TÜSKA
TÜRKİYE HEALTH CARE QUALITY AND ACCREDITATION INSTITUTE

Standards of Accreditation in Health Outpatient Health Services Set

v2.0/2025

SAS

ISQua Acreditation STANDARDS

Health Institutes of Türkiye
Türkiye Health Care Quality and Accreditation Institute

Standards of Accreditation in Health
Outpatient Health Services Set
v2.0/2025

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Türkiye Health Care Quality and Accreditation Institute

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Introduction

TÜSEB TÜSKA
TÜRKİYE HEALTH CARE QUALITY AND ACCREDITATION INSTITUTE

SAS


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Foreward

The rapid advancements in medical technologies and clinical practices have led to fundamental transformations in the physical, functional, and administrative structures of healthcare services. The increasing success of diagnostic and treatment options, the rising demand for healthcare, and the growing awareness of health among individuals and communities have necessitated more effective, safer, and patient-centered approaches in the delivery of healthcare services.

This transformation has required systematic improvements not only in service delivery models but also in many areas ranging from the management structures of healthcare institutions to the design of clinical processes, from employee roles to patient safety. Globally, various accreditation systems have been developed to enhance the quality of patient care, ensure patient and employee safety, reduce organizational risks, and sustain quality in healthcare services. These systems have become important tools in promoting high-quality healthcare by enabling impartial and standards-based evaluation of healthcare institutions' performance.

In Türkiye, efforts toward quality and accreditation in healthcare were institutionalized with the launch of the Health Transformation Program by the Ministry of Health in 2005. The Health Accreditation System, developed in line with the vision of "quality and accreditation for qualified and effective healthcare services" — one of the key components of the program — has provided a national framework that supports quality-focused transformation in healthcare institutions. At the same time, it has led the development and implementation of internationally valid standards.

The SAS Outpatient Health Services Set v2, prepared within this scope, is a comprehensive model that has been prepared for implementation in medical centres, polyclinics, physical therapy institutions and radiology institutions. It is compatible with international accreditation approaches and includes evidence-based and applicable standards, evaluation criteria and requirements. It presents a comprehensive model that includes standards, evaluation criteria, and requirements that are evidence-based, practical, and aligned with international accreditation approaches. The first section of the set provides a historical overview and key concepts of accreditation standards. The second section offers guidance on standard requirements to support accurate interpretation and practical application in the field. This structure not only helps institutions and organizations providing outpatient healthcare services maintain their current service levels but also contributes to the continuous improvement of institutional quality.

The SAS Outpatient Health Services Set v2 is designed to enhance the international competitiveness of healthcare services and offers significant opportunities in areas such as health tourism, accreditation certification, and institutional quality awareness. With the joint implementation of the Quality System and the Accreditation System in healthcare, Türkiye has built a healthcare infrastructure that prioritizes patient and employee safety, supports continuous improvement, and aligns with global standards.

By integrating knowledge, experience, and practical application in the field of healthcare quality and accreditation, the SAS Outpatient Health Services Set v2 aims to serve as a guide for both national implementers and international stakeholders. The future of healthcare systems depends on harmonizing global collaboration, local experience, and universal standards through a holistic approach. In this regard, we firmly believe that this set will contribute to the advancement of quality-focused healthcare services not only in Türkiye but also internationally.

Development of the Standards

Institutional efforts to improve the quality of healthcare services in Türkiye took root with the **Health Transformation Program** started in 2003. Within this program, the concepts of quality and accreditation were defined as core policy priorities. The **Ministry of Health** assumed the role of planner and regulator, institutionalizing responsibility for setting service standards, guiding implementation, and conducting evaluations.

Under the sixth component of the program— **"Quality and accreditation for qualified and effective healthcare services"** —systematic steps were taken to establish an international-level accreditation system for Türkiye. In line with the understanding that the quality-management framework had to meet globally accepted requirements, the **Standards of Accreditation in Health (SAS)** was created in May 2012 under the leadership of the Ministry of Health.

Between 2**012 and 2014**, SAS sets were prepared for use across different levels of healthcare. Among them, the **SAS Outpatient Health Services Set** was first accredited by ISQua in **2014** and has since been updated regularly on a four-year cycle—an approach that guarantees SAS's international credibility and recognition.

All information, documents, and processes related to accreditation were formalized by Ministry approval **(18 October 2015, No. 26325996/147)**. To institutionalize the process further, responsibilities for health accreditation were transferred—by Ministry approval **(05 October 2021, No. E-26325996-804.01-194)** —to the **Türkiye Health Care Quality and Accreditation Institute(TÜSKA)**, established within the **Health Institutes of Türkiye (TÜSEB).** With its statutory foundation, internationally valid standards, and auditor-training programs, TÜSKA now serves as the first and only national, non-profit institution responsible for healthcare accreditation in Türkiye.

The **SAS Outpatient Health Services** Set has been developed in accordance with the principles of the **World Health Organization (WHO)** and ISQua, together with both national and international quality approaches in healthcare. Designed to be fully compatible with Türkiye's quality infrastructure, the set covers all service areas within healthcare organisations, allows goal-oriented interpretation, and adopts a holistic structure. Particular emphasis has been placed on creating a model that is outcome-focused, innovation-friendly, highly applicable, user-friendly, and comprehensive.

With this structure, the SAS Outpatient Health Services Setis not only a valuable resource for Türkiye's national health system but also a strong contribution to the global development of healthcare services that comply with international standards.

SAS Outpatient Health Services Set(v2): Purpose and Scope

The SAS has been developed in alignment with the core principles defined by the World Health Organization (WHO) and the International Society for Quality in Health Care (ISQua). These principles focus on ensuring patient safety, promoting continuous improvement in service quality, adopting a patient- and service-user-centered approach, strengthening institutional planning processes, and advancing the performance-based management of healthcare services. The standards have been structured around the principles of minimum risk, optimal quality, and maximum safety.

The SAS Outpatient Health Services Set (v2) primarily aims to promote the establishment of institutional goals related to meeting quality standards in medical centres, polyclinics, physical therapy institutions and radiology institutions. Developed for use at both national and international levels, this set is applicable to medical centres, polyclinics, physical therapy institutions and radiology institutions of all ownership types—including public, private, and university medical centres, polyclinics, physical therapy institutions and radiology institutions—and seeks to contribute to the systematic development processes of healthcare institutions in the field of quality management.

SAS Outpatient Health Services Set (v2): Objectives

The SAS Outpatient Health Services Set(v2) has been developed taking into account the WHO Patient Safety Goals, ISQua Quality Principles, the scope of international accreditation programmes, and the specific requirements of Turkey's healthcare system. The primary objective of this set is to ensure the sustainable quality of medical centres, polyclinics, physical therapy institutions and radiology institutions. In addition, other key objectives include improving patient and employee safety, promoting excellence in service delivery, monitoring and improving organisational performance, and strengthening a patient-centred service approach. These objectives are outlined in Figure 1.

Figure 1: Quality Objectives

In order for the services provided by a healthcare institution to be considered qualified and reliable, it is essential to achieve certain quality objectives. These objectives can generally be classified into two main categories.

The first category encompasses organizational goals that directly relate to the manner in which services are delivered and focus on institutional operations. Within this scope, concepts such as effectiveness, efficiency, productivity, and a healthy working environment come to the forefront. These objectives, which pertain to the internal functioning of the institution and its service production processes, provide a fundamental framework for sustainable quality management.

The second category includes service-oriented objectives that directly concern individuals who benefit from the services. These include components that assess user experience and the impact of services, such as patient safety, equity, patient-centeredness, appropriateness, timeliness, sustainability, and continuity.
This classification has been made to ensure that the objectives are addressed in a clearer and more systematic manner. However, considering situations such as the impossibility of delivering patient-centered care in an institution lacking a healthy working environment, it is not feasible to evaluate these objectives independently. In this context, rather than prioritizing objectives, implementing them in a harmonious and simultaneous manner constitutes the core approach of the SAS.

The definitions of SAS objectives are shown below:

- **Effectiveness:** The degree to which defined objectives are achieved.
- **Efficacy:** The ability to do things correctly.
- **Efficiency:** Refers to the relationship between the amount of services produced and the resources used to produce these services; achieving objectives with minimum resource use.
- **Healthy Work Life:** Providing a safe, supportive and ideal working life for healthcare workers.
- **Patient Safety:** Measures and improvement activities taken to keep risks that could cause harm to all stakeholders receiving services and that can be predicted in advance at an acceptable level.
- **Fairness:** Ensuring that individuals receiving services enjoy equal rights without discrimination, in line with their treatment and care needs.
- **Patient Focused:** Planning and implementing healthcare services in accordance with evidence-based medical practices, taking into account the patient's safety, satisfaction and preferences.
- **Convenience:** Making and implementing the most beneficial choices for the patient's health in healthcare processes.
- **Timeliness:** Providing diagnosis, treatment, and care services within time frames that are appropriate and acceptable to the patient's needs.
- **Continuity:** Diagnosis, treatment and care services required by the patient are provided without interruption after the completion of treatment through interdisciplinary coordination.
- **Sustainability:** Processes are planned and executed in a manner that guarantees the future orientation of the institution in activities aimed at SAS goals.

SAS Outpatient Health Services Set(v2): Structure

The SAS Outpatient Health Services Set v2 comprises a total of 8 sections, 28 chapters, 79 standards and 351 assessment criteria.

The SAS Outpatient Health Services Setconsists of standards, assessment criteria and related guidelines. The guidelines explain the purposes, objectives and standard requirements.

Standards, assessment criteria, and related guidelines should not be considered independently but are addressed and implemented in a holistic manner.

SAS Outpatient Health Services Set(v2): Sections

The eight sections included in SAS are listed below:

1. Management and Organisation
2. Healthy Working Life
3. Patient Experience
4. Health Services
5. Support Services
6. Disaster and Emergency Management
7. Climate Change and Sustainability
8. Performance Measurement and Quality Improvement

General Objectives and Scope of Sections

The sections included in SAS have been determined to cover all departments of the institution, taking into account the services provided in medical centres, polyclinics, physical therapy institutions and radiology institutions, management activities and service processes.

Management and Organisation

This section aims to establish a management structure that will ensure continuity in medical centres, polyclinics, physical therapy institutions and radiology institutions operations and the systematic execution of activities. In this scope, the objective is to establish an effective corporate quality management system with the participation of senior management and all employees. To achieve this objective, it is necessary to define the medical centres, polyclinics, physical therapy institutions and radiology institutions's organisational structure, determine basic policies and values, establish a quality management system, ensure document management, create an adverse event reporting system, carry out risk and training management activities, implement health promotion and development initiatives, and ensure corporate communication.

Healthy Work Life

This section aims to ensure that employees work in a healthy and safe environment in order to provide quality healthcare services and to evaluate the medical centres, polyclinics, physical therapy institutions and radiology institutions organisation from the perspective of employees. In this regard, human resources management is structured, risks that threaten employee health and safety are prevented, and requirements for improving work life is defined.

Patient Experience

The Patient Experience section aims to approach services from the patient's perspective by ensuring basic patient rights, patient safety, and patient satisfaction. To achieve these goals, the services provided by the medical centres, polyclinics, physical therapy institutions and radiology institutions are organised in a way that respects the rights of patients and their families, provides timely access to services, ensures patient comfort, and guarantees patient safety.

Health Services

This section aims to ensure that all medical service processes provided in the medical centres, polyclinics, physical therapy institutions and radiology institutions are carried out in line with SAS targets. In this context, comprehensive work is done in areas such as infection control, sterilisation services, medication and transfusion management, radiation safety, patient care, laboratory services, safe surgical practices, and emergency health services.

Support Services

The Support Services section aims to establish the necessary infrastructure for the safety and continuity of medical service processes. Within this scope, it is necessary to plan hospitality services, manage facilities, manage waste, manage information, manage materials and equipment.

Disaster and Emergency Management

This section aims to ensure the fastest and most effective response in cases of natural disasters (earthquakes, floods, etc.), emergencies such as fires and explosions, the risk of infant or child abduction, respiratory or cardiac arrest incidents, and situations where employees are exposed to violence, thereby preventing potential dangers and harm.

Climate Change and Sustainability

This section aims to reduce the negative effects of climate change and environmental factors on healthcare systems and to provide healthcare services that are sensitive to society and nature, sustainable, and balanced.

Performance Measurement and Quality Improvement

This dimension aims to identify and resolve issues that arise in administrative, financial, and medical processes in a timely manner and to implement quality improvement interventions. In this regard, continuous improvement is targeted by ensuring the effective use of institutional indicators and performance indicators determined by SAS.

Judgment on the Fulfillment Level for the Standard

Processes aimed at implementing standards using a holistic approach and a concept that develops and encourages a culture of quality are carried out in accordance with the standard implementation criteria specified below.

1. **Scope and Implementation:** The plan, policy and processes related to the Standard/ Assessment Criteria are defined, and the tasks and processes aimed at achieving the purpose of the standard are carried out in all relevant departments of the institution.

2. **Traceability and Continuity:** The work and processes involved in the processes related to the Standard/Assessment Criteria and the information generated during the process can be tracked retrospectively and simultaneously, and the implementation of the Standard/Assessment Criteria is continuous, not limited to certain periods or time frames.

3. **Leadership and Participation:** The level of guidance of employees at all management levels of the institution and the level of knowledge, adoption and implementation of practices related to the participation of institution employees in order to achieve the purpose of the Standard/Assessment Criteria.

Outputs/Evidence

The work carried out in accordance with the specified principles and criteria results in outputs related to the standard. These outputs are evidence in the form of any information and documentation that will enable the level of fulfilment of the standard to be determined during the survey process.

Arriving at the Fulfillment Level Judgment

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

- The fulfillment level is judged for the standard itself.
- The standard, the evaluation criteria, the objectives and goals of the standard, and its requirements are considered as a whole when judging the fulfillment level.
- The fulfillment level of the standard is judged on the conformance/ nonconformance status of the practices that concern the standard.
- The conformance/nonconformance judgment concerning a standard is determined,
  - » In line with the standard implementation criteria,
  - » While focusing on evidence prepared using evidence collection principles and evidence collection methods,
  - » In compliance with fulfillment level criteria.
- The fulfillment level for each standard is judged to belong in one of three categories; “fulfilled”, “partially fulfilled”, “unfulfilled”.

The categories for the fulfillment level of standards/evaluation criteria are as described below;

- **Fulfilled (F)**: If there is no nonconformity or even if it exists, it may be decided that it is fulfilled as a result of the evaluation made within the scope of the Nonconformity Definition Criteria. When there is a nonconformity, the decision of fulfilled can be made in cases where the frequency of the existing nonconformity is low, area of influence is individual and low risk level according to the definitions specified in the Matrix.
- **Partially Fulfilled (PF):** t As a result of the evaluation made within the scope of the Nonconformity Definition Criteria, the Partially Fulfilled decision can be given. When there is a nonconformity, the decision to partially fulfilled can be made in cases where the frequency of the existing nonconformity is middle or high, area of influence is sometimes individual sometimes systematic and low or middle risk level according to the definitions specified in the Matrix.
- **Unfulfilled (U):** As a result of the evaluation made within the scope of the Nonconformity Definition Criteria, the decision of Unfulfilled can be given. When there is a nonconformity, the decision of Unfulfilled can be made in cases where the frequency of the existing

nonconformity is middle or high, area of influence is generally systematic and middle or high risk level according to the definitions specified in the Matrix.
A determination of the fulfillment level is based on evidence that has been collected in sufficient quality and quantity, and on the purpose and objectives of the standard. At this stage, the standard is handled as a whole, together with the evaluation criteria, the standard purposes and objectives, and requirements.

- The scope and implementation level of the standard and the evaluation criterion
- The traceability and continuity of the standard and the evaluation criterion in the implementation
- The leadership of the administrators and the level of involvement of the employees in matters regarding the standard and the evaluation criterion

In the event that a nonconformance (incompleteness & error) regarding the standard or the evaluation criterion is identified via the evidence obtained, the nonconformance is handled according to the "Fulfillment Level Criteria".
The most important point that is remembered is that the "Fulfillment Level Criteria" is regarded as the fundamental parameters to be used to arrive at a correct judgment regarding the fulfillment level of the standard in the event that a nonconformance concerning the standard is identified.
The fulfillment level criteria are;

- Level of Frequency
- Area of Effect
- Magnitude of Risk

Level of Frequency

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

Area of Effect

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

- If the 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 the institution or organization, and additionally, for which the institution or organization can not be held responsible.
- If the nonconformance is influential at an institutional or systemic level: It is identified to be SYSTEMIC. Nonconformances concerning the organization, execution, supervision of the system designed by the institution or the organization fall within this scope.

Magnitude of Risk

Expresses the relation, to patient and employee safety, of the identified nonconformances concerning the standard. Nonconformances considered in this context are those directly related to safety, however the highest potential of the 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 the 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 the 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 the Fulfillment Level Criteria and the intersection zones of these judgments are identified in the matrix below concerning the fulfillment level for the evaluation criterion. The zones identified direct the opinion of the self assessment team, and under light of the unary and binary judgments in the matrix, a judgment on the fulfillment level is made while taking into consideration the levels of fulfillment for the standard, the relevant section of the standard set, and even those other sections that are relevant; that is, from a holistic point of view.

Assessment Criteria Coverage Level Criteria Matrix

FACTOR	SEVERITY	LEVEL OF COVERAGE DECISION*		SEVERITY	FACTOR
MAGNITUDE OF RISK	HIGH	U	U	HIGH	LEVEL OF FREQUENCY
	MEDIUM	U/PF	U	HIGH	
	LOW	F/PF	U/PF	HIGH	
	HIGH	PF/U	U	MEDIUM	
	MEDIUM	F/PF	U/PF	MEDIUM	
	LOW	F	PF/U	MEDIUM	
	HIGH	F/PF	U	LOW	
	MEDIUM	F	U/PF	LOW	
	LOW	F	F/PF	LOW	
FACTOR	SEVERITY	INDIVIDUAL	SYSTEMATIC	SEVERITY	FACTOR
	DOMAIN				

* The colorless boxes in the Fulfillment Level Judgment are decided by the opinion of the self assessment team. The matrix prioritizes the first judgment for the assessors.

Judgment on the Fulfillment Level for the Standard

After the levels of fulfillment for each evaluation criterion have been determined, the judgment on the Fulfillment Level for the Standard is made under light of the following points:

- If all Evaluation Criteria have been judged Fulfilled, the judgment is Standard Fulfilled (F).
- If at least 1 Evaluation Criterion of the Standard has been judged Unfulfilled, the judgment is Standard Unfulfilled (U).
- If all Evaluation Criteria have been granted Partially Fulfilled, the judgment is Standard Partially Fulfilled (PF).
- Provided that at least half of the Evaluation Criteria (if an odd number, the self- assessment team may round down or up at their discretion) are Fulfilled (F), and the rest have been judged to be Partially Fulfilled (PF), the Self Assessment Team judges one or the other of Standard Fulfilled (F) or Partially Fulfilled (PF).
- Provided that all judgments on the Evaluation Criteria are Fulfilled and Partially Fulfilled, if the number of Partially Fulfilled Evaluation Criteria is 2 or more greater than the number of Evaluation Criteria that have been judged Fulfilled, the judgment is Standard Partially Fulfilled.

According to the descriptions above, below is an example of the possible judgments of levels of fulfillment for a standard that has an odd (5) or even (4) number of evaluation criteria.

Possibilities for the Judgment on the Fulfillment Level of a Standard with 5 Assessment Criteria					
Judgment on the Fulfillment Level of the Assessment 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

Possibilities for the Judgment on the Fulfillment Level of a Standard with 4 Assessment Criteria				
Judgment on the Fulfillment Level of the Assessment Criteria				Judgment on the Fulfillment Level of the Standard
1	2	3	4	
F	F	F	F	F
F	F	F	PF	F
F	F	PF	PF	PF/F 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

Accreditation Decision

* All other issues related to the audit process, including the accreditation decision for standards, application and self-evaluation, are carried out in accordance with the TÜSKA Healthcare Facilities Accreditation Program Guide.


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Standards and Guidelines

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Sections and Chapters

1. Management and Organization

1. Organizational Structure and Functioning
2. Quality Management
3. Human Resources Management
4. Document Management
5. Adverse Event Reporting
6. Risk Management
7. Education Management

2. Healthy Working Life

8.Healthy Occupational Life

3. Patient Experience

9. Patient Experience
10. Patient Safety Goals

4. Health Services

11. Patient Care
12. Prevention and Control of Infections
13. Medication Management
14. Safe Anesthesia and Surgical Care
15. Blood and Blood Component Management
16. Cleaning, Disinfection and Sterilization Services
17. Laboratory Services
18. Radiology, Nuclear Medicine and Radiation Oncology Services
19. Emergency Department Services
20. Health Services Requiring Specialized Planning

5. Support Services

21. Facility Management and Hospitality Services
22. Information Management System
23. Records Control and Archive Services
24. Material and Equipment Management
25. Waste Management

6. Disaster and Emergency Management

26. Disaster and Emergency Management

7. Climate Change and Sustainability

27. Climate Change and Sustainability

8. Performance Measurement and Quality Improvement

28. Indicator Management

Objectives

- » Effectiveness
- » Efficacy
- » Efficiency
- » Healthy Work Life
- » Patient Safety
- » Fairness
- » Patient
- » Focused
- » Convenience
- » Timeliness
- » Continuity
- » Sustainability

TÜSKA SAS Outpatient Health Services Set (v2.0/2025) Numerical Distribution of Standards and Assessment Criteria by Department		
Section 1 Management and Organization		
Chapter	**Number of Standards**	**Number of Assessment Criteria**
1. Organizational Structure and Functioning	5	21
2. Quality Management	2	7
3. Human Resources Management	1	9
4. Document Management	1	6
5. Adverse Event Reporting	2	5
6. Risk Management	2	5
7. Education Management	2	6
Section 2 Healthy Working Life		
8. Healthy Occupational Life	2	13
Section 3 Patient Experience		
9. Patient Experience	3	19
10. Patient Safety Goals	8	22
Section 4 Health Services		
11. Patient Care	4	18
12. Prevention and Control of Infections	3	9
13. Medication Management	5	17
14. Safe Anesthesia and Surgical Care	3	14
15. Blood and Blood Component Management	4	14
16. Cleaning, Disinfection and Sterilization Services	3	19
17. Laboratory Services	6	23
18. Radiology, Nuclear Medicine and Radiation Oncology Services	3	9
19. Emergency Department Services	4	18
20. Health Services Requiring Specialized Planning	1	3
Section 5 Support Services		
21. Facility Management and Hospitality Services	2	20

22. Information Management System		2	18
23. Records Control and Archive Services		2	8
24. Material and Equipment Management		3	17
25. Waste Management		1	5
Section 6	**Disaster and Emergency Management**		
26. Disaster and Emergency Management		2	14
Section 7	**Climate Change and Sustainability**		
27. Climate Change and Sustainability		1	4
Section 8	**Performance Measurement and Quality Improvement**		
28. Indicator Management		2	8
Total	**28**	**79**	**351**


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SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 1 Organizational Structure and Functioning (OSF)	
Code	**Standard 1**
OSF.1	Arrangements are made regarding the organizational structure.
Code	**Assessment Criteria**
OSF.1.1	An organizational structure is designed to include all managerial processes and vertical and horizontal relationships with management levels are defined.
OSF.1.2	Management levels for the organizational structure are defined to include responsibilities related to institutional, financial and clinical governance, and relevant responsible persons is identified.
OSF.1.3	The duties, authorities and responsibilities of the units and employees in the organizational structure is defined; unit supervisors is identified.
OSF.1.4	All areas of activity have authorization and permission documents in accordance with the country's legislation and these documents are up-to-date, valid and traceable.
OSF.1.5	Effective leadership, teamwork and communication are ensured in processes related to the organizational structure.
Code	**Standard 2**
OSF.2	Routing strategies are identified and resource planning is done.
Code	**Assessment Criteria**
OSF.2.1	Mission, vision and ethical values are determined and shared with the public.
OSF.2.2	Strategic goals and objectives in line with the mission of the institution/ organization are determined and a strategic plan is created accordingly.
OSF.2.3	Policies for organizational processes are established and all activities are carried out in line with the determined policies.
OSF.2.4	Budget planning is done and reviewed regularly.
OSF.2.5	An operational plan with defined service targets aligned with strategic objectives are developed and progress in achieving these targets are measured.

