.
» Medicines and materials to be used during surgical operations must be supplied and necessary checks must be done. Relevant devices must be ready for use.

» Planning of blood and blood products must be done for the cases having risks of haemorrhage in the pre-operative period. Blood and blood products which may be necessary during surgical operation must be available within the scope of this plan.
» Patients and carers must be informed about the pre-operative preparations and the points to take into consideration. Healthcare professionals must check the preparations.

Anesthesia Applications

» The patient should be evaluated by the anesthesiologist and reanimation specialist in the preoperative period, according to which anesthesia method and necessary premedication should be planned.
» A checklist should be used to ensure the safety of anesthesia applications.
» The anesthesia safety checklist should be kept in the patient file .

Surgical Prophylaxis

Prophylaxis guidelines must be drawn up within the framework of rational use of antibiotics. Efficiency of practices must be monitored in line with these guidelines, and improvements must be made when necessary.

Postoperative Care

» Rules on transferring patients from the operating room and recovery room must be determined.
» Records on patients must be kept at every stage. It must be ensured that information and records on patients must be transferred to the next stage safely.
» The patient must be closely monitored in the postoperative period. Follow-ups relevant to the complications and risks jeopardising the patient safety must be planned and those follow-ups must be recorded.

Safety of Tissues Taken for Diagnosis

» Storage conditions of tissue samples taken for diagnostic purposes during surgical procedure must be defined before and during transfer.
» It must be ensured that tissue samples are taken into appropriate sample container, labeled correctly and completely, and transferred appropriately.

» Employees must be trained to ensure safety of tissue sample.

Records

All records on surgical operation must be kept completely and accurately in order to ensure safety and continuity of care and treatment.

Standard 2

Code	Standard	Code	Assessment Criteria
SH.GC.02.00	Conditions of the operating room must be appropriate to ensure safe surgery.	SH.GC.02.01	Rules regarding operating rooms must be determined.
		SH.GC.02.02	Operating rooms must be arranged so as to ensure patient and employee safety.

Goal

To arrange the conditions of the operating room for patient and employee safety

Objectives

» Patient Safety
» Effectiveness
» Efficiency
» Healthy Work Life

Standard Requirements

Operating Room Areas

» Operating room areas must be handled in at least three different categories in accordance with the procedures taking place in these areas as well as the working conditions and rules. These areas must be defined as:

- Sterile (First) Area: Operating rooms and the place for surgical hand wash.
- Clean (Second) Area: The area between sterile and non-sterile areas. Sterile area must not be opened to non-sterile area without a barrier in between.
- Non-sterile (Third) (Unclean) (Dirty) Area: Area which connects the operating room with the other departments.

» The areas defined must be separated and rules must be established according to the features of each. Rules must be established on patient and personnel entry to and exit from the operating room as well as on transfer of personnel between the areas.

» Cross-domain transitions must comply with national and international rules and norms.

» There must be waiting rooms for the carers/family members of the patient. These areas must be ergonomic and comfortable.

» Arrangements for informing carers/family members must be put in place.

Operating Rooms

» Operating rooms must have such a size and such capacity that the surgical team is dressed and the patient is covered in a sterile way which would not pose any obstacles for the anesthesia team.

» In the operating room: The floor, ceiling and wall surfaces must be smooth. There must not be any cracks on the surfaces. Junction points of door, windows and walls must be smooth and without protrusion. Materials to be used in the wall, ceiling and the floor of the operating rooms must be antibacterial, suitable for disinfection and cleaning. Width of corridors where operating rooms are located must be arranged to allow easy movement of patients.

Ventilation Conditions

» Ideal temperature and humidity rates of operating areas must be determined and controlled.

» HEPA-filtered ventilation system must be used in sterile areas.

» Air stream must circulate from sterile area to unclean area (positive-pressure air stream).

» Ventilation systems must complete at least 15 filtered air exchanges per hour and at least three of them (20%) must be exchanged with fresh air.

» Periodical measurements must be carried out in accordance with the number of particles in the air and supervisors must evaluate the results. Measurements must be recorded.

» Ventilation system must be maintained regularly and filters must be changed at certain intervals deemed necessary.

Medical Gas Systems

Medical gas pressure measurements must be regularly checked through medical gas panel and indicators on the anesthetic apparatus. Medical gas system must be regularly checked and maintained.

Support Services

Standard 1

Code	Standard	Code	Assessment Criteria
DH.OH.01.00	Processes regarding catering for inpatient/ carer and the personnel must be identified.	DH.OH.01.01	Safe supply and storage of the food must be ensured.
		DH.OH.01.02	Processes regarding preparation of the food under the set conditions must be identified.
		DH.OH.01.03	Food must be distributed according to the set rules.
		DH.OH.01.04	Health screening of the personnel distributing the food must be conducted.

Goal

To provide inpatient, carer and personnel with efficient and safe catering services by taking into account their wishes, needs, expectations and values

Objectives

- » Patient-Oriented
- » Patient Safety
- » Healthy Work Life
- » Efficiency

Standard Requirements

Supply and Storage of Food

» Rules to pay attention to with regard to supply according to types of food (qualifications that must be sought in line with types of food, quality control criteria, minimum documents and requirements necessary for admission of the supplier, transportation of food and its delivery) must be determined.

» Storage conditions (temperature, preservation time, packaging conditions if any, rules regarding arrangement of the food on the shelves and in the cabinets etc.) must be identified in line with types of food.

» When storing food, expiry dates must be followed-up in an efficient manner.

» The products in the storehouse must be arranged so as not to come into contact with the ground or wall and food products must be arranged separately.

Preparation Processes of the Food

» Food must be prepared by taking into account the requirements of the medical treatment of the patient.

» Cultural and moral values of the patient must be taken into account within the scope of catering services.

» Food must be prepared in a hygienic way:

- The areas where the food is prepared must be different from other areas. (food storage areas, area where the filthy material is cleaned.)

- All the personnel must use protective equipment such as mask, bonnet, gloves and footwear)
- Material and equipment used while preparing food must be clean.
- Rules about sanitation of the food (like washing fruit and vegetables) must be determined and followed.
- Necessary conditions must be provided to ensure personal hygiene of personnel in charge of food in an efficient manner.

» Replicate samples must be taken from food to make the necessary analyses in the case of food poisoning.

Distribution of Food

» Food must be distributed in line with the types of the food and by taking into account warmth and presentation of the meal and hygiene rules.

» There must be a cover or lid on the food.

» Dinner trolleys and other equipment and material used in transportation and distribution of food must be cleaned and disinfected.

» The personnel distributing the food must use equipment like bonnet, gloves and mask.

Health Screening of the Personnel

All the personnel responsible for catering services must go through health screening periodically and the things to do if a problem that might threaten food safety is detected in screenings must be identified.

Standard 2

Code	Standard	Code	Assessment Criteria
DH.OH.02.00	Laundry services must be provided in a safe and efficient manner to ensure patient and personnel health at ODHS.	DH.OH.02.01	Processes regarding the delivery of laundry services must be identified.
		DH.OH.02.02	The laundry room must be arranged so as to ensure efficient conduct of service processes.
		DH.OH.02.03	Rules regarding the use of laundry equipment must be determined.

Goal

The goal is to make sure that laundry services provided in ODHS are safe in terms of patient and employee health.

Objectives

- Patient-Oriented
- Patient Safety
- Healthy Work Life
- Efficiency

Standard Requirements

Identification of Processes

Processes regarding collection, transport, sorting out, washing, ironing of all the textile products used in ODHS, distribution of the washed

products to the areas where they will be used, storing the products and arrangement of the laundry room must be identified.

Laundry Room

- Laundry room must have enough space for washing, drying, ironing and storing; there must be separate areas for clean and dirty laundry.
- The floor and walls of the laundry room must be made of smooth and strong material that is easy to clean.
- Ventilation and lightning conditions must be appropriate so as to make sure the laundry is clean in an efficient manner and to ensure safety and comfort of the personnel.
- Rules must be determined about the use of equipment in the laundry room and cleaning, maintenance, repair and control of the equipment must be ensured.
- Relevant personnel must be trained on the use of equipment in the laundry room.

Standard 3

Code	Standard	Code	Assessment Criteria
DH.OH.03.00	Patient/ examination rooms and the areas used by patients/carers must be safe and ergonomic	DH.OH.03.01	All departments providing service must be designed in a way that ensures comfort of the patient.
		DH.OH.03.02	Action must be taken to ensure easy access of the patient to the relevant health personnel.

Goal

To boost the morale and motivation of patients/carers by making sure that they are in a safe and comfortable environment

Objectives

» Patient-Oriented
» Patient Safety

Standard Requirements

Patient Comfort

» The following aspects should be taken into account with respect to the services rendered at the ODHS:
  - Clean and spacious ODHS service areas,
  - Waiting areas to sit and relax when needed,
  - Regulation of compulsory areas such as stairs, elevators, toilets, bathrooms, car parking areas in regard to needs of the patient (geriatric patients, pediatric patients, disabled patients etc.)
  - Deleting factors that are dangerous to the safety of the patient
  - The examination rooms containing the requirements for the medical service processes (such as inspection tables, washbasins, hand antiseptics, necessary examination instruments according to the relevant situation)
  - Finding baby care and breastfeeding arrangements in outpatient clinics

Patient Rooms

» In clinics and patient rooms ventilation and lightning conditions must ensure safety and comfort of the patient.

» There must be the furniture necessary for patients in clinics and patient rooms.
» The position of units and patient beds must be adjustable and must ensure safety of the patient.
» In clinics and patient rooms, there must be the equipment and material necessary for diagnosis and treatment of the patient. This equipment and material must be cleaned and disinfected.
» Areas must be determined to meet cleaning needs of patients and carers. There must be material necessary for personal hygiene in these areas.
» An area must be created so that carers can have rest.

Ensuring Easy Access to the Health Personnel

» Action must be taken to make sure that patient and carer can access the health personnel if needed (a call bell etc.)
» The call system for example must be accessible in clinics and patient rooms and in areas allocated for personal hygiene.
» Patient/carer must be informed about how to use the call system.