Code	Standard 3
OSF.3	Arrangements are made regarding corporate communication activities.
Code	**Assessment Criteria**
OSF.3.1	Corporate stakeholders are determined and processes for ensuring effective communication are defined.
OSF.3.2	Corporate stakeholders are ensured to participate in improvement processes.
OSF.3.3	The target audience is identified in line with the organizational structure, basic policies and values, and the communication process and strategies for the target audience are defined.
OSF.3.4	Stakeholders are informed about the corporate organization and activities.
OSF.3.5	Activities are carried out to create a positive corporate image among stakeholders.
OSF.3.6	Social responsibility programs that promote and encourage health are organized, and the results of these programs are monitored and evaluated.
Code	**Standard 4**
OSF.4	Processes and rules regarding outsourcing are defined and proper functioning is ensured.
Code	**Assessment Criteria**
OSF.4.1	Processes and rules for outsourcing are documented.
OSF.4.2	Arrangements are made to control the services provided through outsourcing.
OSF.4.3	Services provided through outsourcing are in compliance with the relevant TÜSKA SAS.
Code	**Standard 5**
OSF.5	Effective management of scientific research is ensured.
Code	**Assessment Criteria**
OSF.5.1	Processes and rules for the management of scientific research are documented.
OSF.5.2	Arrangements are made for the coordination of scientific research.
OSF.5.3	Arrangements are made for the use of patient data, information and materials for Participation in scientific research or for any other reason.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 2 Quality Management (QM)	
Code	**Standard 1**
QM.1	Quality management structure is defined.
Code	**Assessment Criteria**
QM.1.1	A managerial structure for quality management is established and duties, authorities and responsibilities is defined.
QM.1.2	Quality improvement activities are carried out within the scope of quality management.
QM.1.3	Self-assessment activities are carried out.
Code	**Standard 2**
QM.2	The functioning of structures such as committees, boards, units, teams, etc. related to quality management is ensured.
Code	**Assessment Criteria**
QM.2.1	Processes for the functioning of committees, boards, units, teams, etc. are defined.
QM.2.2	Structures such as committees, boards, units, teams, etc. are established and their duties, authorities and responsibilities is defined.
QM.2.3	Committees, boards, units, teams, etc. hold meetings at regular intervals.
QM.2.4	Activities of committees, boards, units, teams, etc. are evaluated and continuous improvements are made.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 3 Human Resources Management (HRM)	
Code	**Standard 1**
HRM.1	Processes and rules for human resources management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
HRM.1.1	Processes and rules for human resources management are documented.
HRM.1.2	A managerial structure for human resources management is established and duties, authorities and responsibilities are defined.
HRM.1.3	Annual targets for human resources management are set and work plans are created.
HRM.1.4	Employees are employed in units and positions in accordance with job descriptions and requirements.
HRM.1.5	An employee recruitment plan is created, and employment processes are defined.
HRM.1.6	Employees are employed in line with job requirements and competencies, and diploma and authorization certificates of the employed personnel are verified.
HRM.1.7	Arrangements are made to evaluate the performance of employees.
HRM.1.8	Employees are informed about their rights and cooperate opportunities.
HRM.1.9	Arrangements are made to receive employees' opinions, suggestions and complaints.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 4 Document Management (DM)	
Code	**Standard 1**
DM.1	Processes and rules regarding document management are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
DM.1.1	Rules for document management are determined.
DM.1.2	Documents are distributed and publicized according to established rules.
DM.1.3	Documents are up to date.
DM.1.4	Documents are preserved, archived and destroyed according to established rules.
DM.1.5	External documents are followed and updated.
DM.1.6	Necessary trainings on document management are provided.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 5 Adverse Event Reporting (AER)	
Code	**Standard 1**
AER.1	Processes and rules regarding adverse event reporting are defined and operations are conducted accordingly.
Code	**Assessment Criteria**
AER.1.1	Processes for reporting adverse events are defined.
AER.1.2	A system for reporting adverse events is formed.
AER.1.3	Employees are trained on the adverse event reporting system.
Code	**Standard 2**
AER.2	Any near misses or adverse events are monitored, and continuous improvement activities are carried out.
Code	**Assessment Criteria**
AER.2.1	Reports submitted to the system are analyzed and necessary improvements are made after the analysis.
AER.2.2	All employees are informed about analysis and improvement efforts.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 6 Risk Management (RM)	
Code	**Standard 1**
RM.1	Processes and rules regarding risk management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
RM.1.1	Processes for risk management are defined.
RM.1.2	A managerial structure for risk management is established and duties, authorities and responsibilities are defined.
RM.1.3	A risk management plan is prepared, risks are determined and analyzed in line with the plan.
RM.1.4	Continuous improvement studies are carried out to eliminate or minimize the identified risks at their source.
Code	**Standard 2**
RM.2	Monitoring and evaluation studies regarding risk management are carried out.
Code	**Assessment Criteria**
RM.2.1	Indicators related to risk management are determined, analyzed and the effectiveness of the studies are monitored at regular intervals.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 7 Education Management (EM)	
Code	**Standard 1**
EM.1	Processes and rules regarding training management are defined and proper functioning is ensured.
Code	**Assessment Criteria**
EM.1.1	Processes and rules regarding training management are documented.
EM.1.2	A structure responsible for planning and coordinating training activities is established.
EM.1.3	Processes regarding patient/caregiver training to ensure continuity of care are defined and implemented.
EM.1.4	Processes for training employees are defined and implemented.
EM.1.5	Processes for training and supervision activities carried out within the scope of vocational training programs (undergraduate, graduate, internship, etc.) are defined and implemented.
Code	**Standard 2**
EM.2	Monitoring and evaluation studies regarding training management are carried out.
Code	**Assessment Criteria**
EM.2.1	The efficiency and effectiveness of the training is evaluated and necessary improvement work is carried out.

SECTION 2 HEALTHY WORKING LIFE	
Chapter 8 Healthy Occupational Life (HOL)	
Code	**Standard 1**
HOL.1	Processes and rules for a healthy occupational life are defined and appropriate operations are conducted accordingly.
Code	**Assessment Criteria**
HOL.1.1	Processes and rules for a healthy occupational life are documented.
HOL.1.2	An administrative structure for a healthy occupational life is established and duties, authorities and responsibilities are defined.
Code	**Standard 2**
HOL.2	Arrangements are made to provide a healthy occupational life.
Code	**Assessment Criteria**
HOL.2.1	Risks that threaten employee health and safety are managed.
HOL.2.2	Arrangements are made for the use of personal protective equipment.
HOL.2.3	Health surveillance of employees are carried out.
HOL.2.4	The psychological well-being of the employee are ensured.
HOL.2.5	The working environment is organized in line with the safety, needs and expectations of the employee.
HOL.2.6	The individual and professional development of the employee is supported.
HOL.2.7	Arrangements are made for the spiritual and social needs of the employee.
HOL.2.8	Activities are carried out to increase employee motivation.
HOL.2.9	Arrangements are made for the health status and needs of the employee such as special needs and chronic diseases.
HOL.2.10	Arrangements are made to ensure inclusion and diversity.
HOL.2.11	Trainings are provided to improve employee health and safety.

SECTION 3 PATIENT EXPERIENCE	
Chapter 9 Patient Experience (PE)	
Code	**Standard 1**
PE.1	Patient access to services is ensured.
Code	**Assessment Criteria**
PE.1.1	Arrangements are made for the provision of reception, orientation and counseling services.
PE.1.2	Arrangements are made to facilitate service use.
PE.1.3	Necessary arrangements are made to ensure that patient registration procedures are carried out effectively and accurately.
PE.1.4	Arrangements are made to keep the procedure times for diagnosis, examination, treatment and care at an optimal level and to increase efficiency.
PE.1.5	Transfer service and implementation processes are defined.
PE.1.6	In institutions/organizations that do not provide emergency health services, arrangements are made to facilitate patient access to emergency health services.
Code	**Standard 2**
PE.2	Arrangements are made for patient rights.
Code	**Assessment Criteria**
PE.2.1	Processes for patient rights are documented.
PE.2.2	An administrative structure for the protection, implementation and improvement of patient rights is established, and duties, authorities and responsibilities are defined.
PE.2.3	Patients are informed about their rights, responsibilities and service processes.
PE.2.4	Patient participation is ensured in service processes.

PE.2.5	Processes for obtaining patient consent are defined.
PE.2.6	Processes are defined to address and resolve ethical dilemmas such as refusal, withdrawal and discontinuation of treatment/procedure in a timely manner.
PE.2.7	Measures are taken to ensure patient privacy .
PE.2.8	Arrangements are made for the patient to maintain their spiritual and cultural needs.
PE.2.9	Access to the patient's medical records related to the care process is ensured.
PE.2.10	Arrangements are made regarding visitation and accompaniment processes .
PE.2.11	Arrangements are made for the provision of medical social services.
Code	**Standard 3**
PE.3	Arrangements are made for feedback processes.
Code	**Assessment Criteria**
PE.3.1	A system for patient and relative feedback is established.
PE.3.2	Patient and caregiver feedback are evaluated, analyzed and necessary improvements is made.

SECTION 3 PATIENT EXPERIENCE	
Chapter 10 Patient Safety Goals (PSG)	
Code	**Standard 1**
PSG.1	Processes and rules for maintaining patient safety are defined and appropriate functioning is ensured.
Code	**Assessment Criteria**
PSG.1.1	Processes to maintain patient safety are documented within the scope of national/international patient safety goals.
PSG.1.2	A managerial structure for maintaining patient safety is established and duties, authorities and responsibilities are defined.
PSG.1.3	Risks regarding patient safety are determined and analyzed.
PSG.1.4	Necessary trainings are provided to employees to maintain patient safety.
Code	**Standard 2**
PSG.2	Patient identity verification is ensured.
Code	**Assessment Criteria**
PSG.2.1	Processes and rules for verifying patient identity are documented.
PSG.2.2	Authentication tools and methods are defined.
Code	**Standard 3**
PSG.3	Falls are prevented.
Code	**Assessment Criteria**
PSG.3.1	Processes and rules for the prevention of patient falls are documented.
PSG.3.2	Patients are assessed for fall risk.
PSG.3.3	Necessary measures are taken to prevent patient falls.

Code	Standard 4
PSG.4	Effective communication between employees is ensured.
Code	**Assessment Criteria**
PSG.4.1	Processes and rules for ensuring effective communication between employees are documented.
PSG.4.2	Arrangements are made for the safe handover of patients between health workers.
PSG.4.3	Arrangements are made for reporting panic/critical values.
PSG.4.4	Arrangements are made to implement verbal prompting.
PSG.4.5	Arrangements are made for abbreviations, symbols and sign that not be used.
PSG.4.6	Arrangements are made for accurate and complete transfer of patient information in consultation processes.
Code	**Standard 5**
PSG.5	The safety of high-risk medications is ensured.
Code	**Assessment Criteria**
PSG.5.1	Processes and rules for ensuring the safety of high-risk medications are documented.
PSG.5.2	Arrangements are made to ensure the safety of high-risk medicines.
Code	**Standard 6**
PSG.6	Use of the Safe Surgery Checklist is ensured
Code	**Assessment Criteria**
PSG.6.1	Processes and rules for the use of the Safe Surgery Checklist are documented.
PSG.6.2	Arrangements are made for the use of the Safe Surgery Checklist.

Code	Standard 7
PSG.7	Hand hygiene is provided.
Code	**Assessment Criteria**
PSG.7.1	Processes and rules for ensuring hand hygiene are documented.
PSG.7.2	Arrangements is made to ensure hand hygiene.
Code	**Standard 8**
PSG.8	Compliance with patient safety objectives is monitored and evaluated.
Code	**Assessment Criteria**
PSG.8.1	Indicators related to patient safety targets are determined and the effectiveness of the studies are monitored at regular intervals.

SECTION 4 HEALTH SERVICES	
Chapter 11 Patient Care (PC)	
Code	**Standard 1**
PC.1	The rules and processes regarding the patient care services are defined and suitable operation is ensured.
Code	**Assessment Criteria**
PC.1.1	The rules and processes regarding patient care are documented.
PC.1.2	The arrangements regarding the processes for safe transfer, referral and discharge of the patient are planned in a way that ensures continuity of the care.
PC.1.3	The arrangements regarding the consultation process are made.
Code	**Standard 2**
PC.2	Arrangements are made for the effective management of the patient assessment and care process
Code	**Assessment Criteria**
PC.2.1	The patient is evaluated by healthcare staff in terms of the care needs.
PC.2.2	The patient is evaluated by the relevant healthcare staff in terms of clinical risks.
PC.2.3	Based on the evaluation results, a multidisciplinary patient care plan for inpatients is prepared.
PC.2.4	Arragements for the evaluation of cases requiring a multidisciplinary approach are established.
PC.2.5	Records related to the patient's care process are complete and accurate, including necessary alerts for the patient's clinical follow-up.
PC.2.6	Changes in the patient's clinical condition are promptly identified, and necessary interventions are ensured.
PC.2.7	The effective use of medical device alarm systems in the patient care process is ensured.
PC.2.8	The participation of patients and their relatives in the care process is ensured.
PC.2.9	Arragements for the management of patients at risk of harming themselves or others are established.

Code	Standard 3
PC.3	Arragements for improving clinical quality are established.
Code	**Assessment Criteria**
PC.3.1	Processes for the development, use, dissemination, and improvement of evidence-based clinical guidelines, protocols, and manuals are defined.
PC.3.2	The effective and safe use of evidence-based clinical guidelines, protocols, and manuals is ensured, and awareness-raising and improvement activities for their dissemination are conducted.
PC.3.3	Indicators for improving clinical quality are identified, and the effectiveness of activities is monitored at regular intervals.
Code	**Standard 4**
PC.4	Arragements for digital health applications used in patient assessment and care processes are established
Code	**Assessment Criteria**
PC.4.1	Processes for the use of digital health applications are defined.
PC.4.2	The safe, effective, and efficient use of digital health applications is ensured.
PC.4.3	The effectiveness of digital health applications is evaluated, implementation monitoring results are reported, and continuous improvement activities are carried out.

SECTION 4 HEALTH SERVICES	
Chapter 12 Prevention and Control of Infections (PCI)	
Code	**Standard 1**
PCI.1	Processes and rules for the prevention and control of infections are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
PCI.1.1	A managerial structure for the prevention and control of infections are established, and duties, authorities and responsibilities are defined.
PCI.1.2	A risk assessment is conducted for the prevention and control of infections.
PCI.1.3	Processes for the management of epidemic or rare infections are defined.
PCI.1.4	Education is provided to patients, relatives and employees on the prevention and control of infections.
Code	**Standard 2**
PCI.2	Studies on the prevention and control of infections are carried out within a program.
Code	**Assessment Criteria**
PCI.2.1	A program for the prevention and control of infections is established.
PCI.2.2	Arragements are made regarding isolation measures.
PCI.2.3	Arragements are made regarding infection control bundles.
PCI.2.4	Arragements are made regarding the rational use of antibiotics.
PCI.2.5	Arragements are made regarding the prevention of facility-acquired infections.
Code	**Standard 3**
PCI.3	Monitoring and evaluation studies on infection prevention and control are conducted.
Code	**Assessment Criteria**
PCI.3.1	Indicators for the prevention and control of infections are determined, the effectiveness of the work is monitored at regular intervals and continuous improvement activities are carried out.

SECTION 4 HEALTH SERVICES	
Chapter 13 Medication Management (MM)	
Code	**Standard 1**
MM.1	Processes and rules regarding medication management are defined and functioning are ensured accordingly.
Code	**Assessment Criteria**
MM.1.1	Processes and policies for medication management are documented.
MM.1.2	A managerial structure for medication management is established.
MM.1.3	Duties, authorities and responsibilities regarding medication management are defined and effective communication is ensured.
MM.1.4	Necessary training is given to relevant employees in all processes involving medication.
Code	**Standard 2**
MM.2	Arrangements are made for the supply, storage and stock management of medications.
Code	**Assessment Criteria**
MM.2.1	Arrangements are made to ensure that the right medication is provided at the right time.
MM.2.2	Medications are stored in accordance with their characteristics and the necessary physical conditions are provided.
MM.2.3	Arrangements are made for the storage of special quality medications.
MM.2.4	Arrangements are made to monitor stock levels and expiry dates of medications.
Code	**Standard 3**
MM.3	Arrangements are made for the request, preparation and transfer of medication.

Code	Assessment Criteria
MM.3.1	Arrangements are made for the medication request process.
MM.3.2	Arrangements are made for the preparation of medications.
MM.3.3	Arrangements are made for the safe transfer of medications.
Code	**Standard 4**
MM.4	Arragements regarding safe medication administration are made.
Code	**Assessment Criteria**
MM.4.1	Arrangements are made regarding the preparation and administration of medications before regulation.
MM.4.2	The medications that come with the patient is checked.
MM.4.3	Arragements are made regarding adverse effects related to medication applications.
MM.4.4	Arrangements are made for the destruction of medications.
Code	**Standard 5**
MM.5	Monitoring and evaluation studies regarding medication management are conducted.
Code	**Assessment Criteria**
MM.5.1	All stages of the processes involving the medication are traceable.
MM.5.2	Indicators for evaluating the performance of processes in which the medication is involved are determined, the effectiveness of the studies are monitored at regular intervals and continuous improvement activities are carried out.

SECTION 4 HEALTH SERVICES	
Chapter 14 Safe Anesthesia and Surgical Care (ASC)	
Code	**Standard 1**
ASC.1	Arrangements are implemented for safe anesthesia.
Code	**Assessment Criteria**
ASC.1.1	Processes and rules for safe anesthesia practices are documented.
ASC.1.2	Arrangements are made regarding the safety of anesthesia practice.
ASC.1.3	Arrangements are made regarding anesthesia practices outside the operating room.
ASC.1.4	Arrangements are made regarding the safe use of anesthetic medicines and gases.
ASC.1.5	Arrangements are made regarding the safe usage of equipment in anesthesia practices.
Code	**Standard 2**
ASC.2	Arrangements are implemented for safe surgical care.
Code	**Assessment Criteria**
ASC.2.1	Processes and rules for safe surgical care are documented.
ASC.2.2	Arrangements are made regarding the preparation process for surgery.
ASC.2.3	Arrangements are made regarding the surgical application process.
ASC.2.4	Arrangements regarding the safety of tissue samples taken for diagnostic purposes are made.
ASC.2.5	Arrangements are made regarding postoperative patient care.

Code	Standard 3
ASC.3	Arrangements are implemented for operating room processes
Code	**Assessment Criteria**
ASC.3.1	Arrangements are made regarding operating room areas.
ASC.3.2	Arrangements are made regarding ventilation systems.
ASC.3.3	Arrangements are made regarding the continual supply of electrical energy.
ASC.3.4	Arrangements are made regarding the management of medications, materials, and equipment in the operating room.

SECTION 4 HEALTH SERVICES	
Chapter 15 Blood and Blood Component Management (BCM)	
Code	**Standard 1**
BCM.1	Processes and rules for the management of blood and blood components are defined and appropriate functioning is ensured.
Code	**Assessment Criteria**
BCM.1.1	Processes and rules for the management of blood and blood components are documented.
BCM.1.2	A managerial structure is established for the safe execution and coordination of processes for blood and blood components, and duties, authorities and responsibilities are defined.
BCM.1.3	A risk assessment is made for the management of blood and blood components, and necessary measures are taken for the identified risks.
Code	**Standard 2**
BCM.2	Arrangements are made for the management of the procurement/donation process of blood and blood components.
Code	**Assessment Criteria**
BCM.2.1	Operating rules regarding the procurement/donation process of blood and blood components are documented.
BCM.2.2	Arrangements are made for the medical questioning and evaluation of the donor and the acceptance or rejection of the donation.
BCM.2.3	Arrangements are made to ensure patient safety during the donation process.
Code	**Standard 3**
BCM.3	Arrangements are made for the preparation, storage, transfer and disposal of blood and blood products.
Code	**Assessment Criteria**
BCM.3.1	Processes for the preparation of blood and blood components are documented.

BCM.3.2	Measures are taken for the preservation of blood and blood components.
BCM.3.3	Safe transfer of blood and blood components is ensured.
BCM.3.4	Rules for the disposal of blood and blood components are determined.
Code	**Standard 4**
BCM.4	Safe transfusion of blood and blood components is ensured.
Code	**Assessment Criteria**
BCM.4.1	Rules for requesting blood and blood components are determined.
BCM.4.2	Measures are taken to ensure patient safety during the transfusion process.
BCM.4.3	Reactions developing due to transfusion process are monitored.
BCM.4.4	Traceability of blood and blood components is ensured and unexpected/ unwanted effects are monitored.

SECTION 4 HEALTH SERVICES	
Chapter 16 Cleaning, Disinfection and Sterilization Services (CDS)	
Code	**Standard 1**
CDS.1	Processes and rules regarding cleaning and disinfection services are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
CDS.1.1	Processes and rules regarding cleaning and disinfection services are defined, and functioning is ensured accordingly.
CDS.1.2	Responsible individuals for cleaning and disinfection services are determined, and their responsibilities are defined.
CDS.1.3	A risk assessment for cleaning and disinfection is conducted, and a cleaning and disinfection plan is established.
CDS.1.4	Arrangements for the cleaning and disinfection of areas, floors, and environmental surfaces are implemented.
CDS.1.5	Arrangements for the cleaning and disinfection of materials and devices are in place.
CDS.1.6	Arrangements for the control of cleaning and disinfection procedures are in place.
CDS.1.7	Necessary training is provided to relevant employees regarding cleaning and disinfection services.
Code	**Standard 2**
CDS.2	Processes and rules regarding high-level disinfection are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
CDS.2.1	Processes and rules regarding high-level disinfection are defined, and functioning is ensured accordingly.
CDS.2.2	Areas where high-level disinfectants are used are identified, and necessary arragements are implemented.
CDS.2.3	Medical devices requiring high-level disinfection are identified, and specific arragements for their operation are established.
CDS.2.4	Arrangements for the preparation, application, monitoring, and disposal of high-level disinfectants are implemented.
CDS.2.5	Necessary training is provided to relevant employees regarding high-level disinfection.