Standard 4

Code	Standard	Code	Assessment Criteria
DH.OH.04.00	Safety/security services must be provided in ODHS to ensure safety of life and property of patient/carer and the personnel.	DH.OH.04.01	Processes regarding the delivery of Safety/Security services must be identified.
		DH.OH.04.02	Safety of life and property of the patient/carer in ODHS must be ensured.

Goal

Ensuring the safety of life and property of patients / patient relatives and employees in ODHS in an efficient and effective manner.

Objectives

» Patient Safety
» Healthy Work Life
» Efficiency

Standard Requirements

Planning of Safety/Security Services

» There must be a plan in place to protect ODHS and people within ODHS from all kinds of threats, dangers and harm such as sabotage, theft, looting and blow and to maintain surveillance, supervision and control services in an uninterrupted manner.
» There must be a security officer and security equipment in the designated areas of ODHS (surveillance camera, alarm system etc.) Storage times for security camera records must be determined.
» Working area, time and terms of reference of security officers must be determined.

Ensuring Safety/Security of Patient/Carer

» Risk analyses must be made in the field of safety of life and property and necessary measures must be taken.
» Risk analyses must encompass all the areas and units of ODHS. There must be areas where patients and carers can safely keep their personal belongings.
» Process for patient personal belongings received and patient personal belongings found must be defined.
» Risk analyzes must be conducted for possible infant and child abductions in ODHS and necessary precautions must be taken.

» Areas must be created where patients and employees can safely store their personal belongings during service delivery phase.
» Notification process must be defined for events that threaten the safety of life and property.
» Reporting process about events that threaten safety of life and property must be identified.
» Necessary improvement work must be undertaken as a result of the analyses made.

Facility Management

Code	Standard	Code	Assessment Criteria
DH.TY.01.00	A quality facility management structure and process must be established to ensure the quality and safety of healthcare services.	DH.TY.01.01	A committee responsible for planning and coordinating activities related to facility management must be formed.
		DH.TY.01.02	Risks originating from the facility must be detected and necessary measures must be taken.
		DH.TY.01.03	Continuity and safety of core facility resources must be ensured.
		DH.TY.01.04	Issues related to physical conditions and operations must be reviewed periodically.
		DH.TY.01.05	Measures must be taken to facilitate access to services by patients who are disabled, old or in need of help due to illness.
		DH.TY.01.06	Physical arrangements must be made to ensure the comfort of service users.

Goal

To establish the necessary infrastructure for permanent, safe and easily accessible service delivery for the patients and the personnel

Objectives

» Efficiency
» Patient safety
» Patient-oriented
» Timeliness
» Continuity
» Healthy Work Life

Standard Requirements

Management and Documentation

» A committee must be formed in order to ensure planning and coordination of facility management-related activities. The duties and responsibilities of the personnel involved in facility management must be defined.

» Core and critical processes regarding facility management must be defined, and methods and rules thereof must be determined. The documents to be generated for this purpose must include at least the following:

- Duties and responsibilities of the facility management committee and supervisors
- Processes related to the identification of the current status of the health facility
- Improvement processes
- Core facility resources

- Access to facility services
- Facility safety

Determination of Current Status and Improvements

» Current physical status and functional service efficiency of the health facility must be evaluated at regular intervals or when necessary.

» Risk analyses must be performed for facility safety.

» Necessary improvement activities must be carried out with regards to the current status and results of the risk analysis.

Please See Risk Management chapter

Primary Facility Resources, Safety and Continuity

» In order for health services provided to continue uninterrupted, continuity of basic facility resources (electricity, water, natural gas, heating, cooling, medical gas, elevator, etc.) in all systems must be ensured, and arrangements must be made for safe use in accordance with relevant country legislation.

These arrangements must be made within plans defined by facility management committee. In this context;

- Maintenance and controls of electrical systems, ODHS transformers, generators, uninterruptible power supplies must be done at regular intervals and recorded.
- Arrangements must be made for electrical outlets and lighting to ensure patient and employee safety.
- It must be provided with safety measures (such as lightning rods, etc.) against dangerous elements that may come from external environment of the building.
- Natural or artificial lighting must be arranged in accordance with purpose of activity and relevant service area.
- Arrangements for safe use of water tanks (physical characteristics of the tank, safety, cleaning, analysis, measurements, maintenance, etc.) must be made.

- Arrangements must be made for safe use of sanitary system (alternative water source and control of this source, waste water control, rain water control and drainage, fire water control, etc.).
- Arrangements, maintenance and controls for medical gas systems (central gas system and floor control panels) must be done.
- Pressure (bar) values of medical gases (oxygen, nitrogen, vacuum and air) must be checked daily and recorded.
- Gases should be stored according to their type and areas where medical gas systems are located must be well ventilated with open air.
- Arrangements for compressed gas cylinders (fixing, fullness and tightness tests, proper storage, etc.) must be made.
- For safe use of elevators, periodic controls and intermediate maintenance must be done by authorized institutions and organizations, and their maintenance and controls must be recorded.
- Arrangements must be made for control and maintenance of ventilation and air conditioning systems. Maintenance and performance tests of ventilation systems using HEPA filters must be done at regular intervals.
- Maintenance of pressure vessels (autoclave, steam boiler, compressor, steam turbines, heating boiler etc.) must be done at regular intervals and annual inspections must be carried out.
- Visuality and safety of exterior of building must be ensured.
- Back-up systems must be established in case of critical failures that may occur. Risky areas to be covered by these systems must be determined by facility management committee.
- Personnel using equipment in basic facility resources must be given training on risks that may arise from use of these equipment's and ways to protect themselves.

Access to Facility Services

» ODHS Necessary arrangements should be made to provide easy access to the departments within ODHS. These regulations should cover at least the following topics:

- Guiding sings and services
- Waiting areas used by patients, carers and visitors
- Comfort and safety of patient rooms
- Air-conditioning of common areas (polyclinic, clinic, waiting areas, etc.)
- The regulations in ODHS for the disabled, elderly and people who need help due to their illness (exit ramps, stairs, elevators, toilets, bathrooms, parking areas, etc.)
- ODHS environmental arrangements (car lots, landscape, etc)

Waste Management

Code	Standard	Code	Assessment Criteria
DH.AY.01.00	Safe and effective management of waste produced at ODHS must be ensured to protect human and environmental health.	DH.AY.01.01	A Waste Management Plan must be prepared.
		DH.AY.01.02	Waste must be sorted at the source.
		DH.AY.01.03	Necessary steps must be taken to ensure that waste is transported, temporarily stored and disposed in appropriate conditions.
		DH.AY.01.04	Personnel involved in waste management must be trained.

Goal

To prevent waste from harming human health and the environment starting from the composition of the waste at ODHS until its delivery to the competent authority for the disposal.

Objectives

- Patient Safety
- Healthy Work Life
- Patient-oriented

Standard Requirements

Preparation of Waste Management Plan

» A Waste Management Plan must be prepared at ODHS. The Waste Management Plan must include at least the following:
  - Source, amount and types of waste
  - Measures related to the minimization of waste at the source
  - Equipment and tools to be used in waste management
  - Collection frequency and rules
  - Temporary storage systems
  - Cleaning and disinfection of relevant equipment
  - Measures to be taken in the case of an accident
  - Training of the personnel assigned to collect and transport waste
  - Determining the institution to which the waste will be delivered
  - Delivery of waste
  - Monitoring of waste processes
» Waste management supervisor must be identified.

Waste Sorting at Source

» Waste must be defined at least in the following categories/types per unit basis:
  - Domestic Waste
  - General domestic waste
  - Packaging waste
  - Medical Waste (infectious, pathogenic, sharp objects)
  - Infectious waste
  - Pathological waste
  - Sharps waste
  - Hazardous Waste
  - Radioactive Waste
» Waste generated at the units must be sorted in accordance with their type.
» Waste must be put in separate bags/boxes having the required properties in accordance with their types.

» The amount of medical and hazardous waste must be measured and monitored on the basis of ODHS and unit. Processes related to waste should be examined in terms of requirements for reducing waste quantities.
» Arrangements must be made for recyclable waste.

Waste Transportation, Temporary Storage and Disposal Operations

» Waste must be collected by personnel trained to perform such tasks.
» The clothes worn by the personnel assigned with the collection and transportation of waste must possess the necessary properties.
» For waste collection and transportation, it must be carried out as far as possible from the areas where human traffic is intense, in line with the sketch to be determined for the waste transportation of the institution.
» Container and temporary waste storage must comply with the minimum conditions specified in accordance with the relevant country legislation.
» Waste should be collected in a temporary storage area.
» Containers or temporary waste storages of appropriate size and quality should be available according to the size and waste capacity of the ODHS.
» Waste must be collected at the temporary storage area.
» There must be containers or temporary waste storerooms in sizes suitable to the size of ODHS and having the suitable properties.
» Waste must be stored temporarily in such a way as not to exceed the maximum waiting period determined within the scope of relevant country legislation
» The stored waste must be submitted to the competent authority for the ultimate disposal.
» Waste storerooms must be cleaned and disinfected.

Waste Management Trainings

Personnel working on waste management must be trained. Trainings must include at least the following:

- Types of waste and sorting of waste in accordance with their types
- Collection, transportation and temporary storage of waste
- Health risks, injuries and diseases which might be caused by waste
- Measures to be taken in the case of an accident or injury

Information Management

Code	Standard	Code	Assessment Criteria
DH.BY.01.00	A safe and effective information management system must be present at ODHS.	DH.BY.01.01	Those in charge of carrying out and coordinating activities related to information management must be identified.
		DH.BY.01.02	The necessary technical and supporting infrastructure must be established for the efficiency of information management.
		DH.BY.01.03	Measures must be taken for the security of medical records that are physically stored.
		DH.BY.01.04	Necessary measures must be taken to ensure information security and confidentiality.
		DH.BY.01.05	It must be ensured that the information is timely and continual.
		DH.BY.01.06	Personnel must be trained for effective use of information management.

Goal

To ensure that medical and personal information obtained in the ODHS processes are recorded and stored properly and safely, and to ensure the communication of the needed information to the right person at the right time.