Code	Standard 3
CDS.3	Processes and rules regarding sterilization services are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
CDS.3.1	Processes and rules regarding sterilization services are documented.
CDS.3.2	Physical and functional arragements for the Central Sterile Services Department (CSSD) are implemented.
CDS.3.3	Arrangements for the collection and washing processes of contaminated materials are established.
CDS.3.4	Arrangements for packaging and loading processes are implemented.
CDS.3.5	Arrangements to ensure the effectiveness of the sterilization process are established.
CDS.3.6	Arrangements for the storage of sterile materials are implemented.
CDS.3.7	Arrangements for the traceability of the sterilization process are established.

SECTION 4 HEALTH SERVICES	
Chapter 17 Laboratory Services (LS)	
Code	**Standard 1**
LS.1	Processes and rules related to laboratory services are defined, and operations align accordingly.
Code	**Assessment Criteria**
LS.1.1	Processes and rules related to laboratory services are documented.
LS.1.2	Laboratory service delivery areas are identified, and necessary physical conditions are ensured for these areas.
LS.1.3	An informative guide related to laboratory services is prepared.
LS.1.4	A healthy working environment in the laboratory is established.
LS.1.5	The control and safe use of reagents, materials, devices, and equipment used in laboratory services are ensured.
LS.1.6	Arragements for reporting and managing adverse events in laboratory services are established.
LS.1.7	Arragements for the use of point-of-care testing devices are established.
LS.1.8	Necessary training is provided to relevant personnel for laboratory services.
Code	**Standard 2**
LS.2	Control of pre-analytical processes is ensured.
Code	**Assessment Criteria**
LS.2.1	Arragements for sample and test requests are established.
LS.2.2	Arragements for sample collection are established.
LS.2.3	Arragements for sample transfer are established.
LS.2.4	Arragements for the acceptance and rejection of samples in the laboratory are established and traceable.
LS.2.5	Arragements for samples accepted into the laboratory are established.
LS.2.6	Arragements for identity verification in pre-analytical processes are established.

Code	Standard 3
LS.3	Control of analytical processes is ensured.
Code	**Assessment Criteria**
LS.3.1	Control of analytical processes is ensured.
LS.3.2	Quality control activities for laboratory tests are conducted.
Code	**Standard 4**
LS.4	Control of post-analytical processes is ensured.
Code	**Assessment Criteria**
LS.4.1	Arragements for the interpretation and reporting of laboratory results are established.
LS.4.2	Laboratory result reporting times are determined, and timely reporting of results is ensured.
LS.4.3	Arragements for the storage and archiving of analysis samples, excess biological material, test data, and results are established.
Code	**Standard 5**
LS.5	Traceability of laboratory service processes is ensured.
Code	**Assessment Criteria**
LS.5.1	All stages of laboratory service processes are traceable.
LS.5.2	Arragements for information management in laboratory service processes are established.
LS.5.3	Arragements for tests conducted through external resources are established.
Code	**Standard 6**
LS.6	Monitoring and evaluation activities for laboratory services are conducted.
Code	**Assessment Criteria**
LS.6.1	Indicators for evaluating the performance of laboratory services are determined, the effectiveness of operations is monitored regularly, and continuous improvement activities are carried out.

SECTION 4 HEALTH SERVICES	
Chapter 18 **Radiology, Nuclear Medicine and Radiation Oncology Services (RNR)**	
Code	**Standard 1**
RNR.1	Processes and rules for radiology, nuclear medicine and radiation oncology services are defined and proper functioning is ensured
Code	**Assessment Criteria**
RNR.1.1	Areas where radiology, radiation oncology and nuclear medicine services are provided defined.
RNR.1.2	Processes and rules for radiology, nuclear medicine and radiation oncology services are documented.
RNR.1.3	Arragements are made for areas where radiology and radiation oncology services are provided.
RNR.1.4	Arragements are made for areas where nuclear medicine services are provided.
Code	**Standard 2**
RNR.2	Monitoring and evaluation studies are conducted for radiology, radiation oncology and nuclear medicine services.
Code	**Assessment Criteria**
RNR.2.1	Works on radiology, radiation oncology and nuclear medicine services are carried out within a program.
RNR.2.2	Protective measures are taken for patients and their relatives in areas where radiology, radiation oncology and nuclear medicine services are provided.
RNR.2.3	Protective measures are taken for employees in areas where radiology, radiation oncology and nuclear medicine services are provided.
Code	**Standard 3**
RNR.3	Arragements are made to ensure radiation safety
Code	**Assessment Criteria**
RNR.3.1	Indicators for radiology, radiation oncology and nuclear medicine services are determined, the effectiveness of the work are monitored at regular intervals and continuous improvement activities are carried out.
RNR.3.2	Periodic field assessments of radiology, radiation oncology and nuclear medicine services are conducted and reports is shared with the committee and senior management.

SECTION 4 HEALTH SERVICES	
Chapter 19 Emergency Department Services (EDS)	
Code	**Standard 1**
EDS.1	Processes and rules related to emergency department service processes are defined, and operations align with these.
Code	**Assessment Criteria**
EDS.1.1	Emergency department service delivery areas are defined.
EDS.1.2	Processes and rules for emergency depart-ment services are documented.
EDS.1.3	If an emergency department is not availab-le, processes for providing emergency he-alth services are defined.
EDS.1.4	Necessary training for staff related to emer-gency department service processes is pro-vided.
Code	**Standard 2**
EDS.2	Arrangements are made for the areas where emergency services are provided.
Code	**Assessment Criteria**
EDS.2.1	Arrangements that facilitate access to the emergency department are made.
EDS.2.2	Arrangements for reception, consultation, guidance, and registration services are ma-de.
EDS.2.3	Arrangements specific to the operation of areas designated for providing emergency department services are made.
EDS.2.4	Access to service delivery areas related to the emergency department is facilitated.
EDS.2.5	Arrangements for expanding the emergency department in cases such as disasters, epi-demics, or major accidents are made.
EDS.2.6	Arrangements for medications, supplies, and devices required in the emergency depart-ment are made.
EDS.2.7	Arrangements to ensure safety in the emer-gency department are made.

Code	Standard 3
EDS.3	Arrangements related to patient care in the emergency department are made.
Code	**Assessment Criteria**
EDS.3.1	Arrangements for prioritizing patients (triage) applying to the emergency department are ma-de.
EDS.3.2	Arrangements for examination, intervention, treatment, consultation, and observation pro-cesses in the emergency department are made.
EDS.3.3	Algorithms for the diagnosis, treatment, and follow-up of critical patient groups served in the emergency department are created.
EDS.3.4	Safe patient transfer is ensured in all service processes in the emergency department.
EDS.3.5	Arrangements related to patient admission, transfer, and discharge from the emergency department are made.
EDS.3.6	Arrangements are made to ensure effective communication in emergency service proces-ses.
Code	**Standard 4**
EDS.4	The traceability of processes related to emergency services is ensured, and monitoring and evaluation studies are conducted.
Code	**Assessment Criteria**
EDS.4.1	All stages of emergency service processes are traceable, performance indicators are determined for performance evaluation, and continuous improvement activities are carried out.

SECTION 4 HEALTH SERVICES	
Chapter 20 Health Services Requiring Specialized Planning (RPS)	
Code	**Standard 1**
RPS.1	Processes and rules for health services that require specialized planning are defined and appropriate functioning is carried out accordingly.
Code	**Assessment Criteria**
RPS.1.1	Patient groups and service areas requiring specia-lized planning are identified and relevant service processes and rules are documented.
RPS.1.2	Arrangements are carried out for service delivery processes specific to patient groups and service areas that require special planning.
RPS.1.3	Special planning is required for patient groups and service areas, and appropriate physical environ-ment conditions, materials, devices, and equipment are provided.

SECTION 5 SUPPORT SERVICES	
Chapter 21 Facility Management and Hospitality Services (FMH)	
Code	**Standard 1**
FMH.1	Processes and rules regarding facility management are defined and proper functioning is ensured.
Code	**Assessment Criteria**
FMH.1.1	Processes and rules for the facility management research are documented.
FMH.1.2	A structure responsible for the planning and coordination of activities related to facility management is established.
FMH.1.3	Risks related to facility management are identified and necessary measures are taken.
FMH.1.4	Arrangements are made for the continuity and safe use of basic facility resources.
FMH.1.5	Arrangements are made to facilitate access to different service units in the facility settlement area and depart-ments within the facility.
FMH.1.6	Arrangements are made for emergency exits.
FMH.1.7	Arrangements are made for the elderly and individuals with special needs.
FMH.1.8	Arrangements are made for the safe use of lifts, escalators and belts.
FMH.1.9	Arrangements are made to prevent facility-related falls.
FMH.1.10	Exterior facade and landscaping of the building is done.
FMH.1.11	Building tours and technical site visits are made for phys-ical condition and functioning.
FMH.1.12	Necessary trainings are given to the relevant employees about the processes related to facility management.
Code	**Standard 2**
FMH.2	Arrangements are made for hotel services.

Code	Assessment Criteria
FMH.2.1	In all areas where services are provided, arrangements are made to ensure the needs, ergonomics and comfort of patients and their relatives.
FMH.2.2	Arrangements are made for patient rooms, examination rooms and waiting areas.
FMH.2.3	During the medical care process, arrangements are made for patients to have easy access to health personnel when necessary.
FMH.2.4	Arrangements are made for personal cleaning areas.
FMH.2.5	Arrangements are made for baby care and breastfeeding rooms.
FMH.2.6	Arrangements are made to ensure the safety of life and property of patients / relatives and employees.
FMH.2.7	Arrangements are made for catering services to be pro-vided to patients / relatives and employees.
FMH.2.8	Arrangements are made for laundry services.

SECTION 5 SUPPORT SERVICES	
Chapter 22 Information Management System (IMS)	
Code	**Standard 1**
IMS.1	Processes and rules related to the information management system are defined, and operations align with these.
Code	**Assessment Criteria**
IMS.1.1	Processes and rules related to the information manage-ment system are documented.
IMS.1.2	Individuals responsible for the information management system are identified, and duties, authorities, and res-ponsibilities are defined.
IMS.1.3	Electronic access to patients' health records is provided at national and institutional levels.
IMS.1.4	Modules within the information management system are integrated.
IMS.1.5	Operations performed on the information management system are traceable.
IMS.1.6	Arragements are established for all computers used wit-hin the information management system.
IMS.1.7	Necessary support is provided to ensure the effective-ness and continuity of the information management system.
IMS.1.8	Updated information regarding servers is recorded.
IMS.1.9	Training is provided to employees to ensure effective use of the information management system.
Code	**Standard 2**
IMS.2	Arragements are made to ensure information security.
Code	**Assessment Criteria**
IMS.2.1	Necessary measures are taken to ensure information security and protect personal data.
IMS.2.2	Risks related to the information management system are identified and analyzed.

IMS.2.3	The security of the server rooms is ensured.
IMS.2.4	Security measures are taken for access from external environments to internal areas.
IMS.2.5	Measures are taken to ensure the security of the server.
IMS.2.6	Measures are taken to ensure the security of the databa-se.
IMS.2.7	Arragements are made for backing up the data on the information management system.
IMS.2.8	Arragements are made for error reporting and resolution processes.
IMS.2.9	The information management system and infrastructure are adapted to technological innovations and require-ments.

SECTION 5 SUPPORT SERVICES	
Chapter 23 Records Control and Archive Services (RCA)	
Code	**Standard 1**
RCA.1	Processes and rules regarding the control of medical and administrative records are defined and appropriate functioning is ensured.
Code	**Assessment Criteria**
RCA.1.1	Processes and rules for the control of medical and admi-nistrative records are documented.
RCA.1.2	Responsible persons for the control of records are identi-fied and their duties, authorities and responsibilities are defined.
RCA.1.3	Arrangements are made for the preparation and use of medical and administrative records.
RCA.1.4	Rules for information privacy and security in access to records are defined.
RCA.1.5	A standard plan for the definition and content of patient files is established.
RCA.1.6	Arrangements are made for electronic records.
Code	**Standard 2**
RCA.2	Processes and rules regarding archive services are defined and proper functioning is ensured.
Code	**Assessment Criteria**
RCA.2.1	Processes and rules for archive services are documented.
RCA.2.2	Arrangements are made for the storage of patient files in the archive section.

SECTION 5 SUPPORT SERVICES	
Chapter 24 Material and Equipment Management (MEM)	
Code	**Standard 1**
MEM.1	Material management processes and rules are defined, and the operation is carried out accordingly.
Code	**Assessment Criteria**
MEM.1.1	Material management processes and rules are docu-mented.
MEM.1.2	Responsible individuals for material management are identified, and their duties, authorities, and responsibi-lities are defined.
MEM.1.3	Arrangements for identifying and procuring materials are made.
MEM.1.4	Arrangements for the storage and inventory control of materials are made.
MEM.1.5	Arrangements for the safe transfer of materials to units are made.
Code	**Standard 2**
MEM.2	Processes and rules for the management of hazardous materials are defined, and the operation is carried out accordingly.
Code	**Assessment Criteria**
MEM.2.1	Processes and rules for the management of hazardous materials are documented.
MEM.2.2	Responsible individuals for the management of hazar-dous materials are identified, and their duties, authori-ties, and responsibilities are defined.
MEM.2.3	An inventory of hazardous materials is created.
MEM.2.4	Arragements for the management of hazardous materi-als are made.
Code	**Standard 3**
MEM.3	Device management processes and rules are defined, and the operation is carried out accordingly.

Code	Assessment Criteria
MEM.3.1	Device management processes and rules are documen-ted.
MEM.3.2	The persons responsible for device management are identified, along with their duties, authority, and res-ponsibilities.
MEM.3.3	The traceability of devices is ensured.
MEM.3.4	Arragements for the safe and efficient use of medical devices are established.
MEM.3.5	Arragements for the usage process and quality control activities of Point-of-care testing devicess are established.
MEM.3.6	Arragements for medical devices identified as unsuitab-le for use or with limited usage decisions, based on test, control, and calibration results, are established.
MEM.3.7	Arragements for device malfunction reporting and re-pair are established.
MEM.3.8	Arragements for reporting adverse events related to medical devices are established.

SECTION 5 SUPPORT SERVICES	
Chapter 25 Waste Management (WM)	
Code	**Standard 1**
WM.1	Processes and rules related to waste management are defined, and the operations are carried out accordingly.
Code	**Assessment Criteria**
WM.1.1	Processes and rules related to waste management are documented.
WM.1.2	Waste management responsibles are assigned, and du-ties, authorities, and responsibilities are defined.
WM.1.3	Waste segregation at the source, collection, transporta-tion, temporary storage, and reduction are ensured.
WM.1.4	Practices to mitigate the effects of climate change are implemented.
WM.1.5	Training is provided to employees regarding waste ma-nagement.

SECTION 6 DISASTER AND EMERGENCY MANAGEMENT	
Chapter 26 Disaster and Emergency Management (DEM)	
Code	**Standard 1**
DEM.1	Arrangements are made regarding disaster and emergency management processes.
Code	**Assessment Criteria**
DEM.1.1	An administrative structure for disaster and emergency management is established and du-ties, authorities and responsibilities are defined.
DEM.1.2	Risk assessment for disaster and emergency management is made.
DEM.1.3	Disaster and emergency plan is created.
DEM.1.4	Emergency plan sketches are available.
DEM.1.5	Arrangements are made for evacuation in disas-ters and emergencies.
DEM.1.6	Arrangements are made for earthquake.
DEM.1.7	Arrangements are made for fire.
DEM.1.8	All employees are trained on disaster and emer-gency plan and drills are conducted.
Code	**Standard 2**
DEM.2	Arrangements are made for emergency warning systems.
Code	**Assessment Criteria**
DEM.2.1	Warning systems for emergencies is established.
DEM.2.2	Persons responsible for the management of emergency warning systems and their responsi-bilities are identified.
DEM.2.3	Response team(s) for emergencies are identi-fied.
DEM.2.4	Necessary medicines and equipment to be used in response to emergencies are identified and their continuity is ensured.
DEM.2.5	Records of interventions is kept.
DEM.2.6	Trainings on emergency warning systems are provided and drills is conducted.

SECTION 7 CLIMATE CHANGE AND SUSTAINABILITY	
Chapter 27 Climate Change and Sustainability (CCS)	
Code	**Standard 1**
CCS.1	Arrangements are made to address climate change and service sustainability.
Code	**Assessment Criteria**
CCS.1.1	A plan to combat climate change and ensure sus-tainable care is developed.
CCS.1.2	Environmentally friendly arrangements are made for the use of resources.
CCS.1.3	Activities are carried out to raise awareness on combating climate change and ensuring sustai-nable care.
CCS.1.4	Arrangements are made to monitor and improve efficiency.

SECTION 8 PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT	
Chapter 28 Indicator Management (IM)	
Code	**Standard 1**
IM.1	Processes and rules regarding indicator management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
IM.1.1	Processes and rules regarding indicator management are documented.
IM.1.2	Duties, authorities and responsibilities regarding indi-cator management are defined.
IM.1.3	Indicators for performance measurement are determi-ned and monitored.
IM.1.4	Indicator cards are created to monitor the determined indicators.
IM.1.5	Indicator data is collected accurately and in high qua-lity using appropriate methods.
IM.1.6	Relevant employees are trained regarding indicator management.
Code	**Standard 2**
IM.2	The effectiveness of indicator management is ensured.
Code	**Assessment Criteria**
IM.2.1	Indicators are analyzed and necessary improvement studies are carried out.
IM.2.2	Indicator data, targets and results are sent to relevant information management systems.

SECTION 1
Management and Organization

TÜSEB TÜSKA
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SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 1 Organizational Structure and Functioning (OSF)	
Code	**Standard 1**
OSF.1	Arrangements are made regarding the organizational structure.
Code	**Assessment Criteria**
OSF.1.1	An organizational structure is designed to include all managerial processes and vertical and horizontal relationships with management levels are defined.
OSF.1.2	Management levels for the organizational structure are defined to include responsibilities related to institutional, financial and clinical governance, and relevant responsible persons is identified.
OSF.1.3	The duties, authorities and responsibilities of the units and employees in the organizational structure is defined; unit supervisors are identified.
OSF.1.4	All areas of activity have authorization and permission documents in accordance with the country's legislation and these documents are up-to-date, valid and traceable.
OSF.1.5	Effective leadership, teamwork and communication are ensured in processes related to the organizational structure.
Code	**Standard 2**
OSF.2	Routing strategies are identified and resource planning is done.
Code	**Assessment Criteria**
OSF.2.1	Mission, vision and ethical values are determined and shared with the public.
OSF.2.2	Strategic goals and objectives in line with the mission of the institution/ organization are determined and a strategic plan is created accordingly.
OSF.2.3	Policies for organizational processes are established and all activities are carried out in line with the determined policies.
OSF.2.4	Budget planning is done and reviewed regularly.
OSF.2.5	An operational plan with defined service targets aligned with strategic objectives is developed and progress in achieving these targets is measured.

Code	Standard 3
OSF.3	Arrangements are made regarding corporate communication activities.
Code	**Assessment Criteria**
OSF.3.1	Corporate stakeholders are determined and processes for ensuring effective communication are defined.
OSF.3.2	Corporate stakeholders are ensured to participate in improvement processes.
OSF.3.3	The target audience is identified in line with the organizational structure, basic policies and values, and the communication process and strategies for the target audience are defined.
OSF.3.4	Stakeholders are informed about the corporate organization and activities.
OSF.3.5	Activities are carried out to create a positive corporate image among stakeholders.
OSF.3.6	Social responsibility programs that promote and encourage health are organized, and the results of these programs are monitored and evaluated.
Code	**Standard 4**
OSF.4	Processes and rules regarding outsourcing are defined and proper functioning is ensured.
Code	**Assessment Criteria**
OSF.4.1	Processes and rules for outsourcing are documented.
OSF.4.2	Arrangements are made to control the services provided through outsourcing.
OSF.4.3	Services provided through outsourcing are in compliance with the relevant TÜSKA SAS.
Code	**Standard 5**
OSF.5	Effective management of scientific research is ensured.
Code	**Assessment Criteria**
OSF.5.1	Processes and rules for the management of scientific research are documented.
OSF.5.2	Arrangements are made for the coordination of scientific research.
OSF.5.3	Arrangements are made for the use of patient data, information and materials for Participation in scientific research or for any other reason.

General Information

Healthcare facilities need to be managed effectively and efficiently due to their critical role in the protection, development and improvement of human health. Management in health services includes planning, organizing, directing, coordinating and controlling functions. The success of health facilities operating in a dynamic environment is possible only if these functions are performed in a planned and organized manner. These functions are carried out by designing the organizational structure, determining duties, authorities and responsibilities, planning financial processes, ensuring communication with internal and external stakeholders, determining strategies, making necessary plans for the effective use of resources, and carrying out research and development activities. Standards for Accreditation in Health provide guidance in ensuring that managerial activities are carried out effectively, efficiently and productively and cover all health service delivery areas.

Individuals who undertake governance, management and leadership in the implementation of this standard have authority and responsibility. Managers and leaders are primarily responsible for the implementation of the Standards for Accreditation in Health and is directly or indirectly involved in all processes as a requirement of governance. Governance and leadership are important elements that have an impact on the performance of health institutions and organizations, the way they conduct their activities, their role in the sector and their relationship with other actors. Governance is defined as "organizational activities in which empowered people act by putting common interests ahead of personal interests for the perfect realization of organizational goals, adopting communication and effective information sharing, mutual trust and transparency, joint decision-making, high emotional intelligence, empathetic, proactive and synergistic behavior". Governance is defined as a multi-actor and interactive management process instead of a single-actor management approach. There are different governance structures depending on the size and type of health facilities. While macro-level health facilities have a board of directors as governance, micro-level facilities is allowed to have only a physician as chairperson and a less structured governance system.

It is important to work with the leadership team for successful governance. Leadership is defined as a process in which an individual influences or directs employees or other people in line with organizational goals. It is important to have effective leaders at all levels of health institutions and organizations in order to effectively manage health facilities that operate in a dynamic and ever-changing environment. For effective leadership, it is necessary to have a good understanding of the needs and behaviors of employees, to have a common vision, to ensure reliable communication between leaders and employees, to exhibit behaviors aimed at influencing results, to use information effectively, to take risks by adhering to the principles and values of the facility, to create opportunities for the development of employees and teams, to develop rational solutions to achieve goals and objectives and to carry out continuous improvement activities.

Chapter 1: Organizational Structure and Functioning (OSF)

Purpose

The purpose of this chapter:

- To define duties, authorities, responsibilities, obligations, communication and approval mechanisms to achieve corporate objectives, to ensure continuity in the functioning of the health facility, to ensure that the workflow is carried out and supervised within a defined organizational structure
- Ensuring the provision, control and traceability of health services and other support services within the scope of the relevant country legislation
- To define the principles that will guide managers and employees in the activities and strategic decisions of the organization by determining the basic policies and values
- To create positive attitudes, behaviors and trust in the target audience; to increase the effectiveness and quality of the services provided with the information obtained from the target audience
- To ensure that the services provided through outsourcing are provided in line with the basic policies and values of the organization and in line with the objectives set within the scope of SAS in order to increase the quality and effectiveness of the services provided
- To prevent environmental damage to the services provided and to ensure efficient use of facility resources.

Objectives

- Effectiveness
- Efficacy
- Efficiency

Standard Requirements

Standard 1

OSF.1
Arrangements are made regarding the organizational structure.

OSF.1.1
An organizational structure is designed to include all managerial processes and vertical and horizontal relationships with management levels are defined.