Objectives

- Efficiency
- Patient Safety
- Timeliness
- Continuity
- Healthy work life

Standard Requirements

Management and Documentation

» Information management supervisors must be identified, and their roles and responsibilities must be defined. The supervisors must identify the current situation in information management, detect the possible risks in the processes and initiate the necessary corrective and preventive activities.

» Information to be used in the information management process and the methods and rules pertaining to those must be determined with the needs and critical processes of ODHS in mind. Documents to be prepared must comprise at least the following topics:

- Physical and technological measures
- Information security
- Information confidentiality

- Information continuity
- Access to external information sources
- Authorization
- Remote access

Technical Support Infrastructure

Risks related to hardware and software problems must be detected, against which measures must be taken for the uninterrupted operation of information management systems.

Information Security and Confidentiality

» The confidentiality and security of personal or medical, written or electronic information obtained about personnel or patients is essential. Access to these records must be limited by way of authorization, and access by external sources must be under control.

» What information can be accessed by the users and when and how they can access it within the scope of the authorization must be defined; measures must be taken against unauthorized access.

» Computers connected to information management at ODHS must be monitored to track unauthorized access.

» Data must be backed up on a regular basis in order to prevent data loss in cases of failure or unauthorized access; regular maintenance and tests must be performed on the servers to prevent failures, and the operation systems or software used in the server must be up-to-date.

» A system must be set to track the changes or deletion in the data when there is unauthorized or erroneous interference with the data from internal or external sources.

» Physically stored medical records must be stored in such conditions as to prevent any harm to the records, within the rules of relevant country legislation. The necessary physical and functional measures must be taken, and security of written information must be ensured for these types of records. Rules for destruction of medical records must be established.

Timeliness and Continuity of Information

» Cases where information management systems have been disabled to make sure healthcare services are delivered on time and to ensure continuity, or where there are slowdowns or failures in the systems must be tracked, improvement must be made and it must be ensured that the information is timely.

» Retrospective follow-up of all the information collected must be performed in information management systems; thus, the continuity of information must be ensured.

Material and Device Management

Code	Standard	Code	Assessment Criteria
DH.MC.01.00	Efficient, effective and safe use of materials and devices must be ensured.	DH.MC.01.01	Those in charge of management of materials and devices must be determined.
		DH.MC.01.02	Materials and devices must be determined and supplied in accordance with the needs of the institution.
		DH.MC.01.03	Materials must be conserved in proper conditions.
		DH.MC.01.04	Necessary physical conditions must be met to ensure that the devices work in proper working conditions.
		DH.MC.01.05	Personnel must be trained in material and device management.
		DH.MC.01.06	Traceability of medical devices must be provided.
		DH.MC.01.07	Necessary maintenance, calibration, adjustments and tests of the devices needed must be conducted.
		DH.MC.01.08	Rules must be set to ensure safe and effective use of materials and devices, the necessary protective material and information concerning the devices must be available.

Goal

To ensure that materials and devices to be used are supplied in a timely manner and are used safely, with a view to guarding the needs of the patients and the personnel

Objectives

- Efficiency
- Productivity
- Suitability
- Timeliness
- Healthy Work Life

Standard Requirements

Management and Documentation

- In order to provide an effective management of materials and devices, all those in charge of planning, coordination and carrying out of all the processes must be determined; the tasks assigned to these people and their responsibilities must be identified.
- Methods and rules regarding the procurement, storage, tracking and use of materials and devices must be clearly identified. Arrangements must be made to use of material and devices. Inventory of all equipment should be maintained and regularly checked for maintenance and update changes. Documents regarding material and device management must be generated taking into consideration the needs of the ODHS and the critical processes.

Documents to be generated must comprise at least the following:

- The roles and responsibilities of employees involved in material and device management

- Tasks and responsibilities of staff working on material and device management
- Detection of material and device needs
- Procurement of materials and devices
- Storage of materials
- Material request, preparation, transfer
- Receipt of materials and devices and inspection acceptance processes
- Delivery and preservation of documents (warranty certificate, user manual, etc.) given by manufacturers for safe use of materials and devices
- Following warranty processes of materials and devices
- Creating a plan for changing and updating materials and devices when necessary
- Monitoring service life of materials and devices
- Indicators for material and device management
- Safe use of materials and devices
- Processes for notification of undesired and unexpected events related to materials and devices must be defined.
- Cleaning and disinfection processes specific to materials and devices
- Indicators for management of materials and devices
- Methods of intervention for dangerous situations which might occur during use of materials and devices
- Materials and devices possessing special properties, requiring special storage conditions or require specific technique or expertise to use
- Maintenance, adjustment and calibration of devices
- Failure and repair processes of materials and devices
- Management processes related to decommissioning of materials and devices

Procurement of Materials and Devices

» Necessary measures must be taken for the timely procurement of the right materials and devices in order to ensure efficient delivery of healthcare services at ODHS.

» Rules and methods regarding the procurement requests for materials and devices must be determined. Within the framework of this action, ODHS must determine who can request materials and devices, the method for the request, and by whom and how the requests would be assessed.

» Materials routinely used or compulsory to keep must be detected, their critical stock levels must be determined and tracked.

» Procurement requests, consumption analyses and the needs of the community must be taken into consideration while carrying out assessments to determine the types and quantity of materials and devices to be procured.

Storage and Transfer of Materials

» Unauthorized access to identified material storerooms and all the unit storages where medical consumption materials are preserved for over 24 hours must be restricted in line with patient safety and security.

» Materials must be preserved in suitable perseveration conditions in the storage areas in accordance with their properties. The floor and ceiling height of material storage areas must be appropriate, security measures must be taken (earthquake, flood, electricity leakage, etc.), heat and humidity must be monitored. According to type and characteristics of material; when necessary, instant, measurable and traceable heat and humidity monitoring systems must be used. For this purpose, the necessary measures must be taken, and these measures must be monitored.

» Storage layout plans must be developed to ensure easy access to materials by personnel and to prevent time loss in emergencies; plans must be kept up-to-date.

» Expiry tracking of the stored materials must be possible electronically.

» For medical devices and materials, product errors and undesirable effects must be monitored; Identified problems, if any, must be forwarded to relevant national notification system.

» Rules regarding withdrawal, storage and return conditions of non-conforming materials must be defined.

» Measures must be taken against breaking and spilling during transfer, and the necessary equipment for safe transfer must be provided. The transfer personnel must be trained in the safe transfer of materials, and regarding special-property or hazardous materials.

Traceability of Medical Devices

Medical devices must have inventory by department. Medical devices must have a device identification card/ label. At least the following information must be on the device ID card/ label:

» Device name

» Brand/Model

» Identification number (biomedical or asset number) that identifies device

» Location

Maintenance, adjustment and calibration processes of medical devices must be followed within a plan. Maintenance, adjustment and calibration of medical devices must be monitored according to a plan.

Safety of Devices

» Protective equipment for devices, information on safe usage information and guides must be available at usage areas; relevant personnel must be trained in safe use of the devices.

» Physical arrangements in areas where devices are present must be realized in accordance with working conditions of devices.

» Calibrations, adjustments, tests and/or maintenance must be realized as frequently as stated in the technical documents of the manufacturers, in such a way as to meet the needs of the ODHS and in line with the usage intensity and within a plan, for the purposes of safe operation, obtaining correct results, keeping the harm which might occur at a minimum.

» It must be ensured that devices requiring special technique/ equipment/ expertise (autoclave etc.) are used by trained and authorized persons.

» Intervention methods must be determined for dangerous situations that may occur during use of device.

Management of Hazardous Substances

There must be documentation for management of dangerous goods. Document must contain at least the following information:

» Safe transport, storage and use of dangerous goods

» What to do in case of exposure to spilled hazardous materials

» Substances contained in safety data sheet

An inventory of hazardous substances used must be created. İnventory should contain at least the following information:

Dangerous substance;

» Name, brand, active ingredient, type (powder, crystal, etc.)

» Usage and expiration date

» Storage conditions

» Substances with which it interacts

» Fire response methods

» Contact intervention methods

» Where it is used and stored

» Mode of transport

» Disposal methods

» Symbols showing the dangerous substance class

» Inventory must be in the warehouse and in the usage area.

» There must be labels showing hazardous substance class on dangerous goods, name of substance and symbol showing dangerous substance class must be on label. Users must be trained on symbols showing hazardous substance class.

» Radioactivity value and measurement date of radioactive materials must be recorded and traceable.

Outsourcing

Code	Standard	Code	Assessment Criteria
DH.DK.01.00	The services provided through outsourcing must be in line with the core policies and values of ODHS and Standards of Accreditation in Health.	DH.DK.01.01	The services to be outsourced must be determined in line with the core policies and values of ODHS.
		DH.DK.01.02	Scope and process of the outsourced services must be defined.
		DH.DK.01.03	It must be ensured that outsourced services will comply with Health Accreditation Standards.

Goal

To ensure that the services provided through outsourcing are in line with the core policies and values of ODHS and that they are provided in line with the targets determined in the Standards of Accreditation in Health.

Objectives

» Patient-oriented
» Continuity
» Productivity
» Safety
» Effectiveness
» Efficiency

Standard Requirements

Determining the Services to be Provided through Outsourcing

» Based on core policies and values, the reasons for the need to outsource and the targets aimed at the service to be provided must be determined.

» ODHS must conduct a needs analysis and make assessments on the services to be provided through outsourcing, and must determine its strategy.

Defining the Scope and Process of Outsourcing

» The services which the external service provider will provide for ODHS must be clearly defined and the completion process must be determined.

» Business processes must be clearly and precisely defined.

» The number and qualifications of the personnel, the equipment and devices required for the external service provider to carry out its activities must be determined.

Compliance with the Standards of Services Provided through Outsourcing

» In accordance with the defined scope and business processes, methods for constant check of the services provided through outsourcing and checking criteria along with performance indicators must be identified.

Emergency Management

Emergency Management

Standard 1

Code	Standard	Code	Assessment Criteria
AD.AD.01.00	Measures must be taken for the natural disasters or events which require emergency response, striving, first aid or evacuation	AD.AD.01.01	Necessary measures must be determined by risk analysis for the events that require extraordinary response, striving, first aid or evacuation.
		AD.AD.01.02	Planning must be done for preventive measures determined and possible emergencies.
		AD.AD.01.03	Trainings must be provided on emergency management and drills must be conducted.

Goal

To define the requirements to prevent people or physical elements from being harmed or to minimize that harm in emergencies such as natural disasters like earthquakes and floods, or in emergencies which would require medical intervention such as fires or explosions at ODHS.

Objectives

» Healthy Work Life

» Patient Safety

Standard Requirements

Risk Analyses

ODHS must determine the specific situations for the preventive measures needed to be taken for incidents requiring extraordinary response and intervention, analyze which emergency situations may bring about what kind of dangers at the institution and must put forth what the necessary preventive measures must be.

Planning

» ODHS for the implementation of the preventive measures determined for the emergencies. The planning for the preventive measures must include at least the following:

- Deciding which preventive tasks must be performed
- Planning the necessary preventive investments and activities
- Budgeting investments and activities

Constant reviewing through drills and observations done to see whether the measures and implementations developed serve their purpose

» What to do in case an incident requiring extraordinary response takes place, despite necessary preventive measures taken against possible emergencies which might take place at ODHS, must be pre-planned as well.

- An emergency management team must be formed at ODHS and its responsibilities must be defined.
- Investments which would make the management of emergencies easier (emergency alert system, communication system, etc.) must be identified and planned.

Trainings and Drills

The most important point about emergency management is the fact that one must be prepared to bring into action the measures planned.

» The necessary trainings must given to all staff for emergency situations at the end of identifying risk analysis.

» Exercises should be carried out at the determined frequency to create awareness in personnel, to cover all relevant processes and to minimize the risks at the time of the incident.

» Exercises performed must be recorded.

Standard 2

Code	Standard	Code	Assessment Criteria
AD.AD.02.00	Timely interventions must be performed in the case of respiratory or cardiac arrest.	AD.AD.02.01	An emergency alert system must be formed for timely intervention in cases of respiratory arrest and/or cardiac arrest.
		AD.AD.02.02	Those in charge of management of the emergency alert system must be determined.
		AD.AD.02.03	Intervention team/teams must be determined.
		AD.AD.02.04	Medicines and equipment to be used in the procedures must be specified.
		AD.AD.02.05	Records must be kept about interventions performed.
		AD.AD.02.06	Emergency alert system trainings must be provided and drills must be conducted.

Goal

To define the requirements for the fastest and most effective intervention to take place in cases of respiratory or cardiac arrest at ODHS.

Hedefler

» Healthy Work Life
» Patient Safety
» Timeliness

Standard Requirements

Emergency Alert System

» Emergency alert system must be put in place in order to respond in shortest time possible to the patients, carers and all the ODHS personnel who need emergency medical intervention.

» The emergency alert system must be structured in such a way as to cover the whole of ODHS and to enable reaching the scene of incident in the shortest time possible at any time of day (3 minutes at the latest), taking into consideration the size of the institution and whether the institution comprises multiple buildings. The call system to be set up for the emergency alert system must be designed in such a way as to inform the personnel in a timely manner, ensure efficient and fast communication through short and clear messages, and prevent panic.

Supervisors

» Code system supervisors must be identified so as to ensure effective operation in line with ODHS structure and type.

» The responsibilities of the Code system supervisors must include at least the following: trainings for the personnel, identifying intervention teams, organizing drills, tracking records, initiating corrective-preventive activities when necessary.

Intervention Teams

» There must be at least one physician and one other health professional trained in CPR (Cardio-Pulmonary Resuscitation) present in the Code system intervention team. İntervention team is responsible for going to scene of incident for which a emergency alert code call has been alerted and for performing the intervention.

» There must be arrangement in place for 24-hour active functioning of Code alert system.

Medicines and Equipment

» The medicines and equipment that would be needed must be determined beforehand and an emergency response kit must be

Standards of Accreditation in Health - ODHS Kit prepared. The emergency response kit must have at least the following: laryngoscope set and additional batteries (for children and adults), balloon-valve-mask system, masks in different sizes, oxygen pipe and masks, intubation tube (in child and adults sizes), auxiliary airway tools (laryngeal mask, airway or kombi tube, etc.), injectors, personal protection equipment. Used in emergency response; defibrillator, aspirator, oxygen tube etc. It must be defined in which areas equipment will be located and how it will be brought.

» The medicines to be kept in the emergency response kit must be determined in accordance with the needs of the department and the patient portfolio. The emergency response kit must be in useable condition.

Record-keeping

» Records must be kept about the intervention performed following emergency alert code call. The following information must be present at least in the records kept:

- When the call was made
- Information about the person who needed intervention
- Which interventions were performed
- Where the interventions were performed
- When and in how much time the team arrived at the scene of intervention
- Result of the intervention
- Who was present in the intervention team

» Analyses must be performed on the records kept and the results acquired from this practice must be periodically monitored.

Trainings and Drills

» Trainings to be provided for all the staff from managers to department staff, from cleaning personnel to security officers,

regarding the importance of emergency alert code and how it would be implemented must be planned.

» Drills regarding emergency alert code must be conducted at least once a year. Records must be kept about drill, results of which must be assessed, and necessary corrective measures must be taken.

Standard 3

Code	Standard	Code	Assessment Criteria
AD.AD.03.00	Timely intervention must be ensured in cases where the health professional is exposed to a risk of violence, or an act of violence is directed towards him/her.	AD.AD.03.01	An emergency alert system defined with Code must be in place for intervention in cases where there is a risk or and actual act of violence towards health professionals.
		AD.AD.03.02	Those in charge of the management of the emergency alert system must be determined.
		AD.AD.03.03	Intervention team/teams must be determined.
		AD.AD.03.04	Emergency alert system trainings must be provided and drills must be conducted.

Goal

To ensure intervention in the shortest time possible in the case of a risk/attempt of violence, or when an actual act of violence is directed towards health professionals working at ODHS.

Objectives

» Patient Safety

» Healthy Working Life

Standard Requirements

Emergency Alert System

» An emergency alert system must be established for cases of risk/act of violence towards health professionals.

» The emergency alert system must be structured in such a way as to cover the whole of ODHS and to enable intervention at any time of day, taking into consideration the size of the institution and whether the institution comprises multiple buildings. The call system to be set up for the emergency alert system must be designed in such a way as to inform the personnel in a timely manner, ensure efficient and fast communication through short and clear messages, and prevent panic.

Supervisors

» Code system supervisors must be identified by ODHS so as to ensure effective operation in line with ODHS structure and type.

» The responsibilities of the Code system supervisors must at least include the following: trainings for the personnel, organizing the drills, tracking records, initiating corrective-preventive activities when necessary.

Intervention Teams

» How the relevant staff, led by security officers, will intervene, and unit and institution- based measures will be implemented when there is a Code White alert must be determined. Security officers at ODHS are responsible to intervene in the incident taking place in their area of responsibility as determined in Code White system.

» There must be arrangement in place for the 24-hour active functioning of the Code White alert system.

Record-keeping

» Records must be kept about the intervention performed after the Emergency Code Alert. The following information must be present at least in the records kept:

- When the call was made
- Information about the person who needed intervention and the person who committed the act of violence
- Reason for the act of violence
- How and where the intervention was performed
- When and in how much time the team arrived at the scene of intervention
- Result of the intervention
- Who were present in the intervention team
- Information about notification of legal authorities about the incident

» Analyses must be performed on the records kept and the results acquired from this practice must be periodically monitored. Violence against employees must be reported to undesirable event reporting system, and improvement must be made when necessary.

Trainings and Drills

» Trainings to be provided for all staff from managers to department staff, from cleaning personnel to security officers, regarding importance of Code system and how it would be implemented must be planned.

» Drills regarding Code system must be conducted at least once a year. Records must be kept about drills, results of which must be assessed, and necessary corrective measures must be taken.

Standard 4

Code	Standard	Code	Assessment Criteria
AD.AD.04.00	There must be an arrangement in place to ensure timely response to fire.	AD.AD.04.01	There must be a fire detection system.
		AD.AD.04.02	Emergency alert system defined with Emergency alert system must be established to respond in time in the case of fire.
		AD.AD.04.03	Those in charge of management of the emergency alert system must be determined.
		AD.AD.04.04	The equipment to be used while responding to fire, rules regarding safe use of this equipment, signs and instructions to be taken into account in the case of fire must be identified.
		AD.AD.04.05	Trainings must be provided on Emergency alert system and drills must be conducted.

Goal

To minimize and/or prevent any danger or harm by responding quickly to fire, in the case of danger of fire at ODHS.

Objectives

» Patient Safety

» Healty Work Life

Standard Requirements

Fire Detection System

» There must be a fire detection system at ODHS covering all the areas, not being affected by power blackouts and which can perform addressing. The system must be connected to the uninterruptible power supply so as not to be affected by the power interruption. System checks must be made regularly and recorded.

Emergency Alert System

» An emergency warning system must be set at ODHS to respond to fire in a timely manner. Emergency warning system to be set must be audiovisual, taking into consideration size of institution and whether institution comprises multiple buildings. While setting emergency warning system, coordination must be ensured with such bodies as fire department etc.

» Emergency warning system to be defined with Code System must be set in such a way as to inform the institution's staff, ensure efficient and fast communication in the case of risk, enable the communication of short and clear messages, save time for correct intervention, and prevent panic.

Supervisors

» Code system supervisors must be identified by ODHS so as to ensure effective operation in line with ODHS structure and type.

» The responsibilities of the Code system supervisors must include at least the following: trainings for the personnel, organizing the drills, tracking records, initiating corrective-preventive activities when necessary. Supervisors must also follow the legislation on fire prevention and extinguishment, and monitor the implementation of the necessary arrangements.

Response to Fire

» How relevant staff will respond, how unit- and institution- based measures will be implemented, and who will be present in fire response team or who would notify the fire department in case of

incidents where response is not possible when a code alert is given, must be determined.