- » An organizational structure (functional, departmental, matrix, etc.) suitable for the facility is designed by evaluating basic elements such as the section of the organization, type of service, target audience, other relevant institutions and their locations, internal and external requirements.
  - The organization chart is prepared with the participation of senior management.
  - The organization chart is approved by senior management.
  - Employees are informed about the organization chart.
- » The organization chart is defined to show vertical and horizontal relationships from the top unit to the bottom unit. The document address at least the following issues:
  - Division of labor and specialization
  - Responsibility and relationships
  - Ways to delegate authority
  - Coordination and integration points
- » The following points are considered when preparing the organization chart:
  - In the organization chart, communication and relationship paths are expressed with different visual elements.
  - Ways of delegation is expressed in job descriptions or letters of appointment.
- » The organizational structure is designed to achieve the goals and objectives set within the framework of fundamental policies and values in the most effective way.
- » The organizational structure includes the administrative, financial, clinical, support, etc. structures of the facility.

OSF.1.2
Management levels for the organizational structure are defined to include responsibilities related to institutional, financial and clinical governance, and relevant responsible persons are determined.

- » Management levels regarding the organizational structure are defined.
  - Management levels are defined to include senior management (chief physician, general manager, etc.), middle management levels and lower management levels (unit/clinic and department managers).
- » The responsibilities of the identified management staff are defined.
- » Responsibilities related to corporate governance are defined to include the following key elements:
  - Transparency

- Accountability
- Participation
- Responsiveness
- Rule of law
- Effectiveness
- Equality
- Strategic vision

» Responsibilities for clinical governance are defined to include at least the following key elements
- Clinical efficiency
- Clinical audit
- Risk management
- Patient and community engagement
- Human resource management
- Vocational and in-service trainings
- Use of information

» Responsibilities for financial governance are defined to include at least the following key elements:
- Defining the budget on institution and unit basis
- Ensuring effective, efficient and productive use of the budget
- Control and monitoring of expenditures and income-expenditure balance

» All managers (chief physician, general manager, director of nursing services, administrative/financial service managers, departerment/division managers, clinical and non-clinical managers, etc.) are defined who appoints them and to whom they are responsible.

» Successful implementation of organizational, financial and clinical governance requires effective leadership, teamwork and communication across administrative, economic, political and clinical processes.

OSF.1.3
The duties, authorities and responsibilities of the units and employees in the organizational structure are defined; unit supervisors are determined.

» The assignment methods of those responsible from the lowest unit of the organization to the top manager are defined and announced. The following points are considered in the applications to be realized within this framework:
- For those working at all levels of management, the letters of appointment/reappointment of senior, middle and junior management is valid and up-to-date.
- Letters of appointment are approved by the competent authority or senior management.
- Employees and managers are informed about appointment/reassignment letters.

» Job descriptions of all units and employees in the organizational structure is made and their authorities and responsibilities is clearly defined.

» Job descriptions include inter-unit relations and is organized in a way to prevent ambiguity and complexity. There is harmony between the authorities and responsibilities given to units and individuals.

» Ethical principles and values such as confidentiality, privacy and confidentiality etc. are observed when defining the duties, authorities and responsibilities of employees

OSF.1.4
All areas of activity have authorization and permission documents in accordance with the country's legislation and these documents are up-to-date, valid and traceable.

» There are up-to-date authorization and permission documents covering all activities, in accordance with the country's legislation.
» There are up-to-date authorization and permission documents covering all employees, in accordance with the country's legislation.
» Authorization and permission documents are checked and traceability is ensured periodically and when needed

OSF.1.5
Effective leadership, teamwork and communication are ensured in processes related to the organizational structure.

» Effective and efficient leadership are demonstrated at all levels and processes.
» Leaders are involved in the process of determining the mission, vision, goals and objectives of the institution/organization.
» Leaders at all levels are involved in ensuring that the health institution/ organization achieves its goals and objectives.
» Leaders ensure that employees work in a coordinated way.
» Leaders ensure the development of a culture of safety and quality improvement.
» Leaders play a role in ensuring communication between the organization and patients, employees and other stakeholders.

Standard 2

OSF.2
Routing strategies are determined and resource planning is done.

OSF.2.1
Mission, vision and ethical values are determined and shared with the public.

» The mission and vision of the institution/organization are determined within the framework of the information obtained as a result of the analysis of internal and external environmental conditions.
  • Mission and vision statements for internal stakeholders are prepared with the participation of department managers, unit managers, quality officers and employees and approved by senior managers.
  • All employees are able to state the health institution/organisation's mission, vision and ethical values in interviews with them.
  • Determination of mission, vision and ethical values are ensured with the Participation of employees and is traceable.
  • Mission, vision and values are reflected in the culture of the organization and

is observable in all processes.
- Mission, vision and values are announced to the public through various communication tools determined by the institution (website, bulletin boards, promotional activities, etc.).

» Values that include the principles and rules to be taken as basis in all activities to be carried out is determined.
- Issues such as ethical principles and codes of conduct, principles that prioritize patient and employee orientation is addressed within the scope of corporate values.

» Care is taken to align core policies and values with the minimum values of employees and service users.
» Ethical values and principles are determined and traceable, taking into account the field of service provided.
» Employee and patient expectations and feedback are reflected in core policies and values

OSF.2.2
Strategic goals and objectives in line with the mission of the institution/organization are determined and a strategic plan is created accordingly.

» In parallel with the fundamental policies and values, corporate and departmental goals and objectives are set for the short, medium and long term:
» Analyses for goals and objectives and if there are any revisions, are made traceable.
» The results of the goals and objectives are measured and the achievement of these goals and objectives are monitored.
» Departmental goals and objectives are in line with institutional goals and objectives.
» Accessibility are based on corporate and departmental goals and objectives.
» When making institutional planning, internal (human resources, financial situation, size, service variety, structural conditions, etc.) and external (legal environment, public relations, health structure of the society, suppliers, competitors, etc.) environmental factors and the characteristics and feedback of patients/service users, employees and the community are taken into account.
» A strategic plan is prepared taking into account political, economic, social, environmental and legal factors.
» The strategic plan is reviewed at specified intervals and stakeholder participation, including service users, are ensured in these processes.
» The strategic plan is reviewed at least once a year and revised when necessary

OSF.2.3
Policies for organizational processes are established and all activities are carried out in line with the determined policies.

» At least the following corporate policies is established for the activities carried out in line with the goals and objectives of the organization:
- Quality Policy
- Patient and employee safety policy

- Education policy
- Human resources policy
- Information management and security policy
- Climate change mitigation and sustainability policy

» All activities are carried out in line with established policies.

OSF.2.4
Budget planning is done and reviewed regularly.

» Budgeting activities are carried out by a managerial structure.
» The budget is reviewed and reported at specified intervals.
» The budget is revised when needed.
» Budget planning is in line with organizational goals and objectives:
- Each objective and target are associated with a budget item.

» Continuous improvement studies are carried out for the provision of financial resources after review and control

Standard 3

OSF.3
Arrangements are made for corporate communication activities.

OSF.3.1
Corporate stakeholders are determined and processes for ensuring effective communication are defined.

» Internal and external stakeholders of the institution/organization are identified.
» Communication with stakeholders is defined to include the processes of planning, organizing, executing, evaluating and improving services and the method of communication, and the communication process is shared with stakeholders.
» Employees are trained on corporate communication.

OSF.3.2
Corporate stakeholders are ensured to participate in improvement processes.

» Feedback is received from internal and external stakeholders on institutional activities..

OSF.3.3
The target audience is identified in line with the organizational structure, basic policies and values, and the communication process and strategies for the target audience are defined.

» The target audience is determined by considering the type and size of the institution/organization, patient profile, regional characteristics, basic policies and values, and internal and external stakeholders.
» Communication strategies for the target audience are defined.
» Within the framework of the communication strategy, communication rules covering at least the following topics are determined for the target audience inside and outside the organization;

- Information and decision flow between departments and elements
- Information and decision flow in evaluation and audit functions
- Communication in training and information activities
- Communication in activities to increase motivation and embrace corporate identity
- Communication with internal and external stakeholders

OSF.3.4
Stakeholders are informed about the corporate organization and activities.

» Information activities specific to the identified stakeholders are carried out.
» Work is carried out for the representation and promotion of the institution/organization in electronic environment.
» The website of the institution/organization is up-to-date, easily accessible/usable and contain at least the following information:
- Mission, vision, core policies and values
- Organization structure
- Departments/branches served
- Specialty branches of physicians and their specific areas of interest if there is any
- Information on specialized services
- Activities carried out within the scope of social responsibility
- Human Resources
- Public relations activities
- Emergency services
- Making appointments and delivering results
- Visiting hours and rules to be followed
- Communication and transportation
- Areas where feedback can be given, etc

OSF.3.5
Activities are carried out to create a positive corporate image among stakeholders.

» An assessment of the current situation is made to create a positive corporate image.
» Improvement efforts are made to address the needs identified as a result of the evaluation.
» The corporate image is evaluated regularly and the results are reported.
» Activities aimed at creating a corporate image are carried out through information channels such as posters, brochures, web-based, etc., as well as through methods such as effective communication between employees and patients and their relatives, providing quality service, and effectively representing the institution/organization.

OSF.3.6
Social responsibility programs that promote and encourage health are organized, and the results of these programs are monitored and evaluated.

» Local, national and global health problems are investigated by the institution/organization and due diligence are carried out by evaluating the following

elements:

- Demographic data such as population, age, gender, education status
- Health statistics including morbidity, mortality and epidemiological data
- Social and cultural characteristics
- Based on the assessment of the situation, health promoting and health enhancing activities for the target population are planned within a program.
- In this context, at least two programs are available.
- Programs are organized around the topics shown below as examples;
  - Fight against smoking
  - Fighting obesity
  - Increasing the awareness and knowledge level of the society on oral and dental health
  - Promoting organ donation
  - Promoting healthy eating for a healthy life
  - Promoting physical activities for a healthy life
  - Promoting psychological, social and cultural development of patients
  - Promotion of breastfeeding
  - Educational activities for pregnant patients
  - Cooperation with local authorities to combat regional factors that threaten public health
  - Rational use of medicines
  - Educational and preventive activities developed to combat chronic diseases
  - Combating climate change
  - Availability of health services for future generations
  - Efficient use of resources for sustainable health services
  - Using artificial intelligence technologies for the benefit of human health

» Program results are evaluated by the institution to determine the effectiveness of the implementation and the degree of achievement of the planned objectives.

» How health promotion programs will be determined, their scope, who will participate, their effectiveness and results are monitored.

» Based on the evaluation results, improvements are made in program activities to achieve the objectives.

Standard 4

OSF.4

Processes and rules regarding outsourcing are defined and proper functioning is ensured.

OSF.4.1

Processes and rules for outsourcing are documented.

» Processes and rules for outsourcing are include at least the following points;

- Services are provided through outsourcing
- Scope and processes of services provided through outsourcing
- The number and qualification of personnel, and the materials and equipment are used, necessary for the external service provider to carry out the activities

- Control and work completion processes related to the services that the external service provider provide to the organization

» The following minimum arrangements are made for the services provided through outsourcing;
- The reasons for the need for outsourcing and the service are provided and the objectives targeted are determined based on the basic policies and values of the health facility.
- The strategy for outsourcing is determined and the activities carried out for this purpose is traceable.
- Using outsourcing decisions are reflected in the organization's work flow procedures by senior management and are shared with all employees at the beginning and during the ongoing use of resources.
- Employees are informed about outsourcing areas, etc. and their feedback on the process are obtained.

» Scope of services provided through outsourcing and processes, at least the following arrangements are made;
- The services and working processes that the external service provider provide to the institution are defined.
  - The scope of outsourced services is determined and work flow charts are created.
  - Business processes are clearly and precisely defined.
  - The number of personnel required for the external service provider performs the activities, their qualifications, and the equipment and devices to be used are determined.
- All kinds of specifications etc. documents showing the transition to the outsourcing process, usage, agreement periods etc. are traceable.
- Activity outputs related to outsourcing and their continuity are traceable

OSF.4.2
Arrangements are made to control the services provided through outsourcing.

» In accordance with the defined scope and business processes, methods for continuous control of outsourced services, control criteria and performance indicators are determined.
- There are control criteria and performance indicators established by the institution/organization according to the specification, and their records and analysis are traceable.

OSF.4.3
Services provided through outsourcing are ensured to comply with the relevant TÜSKA SAS.

» The compliance of the services provided through outsourcing with the basic policies and values of the institution/organization and TÜSKA SAS are guaranteed through contracts.
- Contracts with outsourced service providers include provisions that meet the relevant TÜSKA standards.
- Contracts clearly specify the obligations to audit and report on the outsourced service provider's compliance with these standards.

- Services provided through outsourcing are evaluated regularly.
  - The institution/organization regularly evaluate the compliance of its outsourcing providers with the relevant TÜSKA standards.
  - Based on the evaluation results, the performance of service providers is regularly monitored and reported with the determined key performance indicators. These indicators and implementation reflect compliance with relevant TÜSKA standards.
  - Performance reports are submitted to both the institution/organization management and the outsourcing service provider.

» Corrective and improvement actions (CIA) are planned for nonconformities identified for outsourced services and the effectiveness of these actions are regularly evaluated.

» Outsourcing providers are trained and informed about TÜSKA standards regarding the services they offer.

Standard 5

OSF.5
Effective management of scientific research is ensured. *
* This standard is assessed in institutions/organizations where scientific research is conducted.

OSF.5.1
Processes and rules for the management of scientific research are documented.

OSF.5.2
Arrangements are made for the coordination of scientific research.

» A responsible structure is established for the management of scientific research.

» Duties, authorities and responsibilities for the management of scientific research are defined.

» Detailed policies and procedures are developed for the conduct of scientific research.

» Institutional management are responsible for the protection of human research data.

» The institution's management comply with all legal and professional requirements.

» Conflicts of interest related to research conducted within the institution identified and managed.

» In scientific research, data security, patient rights and compliance with ethical rules are ensured.

OSF.5.3
Arrangements are made for the use of patient data, information and materials for participation in scientific research or for any other reason.

» Scientific research is conducted in accordance with national and international ethical standards and legal arragements, and necessary measures are taken to

ensure compliance with the standards.

- In case of participation in scientific research or use of patient data, information and materials for any reason, verbal and written consent of the patients are obtained.
- Clinical trials are compatible with the institution's quality and patient safety program.
- Patients and their relatives are informed about how they can participate in clinical research, clinical investigations or clinical trials, and protective measures are taken for vulnerable groups to minimise the possibility of being subjected to possible coercion or influence.
- The continuity of scientific research is ensured and traceable.
- Scientific research is supported and encouraged by the management.
- Employees are aware and implement these practices.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 2 Quality Management (QM)	
Code	**Standard 1**
QM.1	Quality management structure is defined.
Code	**Assessment Criteria**
QM.1.1	A managerial structure for quality management is established and duties, authorities and responsibilities is defined.
QM.1.2	Quality improvement activities are carried out within the scope of quality management.
QM.1.3	Self-assessment activities are carried out.
Code	**Standard 2**
QM.2	The functioning of structures such as committees, boards, units, teams, etc. related to quality management is ensured.
Code	**Assessment Criteria**
QM.2.1	Processes for the functioning of committees, boards, units, teams, etc. are defined.
QM.2.2	Structures such as committees, boards, units, teams, etc. are established and their duties, authorities and responsibilities is defined.
QM.2.3	Committees, boards, units, teams, etc. hold meetings at regular intervals.
QM.2.4	Activities of committees, boards, units, teams, etc. are evaluated and continuous improvements are made.

Chapter 2: Quality Management (QM)

General Information

Quality Management Systems (QMS) offer structured and systematic approaches to increase the effectiveness, efficiency and productivity of health institutions and organizations, improve service quality, increase patient satisfaction and ensure patient and employee safety. This system includes processes and practices such as establishing a quality management structure with management and auditing mechanisms, determining policies and procedures, determining quality work areas, and developing a quality culture for the purpose of continuous improvement of the processes and activities of health institutions or organizations. Considering the importance of quality health service provision, the standards in this chapter cover all health institutions and organizations.

Purpose

The purpose of this chapter;

- Defining the roles and responsibilities of all employees, from governance to department employees, in quality improvement efforts
- Establishment of a quality management structure
- Planning, execution and coordination of quality improvement activities
- Developing a quality culture in the organization
- Ensuring continuous quality improvement

Objectives

- Efficacy
- Effectiveness
- Efficiency
- Continuity

Standard Requirements

Standard 1

QM.1
Quality management structure is defined.

QM.1.1
A managerial structure for quality management is established and duties, authorities and responsibilities is defined.

- » A quality management managerial structure (quality directorate, quality directorate, quality management unit, board, etc.) is established under the leadership of the senior management, taking into account the institutional dynamics, to ensure the planning, execution, coordination and continuity of quality improvement activities.
- » The duties, authorities and responsibilities of the people in the managerial structure and the vertical and horizontal relations of this structure are defined.
  - The position of the quality management structure is clearly stated in the organization chart, and duties, authorities and responsibilities are determined.
- » Quality officers are determined on the basis of departments and/or processes to work in coordination with this managerial structure.

QM.1.2
Quality improvement activities are carried out within the scope of quality management.

- » Quality improvement activities are carried out in line with a plan.
- » Activities are regularly monitored, updated and shared with relevant stakeholders through this plan.
- » A document management system is established within the scope of the quality management system.
- » Department and/or process-based quality studies are monitored and coordinated.
- » Committee work is monitored and coordination is ensured between relevant committees.
- » Measurement, evaluation, improvement and monitoring activities are planned, implemented and sustained.
  - The scope and processes for patient/employee experience surveys are defined and implemented at least twice a year and in a way that covers different service areas (outpatients, inpatients, emergency services, patients undergoing day-to-day interventional procedures, chemotherapy patients, etc.) according to the type of service of the institution and reflects the expectations and perceptions specific to these service areas.
  - Processes for receiving and evaluating patient/employee opinions and suggestions are defined and implemented.
  - Performance for quality improvement activities is monitored through performance indicators, and efforts to use the results obtained for improvement is planned and monitored.
  - Performance and quality improvement data are periodically shared with senior management.

- The results of external evaluations are monitored and used for the benefit of the organization.
- Trainings are provided to develop a quality culture.
- Trainings are carried out within a plan that will be updated every year starting from the orientation training.
- All employees are trained on at least the following topics and the effectiveness of the trainings is monitored:
  - Quality Management Systems
  - Document Management
  - National and International Patient Safety Goals
  - Quality Improvement Methods
  - Indicator Management

QM.1.3
Self-assessment activities are carried out.

» Processes for self-assessment are defined.
» Self-assessments are conducted at regular intervals, at least twice a year.
» Self-assessments are implemented to cover all processes and departments.
» A plan for the process is made before self-assessments.
  - The team or teams involved in self-assessment is identified.
  - A self-assessment calendar is prepared.
  - Departments are informed about the self-assessment schedule in advance.

» Self-assessments cover all TÜSKA SAS sections.
» Self-assessment is made in line with the planned processes.
» Senior management is informed about the nonconformities identified as a result of self-assessments and necessary improvements are made.

Standard 2

QM.2
The functioning of structures such as committees, boards, units, teams, etc. related to quality management is ensured.

QM.2.1
Processes for the functioning of structures such as committees, boards, units, teams, etc. are defined.

» Processes for the functioning of structures such as committees, boards, units, teams, etc. include at least the following issues;
  - Subjects to be studied
  - Duties, authorities and responsibilities
  - Operation, procedures and principles of structures such as committees, boards, units, etc.

QM.2.2

Structures such as committees, boards, units, teams, etc. are established and their duties, authorities and responsibilities are defined.

» Within the scope of TÜSKA SAS, committees, boards, units, teams, etc. are established for the following issues;
  - Education Management
  - Employee Safety
    - In institutions/organizations that have an Occupational Health and Safety Committee, responsibilities in the field of employee health and safety is carried out by this committee.
  - Patient Safety
  - Prevention and Control of Infections
  - Facility Management
  - Radiation Safety
  - Medication Management
  - Execution and coordination of processes for blood and blood components
  - Human resource management
  - Budget planning
  - Tackling climate change and sustainable care
  - Risk management
  - Solving ethical dilemmas
  - Protecting, implementing and improving the rights of patients and their relatives
  - Radiology, radiation oncology and nuclear medicine services
    - It is established in the presence of at least two of the radiology, nuclear medicine and radiation oncology applications using ionizing radiation sources within the scope of the Radiation Protection Program.
  - Waste management
  - Disaster and emergency management
  - Management of CBRN hazards
  - Organ, tissue and/or cell donation
  - Organ, tissue and/or cell transplantation
    - It is created in health institutions/organizations where organ, tissue and/or cell transplantation programs are implemented.

» If needed, new committees, boards, units, teams, etc. is formed according to the scope of service.

» It is ensured that structures such as committees, boards, units, teams, etc. work in a multidisciplinary manner.

» The persons who will serve in committees, boards, units, teams, etc. are qualified and sufficient in number for the purpose.

» The responsibilities and areas of authority of the persons who will take Chapter in structures such as committees, boards, units, teams, etc. is determined in accordance with the field of work and job descriptions are made accordingly.

» Identifying new indicators for continuous improvement activities, collecting, analyzing, reporting and reporting data to senior management is among the responsibilities of the relevant committee, board, unit, team, etc.

» The functioning, procedures and principles of committees, boards, units, teams, etc. are determined and announced.

» Processes for ensuring cooperation and coordination with other committees, boards, units, teams, etc. are defined.

QM.2.3
Committees, boards, units, teams, etc. hold meetings at regular intervals.

» Processes for meeting management of committees, boards, units, teams, etc., such as determining the meeting frequency and agenda, who will attend, etc. are defined and effective implementation is ensured.
» Meeting minutes of committees, boards, units, teams, etc. is traceable.
» Participation of members of committees, boards, units, teams, etc. in meetings is ensured.
» Meeting results are reported to senior management.

QM.2.4
Activities of committees, boards, units, teams, etc. are evaluated and continuous improvements are made.

» It is assessed whether committees, boards, units, teams, etc. are operating in line with the purpose and objectives.
» Meeting minutes and work reports of committees, boards, units, teams, etc. are submitted to senior management to ensure senior management's participation in the process.
» Activities of committees, boards, units, teams, etc. are evaluated at the end of each year and continuous improvement activities are planned and executed with the participation of senior management.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 3 Human Resources Management (HRM)	
Code	**Standard 1**
HRM.1	Processes and rules for human resources management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
HRM.1.1	Processes and rules for human resources management are documented.
HRM.1.2	A managerial structure for human resources management is established and duties, authorities and responsibilities are defined.
HRM.1.3	Annual targets for human resources management are set and work plans are created.
HRM.1.4	Employees are employed in units and positions in accordance with job descriptions and requirements.
HRM.1.5	An employee recruitment plan is created, and employment processes are defined.
HRM.1.6	Employees are employed in line with job requirements and competencies, and diploma and authorization certificates of the employed personnel are verified.
HRM.1.7	Arrangements are made to evaluate the performance of employees.
HRM.1.8	Employees are informed about their rights and cooperate opportunities.
HRM.1.9	Arrangements are made to receive employees' opinions, suggestions and complaints.