» Tools and equipment such as fire hydrants, fire extinguishers and fire hoses must be identified, and rules regarding their use must be defined. Also, usability and operability of equipment must be periodically checked.

Trainings and Drills

» Trainings to be provided for all the staff from managers to department staff, from cleaning personnel to security officers, regarding the importance of Code system and how it would be implemented must be planned.

» Drills regarding Code system must be conducted at least once a year. Records must be kept about the drill, results of which must be assessed, and necessary corrective measures must be taken.

Definitions And Abbreviations

Instant sterilization (Flash sterilization):

It is the process of washing, drying and sterilizing medical devices in the use area in an emergency in a short time using a special program in steam autoclaves without packaging.

Biological Validation:

It is validation based on biological inactivation. When it is proven that the spores in the biological indicator are dead, the product is delivered. For sterilization methods that cannot be parametrically validated (low temperature sterilization methods), biological validation is mandatory. Biological validation, like parametric validation, should be repeated at least once a year. It is made by placing biological indicator(s) on each shelf of the sterilizer where sterilization conditions are the worst. The biological indicator should be placed in the compelling package and this package should be packaged as in the reference package. The sterilizer is operated half-cycle and the remaining spores, if any, are counted microbiologically and the logarithmic decrease in the number of spores is determined. This procedure should be repeated for three consecutive tests, both in the empty sterilizer and at full load with one load variant. Biological validation is complete if it is verified that no live spores remain in all cycles. Since the product will be delivered according to the results of the biological control, a biological indicator must be used in each load and if there is no growth, the material must be delivered.

Acceptance or Rejection Criteria: In prosthesis laboratory, rules of conduct regarding arrived measure convenience to determined criteria by laboratory management in accordance with scientific requirements. **Hospitality Service:** In the health facility, except of the scope of medical services, they are services offering the hospitality, cleaning, washing, eating and drinking the patient, the patient's relatives and staff and ensuring to give these services in a safety environment which provides life and property safety.

Adverse Event: Events that may or does affect the safety of patient, relatives, employees or the other people negatively in health facilities.

Adverse events related to patient safety may occur in the terms of drug safety, surgical safety, transfusion safety, facility safety, falls, radiation safety and information security.

Adverse events related to employee safety may occur in the terms of stab wounds, facility safety, radiation safety, occupational infections, contact with blood and body fluids.

Antisepsis: Killing of microorganisms in or on living tissue or inhibition of reproduction of these microorganisms is called antisepsis.

Asepsis: The measures taken to avoid the migration of germ to clean surface, medium or material is called asepsis.

Basic Policy: Determining the health facility's mission and vision with corporate goals and objectives.

Calibration: It is a series of operations in which, under certain conditions, a relationship is established between magnitude values and measurement uncertainties provided by measurement standards in first stage and corresponding indicator values and the related measurement uncertainties, and in second stage, this information is used to derive measurement result from indicator.

Chemical Waste: Gas, solid or liquid waste of chemicals used in medical fields such as treatment or diagnosis and which may be harmful to the health of humans and the environment with various effects.

Code of Document: Providing traceability of the document, the document management system directory refers to the identification system established in accordance with the rules set by institutions and organizations.

Consent Document: Applied for medical Treatment, process will be transferred to the patient by health care providers with information and documents are created to get the consent of the patient.

Container: Temporary storage unit with 0,8 m3 volume at least, wheel, cap, caps lock, made of stainless metal, plastic or material and so on.

Contamination: Being infected with foreign matter. Transition of bacteria and virus from contaminated surface to another.

Contraindication: Situation that prevents a treatment administration or discovery of patient status/complication that prevents treatment or intervention.

Container: Temporary storage unit with 0,8 m3 volume at least, wheel, cap, caps lock, made of stainless metal, plastic or material and so on.

Contamination: Being infected with foreign matter. Transition of bacteria and virus from contaminated surface to another.

Contraindication: Situation that prevents a treatment administration or discovery of patient status/complication that prevents treatment or intervention

Corporate Communications: In the process of production and management; institution that make up the information flow between departments and elements, motivation, integration, education, decision making and control functions such as implemented in the framework of certain rules in order to ensure, and the process carried out taking into consideration the reputation of the institution while interacting with the external communication.

Date of Publish: the documents was referred to date of publish.

Decontamination: As well as, as a word includes all applications for removal of micro-organisms or organic soils (cleaning, disinfection, sterilization), it is used in the meaning of removal of organic substances and pathogens from a surface or material by pre-cleaning process

comprising physical and / or chemical methods and making the surface or material useable without using any personal protective before sterilization or disinfection in practice.

Disinfection: The process of destruction or stopping reproduction of the majority or all of the pathogenic microorganisms (except bacterial spores) on inanimate surfaces. Disinfection process is considered in 3 three groups high, medium and low disinfection according to the affect levels of bacterial spores and mycobacteria.

Document: Environments containing the information.

External Document: Document not prepared by the institution itself, but benefited from the realization of the activities.

Facility Management: For health facility in order to achieve its purpose, it is coordination of all activities related to planning, application and management of necessary working environment physical and functional arrangements which provides the best way to meet the growing health care needs.

Form: Document prepared for filling write the desired data or information.

Functional Structure: Functional structure is classification of activities according to resemblance of used information, skill and resources. As a result of this classification, departments are formed. In this context, functional structure can be considered as classification according to institutional resources. Health institutions adopting this structure generally have the departments of diagnosis, treatment, management and support.

Goal: Refers to the general results that the organization wants to reach in the long term.

Guide: The document was created for informational purposes and guiding activities.

Hand Hygiene: It is a general term referring to any action of hand cleansing.

Handover: In order to ensure the patient safety and continuity of care, it is a transfer of patient's special information from a caregiver to another or from a system featured in an organized team to another with a modern interaction process transferred in a interactive way.

Hazardous Waste: Genotoxic, pharmaceutical and chemical wastes arising from units and wastes containing heavy metals and pressured containers.

Healthcare Associated Infection: These infections are the ones which develop after the patient is admitted to the health facility and which are not on incubation period on admission. Service associated infections after discharge and occupational infections are included in the matter.

High Risk Medicine: These are the medicines that are therapeutics and maximum dosages are close to each other. When used in a wrong way, these can affect the patient negatively irremeable or permanently.

High-Level Disinfection: Some of the chemicals may kill all spores by long term (3-12 hours) treatment. In similar concentrations but in a shorter treatment period (e.g. 20 minutes with glutaraldehyde) the same disinfectant kills all microorganisms except bacterial spores. This process is called high-level disinfection.

Household Waste: Non-contaminated wastes, which is mainly originated from kitchen, garden, and administrative units

IMS: Information Management System. Trained users and devices connected to the computer through a network of institutions, every effort is made to perform (clinic, prosthesis laboratory, radiology etc.), with electronic software to maintain the record.

Indication: It is a term, which refers that situations, in which should be done an application, a treatment or a process.

Indicator: When a topic becomes digitized and measured, this is a tool that contributes to making improvement activities.

Infectious Waste: All kinds of body fluids and human tissues, organs and other pathological material; blankets, sheets, bandages, adhesive tape, tampons, swab and other wastes; bacteria and virus retaining air filters which known as infectious agents carriers or likely to carry them.

Information Security: It means to protect the information from damages and to prevent obtaining the information by unwanted users in any environment using the appropriate technology in the right way for the right purpose.

Inpatient: They are patients whose diagnosis and treatment are conducted during ODHS stay. Daily ODHS stays are also included in this term

Institutional Structure (Design): Institutional structure includes authorities and responsibilities in institution and forming communication channels. Organizational structure of the health institution is formed after these studies. This structure is shown in the organization scheme. In the organization schemes, positions in the institution, units, departments and authority, responsibility and communication relations between them are shown.

Instruction: A single document containing the steps of the activity.

Intended Population: Employees of the company, people who get the service and all the people that interact with the organization and institutions (media, insurance agencies, suppliers, government agencies, non-governmental organizations, universities, local government units, community leaders, experts, etc.)

Isolation Precautions: Activities carried out and measures to prevent transmission of apathogen microorganism from person to person, from person to environment or vice versa.

List: Similar items listed consecutively document.

Low Level Disinfection: In this process, in a short time (less than 10 minutes) most of the vegetative bacteria, some fungi and some viruses dies.

Matrix Structure: Matrix structure is the use of both functional and sectional structure at the same time in the health institution. For example, services provided in operation room require coordination of people and units that have different functions and from different departments.

Measure Time: It means the date and exact hour of measurement by the dentist.

Measurement (for dentistry field): Creating a copy of mouth part where prosthesis will be placed. A negative of teeth and/or support tissue is captured with the use of soft, half-fluid measurement materials for this purpose.

Medical Gas: Gas that is produced and packed to be used in anesthetic processes or diagnosis and treatment interventions.

Medical Intervention: In the purposes of disease diagnosis/treatment and protecting health, physical and psychological interventions within medicine limits in accordance with occupational responsibilities and standards by people who have authority to practice medicine.

Medical Waste: Infectious, pathologic and penetrating wastes which results from units.

Mission: It is the pure and general object, which determines the reason of health facility's being, its philosophy with provided products and services

that lays down their unique differences and separate them from other health institutions

Morbidity: incidence of disease

Narcotic Medicine: These are medicines that are like morphine and has painkiller specifications, natural, semi artificial and artificial and these may cause strong physical and psychological addiction.

Objective: States short term processes for reaching the goals. Objectives are more open and has measurable features comparing to goals.

ODHS: Consists of following institutions of Türkiye who provide service actively in oral and dental health field:

- Oral and Dental Health Centers,
- Oral and Dental Health Hospitals,
- Faculties of Dentistry

Organization Scheme: It is a graphic that shows institutional structure as a whole and it also shows various relations between service units in a comprehensive order.

Outpatient: They are the patients without ODHS stay procedures but with necessary diagnostic and therapeutic procedures.