Chapter 3: Human Resources Management (HRM)

General Information

The most fundamental duty of health institutions/organizations are to provide quality healthcare services and the most important factor in the effective and efficient delivery of healthcare services are well-equipped and competent human resources. The most important functions of human resources management are to manage and continuously develop human resources, to employ them in the right positions, to increase their motivation and performance, to meet their training and development needs and to increase job satisfaction. Human resources management in health institutions and organizations covers various functions such as personnel planning, recruitment, training, performance evaluation, career planning, wage and social rights management. The standards in this chapter provide guidance for health institutions/organizations in the effective management of human resources.

Purpose

The purpose of this chapter:

- Defining a management structure that will carry out activities such as task allocation, coordination and evaluation for the work and operations required for a healthy working life
- To identify and ensure the implementation of the requirements for the recruitment and harmonization processes of employees and the requirements for the continuous improvement of their working lives.

Objectives

- Healthy Work Life

Standard Requirements

Standard 1

HRM.1
Processes and rules for human resources management are defined and functioning is ensured accordingly.

HRM.1.1
Processes and rules for human resources management are documented.

» The processes and rules for human resources management include at least the following issues:
- Job descriptions
- Work requirements
- Recruitment
- Orientation
- Developing and supporting employees
- Providing physical and social opportunities for employees
- Minimizing risks for employee safety
- Enhancement of job motivation

HRM.1.2
A managerial structure for human resources management is established and duties, authorities and responsibilities are defined.

» A managerial structure for the planning, organization, direction, coordination and control of human resources is established.
» The managerial structure is defined to show all vertical and horizontal relationships from the top management level to the lowest unit.
» Job descriptions, authorities and responsibilities of all personnel in the human resources management structure are defined

HRM.1.3
Annual targets for human resources management are set and work plans are created.

» To ensure a healthy working life, annual objectives are set together with senior management and department heads.
» A work plan is created to achieve the set objectives, considering factors such as budget, time, and physical conditions for the activities to be carried out.
» The work plan which is created to achieve the set objectives determines, implements, and monitors improvements.
» The set objectives are evaluated at least once a year with the participation of senior management and department heads.
» The targets set is evaluated at least once a year with the Participation of senior management and department heads.

HRM.1.4.
Employees are employed in units and positions in accordance with job descriptions and requirements.

» The duties of employees and their areas of authority and responsibility are determined and regularly reviewed in line with the service processes.
  • The requirements of this assessment criterion apply to any "employee/ staff" for whom a job description is required (e.g. full-time, Chapter-time, permanent, voluntary, temporary assignment and contractual status employees).
  • The responsibilities of clinical staff who are not authorized to practice independently are defined in existing job descriptions. For members of the medical staff and other clinical staff who are permitted by law and arragements to work independently by the health institution/organization and therefore work under clinical authorizations and not a formal job description, there are situations where some roles will require a formal job description. Examples of these situations include an administrative role, such as a line manager; the acquisition of a new clinical skill that requires supervision; Participation in a theoretical or practical training program that requires supervision; or temporary staff. Regardless of the type of job description, it is the responsibility of the health institution/organisation to establish and keep up to date a policy that specifies how often each job description will be reviewed and updated and ensures that the job description is in line with health institution/organisation policy..

HRM.1.5
An employee recruitment plan is created and employment processes are defined.

» Human resources needs are determined in line with job analyses (job descriptions and job requirements), unit demands, new units or units with capacity changes.
» An employee recruitment plan is developed in line with human resources needs.
» Basic processes such as the qualifications of the personnel needed in service areas, the number of personnel to be employed, recruitment and training of personnel are planned.
» The recruitment plan include the number and qualifications of personnel to meet the needs of the services to be provided, taking into account the relevant country legislation, different disciplines and professional groups.
» Job descriptions are made for each department and process, and employee needs are monitored regularly, and human resources planning is carried out. Measures are determined for how to recruit employees and what qualifications and numbers of employees will be provided based on the identified needs.
» The required information and documents for the application and recruitment processes, the steps for evaluation and approval processes are defined, and the recruitment processes are announced

HRM.1.6
Employees are employed in line with job requirements and competencies, and diploma and authorization certificates of employed personnel are verified.

» Employees are recruited taking into account the needs of the organization, job requirements and competencies of the employees.
» All activities are carried out by persons whose professional competence is defined within the framework of the relevant country legislation.
» Diploma and authorization certificates of newly recruited personnel are verified.
  • Authorization documents are checked at regular intervals according to the validity period of the document.
  • These documents are kept in the personnel file

HRM.1.7
Arrangements are made to evaluate the performance of employees.

» Performance Assessment Criteria of employees are determined by taking into account the opinions of the employees and are announced to the employees.
» Measurements are made for employee performance based on the determined performance criteria.
» As a result of the measurement, training needs for improving performance are identified and necessary trainings are provided

HRM.1.8
Employees are informed about their rights and cooperate opportunities.

» All personnel are informed about corporate facilities and opportunities and employee rights.

HRM.1.9
Arrangements are made to receive employees' opinions, suggestions and complaints.

» The scope of employee feedback and the tools to be used to obtain feedback are defined.
» The needs and expectations of employees are taken into account and their participation in decision-making mechanisms are ensured.
» Studies to identify the needs and expectations of employees cover at least the following requirements:
  • Periodic satisfaction surveys (every three (3) months)
  • One-on-one and face-to-face meetings (at least monthly with immediate supervisors)
  • Receiving opinions, suggestions and complaints
» Employee feedback is evaluated at least once every three (3) months, findings are shared with senior management and relevant units and improvements are planned.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 4 Document Management (DM)	
Code	**Standard 1**
DM.1	Processes and rules regarding document management are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
DM.1.1	Rules for document management are determined.
DM.1.2	Documents are distributed and publicized according to established rules.
DM.1.3	Documents are up to date.
DM.1.4	Documents are preserved, archived and destroyed according to established rules.
DM.1.5	External documents are followed and updated.
DM.1.6	Necessary trainings on document management are provided.

General Information

Documents used in healthcare services are comprehensive documents that protect institutional memory, ensure that professional practices are carried out correctly and regularly, and determine the rules related to processes. An effective document management system is essential for effective healthcare delivery. Document management becomes even more critical with the increase in the number and variety of documents. Therefore, the preparation, organization, preservation and correct use of documents require great care. Effective document management helps to plan the decision-making process, reduces costs by reducing potential errors and incomplete records, creates documents that is used in legal processes, provides reference for new documents, and contributes to the orderly management of documents and records by providing a systematic approach. The standards in this chapter guide the process of establishing and operating a document management system in accordance with TÜSKA SAS

Purpose

The purpose of this chapter:

- To ensure the control, accessibility, secure storage and updating of documents and to support the flow of information by creating an institutional memory.

Objectives

- Effectiveness
- Efficacy

Standard Requirements

Standard 1

DM.1
Processes and rules regarding document management are defined, and functioning is ensured accordingly.

DM.1.1
Rules for document management are determined.

- » Processes and rules for the management of documents include at least the following
  - Identification of necessary documents
  - The document contain at least the following information:
    - Name
    - Code
    - Publication Date
    - Revision Date
    - Revision Number
    - Page No/ Number of Pages
    - Prepared, Checked, Approved information
    - Original copies of the documents bear the title and signature of the person(s).
  - Documents;
    - Preparation
    - Control and approval
    - Distribution and announcement
    - Evaluation and updating
    - Changes made in revisions
    - Containment
    - Ensuring security
    - Archiving
    - Decommissioning
    - Destruction
  - Identification and follow-up of outsourced documents
- » Policies, procedures, processes and plans for all core functions of the organization are documented.
- » The documents to be prepared are determined by taking into account the section, service delivery areas and processes of the organization.
  - The main objective in document preparation is to prepare the minimum number of documents that are effectively used, necessary, useful and accessible to the records kept to be presented as evidence when necessary.
- » Prepared documents are evaluated periodically and the date of evaluation is recorded.
- » Documents include at least the following types:
  - Procedure
  - Instruction
  - Guide

- Form
- Plan
- Consent Document
- List
- Auxiliary Documents
  - Politics
  - Protocol
  - Targets
  - Duties-Authorities-Responsibilities
  - Clinical Guidelines
  - Workflow
  - Drug Destruction Record
  - Meeting Minutes

» Documents are prepared to include the following points:
- Documents are prepared by the relevant department/committee/team employees.
  - If it is a committee that prepared the document, records such as the minutes of the meeting where the committee evaluated the relevant document, etc. is traceable.
  - If the preparation of the document is made by the employees of a department/committee/team, the relevant process responsible have information about the process.
- Documents are clear, concise and concise.
- Documents are functional and unnecessary use is avoided.

» Documents are checked by the Quality Management Structure and approved by senior management.

DM.1.2
Documents are distributed and publicized according to established rules.

» It is ensured that current versions of documents are effectively shared with relevant employees.
- All documents are published on the IMS and/or as physical copies and access to the documents is ensured for relevant employees.
- Outdated documents not be used in application areas.

» New, updated and retired documents are announced to the relevant Chapteries.

» Documents/announcements to be posted on the boards are up-to-date and visually aesthetic.

» Employees know how to access up-to-date documents.

DM.1.3
Documents are up-to-date.

» The documents are evaluated and updated at intervals determined by the institution/organization.

» If changes in the processes of the institution/organization require document changes, the update is carried out immediately.

» The update follows all the same rules as for the initial preparation of the document.

» With the approval of the management, the updated document is published, announced to the relevant persons and the updated document is explained to the relevant persons within the scope of a training activity as soon as possible.
» Revision number and revision date is written on the updated document.
  • In the first publication of the document, the revision number is zero (0) and the revision date is blank.
  • The old versions of the document are archived by the Quality Management Structure in order to track the change.
» There are a list of all documents used and this list also allow for tracking of updates.
  • The document list contain at least the following information:
  • Document Name
  • Document Code
  • Publication Date
  • Revision Dates
  • Revision Number

DM.1.4
Documents are preserved, archived and destroyed according to established rules.

» All original documents with physical or electronic signatures are retained by the Quality Management Structure.
  • Electronic system is used for document storage.
  • Rules regarding access to electronic or physical documents and security requirements of records is defined, and confidentiality ratings is made when necessary.
» Original physical documents are systematically filed, and necessary precautions are taken to ensure readability.
» Rules regarding the storage of electronically signed documents in electronic environment is defined and necessary measures are taken for the security of documents.
  • All information and documents in electronic format are archived electronically, ensuring they are accessible, stored, withdrawn, and transferable.
» Rules for archiving and destruction of documents are determined
  • It is ensured that practices comply with the relevant country legislation

DM.1.5
External documents are followed and updated.

» Monitoring and updating of external documents are ensured by a method determined by the institution/organization.
  • Responsible persons are identified to ensure the follow-up of outsourced documents.
  • Employees responsible for outsourced documents know and apply the processes

DM.1.6

Necessary trainings on document management are provided.

- » Relevant employees are provided with necessary training on document management.
  - The training content is planned based on the relevant users and covers processes and rules regarding document preparation, updating, preservation, monitoring current document announcements, and using documents correctly.
- » Training is conducted according to the plan, and the effectiveness of the training is monitored.
- » Training records are traceable retroactively

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 5 Adverse Event Reporting (AER)	
Code	**Standard 1**
AER.1	Processes and rules regarding adverse event reporting are defined and operations are conducted accordingly.
Code	**Assessment Criteria**
AER.1.1	Processes for reporting adverse events are defined.
AER.1.2	A system for adverse event reporting is established.
AER.1.3	Employees are trained on the adverse event reporting system.
Code	**Standard 2**
AER.2	Any near misses or adverse events are monitored, and continuous improvement activities are carried out.
Code	**Assessment Criteria**
AER.2.1	Reports submitted to the system are analyzed and necessary improvements are made after the analysis.
AER.2.2	All employees are informed about analysis and improvement activities.

General Information

The Adverse Event Reporting (AER) is a system where employees working in health institutions/organizations can report the events employees have encountered, witnessed, and near-miss incidents during medical processes, therefore enabling the determination and improvement of the most frequently encountered adverse events. The system plays a crucial role in ensuring patient and employee safety by providing reports of near misses (near misses that do not occur at the last moment) or actual adverse events. AER promotes a safety culture where employees can report incidents without fear of retribution and fosters a culture of learning from failures so that advers events do not occur in the future. This chapter covers all health institutions and organizations as it targets the improvement of patient and employee safety..

Purpose

The purpose of this chapter:

- To report and monitor near misses or advers events and to ensure that necessary measures are taken as a result of the reports.

Objectives

- Patient Safety
- Healthy Work Life

Standard Requirements

Standard 1

AER.1
Processes and rules regarding adverse event reporting are defined and operations are conducted accordingly.

AER.1.1
Processes for reporting adverse events are defined.

» Processes for adverse event reporting include at least the following topics:
  - Establishment of an adverse event reporting system reporting to the system
  - Analyzing notifications
  - Reporting of notifications
  - Providing training to employees on the advers event notification process

» Responsibilities for notification, analysis and reporting of adverse events are determined and responsibilities are defined.

AER.1.2
A system for adverse event reporting is established.

» The AER is formed to enable reporting of all aspects that threaten patient and employee safety.

» The AER is formed to be easily accessible, user-friendly, and structured in a way that employees can feel secure about notifications.

» The AER is covered in at least two modules:
  - The Patient Safety Module include at least the following topics (issues that threaten the safety of patients' relatives and visitors also be reported in this module):
    - Medication Safety
    - Falls
    - Transfusion safety
    - Surgical safety
  - The Employee Safety Module include at least the following topics:
    - Sharp injury
    - Exposure to blood and body fluids
    - Violence

» The notification screen or document contains at least the following information:
  - Subject of the event
  - Development of the event
  - Any opinions and recommendations regarding the event, if applicable

» The AER is used in web-based, intranet, electronic or printed forms.

» The AER is designed so that all employees are able to report.

» The AER notifications not include personally identifiable information in the patient safety module.

» The principle of confidentiality is applied to the reporting and sharing of reports and no identifying information is included.

» Employees' opinions and suggestions regarding the notification system are

received and feedback is provided to employees at regular intervals.
» It also be ensured that undesirable events reflected in the law are analyzed within the scope of the system

AER.1.3
Employees are trained on the adverse event reporting system.
» All employees are provided with training on at least the following topics regarding AER:
  • The purpose, importance, and responsibilities of AER
  • Events within the scope of AER
  • The adverse event reporting process and system structure
  • Confidentiality and security of advers event notifications
  • A culture of learning from mistakes and constant improvement
  • Approach to error reporting (focusing on the error, not the individual)
  • How the notification is made and the rules to be followed
  • Filling out notification forms
  • Evaluation and analysis of notifications
  • Sample cases to the notification system
  • Informing the patient and the patient's relatives in case of advers events
  • Procedural event reporting and root cause analysis (simulation)
» The trainings are recorded

Standard 2

AER.2
Any near misses or adverse events are monitored, and continuous improvement activities are carried out.

AER.2.1
Reports submitted to the system are analyzed and necessary improvements are made after the analysis.
» Notifications made to the system are evaluated and root cause analyses are performed on an event basis.
» The degree of importance is considered in the evaluation of reported events.
» Notifications made to the system are regularly analyzed, reported, and evaluated.
» After the analysis, necessary constant improvement activities are carried out, and the results are monitored

AER.2.2
All employees are informed about analysis and improvement activities.
» Reports submitted to the system, as well as work regarding analysis and improvement activities, are shared with senior management and all employees via an intranet, bulletin boards, text messages, corporate emails, and other methods.

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 6 Risk Management (RM)	
Code	**Standard 1**
RM.1	Processes and rules regarding risk management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
RM.1.1	Processes for risk management are defined.
RM.1.2	A managerial structure for risk management is established and duties, authorities and responsibilities are defined.
RM.1.3	A risk management plan is prepared, risks are determined and analyzed in line with the plan.
RM.1.4	Continuous improvement studies are carried out to eliminate or minimize the identified risks at their source.
Code	**Standard 2**
RM.2	Monitoring and evaluation studies regarding risk management are carried out
Code	**Assessment Criteria**
RM.2.1	Indicators related to risk management are determined, analyzed and the effectiveness of the studies are monitored at regular intervals

General Information

Risk management is a set of processes that ensure patient and employee safety, the improvement of health service quality and the efficient and effective execution of institution/organization activities. This multifaceted process ensures that risks are kept at an acceptable level by identifying and analyzing the risks related to the services provided and taking the necessary measures. Risk management contributes to the organization's achievement of planned goals and its ability to do things right. It also minimizes hazards that cause harm to patients and employees and creates an ideal and safe working environment for employees. This chapter guides all health institutions and organizations in the effective management of risk management processes.

Purpose

The purpose of this chapter:

- To ensure that the risks related to the services provided in the institution/organization are prevented or minimized by combating them at the source, taking into account the safety of patients, relatives, visitors, employees, facilities and the environment.

Objectives

- Patient Safety
- Healthy Work Life
- Effectiveness
- Efficacy

Standard Requirements

Standard 1

RM.1
Processes and rules regarding risk management are defined and functioning is ensured accordingly.

RM.1.1
Processes for risk management are defined.

» Risk management is addressed within the scope of at least the following processes for management, employees, patients, relatives and visitors:
  - Medical processes
  - Governance processes (covering administrative, financial and strategic risks)
  - Processes related to information management system
  - Processes related to facility security
  - Processes related to environmental safety
  - Physical, chemical, biological, ergonomic and psychosocial risks

» The document for risk management is created to cover at least the following topics:
  - Aims and objectives
  - Scope
  - Risk analysis method
  - Obtaining the opinions of relevant employees
  - Reporting of identified risks
  - Analysis of identified risks and determination of risk levels
  - Necessary improvement Works
  - Training of employees

RM.1.2
A managerial structure for risk management is established and duties, authorities and responsibilities are defined.

» A managerial structure such as a committee, team, unit, manager, responsible person, etc. is established according to the size of the institution/organization for the identification, prevention, minimization and improvement of risks.

» Risk management officers are determined on the basis of departments and/or processes to work in coordination with the managerial structure.

» Risk management activities are carried out in coordination with the quality management structure, relevant committees and department heads. In order to ensure effective risk management, duties, authorities and responsibilities are defined and coordination is ensured.

» Relevant department and/or process quality officers and employees are included in the risk management activities carried out in departments.

» Assigned employees know their duties, authorities and responsibilities and contribute to the process.

» Risk management team assignments are reviewed periodically and kept up to date.

» The governance structure report to senior management at regular intervals and through meetings when necessary, and senior management take decisions for improvement when necessary.
» The implementation of decisions taken is monitored and evaluated by the management structure

RM.1.3
A risk management plan is prepared, risks are determined and analyzed in line with the plan.

» The risk management plan covers patient, patient relatives, visitors, employees, facility and environmental safety and all administrative and financial service processes and include at least the following topics
  • The process, activity or element for which the risk is assessed
  • Identified risks related to the relevant process, activity or element
  • Levels of identified risks
  • Measures to be taken against risks
  • Responsible
  • Timeframe for taking measures
» All identified risks are recorded in the risk management plan.
» Updates and improvements related to the risk management plan are recorded and monitored.
» Risks are identified on a department or process basis, with the participation of the relevant department responsible and employees.
» Risk levels are graded in at least 3 categories (low, medium, high), taking into account the probability of occurrence and possible impacts of risks.
» Risk analyses for the identified risks are conducted within the framework of the relevant legislation and updated when necessary.
» Risks is analyzed according to methods determined by the organization.
» Risk analysis methods are simple, understandable and applicable (e.g. 5X5 matrix method, HTSA, Fine Kinney, etc.).
» Risk assessment is carried out at least once a year and updated when necessary.
» The risk assessment is fully or partially updated if the following situations develop outside the specified time intervals:
  • Relocation of the institution or changes in buildings
  • Changes in the technology, materials and equipment used in the organization
  • Changes in the service processes of the organization
  • Occupational accident, occupational disease or near-miss event
  • A change in legislation regarding the limit values of the working environment
  • If deemed necessary according to the results of work environment measurement and health surveillance
    - The emergence of a new hazard arising from outside the organization that is allowed to affect the workplace
    - Emergence of disasters and emergencies

RM.1.4
Continuous improvement efforts are made to eliminate or minimize identified risks at their source.

- For the identified risks; measures are taken on a department and/or process basis according to the risk levels, improvement activities are carried out and the improvement activities are announced.
- Unit/department employees are informed about the planned improvement activities.
- Those responsible for the measures to be taken is identified.
- Improvement activities are planned and implemented according to the realization of the measures.

Standard 2

RM.2
Monitoring and evaluation studies regarding risk management are carried out.

RM.2.1
Indicators related to risk management are determined, analyzed and the effectiveness of the studies are monitored at regular intervals.

- Indicators for monitoring the effectiveness of risk management, such as changes in the level of risk, the elimination of risk or the transformation of risk into an event, are determined and monitored.
- Results from indicators are monitored, reported and improved where necessary.
- Risks identified within the framework of risk management and the effectiveness of improvement efforts are reviewed at regular intervals.
- Continuity of the measures taken to ensure effectiveness in risk management are ensured

SECTION 1 MANAGEMENT AND ORGANIZATION	
Chapter 7 Education Management (EM)	
Code	**Standard 1**
EM.1	Processes and rules regarding training management are defined and proper functioning is ensured.
Code	**Assessment Criteria**
EM.1.1	Processes and rules regarding training management are documented.
EM.1.2	A structure responsible for planning and coordinating training activities is established.
EM.1.3	Processes regarding patient/caregiver training to ensure continuity of care are defined and implemented.
EM.1.4	Processes for training employees are defined and implemented.
EM.1.5	Processes for training and supervision activities carried out within the scope of vocational training programs (undergraduate, graduate, internship, etc.) are defined and implemented.
Code	**Standard 2**
EM.2	Monitoring and evaluation studies regarding training management are carried out.
Code	**Assessment Criteria**
EM.2.1	The efficiency and effectiveness of the training is evaluated and necessary improvement work is carried out.

Chapter 7: Education Management (EM)

General Information

Trainings provided for patients, employees and students studying within vocational training programs in health institutions/organizations are of great importance in terms of safe and quality service delivery. Trainings ensure the active participation of patients/patient relatives in the care process. Trainings for healthcare professionals improve their perception of the work environment by strengthening their knowledge, skills and competencies and increasing their productivity in order to provide safe, effective and evidence-based care. The trainings given to students combine theoretical knowledge with practice to gain professional competence, teamwork, ethical behavior development, critical thinking and patient-oriented care approach. The standards in this chapter provide guidance to institutions/organizations in the effective management of trainings for patients/patient relatives, employees and students within vocational training programs

Purpose

The purpose of this chapter;

» Planning training activities (for patients, patient relatives, employees and students studying within vocational training programs), determining their needs, implementing them, monitoring their effectiveness and making necessary improvements.

Objectives

» Efficacy
» Effectiveness
» Continuity
» Convenience
» Efficiency

Standard Requirements

Standard 1

EM.1
Processes and rules regarding training management are defined and proper functioning is ensured.

EM.1.1
Processes and rules for training management are documented.

» The processes and rules for training management include at least the following
- Duties, authorities and responsibilities for education management
- Identification of training needs
- Creating of training plans
- Implementation of planned training activities
- Monitoring, evaluating and improving the effectiveness of the implemented trainings

EM.1.2
A structure responsible for the planning and coordination of training activities is established.

» A responsible structure (committee, team, unit, manager, responsible, etc.) is established according to the size of the institution/organization to manage the decision-making, planning, coordination, communication and evaluation steps in order to implement the trainings effectively and efficiently.
- The governance structure carries out its work in cooperation with other operating units and structures.
- The duties, authorities and responsibilities of the managerial structure are defined within the scope of education management processes, and the area of duty include at least the following issues:
  - In-service trainings
  - Compliance trainings
  - Trainings for patients/patient relatives
  - Trainings for students studying within vocational education programs

» Education plans are created to ensure that the aim, objective, content, teaching method, implementation and evaluation processes are organized within a system.
- Training plans are formulated in short, medium and long term, taking into account the nature of the training needs, objectives, and the time to achieve the objectives, in line with the goals and objectives for the institutional policy and change process.
- The training plan include at least the following headings:
  - Nature of training (basic training, advanced training, theoretical and practical training, etc.)
  - Aims and objectives of the training
  - Trainer(s) and participant(s) characteristics
  - Time for education
  - Duration of training

- Teaching method(s)
- Location of training
- Content of the training
- Training materials
- Method(s) for evaluating training effectiveness

• The plan is revised in case of changes in the plan and/or off-plan training is organized.
• The level of compliance with training plans is monitored and measures is taken to increase compliance with the plan.

» The realization and implementation of trainings is monitored and evaluated by the managerial structure.
» Effectiveness, efficiency and continuity of trainings is ensured.
» Senior management is informed about training activities at regular intervals.

EM.1.3
Processes regarding patient/caregiver training to ensure continuity of care are defined and implemented.

» Processes related to patient/caregiver trainings are defined to include patient admission, treatment and discharge processes and at least the following topics:
• Subject of the training
• Content of the training
• Trainer(s)
• Encouraging participation in trainings and ensuring their continuity
• Recording of trainings
• Repeating trainings when necessary

» The following points are considered when determining the topics and scope of training needs:
• Within the scope of improvement activities; evaluation results (self-assessments, data obtained from indicators, etc.)
• Effectiveness results from previous trainings
• Feedbacks, requests, observations on training activities

» The information provided at patient admission includes the following topics:
• Introduction of the institution/organization/department to the patient/patient relatives (patient room and belongings, nearby locations, place of worship, market, ATM, etc.)
• Rules to be followed in the institution/organization (use of identifiers, breakfast and meal times, telephone use, visiting hours, companion rules, etc.)
• Transportation/access to health workers (nurse call system, doctor's room, etc.)
• Emergency exit doors/what to do in an emergency
• Basic safety measures according to risk assessment
• Management of medicines brought by the patient (collection, use, return or disposal, etc.)
• Preventing infections and maintaining hand hygiene
• Discharge education (determination of needs, making the plan, etc.)

» Trainings for the treatment process related to continuity of care include at least the following topics:

- Trainings for the needs of the patient (self-care, nutrition and diet, meeting their needs, pre- and post-operative care, chemotherapy, pressure sores, oxygen administration, breast milk and breastfeeding, etc.).
- Trainings on patients' current health problems (use of medication, use of medical equipment to assist treatment, etc.)

» Trainings on the discharge process of patients include at least the following topics:
- Ongoing care needs and home/institutional care
- Medications to be used after discharge
- Tools to be used
- Nutrition plan/diet
- Physical activity level/movement limitations
- Control process (time and frequency)
- Contact information of the employee/unit to be contacted when necessary

EM.1.4
Processes for training employees are defined and implemented.

» Processes for the training of employees are defined to include at least the following topics:
- Identification of training needs
- Creating of training plans
- Implementation of planned training activities
- Evidence of participation in trainings (list of participants, etc.)
- Monitoring and evaluating the effectiveness of the implemented trainings and making necessary improvements

» In line with improvement targets, who needs training, on which subjects, at what level and scope, is determined at least once a year and when necessary.

» Training plans is created in line with the training needs of employees (at least once a year in line with improvement targets and updated when necessary; including who needs training, on which subjects, at what level and scope).

» The following points are considered when determining the topics and scope of training needs:
- Within the scope of improvement activities; evaluation results (self-assessments, data obtained from indicators, etc.)
- Effectiveness results from previous trainings
- Feedbacks, requests, observations on training activities
- Mandatory trainings

» Employee training include at least the following topics:
- Structure of the institution/organization
- Basic and professional rules to be followed
- Basic working principles of the institution/organization
- Hierarchical order
- Physical and social facilities
- Employee rights and responsibilities
- Patient rights and responsibilities
- Control and prevention of infections
- Patient and employee safety

- Waste management
- Disaster and emergency management
- Risk management
- Device use and safety
- Unit-based vocational trainings
- Evidence-based trainings
- Trainings to improve employee performance and safety
- Personal development trainings

» General and departmental orientation trainings are organized for employees (permanent, contracted, volunteer employees, students and interns, etc.).
- General and departmental orientation trainings for employees are planned and implemented by taking into account characteristics such as service delivery area and professional differences.
- Guidelines for general and departmental orientation trainings are developed.
- Orientation trainings are provided as soon as possible after new assignments, departmental changes, and long leaves such as maternity leave.

» In-service trainings for employees are planned and implemented by taking into account characteristics such as service delivery area and professional differences.

» Employees have access to training materials and documents.

EM.1.5
Processes for training and supervision activities carried out within the scope of vocational training programs (undergraduate, graduate, internship, etc.) are defined and implemented.

» Processes for training and supervision activities carried out within the scope of vocational training programs (undergraduate, graduate, internship, etc.) include at least the following topics:
- Training rules and responsibilities
- Prevention and control of infections
- Employee rights and responsibilities
- Patient rights and responsibilities
- Patient and employee safety
- Risk management
- Waste management
- Disaster and emergency management

» Orientation training programs for students/trainees in post-graduation education are determined and implemented in accordance with the institution/organization and their specific duties and responsibilities.

» Within the scope of vocational training programs (undergraduate, graduate, internship, etc.), practical and theoretical in-service trainings are determined and implemented for students/interns to improve their knowledge and skills.

» The effectiveness of vocational training programs (undergraduate, graduate, internship, etc.) is monitored and necessary improvements is made.
- An audit process for evaluating the effectiveness of training programs is defined and implemented by those responsible for undergraduate and graduate education programs

Standard 2

EM.2
Monitoring and evaluation studies regarding training management are carried out.

EM.2.1
The efficiency and effectiveness of the training is evaluated and necessary improvement work is carried out.

- The level of compliance with training plans is monitored and measures are taken to increase compliance with the plan.
- The efficiency and effectiveness of the trainings are evaluated in line with the determined goals and objectives.
  - The following methods are used to evaluate the effectiveness and efficiency of training:
    - Pre-test and post-test
    - Self-assessments
    - Observations
    - Interviews with people
    - Evaluations made with the department managers
    - Surveys
    - Measurement methods for behavioral change due to training (such as accepted scales)
- Training evaluations include the evaluation of the training process such as training content, training environment, teaching methods, meeting expectations, evaluation of the trainer, etc.
- Evaluation results are shared with relevant employees and trainers at regular intervals.
- Indicators related to training management are determined, analyzed and necessary improvement studies are carried out. (See Indicator Management)


TÜSEB
TÜSKA
TÜRKİYE HEALTH CARE QUALITY AND
ACCREDITATION INSTITUTE

SECTION 2
Healthy Working Life

TÜSEB TÜSKA
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SECTION 2 HEALTHY WORKING LIFE	
Chapter 8 Healthy Occupational Life (HOL)	
Code	**Standard 1**
HOL.1	Processes and rules for a healthy occupational life are defined and appropriate operations are conducted accordingly.
Code	**Assessment Criteria**
HOL.1.1	Processes and rules for a healthy occupational life are documented.
HOL.1.2	An administrative structure for a healthy occupational life is established and duties, authorities and responsibilities are defined.
Code	**Standard 2**
HOL.2	Arrangements are made to provide a healthy occupational life.
Code	**Assessment Criteria**
HOL.2.1	Risks that threaten employee health and safety are managed.
HOL.2.2	Arrangements are made for the use of personal protective equipment.
HOL.2.3	Health surveillance of employees is carried out.
HOL.2.4	The psychological well-being of the employee is ensured.
HOL.2.5	The working environment is organized in line with the safety, needs and expectations of the employee.
HOL.2.6	The individual and professional development of the employee is supported.
HOL.2.7	Arrangements are made for the spiritual and social needs of the employee.
HOL.2.8	Activities are carried out to increase employee motivation.
HOL.2.9	Arrangements are made for the health status and needs of the employee such as special needs and chronic diseases.
HOL.2.10	Arrangements are made to ensure inclusion and diversity.
HOL.2.11	Trainings are provided to improve employee health and safety.

Chapter 8: Healthy Occupational Life (HOL)

General Information

Healthy occupational life refers to the occupational setting where the necessary conditions are provided to ensure and maintain employees' physical, mental, and social well-being. This notion is a comprehensive approach that, together with occupational health and safety measures, seeks to develop the overall well-being of employees. Occupational settings pose health and safety threats and risks to employees. Problems, threats, and risks that arise in the occupational setting may cause setbacks in service production and adversely affect employees' physical and mental health. A healthy and safe occupational setting reduces employees' work stress and increases their work efficiency, motivation, and satisfaction levels. A safe occupational environment significantly reduces malpractice and improves the quality of care and the efficiency of health services. This chapter guides all health institutions and organizations in providing a healthy and safe occupational setting and life..

Purpose

The purpose of this chapter:

» To ensure that employees work in a safe environment in a health institution or organization, have a healthy occupational life, and protect employees against physical, biological, and psychological threats or risks arising from the occupational setting.

Objectives

» Healthy Work Life

Standard Requirements

Standard 1

HOL.1

Processes and rules for a healthy occupational life are defined and appropriate operations are conducted accordingly.

HOL.1.1

Processes and rules for a healthy occupational life are documented.

» The processes and rules regarding healthy occupational life include at least the following topics:
- Duties, authorities, and responsibilities
- Risk assessment
- The usage of personal protective equipment
- Health surveillance of employees
- Supporting employee's psychological well-being
- Training to improve employee's health and safety
- Arrangements for the occupational setting
- Individual and professional development of the employee
- Supporting employees' spiritual and social needs
- Activities to enhance employee motivation
- Arrangements for the health status (special needs, chronic diseases, etc.) and needs of the employee
- Considering inclusivity and diversity

HOL.1.2

An administrative structure for healthy occupational life are established and duties, authorities and responsibilities are defined.

» An administrative structure (e.g., board, committee, team, or designated officer) is established for a healthy occupational life based on the size of the institution/organization.

» In institutions/organizations with an Occupational Health and Safety Committee structure, responsibilities in the field of employee health and safety are carried out by this committee. (See: Quality Management)

» The duties, authorities, and responsibilities of the employees working in the administrative structure are defined.

» The administrative structure reports to senior management at regular intervals.
- The reports include topics such as advers events, root causes, improvement activities, and assessment of the positive impact of the improvements provided.
- The implementation of decisions is monitored and evaluated by the administrative structure.
- The efficiency, effectiveness, and continuity of improvements are ensured.

Standard 2

HOL.2
Arrangements are made to provide a healthy occupational life.

HOL.2.1
Risks that threaten employee health and safety are managed.

» Risks related to employee health and safety are identified and analyzed following the risk management plan. (See: Risk Management)
» At least the following topics related to ensuring employee health and safety are addressed:
  - Establishment of administrative policies within the scope of employee health and safety
  - Prevention of infections
  - Planning and implementation of health surveillance
  - Chemical and radiation safety
  - Food safety
  - Noise control
  - Lighting
  - Ventilation and air conditioning
  - Fall prevention
  - Management of facility-related risks
  - Ergonomic factors
  - Prevention of violence against employees and rapid response to acts of violence
  - Management of risks for staff working in specialized areas such as psychiatric clinics, intensive care units, and emergency departments
  - Prevention of workplace bullying (mobbing) among employees
  - Waste management
  - Immunization
  - Shift management
  - Reduction of unnecessary workload
  - Stress management
» Continuous improvement activities are conducted based on the identified risks related to employee health and safety.
» Reporting of adverse events (near-misses, actual incidents) that threaten employees' health and safety are ensured. (See: Adverse Event Reporting)

HOL.2.2
Arrangements are made for the use of personal protective equipment.

» The required personal protective equipment (e.g., gloves, masks, gowns, biosafety cabinets, lead aprons, headphones, etc.) is determined based on each department.
» Personal protective equipment is made available in the specified work areas in the quantity determined by the institution, according to the needs, and measures are taken to ensure its proper use.

HOL.2.3
Health surveillance of employees is carried out.

» The program for health surveillance of employees is prepared and monitored by the administrative structure.
  • The program is developed based on the opinions of relevant unit specialists, such as physicians, nurses, occupational health and safety experts, etc.
  • Department-specific risks are taken into consideration when designing the program.
  • The program includes the scope, timing, and frequency of health screenings to be conducted at the department level.
» The program's implementation, the evaluation of results, and the processes to follow in case of adverse outcomes are defined.
  • Health screening results are assessed by relevant specialists.
» Employees are informed about the screening results.
  • Information security regarding health screening results is ensured.
» Necessary treatment and care services are provided for employees identified with adverse findings in their health screening results.
» Immunization, vaccination, screening, and precautions in case of contact with any infectious agent are defined and implemented.

HOL.2.4
The psychological well-being of the employee is ensured.

» Employees have access to psychological counseling and support services.

HOL.2.5
The working environment is organized in line with the safety, needs and expectations of the employee.

» Improvements are made to the working environment by taking into account the needs and expectations of employees.
  • There are rest areas for employees.
  • There are dressing areas for employees and lockers where they are able to keep their personal belongings.

HOL.2.6
The individual and professional development of the employee is supported.

» Activities such as training, congresses, courses, projects, etc. related to the individual and professional development of the employee are supported

HOL.2.7
Arrangements are made for the spiritual and social needs of the employee.

» The spiritual and social needs of employees are determined, and necessary arrangements are made accordingly.
» Physical and social facilities such as prayer areas, reading and sports areas, kindergartens, children's clubs, etc. are provided for employees.

HOL.2.8
Activities are carried out to increase employee motivation.

» Motivational activities such as out-of-work activities are organized for employees.

HOL.2.9
Arrangements are made for the health status and needs of the employee such as special needs and chronic diseases.

» Arrangements are made for the needs of employees with special needs and chronic diseases, such as transportation, diet and a suitable working environment.
» The working areas and conditions of pregnant and breastfeeding employees is determined and they are ensured to work under appropriate conditions.
» Care is taken to ensure that the opportunities provided to employees are easy, accessible, practical and employee-oriented

HOL.2.10
Arrangements are made to ensure inclusion and diversity.

» In order to ensure that employees from different cultures are able to work without discrimination, workplace policies are established, trainings supporting diversity are planned, and a safe working environment is provided to enable each employee to express themselves.

HOL.2.11
Trainings are provided to improve employee health and safety.

» Trainings are provided on at least the following topics to improve employee health and safety:
  - Improving the mental health status of employees
  - Combating stressful work environment
  - Precautions for potential hazards and occupational accidents
  - Occupational diseases

BOYUT 3
Patient Experience

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SECTION 3 PATIENT EXPERIENCE	
Chapter 9 Patient Experience (PE)	
Code	**Standard 1**
PE.1	Patient access to services is ensured.
Code	**Assessment Criteria**
PE.1.1	Arrangements are made for the provision of reception, orientation and counseling services.
PE.1.2	Arrangements are made to facilitate service use.
PE.1.3	Necessary arrangements are made to ensure that patient registration procedures are carried out effectively and accurately.
PE.1.4	Arrangements are made to keep the procedure times for diagnosis, examination, treatment and care at an optimal level and to increase efficiency.
PE.1.5	Transfer service and implementation processes are defined.
PE.1.6	In institutions/organizations that do not provide emergency health services, arrangements are made to facilitate patient access to emergency health services.
Code	**Standard 2**
PE.2	Arrangements are made for patient rights.
Code	**Assessment Criteria**
PE.2.1	Processes for patient rights are documented.
PE.2.2	An administrative structure for the protection, implementation and improvement of patient rights is established, and duties, authorities and responsibilities are defined.
PE.2.3	Patients are informed about their rights, responsibilities and service processes.
PE.2.4	Patient participation is ensured in service processes.
PE.2.5	Processes for obtaining patient consent are defined.

PE.2.6	Processes are defined to address and resolve ethical dilemmas such as refusal, withdrawal and discontinuation of treatment/procedure in a timely manner.
PE.2.7	Measures are taken to ensure patient privacy .
PE.2.8	Arrangements are made for the patient to maintain their spiritual and cultural needs.
PE.2.9	Access to the patient's medical records related to the care process is ensured.
PE.2.10	Arrangements are made regarding visitation and accompaniment processes .
PE.2.11	Arrangements are made for the provision of medical social services.
Code	**Standard 3**
PE.3	Arrangements are made for feedback processes.
Code	**Assessment Criteria**
PE.3.1	A system for patient and relative feedback is established.
PE.3.2	Patient and caregiver feedback are evaluated, analyzed and necessary improvements is made.

General Information

Patient experience refers to the perceptions and experiences of patients and their relatives about the health institution/organisation before their application to the health institution/organisation and all their interactions with the health institution/organisation, including post-discharge processes. Patient experience, which is an integral component of healthcare quality, includes various aspects of healthcare delivery such as easy access to service, involvement in the care process, ease of access to information and effective communication with healthcare professionals. In order to improve the patient experience, leadership, patient-centred service delivery, employee involvement in the process, patient safety culture, and measurement and improvement studies are necessary. This chapter provides guidance to all health institutions/organisations that interact with patients and their relatives in improving the patient experience.

Purpose

The purpose of this chapter;

- To ensure that the patient receives quality and safe health care in all processes, including before application to the health institution / organization and after discharge
- To ensure that patients and their relatives have timely, efficient and effective access to services
- To ensure that patient rights are secured and services/processes are organized accordingly
- To ensure that feedback from patients and their relatives about the services they receive is systematically received and necessary improvements are made

Objectives

- Patient Safety
- Patient Focused
- Fairness
- Efficacy
- Effectiveness
- Convenience
- Timeliness
- Continuity

Standard Requirements

Standard 1

PE.1
Patient access to services is ensured.

PE.1.1
Arrangements are made for the provision of reception, orientation and counseling services.

» Welcoming, counselling and orientation services are provided in order to facilitate access to services for all patients, including foreign patients, considering the patient population served.
  • The number of personnel to work in the execution of these services is determined in advance by taking into account factors such as the average number of outpatient clinics per day.
» In which parts of the institution/organisation the reception, guidance and counselling services will be deployed and the duties, authorities and responsibilities of the people who will work in these areas are defined.
  • Information services are provided in areas such as the main entrance, outpatient clinic areas, emergency service, operating room waiting areas.
» There are a guide, introductory brochure, in-house telephone directory, etc. to facilitate access to the services provided.
» Arrangements are made to ensure that employees providing reception, guidance and counseling services are distinguished from other employees.
  • Employees are trained periodically on service delivery processes (patient rights, responsibilities and rules to be followed, communication skills, etc.).

PE.1.2
Arrangements are made to facilitate service use. (See Facility Management)

» Arrangements such as exit ramps, grab bars, elevators, escalators, toilets, braille alphabet, audible warning systems, wheelchairs, auxiliary personnel, etc. are made to facilitate access to departments in all areas where services are provided.
  • Arrangements are made to facilitate access to services and waiting areas according to age, illness and special needs.
    ▪ For elderly, special needs and special patient groups (psychiatric patients, newborns, etc.), there are sufficient number and quality of stretchers and wheelchairs in the relevant departments, taking into account the patient density.
    ▪ Arrangements such as audible warning systems for elderly, special needs and special patients are made in elevators.
    ▪ Arrangements are made to ensure that the elderly, people with special needs and patients with special needs have priority seating in service delivery areas.
    ▪ In emergencies, planning is made for the evacuation of elderly, special needs and special patient groups from the institution/organization.
    ▪ Functional arrangements are made to ensure the transportation of the

elderly, special needs and special needs within the institution.
    - Parking lots, sinks, toilets and bathrooms are suitable for use by patients with special needs.
- » There are direction signs throughout the institution/organization to facilitate access to departments.
- » In all patient communication units and service receiving points, including patient registration reception areas, there is no physical barriers (such as glass, windows, heights) between patients and employees.
- » Parking lots is planned separately for emergency and outpatients according to patient density.
    - There is a special parking area for patient groups with special needs.
- » There are sufficient number of seats, chairs, etc. in the waiting areas, taking into account the patient density.
- » Accompanying chairs in inpatient rooms are foldable.
- » Arrangements are made for priority patients in service provision.
    - Prioritized patient groups are defined in accordance with the relevant country legislation and patient population.
    - The priority patient group is posted in the registration units of all diagnostic and treatment units in a manner visible to patients.

PE.1.3
Necessary arrangements are made to ensure that patient registration procedures are carried out effectively and accurately.

- » There is a unit where patient registration procedures are performed.
- » The number of personnel to provide registration services is determined within the framework of factors such as the average number of outpatient clinics per day.
- » Arrangements are made to provide personnel who is able to speak foreign languages and sign language when necessary.
- » Arrangements are made to distinguish employees from other employees
- » Arrangements are made for the effective execution of patient registration procedures in emergencies.
- » Periodic trainings on service processes are provided to employees

PE.1.4
Arrangements are made to keep the procedure times for diagnosis, examination, treatment and care at an optimal level and to increase efficiency.

- » The time intervals and estimated waiting times for patients to be examined is defined taking into account the conditions of the institution, emergencies, priority patients and patients' needs.
    - The patient's appointment time and the time of the examination is monitored on the IMS.
    - Patients is informed about waiting times.
    - The time interval between the appointment times of patients who are examined by appointment and the time they are examined is in compliance with the specified time limits.
    - Improvement activities for possible delays in waiting times are planned.
        - Delays in appointments and turnaround times are monitored with the

involvement of management and line staff.
- Root cause analysis of delays is conducted and corrective and preventive actions are initiated when necessary.
- The positive or negative effects of the improvements on the process is traceable.

• Processes for the management of patients without an appointment is defined and implemented.

» Procedures to identify system problems and limitations that are allowed to pose a risk to patient safety by extending the duration of diagnosis, examination, treatment and care is examined, and measures is taken to optimally shorten procedure times and increase efficiency.
• Service processes are evaluated within this framework and efforts to increase effectiveness, efficiency and security is traceable

PE.1.5
Transfer service and implementation processes are defined.

» Patient groups to be transferred (dialysis patients, physical therapy patients, etc.) are defined.
» Patients' transfer needs are assessed during referral and/or discharge processes.
» The transfer service is provided by secure transfer vehicles, including contracted services.
• The transfer vehicle have the necessary equipment, heating and ventilation system.
• The transfer vehicle is equipped with a fire extinguisher.
• The transfer vehicle have arrangements to ensure that patients are able to get on and off easily.
• Cleaning and maintenance of vehicles are done periodically and recorded.
» Patient/caregiver and employee feedback mechanarems about the transfer service are establarehed.

HD.1.6
In institutions/organizations that do not provide emergency health services, arrangements are made to facilitate patient access to emergency health services.

» In institutions/organizations that do not have an emergency service or do not provide emergency health services out of working hours, the process for patient access to emergency health services are defined.

Standard 2

PE.2
Arrangements are made for patient rights.

PE.2.1
Processes for patient rights are documented.