Outsourcing: It means that health service provider receives some services from an institution or organization other than some health institution **through a contract, protocol or public-private cooperation method.**

Parametric validation: It is the process validation of sterilization based on measurement of physical parameters. Product delivery is made according to measurement results of critical parameters (parametric product delivery). Test charts obtained with reference load are compared with cycle chart in each cycle to determine whether there is a deviation and product is delivered by interpreting daily Bowie-Dick and weekly vacuum leak results. In this case, difficulty of using chemical and biological indicators in routine controls (except for Bowie-Dick and Exposure indicators9) disappears. In order to be able to deliver parametric products, proficiency tests should be carried out in steam sterilizer during installation (installation validation) and when operation starts (operation and performance validation) and repeated once a year.

Particle: Smallest part of matter or energy

Pathogen Microorganism: Microorganisms that cause infectious diseases

Pathological Waste: Tissues, organs and body parts as a result of surgical intervention

Patient Care: Patient care encompasses the whole health service processes starting from admission of the patient to ODHCODHS ODHS to monitoring of the patient after discharge. It also includes service processes of all other relevant occupational groups beside diagnosis/ treatment processes provided in policlinics for outpatients and in clinics for inpatients.

Perioperative Period: The period during surgical operation

Personal Hygiene Area: In accordance with the hygiene rules, these are the areas like toilets, baths or sinks, which provides body cleaning and meets hygiene needs.

Plan: the intended purpose ensure achievement of steps, what, when, why and document that shows how to do it.

Postoperative Period: The period after surgical operation

Primary Facility Resources: It expresses the need of minimum formation of the infrastructure of technologies which will be used in the provision of health care (water, electricity, air conditioning and medical gas systems, etc.).

Privacy: Represents the living area of the patient that has to be clarified for the patients care, treatment (test results, information about the disease and treatment) or for any other reason but hiding them from all other individuals in the society.

Procedure: Document describing how the execution of the activities of a process.

Promotion and Enhancement of Health: is the course in which people increase the control on their health and are able to enhance it. Promotion and enhancement of health represents a social and political progress. It does not only mean the activities that increases the skill and capacity of individuals but also changing social, environmental and economic conditions, thus it also means the activities aimed at easing their impacts on the health of society and individuals. Promotion and enhancement of health is the course of increasing the control on health determiners (such as biological, environmental, economical, social and life style elements) and thus it is the progress of enhancing their own health.

Prosthesis: In-mouth prostheses consists of all artificial devices which are used to recover worn, damaged teeth, replace unstructured/lost teeth, and get rid of aesthetic defects. These prostheses are artificial matters that correct lost aesthetic and functional needs primarily chewing.

Prosthesis Laboratory Services: All processes that ensures prosthetic material acceptance in convenient conditions, preparation before process, implementation of process and delivery of prosthesis to patient

Prosthetic Material: No matter what kind it is, defines the material used for any prosthesis in all steps such as measurement, material, mid- product and prosthesis

Prosthesis Safety: In processes between measurement and arrival of prosthesis to dentist or patient, evaluation and prevention of all kind of risks that can damage safety and validity of the process

Psychotrope Medicine: these are the medicines that affect central nervous system and cause some temporal changes in sense, mood, consciousness and behaviors by changing the functions of the brain. And also these may cause physical addiction when used for a long time.

Radioactive Waste: Waste including radioactive material such as fluids left from radiation therapy or laboratory research; contaminated glassware, packaging or paper

Rational Use of Antibiotics: Acting according to the following 5 TRUE bases for the treatment or prophylaxis of an infectious disease.

- Right person
- Right time
- Right way (swallowing, chewing, vascular, etc.)
- Correct amount
- Correct drug

Revision Date: The document was last updated refers to the date.

Revision Number: The document is updated refers to the number of times.

Risk analysis: It refers to identification of risks using methods allowing a comprehensive understanding of the risks, assessment of the severity of the damage in case of risks that may arise. In this context, risk analysis includes following processes; Identification of dangers which patients may be exposed to Determination of the frequency and level of exposure to hazards Assessment of which patient or patient groups are affected.

Risk: It refers to the probability of occurrence and the severity of an event that can damage human health as a result of exposure to a hazard.

Sectional Structure: In this structure type, outcomes are based on and departments (sections) are classified according to these outcomes. Departments in health institutions are formed with respect to certain medical specialties (such as anesthesia, radiology etc.). In this structure, there are functional directors working under department directors. Functional directors are responsible not only to department director but also to higher functional directors of the health facility.

Sharp Waste: Wastes such as injection, injection syringe and all other subcutaneous venture injections, cylinders, cartridges and cans enclosing all the gases used in procedure, lancets, scalpel, knife, serum kit needles, surgical suture needles, biopsy needles, intracath, broken glass, bulbs, solid-lamellae, broken glass tubes and petri dishes and these waste may cause stinging, punching, scrape and injuries.

Side Effect: All pharmacological effects, that are unintended, without taking the harm of the medicine into consideration.

Staff/Employee/Personnel: "Staff, employee and personnel" terms in this standard set means all permanent, temporary, volunteer, daily or independent people involved in service provision.

Sterilization: Killing all microorganisms found on anybody or substance by physical or chemical methods including spores.

Supporting Document: Procedure, Direction, Guide, Form, Plan, List, Consent Document, and External Document or this document is supportive documents.

Surgical Prophylaxis: Medical interventions aimed at preventing surgical infections.

Temporary Storage: The process of keeping waste wait in units built in the unit or containers for a temporary period not to exceed 48 hours before the transportation.

Transportation: The process of transporting waste by convenient transportation vehicles from temporary storage units to disposal area.

Ultimate Disposal: Destruction or disarmament through incinerating or storing the waste in plants where all measures provided in applicable legislation are taken without any damage to the environment and human health.

Value: Defined rules and principle series which directs their members to certain acts for securing the survival of institution.

Verbal Request: verbal request is defined as the doctor's conveyance of the request to the nurse in a verbal way in the obligatory cases which the physician can not give a written request.

Vision: Expression of health facility's hope to reach the status under current conditions and its main philosophy for the future with sentences that features excellence and being ambitious.

Waste Management Plan: Determining the general principles for not harming the environment and human health when the process of composing waste till disposal of them.

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Relevant Legislations of Standards

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Organizational Structure	YO.OY.01.00	An organizational structure to cover all ODHS activities must be established.	•Presidential Decree No. 1, T.R. Official Gazette Issue: 30474, 10.7.2018 • Health Services Fundamental Law, T.R. Official Gazette, Issue:3359, 15.05.1987 • Civil Servants Law. T.R. Official Gazette Issue: 12056, 23.7.1965 • Decree on the Organization and Duties of the Ministry of Health and its Affiliates T.R. Official Gazette Issue: 28103, 2.11.2011 • Regulation on Private Health Institutions Providing Oral and Dental Health Services, T.R Official Gazette, Issue:: 29256, 03.02.2015
	YO.OY.02.00	ODHS must have all necessary authorization and permits for all its activities	
Core Policies and Ethical Values	YO.PD.01.00	Core policies and ethical values of ODHS must be defined	
	YO.PD.02.00	ODHS must organize programs related to health promotion according to public health structure and general health problems.	
Quality Management Structure	YO.KY.01.00	Planning, implementation, coordination and continuity of quality improvement activities must be ensured.	• Regulation on Improvement and Evaluation of Quality in Health, T.R. Official Gazette, Issue: 29399, 27.06.2015

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Document Management	YO.DY.01.00	Management of documents at ODHS must be ensured.	•Directive on Medical Record and Archive Services of Inpatient Treatment Institutions, T.R. Official Gazette: Issue:10588, 06.11.2001 • Regulation on State Archive Services, T.R. Official Gazette Issue:30922, 18.01.2019
Adverse Event	YO.OB.01.00	Reporting of adverse events that may or does affect the safety of patients and staff negatively must be ensured, and necessary measures must be taken.	• Act No.6331 on Occupational Health and Safety, T.R. Official Gazette, Issue: 28339, 30.6.2012 • Regulation on Improvement and Evaluation of Quality in Health, T.R. Official Gazette, Issue: 29399, 27.06.2015.
Risk Management	YO.RY.01.00	Risks related to ODHS and services provided must be managed	• Regulation on Medical Laboratories, T.R. Official Gazette Issue:28790, Date 09 .10.2013. • Occupational Health and Safety Risk Assessment Regulation, T.R. Official Gazette Number: 28512, 29.12.2012

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Risk Management	YO.RY.01.00	Reporting of adverse events that may or does affect the safety of patients and staff negatively must be ensured, and necessary measures must be taken.	•Regulation on the Prevention of Exposure Risks to Biological Factors, T.R. Official Gazette Number: 28678 ,15.06.2013 •Regulation on the Protection of Employees from Hazards of Explosive Environments, T.R. Official Gazette Number 28633, 30/04/ 2013 •Regulation on Health and Safety Measures in Working with Chemical Substances, T.R. Official Gazette, Number: 28733 12.08.2013 •Regulation on Protection of Employees from Noise-Related Risks, T.R. Official Gazette, Number: 28721, 28.07.2013 •Regulation on Emergencies at Workplaces, T.R. Official Gazette Issue: 28681, 18.06.2013
Training Management	YO.EY.01.00	In accordance with quality improvement activities, training needs of patients, carers and staff must be determined, and it must be ensured that necessary training is conducted effectively.	• Regulation on Improvement and Evaluation of Quality in Health, T.R. Official Gazette, Issue: 29399, 27.06.2015. • Regulation concerning the Procedures and Principles of Occupational Health and Safety Trainings of Employees, T.R. Official Gazette, Issue: 28648, 15.05.2013. • Ministry of Health In-service Training Regulation T.R. Official Gazette Issue:15296, 11.12.2009