» Processes for the protection, implementation and improvement of the rights of patients and their relatives include at least the following issues:
• Informing the patients and patient relatives

  - The person to provide information
  - Time of information
  - Frequency of information
  - Information content
  - Information method
- Obtaining the consent of the patient/patient's relative
- Refusal and withdrawal of treatment/procedure
- Patient visits
- Accompaniment rules

PE.2.2

An administrative structure for the protection, implementation and improvement of patient rights is established, and duties, authorities and responsibilities are defined.

» A managerial structure such as a committee, team, unit, manager, responsible person, etc. is established according to the size of the institution/organization for the protection, implementation and improvement of patient rights.

» The duties, authorities and responsibilities of employees within the managerial structure are defined.

» The governance structure report to senior management periodically and through meetings when necessary.
- Meeting reports include topics such as examination of suggestions, opinions and complaints, planning and evaluation of necessary improvement activities by finalizing them in a timely manner.
- Effectiveness, efficiency and continuity of improvements are ensured.

PE.2.3

Patients are informed about their rights, responsibilities and service processes.

» The patient and patient relatives are informed about patient rights and responsibilities at least in the following subjects:
- Ensuring privacy
- Respect and dignity
- Confidentiality of patient information
- Patient safety
- Ensuring patient safety
- Selecting an institution/organization
- Selecting physicians, nurses, etc.
- Informing about the service and patient consent
- Prioritization
- Refusal of treatment
- Responsibilities

» Patients are informed about the expected and unexpected consequences of the care and treatment they receive.

» During and after discharge, the patient and/or the patient's relatives are informed in writing (language, etc.) about the treatment received by the patient, medications to be used, physical activities, control process, people to be contacted when necessary and contact information.

» It is ensured that patients is able to easily apply for patient rights and provide feedback.

- For this purpose, methods such as direct application, the website of the institution/organization, social media tools, opinion, suggestion and complaint boxes, etc. are used.

PE.2.4
Patient participation is ensured in service processes.

» The participation of the patient and the patient's relatives in the care and decision-making process are supported and encouraged.
» There is a regulation to guarantee the patient's right to choose a physician.
» The procedure to be followed in case the patient wishes to receive treatment from a different physician is defined.
» The patient's right to determine who they want to be involved in decisions about their care is respected.
» The conditions under which information about the patient's care is shared with the patient's family and other persons are regulated in accordance with the preferences of the patient and his/her family

PE.2.5
Processes for obtaining patient consent are defined.

» The patient receiving inpatient/outpatient services are informed about the procedures that is performed during the diagnosis and treatment process and their consent is obtained.
» The patient is informed and written consent is obtained prior to surgical or interventional procedures, use of blood and blood components, procedures performed under anesthesia (including moderate and deep sedation) and other high-risk procedures.
  - Written consent include at least the following headings:
    - Expected benefits of the transaction
    - Consequences that are encountered if the procedure is not performed
    - Alternatives to the transaction, if any
    - Risks and complications of the procedure
    - Estimated duration of the process
    - Name, surname, title and signature of the person who will perform the transaction
    - Patient's name, surname and signature
    - Date and time of consent
  - The date and time of consent and the date and time of the procedure is consistent.
» Information and consent processes are defined and necessary arrangements is made for patients who are not capable of making decisions regarding diagnosis and treatment (unconscious patients, patients with mental special needs, pediatric patients, etc.) and patients requiring emergency intervention.
» Patient consent is obtained in case of Participation in research and experimental studies or use of data, information and materials belonging to the patient for any reason

PE.2.6

Processes are defined to address and resolve ethical dilemmas such as refusal, withdrawal and discontinuation of treatment/procedure in a timely manner.

» In the presence of ethical dilemmas related to care, such as refusal to accept treatment decided by the physician, withdrawal or discontinuation of treatment, etc., how the process is managed is defined in advance.
  • In case of patients leaving the institution/organization without the physician's permission, the actions to be taken are determined.
» An ethics committee, including the patient and the physician, is established to resolve ethical dilemmas.
» In cases of ethical dilemmas, the ethics committee is convened and a solution is reached as soon as possible, prioritizing patient safety

PE.2.7

Measures are taken to ensure patient privacy.

» Arrangements are made to ensure the physical privacy of the patient during examination, diagnosis and treatment processes.
» During any kind of healthcare service, persons other than the relevant healthcare worker(s) and the patient's relatives (with the patient's consent) are prevented from being present in the environment.
» There are arrangements such as curtains, screens, etc. between patient examination tables and beds to ensure patient privacy.
» The patient's expectations and needs regarding privacy during care and treatment is met.
  • The patient's stated need for privacy is respected during all clinical interviews, examinations, procedures/treatments and patient transfer.
  • In case of visual and auditory recording, the patient's consent is obtained.
» Arrangements are made to ensure the patient's information privacy.
  • Confidentiality of information covers the psychological, economic and sociocultural status of the patient, etc.
  • Confidentiality (authorization and access, etc.) of information regarding medical evaluations and practices for the patient is ensured.
  • The persons and conditions under which information and documents related to diagnosis and treatment processes are shared outside the patient is determined.
» Arrangements are made to ensure patient privacy when informing patients and their relatives.
» Patient privacy is respected during the flow of medical information between healthcare professionals.

PE.2.8

Arrangements are made for the patient to maintain their spiritual and cultural needs.

» Care is provided that respects the patient's personal values and beliefs.
» It is taken into account that there is differences in values, beliefs and expectations regarding privacy between different societies and religious beliefs

PE.2.9
Access to the patient's medical records related to the care process is ensured.

- » There is an arrangement that allows the patient to access a copy of the medical records related to the care process, such as documents related to procedures, tests or personal information, etc.
- » Situations where medical records is shared with the patient's relatives is determined

PE.2.10
Arrangements are made regarding visitation and accompaniment processes.

- » The visitor policy of the institution/organization is determined and rules regarding patient visits is defined.
- » The accompaniment policy of the institution/organization is determined and the rules regarding patient accompaniment is defined.

PE.2.11
Arrangements are made for the provision of medical social services.

- » Responsible persons and responsibilities in medical social service provision are defined, and the process regarding the services to be provided are defined.
- » Medical social service processes include at least the following headings.
  - Effective utilization of medical treatment by the patient
  - Protection and promotion of social health
  - Regulation of family and environmental relations
  - Managing psycho-social and socio-economic problems
  - Social service practices to be planned for them to regain their social functionality

Standard 3

PE.3
Arrangements are made for feedback processes.

PE.3.1
A system for patient and relative feedback is established.

- » Processes (unit, personnel, trainings, mechanisms, etc.) for the patient and patient relatives feedback system is defined.
- » Information on patient and patient relatives feedback processes include at least the following topics.
  - Feedback methods (suggestions, requests, complaints, etc.)/ mechanisms (web page, survey, interview, etc.)
  - Feedback management process (unit to contact, etc.)

PE.3.2
Patient and caregiver feedback are evaluated, analyzed and necessary improvements is made.

- » Feedback from patients and relatives is systematically analyzed and findings evaluated.
- » A patient-represented evaluation commission is established to evaluate feedback containing complaints.
- » Patient and relative complaints are finalized in a timely and fair manner.
- » The relevant patient or patient's relatives is informed about the results.
- » Necessary improvements are made by taking into account the results of the analysis of patient and patient relatives' feedback.
- » Analysis results are shared with senior management and relevant units

SECTION 3 PATIENT EXPERIENCE	
Chapter 10 Patient Safety Goals (PSG)	
Code	**Standard 1**
PSG.1	Processes and rules for maintaining patient safety are defined and appropriate functioning is ensured.
Code	**Assessment Criteria**
PSG.1.1	Processes to maintain patient safety are documented within the scope of national/international patient safety goals.
PSG.1.2	A managerial structure for maintaining patient safety is established and duties, authorities and responsibilities are defined.
PSG.1.3	Risks regarding patient safety are determined and analyzed.
PSG.1.4	Necessary trainings are provided to employees to maintain patient safety.
Code	**Standard 2**
PSG.2	Patient identity verification is ensured.
Code	**Assessment Criteria**
PSG.2.1	Processes and rules for verifying patient identity are documented.
PSG.2.2	Authentication tools and methods are defined.
Code	**Standard 3**
PSG.3	Prevention of falls are ensured.
Code	**Assessment Criteria**
PSG.3.1	Processes and rules for the prevention of patient falls are documented.
PSG.3.2	Patients are assessed for fall risk.
PSG.3.3	Necessary measures are taken to prevent patient falls.

Code	Standard 4
PSG.4	Effective communication between employees is ensured.
Code	**Assessment Criteria**
PSG.4.1	Processes and rules for ensuring effective communication between employees are documented.
PSG.4.2	Arrangements are made for the safe handover of patients between health workers.
PSG.4.3	Arrangements are made for reporting panic/critical values.
PSG.4.4	Arrangements are made to implement verbal prompting.
PSG.4.5	Arrangements are made for abbreviations, symbols and sign that not be used.
PSG.4.6	Arrangements are made for accurate and complete transfer of patient information in consultation processes.
Code	**Standard 5**
PSG.5	The safety of high-risk medications is ensured.
Code	**Assessment Criteria**
PSG.5.1	Processes and rules for ensuring the safety of high-risk medications are documented.
PSG.5.2	Arrangements are made to ensure the safety of high-risk medicines.
Code	**Standard 6**
PSG.6	Use of the Safe Surgery Checklist is ensured.
Code	**Assessment Criteria**
PSG.6.1	Processes and rules for the use of the Safe Surgery Checklist are documented.
PSG.6.2	Arrangements are made for the use of the Safe Surgery Checklist.

Code	Standard 7
PSG.7	Hand hygiene is provided.
Code	**Assessment Criteria**
PSG.7.1	Processes and rules for ensuring hand hygiene are documented.
PSG.7.2	Arrangements are made to ensure hand hygiene.
Code	**Standard 8**
PSG.8	Compliance with patient safety objectives is monitored and evaluated.
Code	**Assessment Criteria**
PSG.8.1	Indicators related to patient safety targets are determined and the effectiveness of the studies are monitored at regular intervals.

General Information

The primary goal of healthcare services is to provide care in line with the principle of "do no harm first." The World Health Organization (WHO) defines patient safety as the absence of preventable harm in the healthcare process and the minimization of risks associated with healthcare services. Patient safety encompasses near-misses or adverse events that occur in all areas of healthcare delivery, regardless of the scope or type of healthcare service. Ensuring patient safety is at the center of TÜSKA SAS (Türkiye Health Care Quality and Accreditation Institute Accreditation Standards in Healthcare). Standards play a vital role in achieving prioritized and current patient safety goals. It highlights areas of concern regarding patient safety. It helps minimize events that negatively impact patient safety and the risk of medical errors. It provides consensus-based solutions that enable targeted improvements worldwide. Within the scope of this standard, the WHO Patient Safety Goals are taken as a basis for improving healthcare services. These goals are the top priority targets among near misses and undesirable events reported worldwide. Additionally, patient safety is addressed within the scope of TÜSKA SAS through various standards, including medication management, infection prevention and control, facility management, and undesirable event reporting and management. This chapter provides a framework for coordinating patient safety efforts by contributing to the development of a culture of learning from errors and supporting continuous improvement.

Purpose

The purpose of this chapter:

» To design systems and processes that prioritize patient safety, to identify factors that is allowed to threaten patient safety in advance and to ensure that patients receive safe healthcare services

Objectives

» Patient Safety

Standard Requirements

Standard 1

PSG.1
Processes and rules for maintaining patient safety are defined and appropriate functioning is ensured.

PSG.1.1
Processes to maintain patient safety are documented within the scope of national/ international patient safety goals.

» The 2021-2030 Global Patient Safety Action Plan published by WHO is taken into consideration when planning processes to maintain patient safety. While planning these processes, national and/or international patient safety goals are taken into consideration (See Ministry of Health National Patient Safety Goals, relevant country arragements, etc.).
» Processes and rules regarding patient safety include at least the following topics:
  • Managerial structure
  • Duties, authorities and responsibilities
  • Risks to patient safety
  • National and/or international patient safety goals
  • Trainings

PSG.1.2
A managerial structure for maintaining patient safety is established and duties, authorities and responsibilities are defined.

» A managerial structure (committee, team, manager, responsible, etc.) is established to identify existing or potential patient safety threats in the institution/ organization and to take measures.
» The persons who will take chapter in the managerial structure is determined in a way to ensure the effectiveness and continuity of the work in this field, taking into account the size of the institution/organization and the diversity of the services provided.
» By the governance structure created;
» Patient safety goals are monitored and evaluated.
» Meetings are held periodically and when necessary, and reports are submitted to the senior management on issues such as near misses and unintended events, root causes, activities for improvement and results.
» Continuity of the improvements realized in line with the decisions taken are ensured.
» Patient safety programs are led by senior management and senior management is involved in processes to measure, evaluate and improve programs

PSG.1.3
Risks regarding patient safety are determined and analyzed.

» Risks to patient safety are identified and analyzed on a clinical and patient basis in line with the risk management plan (See Risk Management).

» At least the following topics are addressed to ensure patient safety:
  - Infection prevention and control
  - Medication safety
  - Fall prevention
  - Identity verification
  - Safe surgery
  - Effective communication between employees
  - Radiation safety
  - Transfusion safety
  - Adverse event reporting
  - Facility security
  - Information security
  - Material and device safety
  - Waste management
  - Disaster and Emergency Management
  - Use of advanced technology
  - Other factors threatening patient safety
» Continuous improvement activities are planned for the risks identified as a result of risk analysis.
» Planned and realized improvement activities and their results are monitored.

PSG.1.4
Necessary trainings are provided to employees to maintain patient safety

» Training topics to be provided to ensure patient safety is determined by considering national/international patient safety goals and the studies to be carried out towards these goals.
» Trainings include progress in meeting patient safety objectives and the results of the analysis of adverse events.
» Trainings are in line with employees' areas of work and their roles and responsibilities in the patient safety program.
» Trainings are traceable in annual training plans and training records.

Standard 2

PSG.2
Patient identity verification is ensured.
Identity verification is defined as applications that ensure that the individual receiving healthcare services are the right person.

PSG.2.1
Processes and rules for verifying patient identity are documented.

» Authentication processes is defined to include at least the following topics:
  - Authentication methods and tools based on healthcare processes
  - Identification and authentication processes for patients with unknown identity, patients with similar names who are hospitalized in the same ward, patients who have died, patients with physical or medical disabilities for armband/ wristband use, patients with allergies, patients with multiple pregnancies, etc.

- Identification and authentication processes in special patient groups such as patients with mental or physical special needs etc.
- Identification and authentication processes in situations where identity verification is not possible, such as patients who cannot be contacted, are under anesthesia, elderly or foreign patients

» Authentication practices in diagnosis, treatment and care processes are traceable

PSG.2.2
Authentication tools and methods are defined.

» Patient identity is verified in all processes from the patient's application to the institution/organization until departure (before any test or procedure, before administration of drugs and blood/blood products, during patient transfer, etc.).

» The following examples of identifiers is used for authentication purposes:

- In outpatients, official and official documents with patient's identity information (defined within the scope of the country's legislation)
- Inpatients
  - Armbands/bracelets
  - Barcode and QR code
  - Biometric systems (retinal scanning, fingerprint scanning, palm authentication system, etc.)
  - Other methods that is able to identify patient identity determined by the institution/organization
- In the case of the use of armbands/wristbands as identifiers, the following points is noted.
  - White colored armbands/bracelets etc. are used for hospitalized patients and red colored armbands/bracelets etc. are used for patients with allergies.
  - Armbands/wristbands contain at least patient name/surname, date of birth, protocol number, etc.
  - The information on the armband/wristband are legible and not erasable.
  - During delivery, pink colored arm bands/bracelets is used for baby girls and blue colored arm bands/bracelets for baby boys.
  - If an armband/bracelet is used, mother-baby armband/bracelet with the same serial number is used.
  - The white colored armband/bracelet on the mother is replaced with the armband/bracelet determined according to the sex of the baby.
  - The baby's armband includes at least the mother's name and surname, the baby's date of birth (day/month/year) and the mother or baby's protocol number.
  - Armbands/wristbands are replaced when the mother gives birth, when the patient is found to be allergic, when the armband/wristband loses its properties.

» Patient identity is verified with identifiers. Identification is allowed to consist of the following information (at least two identifiers is used):

- Patient name-surname
- Citizenship number
- Date of birth (day/month/year)
- Father name

- Protocol number

» Examples of the methods to be used to verify patient identity are given below;
  - Inpatients
    - Verbally asking and confirming the patient about the identification parameters in the patient records
    - Comparing patient records with the identification parameters on the patient armband
    - Verbally asking and confirming the patient about the identification parameters written on the patient armband
  - Outpatients
    - Verifying patient identity with photo ID check
    - Compare patient records with the identification parameters on the label on the laboratory test specimen container or ask the patient verbally
    - Verbally asking and confirming patient identification parameters on the test request form to the patient

» Tissues taken for diagnostic purposes during surgical practice is properly identified, labeled, and transferred to the pathology laboratory appropriately.
  - Patient identification parameters to be used on specimen labels to be sent to the pathology laboratory is defined.

» In laboratories, the stages such as sampling and sample acceptance, which require authentication in the pre-analysis process, and the authentication parameters and rules to be used in these stages is defined.

» In the initial examination of hemodialysis patients, identity verification is done through the patient's official ID.
  - Authentication parameters and rules to be used before opening the vascular access in each hemodialysis session is defined.

» Patients and healthcare professionals is informed about the use of identifiers and the importance of authentication.

Standard 3

PSG.3
Prevention of falls are ensured.

PSG.3.1
Processes and rules for the prevention of patient falls are documented.

» Processes to prevent patient falls is defined holistically under the leadership of senior management and with the Participation of all employees, including at least the following information:
  - How risks are identified (department/unit based, patient/disease based, etc.)
  - Assessment of risk levels of patients (patients to be risk assessed, scales to be used in risk assessment, definition of risk levels, etc.)
  - Measures to be taken according to the identified risks (patient/disease-based measures, environmental measures, etc.)
  - Monitoring processes (notification time, method, evaluation of results, etc.) for actual fall events (See Adverse Event Reporting)

PSG.3.2
Patients are assessed for fall risk.

» Fall risk assessment is performed for inpatients and outpatient groups determined by the institution/organization.
» Fall risk assessment of inpatients are performed by the relevant department nurse or the relevant physician following admission to the department where the patient will receive service.
  • Fall risk scoring scales are used for risk assessment (Morse, Hendrich II, Itaki Fall Risk Scale, Harizmi Fall Risk Scale, etc.).
    ▪ Specialized units use scales, if any, specific to the patient groups they serve.
  • The risk assessment is repeated when the patient is transferred between departments, in the postoperative period, in the event of a change in the patient's condition and in the event of a fall.
  • Patient groups requiring special planning (geriatric patients, pediatric patients, adult/child/neonatal intensive care patients, etc.) is considered high-risk without risk assessment and necessary measures is taken.
  • Hemodialysis patients are considered at high risk for falls due to treatment-related complications such as diabetic neuropathy, visual impairments, peripheral vascular and cardiac diseases, and post-dialysis hypotension and muscle cramps.
  • Fall risk assessment results are included in patient records.
  • Information on patients at high risk of falls is transferred between health workers during handover.
» In outpatients, patient groups at risk for falls are determined by the institution/organization.
  • The following patient groups are considered as high-risk patient groups in terms of fall risk:
    ▪ Patients undergoing day surgery under sedation or anesthesia
    ▪ Patients with blurred vision as a result of eye surgery
    ▪ Endoscopy unit patients
    ▪ Patients with a history of falls, gait and balance disorders, vision loss
    ▪ Patients using walking aids
    ▪ Patients taking sedatives, sensory-altering drugs and medications that impair balance and gait
    ▪ Physical therapy or neurology patients
    ▪ Patients over 65 years of age
    ▪ etc.

PSG.3.3
Necessary measures are taken to prevent patient falls.

» Preventive measures are implemented at the patient, unit, and facility levels according to identified risk levels to prevent patient falls.
» Patient-specific measures include general precautions based on risk levels and specific interventions addressing risk factors identified through risk assessment.
  • For hospitalized patients at high risk, at least the following general measures apply:
  • High-risk patients are identified with a symbol determined by the institution/

organization to alert healthcare personnel in all areas where the patient is present or transferred.
  - Protective measures in the care plans of high-risk patients are monitored.
  - The observation frequency for high-risk patients is determined.
  - Patients and their relatives receive information about the risk of falls.
- » A risk assessment is conducted for fall incidents related to the unit/facility, and at least the following measures are implemented:
  - Patient rooms are kept simple, unnecessary equipment, materials, and items are removed, and adequate lighting is ensured.
  - Patient beds are positioned to prevent falls.
  - Bed rails are raised, and bed safety locks are secured.
  - Walking areas are kept dry to prevent falls, warning signs are placed on slippery surfaces, and objects obstructing movement are removed.
  - Handrails are installed where necessary for patient support.
  - Staircases are equipped with handrails.
  - Warning signs are used for low ceilings, slippery and wet floors, and similar hazards.
  - Preventions are taken to eliminate obstacles on the floor.
  - Adequate lighting is ensured in service areas.
- » A sufficient number of wheelchairs are available in accordance with daily patient capacity at institution/organization entrances.
- » Diagnostic, examination, treatment, and care areas are accessible by wheelchair across the institution/organization.
- » All staff are engaged in fall prevention efforts, with awareness and participation ensured.
- » Patients and healthcare workers receive training on fall prevention.

Standard 4

PSG.4
Effective communication between employees is ensured.

PSG.4.1
Processes and rules for ensuring effective communication between employees are documented.

- » Processes and rules for ensuring effective communication between employees are defined to include at least the following issues:
  - Safe handover of patients between healthcare professionals
  - Reporting of panic/critical values
  - Verbal order application
  - Use of abbreviations, symbols and icons
  - Accurate and complete transfer of patient information during consultation processes

PSG.4.2

Arrangements is made for the safe handover of patients between health workers.

» Shift handover processes among healthcare professionals are defined.

» The following points are considered as a minimum during duty shift handovers:

- During the shift handover, patient information is transferred via records and handed over by making a bedside visit.
- All necessary information related to the patient care process (such as medications used, clinical progress, special circumstances related to patient care, etc.) is communicated during the handover.

PSG.4.3

Arrangements are made for reporting panic/critical values.

» Processes for reporting of panic/critical values are defined.

- This plan includes information such as what the panic/critical value is, how, by whom and to whom it will be reported when it occurs, etc.

» Panic values are defined on the IMS.

» It is ensured that the patient's responsible physician or nurse is informed about the panic value as soon as possible.

» The process for panic value notification are traceable. Panic value notification records include at least the following information:

- Patient's name and surname
- Protocol number
- Service
- Name of the test
- Panic/critical value
- Date and time of the test result
- The person making the notification
- Notified person
- Date and time of notification
- By which means the notification was made

» The panic/critical value reported by telephone is verified using the read-back method.

» Relevant personnel is trained on the process for panic/critical value reporting.

PSG.4.4

Arrangements are made to implement verbal prompting.