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Institutional Communication	YO.Kİ.01.00	Institutional communication activities must be carried out effectively.	
Monitoring Of Indicators	PÖ.Gİ.01.00	Institutional indicators must be monitored and evaluated in order to continuously improve processes related to service delivery, led by administrative, financial and medical steps.	• Regulation on Improvement and Evaluation of Quality in Health, Official Gazette, Issue:29399, 27.06.2015.
Human Resources Management	SÇ.İK.01.00	A management structure that will fulfill the requirements concerning planning of human resources, improvement of work life and the personnel must be established.	
Human Resources Management	SÇ.İK.02.00	The requirements necessary to constantly improve recruitment and compliance processes of the personnel and their work life must be determined and fulfilled.	•The Law on the Mode of Execution of Medicine and Medical Arts, T. R. Official Gazette, Issue:6283, 25.02.1954 • Nursing Law, T. R. Official Gazette Issue:8647, 02.03.1954 • Law concerning the Making Amendment in the Nursing Law , T.R. Official Gazette Number 26510, 02.05.2007. • Nursing Regulation, T.R. Official Gazette, Issue: 27515, 08.03.2010,

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Human Resources Management	SÇ.İK.02.00	The requirements necessary to constantly improve recruitment and compliance processes of the personnel and their work life must be determined and fulfilled.	• Regulation Amending the Nursing Regulation, T. R. Official Gazette, Issue: 27910, 19.04.2011 • General Regulation on Training of Candidate Officers, T. R. Official Gazette, Issue: 18090, 27.6.1983 • Regulation on Promotion and Change of Title of Ministry of Health Personnel , T.R. Official Gazette, Issue: 28975, 17.04.2014 • Regulation on Appointment and Change of Location of Contracted Healthcare Personnel subject to the law no 4924 of Ministry of Health and Affiliated Corporations, T.R. Official Gazette, Issue: 29264, 11.02.2015 • Regulation on Ministry of Health Appointment and Change of Location, T.R. Official Gazette, Issue: 28599, 26.03.2013 • Regulation concerning the Appointment Procedures and Principles of Healthcare Personnel to be appointed by open lot to the State Institutions and Organizations, T.R. Official Gazette, Issue: 29412, 10.07.2015 • Regulation Amending the Regulation on Appointment and Relocation of the Ministry of Health and Affiliates, T.R. Official Gazette, Issue: 30348, •02.03.2018

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Employee Health and Safety	SÇ.ÇG.01.00	Factors threatening the health and safety of employees should be identified and necessary precautions should be taken to establish a healthy and safe working environment.	•Regulation concerning the Procedures and Principles of Occupational Health and Safety Trainings of Employees, T.R.Official Gazette, Issue:28648, 15.05.2013. • Regulation concerning the Duty, Authorization, Responsibility and Educations of Occupational Safety Specialist,T.R. Official Gazette, Issue:28512,29.12.2012. • Regulatiion on Occupational Health and Safety Services, T.R. Official Gazette, Issue:28545, 29.12.2012. • Occupational Health and Safety Law, Law No:6331, Date of Acceptence 20.06.2012. • Regulation on Occupational Health and Safety Committees, T.R. Official Gazette, Issue: 28532, 18.01.2013. • Notification concerning the Making Amendment on the Notification of Workplace Hazard Classess related to the Occupational Health and Safety,T.R. Official Gazette, Issue: 28602, 29.03.2013. • Regulation on the Use of Personal Protective Equipment at Workplaces, T.R. Official Gazette Number: 28695, 02.07.2013

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Basic Patient Rights	HD.HH.01.00	The services provided in ODHS must be organized in such a way as to protect patient and carer rights.	• Regulation on Patient Rights, T.R. Official Gazette, Issue: 23420, 01.08.1998
Patient Safety	HD.HG.01.00	The services provided at ODHS must be organized in such a way as to protect the safety of patients and their carers.	• Regulation on Patient Rights, T.R. Official Gazette, Issue: 23420, 01.08.1998
Patient Feedback	HD.GB.01.00	A system must be established to receive feedback (comments, suggestions and complaints etc.) from patients and their carers about the services that are provided.	• Regulation on Patient Rights, T.R. Official Gazette, Issue: 23420, 01.08.1998
Access to Service	HD.HE.01.00	Necessary precautions must be taken in order to provide patient able to reach services in time.	• Regulation on Patient Rights, T.R. Official Gazette, Issue: 23420, 01.08.1998 • Circular on Order of Priority in Polyclinic Services. (2017, 12 June). T.R. Ministry of Health, General Directorate of Health Services (Number:2683)

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Prevention and control of Infections Institutiona Communication	SH.EÖ.01.00	Necessary measures must be taken for the prevention and infections	• T.R. Ministry of Health, General Directorate of Treatment Services, "Regulation on Infection Control of Inpatient Treatment Institutions" , T.R. •Official Gazette Issue: 25903, 11.08.2005. • Regulation Amending the Infection Control Regulation of Inpatient Treatment Institutions, T.R. Official Gazette Issue: 27975,2011, 25.06.2011 • Communicable Diseases Surveillance and Control Principles Regulation T. R. Official Gazette, Issue: 26537, 30.05.2007
Sterilization Management	SH.SY.01.00	Processes concerning sterilization services must be identified and taken under control.	• Operating Regulation of Inpatient Treatment Institutions, T. R. Official Gazette Issue:17927, 13.1.1983
Drug management	SH.İY.01.00	Efficient and safe drug management must be ensured in the institution.	Efficient and safe drug management must be ensured in the institution. •Regulation on Pharmacists and Pharmacies, T. R. Official Gazette Issue:28970, 12.04.2014 • Regulation on Safety of Medicines, T. R. Official Gazette Issue:28973, 15.04.2014

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Patient Care	SH.HB.01.00	Patient care processes must be conducted in line with the needs of the patient and so as to ensure patient safety.	•Nursing Law, T. R. Official Gazette , Issue:8647, 02.03.1954 • Law concerning the Making Amendment in the Nursing Law , T.R. Official Gazette •Issue: 26510, 02.05.2007. • Nursing Regulation, T.R. Official Gazette, Issue: 27515, 08.03.2010 • Regulation Amending the Nursing Regulation, T. R. Official Gazette, Issue: 27910, 19.04.2011 • Regulation On The Provision Of Home Health Services By The Ministry Of Health And Its Affiliates, T. R. Official Gazette, Issue: 29280, 27.02.2015
	SH.HB.02.00	Patients who are at risk of harming themselves or others must be take under control	
	SH.HB.03.00	Standardization of care practices for specific patient groups must be ensured.	

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Radiation Safety	SH.RG.01.00	Measures must be taken to ensure radiation safety for patient/ carers and the personnel.	• Regulation on Radiation Safety, TR Official Gazette, Issue:23999, 05.07.2000 •Regulation Amending the Radiation Safety Regulation. (30.06.2010, T.R. Official Gazette (Issue: 27600) • Regulation on Radiation Dose Limits and Working Principles of Personnel Working with Ionizing Radiation Sources in Health Services, Official Gazette, Issue:28344, 05.07.2012 .

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Prosthesis Laboratory Services	SH.PL.01.00	Physical environment of the prosthesis laboratory must be arranged so as to ensure safety of the prosthesis and the personnel.	• Dental Prosthesis Laboratories Regulation, T.R. Official Gazette Issue:26016, Date 07 .12.2005 • Amendment to the Regulation on Dental Prosthesis Laboratories Regulation on the Making, T.R. Official Gazette Issue:28159, Date 31.12.2011 • Medical Laboratories Regulation, T.R. Official Gazette Issue:28790, Date 09.10.2013
	SH.PL.02.00	The processes that precede the fabrication of prosthesis must be checked	
	SH.PL.03.00	The processes regarding the fabrication of prosthesis must be checked.	
	SH.PL.04.00	The processes that follow the fabrication of prosthesis must be checked.	
	SH.PL.05.00	Traceability of the processes regarding prosthesis laboratory must be ensured.	
Surgical Safety	SH.GC.01.00	Patient safety must be ensured in surgical procedures.	
	SH.GC.02.00	Conditions of the operating room must be appropriate to ensure safe surgery.	

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Hospitality Services	DH.OH.01.00	Processes regarding catering for inpatient/ carer and the personnel must be identified.	• T.R. Ministry of Health, General Directorate of Treatment Services, "Regulation on Infection Control of Inpatient Treatment Institutions" , T.R. Official Gazette Issue: 25903, 11.08.2005. •Regulation on Inspection and Control of Food Safety and Quality, T. R. Official Gazette Issue: 27009, 26.09.2008 T.R. Ministry of Health, General Directorate of Treatment Services, "Regulation on Infection Control of Inpatient Treatment Institutions" , T.R. Official Gazette Issue: 25903, 11.08.2005.
	DH.OH.02.00	Laundry services must be provided in a safe and efficient manner to ensure patient and personnel health at ODHS.	• T.R. Ministry of Health, General Directorate of Treatment Services, "Regulation on Infection Control of Inpatient Treatment Institutions" , T.R. Official Gazette Issue: 25903, 11.08.2005. • Regulation on Patient Rights, T.R. Official Gazette, Issue: 23420, 01.08.1998 • Legal Aid and White Code Practice Circular, Issue: 6367, 16.03.2016. • Regulation on the Implementation of the Law on Private Security Services, T.R. Official Gazette Issue: 25606, 07.10.2004
	DH.OH.03.00	Patient/examination rooms and the areas used by patients/carers must be safe and ergonomic.	
	DH.OH.04.00	Safety/security services must be provided in ODHS to ensure safety of life and property of patient/carer and the personnel.	

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Facility Management	DH.TY.01.00	A quality facility management structure and process must be established to ensure the quality and safety of healthcare services.	• Regulation on Evaluation and Management of Environmental Noise, T.R. Official Gazette Issue:27601, 04.06.2010 • Communiqué on Facilities Performing the Production, Filling, Storage and Sale of Medical Gases T.R. Official Gazette Issue:29471, 10.09.2015 • Republic of Turkey Ministry of Health, Department of Construction and Maintenance, "Communique concerning the minimum technical standards to be complied in the current or new healthcare facilities", 30.10.2012. • Building Control Implementation Regulation T.R. Official Gazette Issue: 26778, 05.02.2008 • Electrical Energy Emergency Groups and Autoproducer Facilities Licensing Regulation, T.R. Official Gazette Issue: 19917 ,02.09.1988 • Pressure Equipment Regulation, T.R. Official Gazette Issue:30349, 03.03.2018 • Regulation on Elevator Operation, Maintenance and Periodic Control, T.R. Official Gazette Issue: 29396, 24.06.2015 • Elevator Periodic Control Regulation, T.R. Official Gazette Issue:30411, 04.05.2018 • Regulation on Health and Safety Measures to be Taken in Workplace Buildings and Additions, T.R. Official Gazette Issue: 28710, 17.07.20

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Waste Management	DH.AY.01.00	Safe and effective management of waste produced at ODHS must be ensured to protect human and environmental health.	• Regulation on Medical Waste Control, T.R. Official Gazette, Issue:25883, 22/07/2005. • Hazardous Waste Control Regulation, T.R. Official Gazette, Issue:25755, 14.03.2005 • Regulation Amending the Regulation on Control of Hazardous Wastes, T.R. Official Gazette Issue: 28812, 05.11.2013 • Regulation concerning the General Principles of Waste Management, T.R. Official Gazette, Issue:26927, 05/07/2008 • Regulation on Regularly Waste Storage, T.R. Official Gazette, Issue:27533, 26/03/2010 •Waste Management Regulation, T.R. Official Gazette Issue: 9314, 02/04/2015 • Radioactive Waste Management Regulation T.R. Official Gazette Issue: 28582,09.03. 2013 • Regulation on Amending the Regulation on the Landfill of Wastes T.R. Official Gazette, Issue: 30990, 26.12.2019

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Information Management	DH.MC.01.00	Efficient, effective and safe use of materials and devices must be ensured.	• Regulation on Medical Devices, T.R. Official Gazette, Issue:27957, 07/06/2011 • Regulation on Testing, Control and Calibration of Medical Devices T.R. Official Gazette Issue: 2939799, 25.06.2015 • Circular on TKHK Stock Management and Movable Goods Applications Number:01586109, 01.07.2013 • Regulation on Principles and Procedures of Market Surveillance and Inspection by the Ministry of Health Official Gazette Number: 26563,25.06.2007 • Movable Property Regulation Number: 26407, 18.01.2007 • Ministry of Environment, Dangerous Chemicals Regulation Official Gazette Number: 24379, 20/04/20 • Circular on the Purchase of Medicines and Medical Consumables. (2010, February 25). T.R. Ministry of Health, General Directorate of Treatment Services (Issue: 7816)

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Outsourcing	DH.DK.01.00	The services provided through outsourcing must be in line with the core policies and values of ODHS and Standards of Accreditation in Health	•Regulation on Making Amendment in the Service Procurement Tender Application Regulation, T.R. Official Gazette, Issue:29428, 28.07.2015
Emergency Management	AD.AD.01.00	Measures must be taken for the natural disasters or events which require emergency response, striving, first aid or evacuation.	• Regulation on Disaster and Emergency Response Services, T.R. Official Gazette,28855, 18.12.2013 • Regulation concerning the Fire Protection of Buildings, T.R. Official Gazette, Issue: 26735, 19.12.2007 • Hospital Disaster and Emergency Plans (HAP) Implementing Regulation Official Gazette Number: 29301, 20.03.2015

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Emergency Management	AD.AD.02.00	Timely interventions must be performed in the case of respiratory or cardiac arrest.	•Regulation on Patient Rights, Official Gazette, Issue: 23420, 01.08.1998
Emergency Management	AD.AD.03.00	Timely intervention must be ensured in cases where the health professional is exposed to a risk of violence, or an act of violence is directed towards him/her.	•Regulation concerning the Procedures and Principles of Legal Support to be made to the Ministry of Health Personnel due to the crime made against them, Official Gazette Issue:: 28277, 28.04.2012 • Circular on Employee Safety, Issue: 2012/23, 14.05.2012

Legislation Related to Standards			
Chapter Name	Standard Code	Standard	Related Legislation
Emergency Management	AD.AD.04.00	There must be an arrangement in place to ensure timely response to fire.	•Regulation on Disaster and Emergency Response Services, T.R. Official Gazette, Issue:28855, 18/12/2013 • Regulation concerning the Fire Protection of Buildings, T.R. Official Gazette,Issue:26735, 19/12/2007 •Regulation Amending the Regulation on the Protection of Buildings from Fire T.R. Official Gazette Issue:30361, 15.03.2018 •Ministry of Health Fire Prevention and Extinguishing Directive, T.R. Official Gazette Issue:2652, 20.08.2008

Annex

ANNEX – SAS Indicators List
SAS ODHS (v3.0/2022) INDICATOR LIST

SAS Indicators Table 1 – Management and Organization Aspect

Management and Organization		
Indicator Code	Indicator	Mandatory/ Optional)
Y.1.Z	Target Achievement Rate	M
Y.2.Z	Corrective Preventive Action Completion Rate	M
Y.3.Z	Document Revision Numbers Monitoring the Realization Rate of Risks Identified (comparison among periods)	M
Y.4.Z	Training Participation Rate of Staff	M
Y.5.Z	Realization Rate of Trainings Planned	M
Y.6.0	Length of Command Line (Number of managers in an hierarchal order, including the top manager, to whom the staff at the bottom unit is accountable)	0
Y.7.0	Realization Rate of Trainings Planned Control Area (Number of people directly accountable to a manager)	0

SAS Indicators Table-2 Healthy Working Life Aspect

Healthy Working Life		
Indicator Code	Indicator	Mandatory/ Optional)
Ç.1.Z	Staff Satisfaction Rate	M
Ç.2.Z	Staff Turnover Rate	M
Ç.3.Z	Rate of Staff Working in a Department not Compatible with Their Vocational Training	M
Ç.4.Z	Exposure Rate of Staff to Sharp Objects	M
Ç.5.Z	Exposure Rate of Staff to Blood and Body Fluid	M
Ç.6.Z	Number of Violence Event Against Staff	M
Ç.7.Z	Completion of Health Scanning towards Staff	M

SAS Indicators Table -3 Patient Experience

Patient Experience		
Indicator Code	Indicator	Mandatory (M) /Optional (O)
H.1.Z	Patient Satisfaction Rate	M

SAS Indicators Table -4 Healthcare Services Aspect

Healthcare Services		
Indicator Code	Indicator	Mandatory (M) /Optional (O)
Patient care		
S.1.Z	Rate of Patient Falls	M
S.2.O	Timely Transfer of Discharge Summary	O
S.3.Z	The rate at which the patient care plan achieves the target	M
S.4.Z	Rate of Completion of First Evaluation by Physicians According to all Components Specified in Patient Evaluation Procedures (For physicians, patient story, physical examination, background, family history, preliminary diagnosis and treatment plan that shall be followed.)	M
S.5.Z	Fissur Sealant implementation rate	M
S.6.Z	Rate of Reapplication with the Same Reason (length should be determined by institution) • Rate of Reapplication due to Prosthesis • Rate of Reapplication due to Filling • Rate of Reapplication due to Root Canal Operation • Rate of Reapplication due to Failure of Antibiotic Therapy	M
S.7.Z	• Rate of Incorrect Impression Taking	M
S.8.Z	Rate of Retaking Impression	M
Prevention of Infections		
S.9.Z	Rate of Using Appropriate Antibiotics in Surgical Prophylaxis	M
S.10.Z	Hand Hygiene Compliance	M
Drug Managemen		
S.11.Z	Medication Error Reporting Rate	M
S.12.Z	Rate of Adverse Drug Effects	M
S.13.O	Incidence of Drug Interaction	O
S.14.O	Drug Disposal Rate	O

Healthcare Services		
Indicator Code	Indicator	Mandatory (M) /Optional (O)
Radiation		
S.15.Z	Number of Repeated Imaging	M
S.16.Z	Waiting Times in Radiated Zones	M
S.17.Z	Imagings for Pregnant and/or Suspected Pregnant Women	M
Prosthesis Laboratories		
S.18.Z	Rate of Refused Impression which has been taken	M
S.19.Z	Rate of Incorrect Models	M
S.20.Z	Rate of Impression Taking Matched with Wrong Patient • Rate of Impression Taking Matched with Wrong Patient which has been realized before working on it • Rate of Impression Taking Matched with Wrong Patient which has been realized after working on it	M
S.21.Z	Rate of Missing Impression Taking/	
S.22.Z	Rate of Missing Impression Prosthesis	M
S.23.Z	Rate of Missing Impression Plaster Model	M
S.24.Z	Rate of Prosthesis Not Delivered on Time • Total Length of Time used for making prosthesis (Average length of time on the basis of prosthesis is taken) Average length of time passing from impression taking to making of prosthesis • Average length of time passing from taking impression to modelling • Average length of time passing from admission to laboratory to delivery	M

Healthcare Services		
Indicator Code	Indicator	Mandatory (M) /Optional (O)
Surgical Operation		
S.25.Z	ODHS Rate of Safe Surgery Checklist Use	M
S.26.Z	Rate of Patients Developing Postoperative Respiratory Failure	M
S.27.Z	Unplanned Return to Operating Room	M
S.28.O	Anaesthesia Complications Rate in Surgical Operations Anesthesia-Related Complication Rate	O

SAS Indicators Table -5 Support Services Aspect

Support Services		
Indicator Code	Indicator	Mandatory (M) /Optional (O)
D.1.Z	Number of Faulty Days in Facility Resources	M
D.2.Z	Response Time for Facility-based Problems	M
D.3.Z	Waste turnover rate (Determining how frequently the waste is collected from the temporary storing areas by relevant agency /agency in charge)	M
D.4.Z	Number of Hazardous Waste Accidents	M
D.5.Z	Average Response Time for Technical Unit to ODHS Information Management System (HIMS) failures	M
D.6.Z	Information Management System Down-time	M
D.7.Z	Response Time to Medical Device Failures	M
D.8.Z	Medical Device Failure Frequency	M
D.9.Z	Number of Days on which Devices Are Defective	M
D.10.Z	Information Management System Revision Requests • Rate of response to request • Length of time for responding to requests	M

SAS Indicators Table -6 Support Services Aspect

Emergency Case Management		
Indicator Code	Indicator	Mandatory (M) /Optional (O)
A.1.Z	Rate of Completely Filled in Code Event Form	M
A.2.Z	Rate of Compliance with the Targeted Response Time in Emergency Code Alert System	M