» The processes related to the verbal request application in the institution/ organization are defined to include at least the following headings:

- Rules for the implementation of verbal order application is defined.
- The name of the drug, dosage form (tablet-capsule-inhalant, etc.), dose, route of administration, amount and/or time is clearly stated during verbal ordering.
- Where a verbal request is received, it is verified to include at least the following steps:
  - When receiving a verbal request, the request is first listened to.
  - The request received is recorded.
  - The written request is then read back and its correctness is confirmed by the person who issued the request.
  - The person receiving the request is able to read back the request when

verifying the request with the following methods:
  - Spelling the drug name
  - Using both generic and trade names of drug names
  - Specify the purpose for which it will be used
  - Not using numbers that is confused when speaking
  - Avoiding drug names that is confused as prefixes and suffixes. Develop a differential spelling method for these (such as TÜSKA for T)
  - If necessary, to ask for the name of the medication to be repeated with the coding method
- If there is a correction in the request, the request is re-registered.
- All verbal requests are put in writing as soon as possible, recorded in the medical records and signed by the person giving the request.
  - Verbal request records indicate how the request was received (verbally, by phone, etc.).
  - In verbal order records; the patient's name and surname, age, name of the drug, dosage form, dosage, route of administration, amount and/or time, name and surname of the person giving the order are indicated.
- Verbal requests not be made for high-risk medicines identified by the institution/organization.
- Nurses and physicians are trained on verbal ordering

PSG.4.5
Arrangements are made for abbreviations, symbols and signs that not be used.

» The rules for the use of abbreviations, symbols and signs are defined by the institution/organization.

PSG.4.6
The rules for the use of abbreviations, symbols and signs are defined by the institution/organization.

» Rules regarding internal/external and emergency consultation processes are defined.

» Complete and accurate transfer of patient information is ensured during consultation processes (See Patient Care)
- Important information about the patient (reason for consultation, diagnosis, treatment, medications, allergies, etc.) is clearly and concisely stated.

Standard 5

PSG.5
The safety of high-risk medications is ensured.

PSG.5.1
Processes and rules for ensuring the safety of high-risk medications are documented.

» Processes to ensure the safety of high-risk medicinal products is defined to include at least the following topics
- Storage/storage

- Prompt
- Packaging
- Labeling
- Application etc.

» Control steps for the safe use of high-risk medicines is defined and implemented.
» A list of high-risk medicines used by the institution/organization is prepared.
- The list is reviewed and updated at least annually.
- The list of high-risk medications used is updated in the event of the addition of new medicines considered to be high-risk, changes in the services provided or patient groups

PSG.5.2
Arrangements are made to ensure the safety of high-risk medications.

» Risks related to the use of high-risk medications are identified. (See Risk Management)
» The high-risk medication list is kept up to date.
» Easy access to information about high-risk medications is ensured.
» Access to high-risk medications is restricted.
» Warning labels and other indicators for high-risk medications are used effectively.
- Additional warnings are used in storage and usage areas for high-risk medications.

» Near-miss and actual adverse events for high-risk medication errors are reported, analyzed and improvement activities are carried out. (See: Adverse Event Reporting)
» Employees are trained to ensure the safety of high-risk medications.

Standard 6

PSG.6
Use of the Safe Surgery Checklist is ensured.

PSG.6.1
The processes and rules for the use of the Safe Surgery Checklist is documented.

» The processes and rules for the use of the Safe Surgery Checklist is defined to The processes and rules for the use of the Safe Surgery Checklist is defined to include at least the following points.
- In order to ensure the safety of surgical care, the “Safe Surgery Checklist” is applied before leaving the clinic, before anesthesia is administered, before the surgical incision and before leaving the operation.
- SSC is used in all operations performed under general, regional and local anesthesia.
- The focal points and responsibilities for SSC implementation is identified for each phase.
- Within the framework of institutional requirements, arrangements is made on the list provided that the minimum requirements in the DST Safe Surgery Checklist are met.

PSG.6.2

Arrangements are made for the use of the Safe Surgery Checklist (SSC).

- Responsible individuals are determined for each stage of SSC, and efficient implementation of SSC is ensured.
  - SSC responsible individuals ensure the completion of all listed tasks at each stage and authorize the transition to the next phase.
  - All steps in SSC are checked and recorded.
- Every step is verbally verified to ensure the execution of key activities.
- SSC is archived in the patient file.
- The following controls are made to evaluate the patient's pre-discharge process from the clinic:
  - Verification of patient identity
  - Obtaining patient consent
  - Completion of pre-operative physical preparations (fasting status, shaving needs, makeup, nail polish, prosthesis check, etc.)
  - Completion of necessary pre-operative procedures (enema, bladder catheterization, compression stockings, etc.)
  - Confirmation of the preparation of special materials, implants, blood, and blood products that may be needed for surgery
  - Review of required laboratory and radiology tests
- If the pre-discharge stage of SSC is not implemented, the patient is not admitted to the operating room.
- Before anesthesia:
  - The SSC responsible individual verbally verifies the patient's identity and intervention site, checks patient consent, and confirms area marking.
  - Pre-checks for safe anesthesia, including allergic reactions, airway assessment, and potential blood loss, are conducted.
- Before the surgical incision:
  - Each team member introduces themselves with their name and role.
  - The staff vocally confirms that the correct surgery is being performed on the right patient at the correct location.
  - Critical elements such as prophylactic antibiotic application, anticoagulant use, and deep vein thrombosis prophylaxis are verbally controlled.
- Before leaving the operating room:
  - Instrument, sponge, and gauze counts are completed.
  - All collected surgical specimens are labeled.
  - Malfunctions in instruments and any other issues requiring attention are reviewed.
  - Critical aspects of post-surgical care and points requiring attention are documented.

Standard 7

PSG.7
Hand hygiene is provided.

PSG.7.1
Processes and rules for ensuring hand hygiene are documented.

» Processes for ensuring hand hygiene are defined to include at least the following topics:
  - Determination of responsible individuals for the hand hygiene monitoring program
  - Determining hand hygiene rules
  - Evaluation of hand hygiene compliance
  - Practices for improve hand hygiene compliance

PSG.7.2
Arrangements are made to ensure hand hygiene.

» Within the scope of WHO suggestions, “5 Indications” for hand hygiene performed by healthcare workers are as follows:
  - Before contact with the patient
  - Before aseptic procedures
  - After contact with body fluids
  - After contact with the patient
  - After contact with patient’s surroundings

» Hand hygiene practices are implemented in all areas where patient care is not provided but indirect healthcare services are provided to patients, including laboratories, pharmacies, sterilization units, and departments involved in the preparation of medications, food, etc.

» Hand hygiene compliance is evaluated.
  - Hand hygiene compliance refers to the correct timing, appropriate method, proper execution, and correct duration of hand hygiene. Hand hygiene compliance means not only washing and rubbing hands, but also doing these correctly.
  - Hand hygiene compliance is measured using methods such as scheduled observations, tracking hand hygiene materials used by departments, and surveys to assess healthcare workers’ awareness, knowledge level, and compliance.
  - Necessary improvement activities are planned based on the data obtained from evaluations.

» The following minimum actions are taken to improve hand hygiene compliance:
  - Establishment of a hand hygiene policy
  - Determination of hand hygiene responsible individuals
  - Trainings
  - Supporting skin care for healthcare workers
  - Reminder, and alert messages
  - Facilitation of easy access to materials

» Hand hygiene materials are available in all areas where healthcare services are provided.

- Management makes necessary plans and takes measures related to access to handwashing areas.
- Liquid soap, disposable towels, and other materials are accessible in handwashing areas/washbasins.
  - Within the framework of recommendations in the WHO guidelines; alcohol-based hand antiseptics are available at patient care points where patient, healthcare worker, patient or surroundings' contact is involved in care or treatment processes.
  - Alcohol-based hand antiseptics are easily accessible at patient care points.
  - Outpatient care and treatment areas are also included within this scope. The purpose here is ensuring patient-side products are available in a way that they can be accessed without leaving the patient area.
  - Access to alcohol-based antiseptics is provided through methods such as pocket-sized bottles carried by healthcare workers, bottles fixed to the wall or patient bed, bottles on bedside tables, or those found in medication carts.

» Training on hand hygiene is provided to all employees.
- The content and frequency of the training are determined based on professional groups and hand hygiene compliance measurement results.
- Trainings include at least the following topics:
- The importance of hand hygiene
- Methods and indications
- Use of gloves
- Points to take into consideration

Standard 8

PSG.8
Compliance with patient safety objectives are monitored and evaluated.

PSG.8.1
Indicators related to patient safety targets are determined and the effectiveness of the studies are monitored at regular intervals.

» The outcomes of patient safety plans and programs are monitored, evaluated, and continuously improved.
» Indicators are determined, monitored, and evaluated based on the type of service and patient profile (See: Indicator Management), including:
- Ensuring hand hygiene
- Medication safety
- Prevention of falls
- Identity verification
- Usage of the safe surgery checklist
- Effective communication among employees

» The indicators in question are selected from those listed in the SAS (Accreditation Standards in Healthcare) indicator list or determined by the institution/organization.
» Indicators results are analyzed, their alignment with set targets is evaluated, and continuous improvement practices are made.
» The results are shared with management and relevant employees.


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SECTION 4
Health Services

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SECTION 4 HEALTH SERVICES	
Chapter 12 Patient Care (PC)	
Code	**Standard 1**
PC.1	The rules and processes regarding the patient care services are defined and suitable operation is ensured.
Code	**Assessment Criteria**
PC.1.1	The rules and processes regarding patient care are documented.
PC.1.2	The arrangements regarding the processes for safe transfer, referral and discharge of the patient are planned in a way that ensures continuity of the care.
PC.1.3	The arrangements regarding the consultation process are made.
Code	**Standard 2**
PC.2	Arrangements are made for the effective management of the patient assessment and care process
Code	**Assessment Criteria**
PC.2.1	The patient is evaluated by healthcare staff in terms of the care needs.
PC.2.2	The patient is evaluated by the relevant healthcare staff in terms of clinical risks.
PC.2.3	Based on the evaluation results, a multidisciplinary patient care plan for inpatients is prepared.
PC.2.4	Arragements for the evaluation of cases requiring a multidisciplinary approach are established.
PC.2.5	Records related to the patient's care process are complete and accurate, including necessary alerts for the patient's clinical follow-up.
PC.2.6	Changes in the patient's clinical condition are promptly identified, and necessary interventions are ensured.
PC.2.7	The effective use of medical device alarm systems in the patient care process is ensured.
PC.2.8	The participation of patients and their relatives in the care process is ensured.
PC.2.9	Arragements for the management of patients at risk of harming themselves or others are established.

Code	Standard 3
PC.3	Arragements for improving clinical quality are established.
Code	**Assessment Criteria**
PC.3.1	Processes for the development, use, dissemination, and improvement of evidence-based clinical guidelines, protocols, and manuals are defined.
PC.3.2	The effective and safe use of evidence-based clinical guidelines, protocols, and manuals is ensured, and awareness-raising and improvement activities for their dissemination are conducted.
PC.3.3	Indicators for improving clinical quality are identified, and the effectiveness of activities is monitored at regular intervals.
Code	**Standard 4**
PC.4	Arragements for digital health applications used in patient assessment and care processes are established
Code	**Assessment Criteria**
PC.4.1	Processes for the use of digital health applications are defined.
PC.4.2	The safe, effective, and efficient use of digital health applications is ensured.
PC.4.3	The effectiveness of digital health applications is evaluated, implementation monitoring results are reported, and continuous improvement activities are carried out.

General Information

Patient care is one of the core activities of healthcare institutions and organizations, ensuring the fulfilment of patients' physical, psychological, social, and emotional needs. Providing patient care through a holistic approach and by a multidisciplinary team positively impacts the patient's recovery process. Additionally, the active participation of the patient and their family in the care process influences the success of the care process. A successful care process ensures patient safety, increases patient satisfaction, and enhances collaboration among staff. In this regard, this chapter guide healthcare institutions and organizations in providing effective, efficient, and safe care.

Purpose

The purpose of this chapter is to;

- Ensure that all patients in the service area receive qualified and safe care at every stage of the patient care process
- Promote the improvement of clinical quality
- Ensure the effective, efficient, and safe use of digital health applications in the care process

Objectives

- Patient Safety
- Efficacy
- Convenience
- Timeliness
- Fairness

Standard Requirements

Standard 1

PC.1
The rules and processes regarding the patient care services are defined and suitable operation is ensured.

PC.1.1
The rules and processes regarding patient care are documented.

» The processes related to patient care are encompassed by outpatient, inpatient, and emergency patients.
» The processes related to patient care include emergency services, dialysis, same-day surgeries, etc., for outpatient patients, diagnostic/treatment processes provided in outpatient clinics, and diagnostic/treatment processes for inpatient patients, along with service processes related to all other professional groups.
» The processes related to patient care are defined with the participation of relevant healthcare workers.
» The processes related to patient care include at least the following topics:
- How, when, and by whom patient care needs are evaluated
  - Population-specific scales, evaluation forms, etc., to be used in the assessment are determined.
- Planning of patient care after evaluation
  - The care plan prepared includes data on problems identified with the patient, goals for those problems, measures taken, and interventions made.
- The planned care is provided to the patient
- The results of the care plan are evaluated, and the patient is monitored
- The care plan is updated according to the requirements
- Coordination of multidisciplinary care team members is ensured at all stages of the care process
- Patient safety is ensured during the care process
- The participation of the patient/patient's relatives in the care process is ensured
- The care plan and outcomes for inpatient/outpatient patients are traceable.
- Providing medical information about the deceased patient (determining the individuals authorised to provide information, the area planned for providing information, etc.)

PC.1.2
The arrangements regarding the processes for safe transfer, referral and discharge of the patient are planned in a way that ensures continuity of the care.

» The processes related to the transfer, referral, and discharge of the patient are carried out within a plan.
» The plan is in accordance with national and international arragements.
» The plan includes department/unit-based transfer, referral, and discharge criteria.
» Procedures to be followed for patients leaving the institution or refusing treatment without a physician's consent are determined in the plan.

» The processes related to the safe transfer of the patient within and outside the institution include at least the following topics:
  - The plan is in accordance with national and international arragements
  - The transfer of the patient outside the institution
  - The transfer of inpatient and emergency service patients
  - The transfer of patient groups requiring special planning, such as neonates, intensive care, dialysis, and psychiatric patients
  - Considerations for the patient's transfer
  - The suitability and use of vehicles for transfer
  - Identification of the staff involved in the transfer
» In case of the patient's transfer and/or referral within or outside the institution:
  - The patient's transfer within the institution is carried out with the accompaniment of a healthcare worker.
  - Suitable equipment ensuring patient safety (such as stretchers, wheelchairs, transport incubators, neonatal trolleys) is available and used for the transfer.
    - The checks and maintenance of the equipment used are performed.
  - The participation of the patient and their relatives in the transfer and/or referral process is ensured, and necessary information is provided.
  - Coordination with the institution/unit to which the patient will be transferred or referred is ensured before the transfer and/or referral.
» During the transfer and/or referral, the patient's clinical status, any interventions performed, diagnosis/treatment procedures, current care plan, and care process-related information are communicated accurately and completely.
  - Medical records containing the patient's information (at least the patient's clinical status, ongoing care needs, reasons for transfer/referral, and any special circumstances related to the transfer/referral) are sent to the receiving institution/unit.
  - The name of the accepting institution/organization and unit, and the name of the person accepting the patient are included in the records of the transferred/referred patient.
» Transfer and/or referral services, including contracted services, and the transportation vehicles used for these services are in compliance with the relevant national arragements and meet the quality and safety criteria set by the institution/organization.
  - Transport vehicles are compatible with infection prevention and control programs, and medical equipment, materials, and medications that meet the needs of the transferred patient are available in these vehicles.
» The patient's medical condition during the transfer and/or referral is monitored and recorded.
» The validity of ambulance drivers' licenses is regularly checked.
» In case of the patient's discharge:
» The patient's discharge needs are evaluated, and necessary planning is done.
  - The planning includes education on meeting care needs, assessment of transfer needs, etc.
  - The discharge plan is made with the patient.
  - Discharge planning is initiated upon the patient's admission to the institution and includes potential psychosocial or physical care, treatment, and service

needs.
    - Discharge planning includes topics such as medications/high-risk medications, physical activity, infection control measures, pain management, and safe and effective use of medical devices.
- » Processes related to ongoing care and treatment after discharge are defined.
- » The written discharge plan is explained and provided to the patient/patient's relatives during discharge/referral.
- » Patients who are discharged are informed about their post-discharge home care, medications, any prescribed diet, physical activities, movement restrictions, follow-up times, and whom to contact if necessary, along with their contact details.
- » Records related to the discharge process are kept.
- » The discharge summary, along with the discharge decision, is written as soon as possible and includes at least the following information:
    - The reason for the patient's admission
    - Important findings
    - The diagnosis
    - The treatments applied
    - The patient's general condition at discharge
    - Medications to be used after discharge
    - Follow-up time
    - Emergency contact numbers for the patient
    - Important considerations for the patient
- » A copy of the discharge summary is kept in the patient's file, and the other copy is provided to the patient.
- » Training on the safe transfer, referral, and discharge of patients is provided to the relevant staff.

PC.1.3
The arrangements regarding the consultation process are made.

- » The following minimum processes and rules related to intra-institutional/external and emergency consultations are defined:
    - Consultation request
    - Implementation
    - Duration
    - Record keeping (consultation reason, evaluation result, and actions taken based on the result, etc.)
    - The consultation result is communicated to the patient's care/treatment.
    - Intraoperative pathology consultations
    - External consultation of a test material (transfer of the material, reporting of the consultation result, communication of the result to the relevant patient and/or physician, etc.)
- » The consultation process is monitored by the responsible physician, and the patient care process is reassessed according to the consultation report.
- » Consultation services are provided in a timely manner without disrupting the patient care process.
- » Records related to the consultation process are kept regularly.

Standard 2

PC.2
Arrangements are made for the effective management of the patient assessment and care process.

PC.2.1
The patient is evaluated by healthcare staff in terms of the care needs.

- » Patient care needs are assessed with a holistic approach by the relevant healthcare professionals when the inpatient is admitted to the department and, if necessary, in the outpatient setting in the department providing the service.
- » All members of the care team assess the patient within their area of expertise and identify the patient's care needs.
- » When identifying care needs, the patient's history, physical examination, and, if available, diagnostic test results, along with the patient's overall condition, are assessed with a holistic approach considering physical, mental, and social aspects.
- » This assessment includes the patient and/or their family.
- » All evaluations made are recorded.

PC.2.2
The patient is evaluated by the relevant healthcare staff in terms of clinical risks.

- » Each patient's initial assessment includes a physical examination, medical history, and an evaluation of psychological, (where applicable) spiritual/cultural, social, and economic factors.
- » To prevent adverse outcomes in the care process, inpatient clinical risk assessments specific to the department are conducted by relevant healthcare professionals, covering at least the following areas:
  - Allergic risk assessment
  - Pain assessment for inpatient and identified outpatient groups
  - Assessment of nutritional status
  - Pressure ulcer risk assessment
  - Catheter care and monitoring
  - Monitoring of consciousness level
  - Safe transfer of patients
  - Patient monitoring for ventilator-associated pneumonia
  - Extremity pulse monitoring and edema grading
  - Oral care and monitoring
  - Assessment of device-related risks

Pain Assessment

- » Processes for pain assessment and the associated rules are defined for patients receiving inpatient/outpatient care and treatment.
- » Population-specific risk assessment tools, valid at the national/international level, are used in pain assessment.
- » The process for reassessing pain is conducted according to the reassessment frequency suggested by the assessment scale/tool.

» Based on the pain assessment results, necessary interventions for the patient are planned, implemented, and documented.

Medical Nutrition

» Processes for medical nutrition and the associated rules are defined for patients receiving inpatient/outpatient care and treatment.
» Medical nutrition processes include nutrition team involvement, nutrition risk assessment for outpatient and inpatient patients, processes and rules for the care and monitoring of patients identified with a need for medical nutrition support, nutrition risk management, and nutrition education processes for both inpatient/outpatient patients and post-discharge.
» A team is established to manage the patient's medical nutrition treatment processes, including at least a doctor, nurse, dietitian, and pharmacist, and the team's responsibilities are defined.
» The patient's nutrition risks are assessed and documented, using valid and reliable population-specific scales for this purpose.
» After the risk assessment, the medical nutrition treatment identified according to the patient's needs is applied and documented.
» Arrangements are made to ensure the continuation of medical nutrition treatment after discharge, including education, monitoring processes, and information about the use of nutrition equipment.

Pressure Injuries

» Processes to prevent pressure injuries are defined for both inpatient and outpatient care.
» Patient groups requiring risk assessment for pressure injuries are identified.
» Patients are assessed for the risk of pressure injuries using valid scales/tools such as Braden, Norton, Waterlow, etc.
» Measures to prevent pressure injuries are taken according to the risk level and recorded in the care plan.

Catheter and Tubes' Safety

» Processes and rules to ensure the safe use of catheters and tubes are defined for both inpatient and outpatient care.
» The used catheters and tubes are identified.
» Warning markers are applied to high-risk catheters, such as arterial, epidural, and intrathecal catheters.
» Healthcare workers are informed and trained on the defined rules.
» Patients and their families are informed and trained on the necessary precautions related to the catheters and tubes used.
» For patients at high risk, such as those with sepsis or cardiopulmonary arrest, early warning system scores or call criteria are used.
» Necessary precautions are taken for patients identified as high risk.

PC.2.3
Based on the evaluation results, a multidisciplinary patient care plan for inpatients is prepared.

- » The care plan is prepared within the first 24 hours following the patient's admission to the institution.
- » The care plan is prepared to cover the entire duration of the inpatient care.
- » The care plan is created to include the processes of all healthcare professionals involved in the patient's care.
- » The care plan is coordinated and prepared by the relevant disciplines providing care to the patient, ensuring that the plan can be monitored in the same area.
- » The care plan is trackable; it includes the patient's care needs, measurable goals for these needs, care-related interventions, and the evaluation of the outcomes of these interventions.
- » The care plan is updated according to the patient's care needs.
- » The actions performed within the care plan are recorded simultaneously.
- » All changes/developments during the patient's care (such as changes in the patient's clinical condition, changes in medications, any interventions performed, etc.) are reflected in the care plan simultaneously.
- » The care plan is updated at the end of each shift to reflect the patient's current status.
- » All updates made to the care plan are trackable by the relevant healthcare professionals.
- » Internationally recognized terminologies such as ICD 10, NANDA, NIC, NOC, etc., are used in the care plan.

PC.2.4
Arragements for the evaluation of cases requiring a multidisciplinary approach are established.

- » The process for evaluating cases requiring a multidisciplinary approach is planned..

PC.2.5
TRecords related to the patient's care process are complete and accurate, including necessary alerts for the patient's clinical follow-up.

- » Records related to the patient's care process are completed accurately and comprehensively by all relevant healthcare professionals and include necessary alerts for clinical follow-up.
  - Information about diagnostic procedures and treatments performed, including by whom and on what date, is included in the records and is accessible for future patient visits.
  - The completeness and accuracy of information in patient files and records are ensured.
  - Patient records are written legibly and clearly.
  - Alerts critical to the patient's clinical follow-up are included in the patient's file

PC.2.6

Changes in the patient's clinical condition are promptly identified, and necessary interventions are ensured.

- » Processes related to recognizing and responding to physiological signs of patient deterioration, both inside and outside the clinic, are defined and implemented.
- » All patients are reassessed at defined intervals based on their condition and response to treatment.
- » Methods for seeking assistance when additional intervention is needed are outlined for staff.
- » Patients and their families are informed about how to seek help if they notice concerning changes in the patient's clinical condition.

PC.2.7

The effective use of medical device alarm systems in the patient care process is ensured.

- » Medical device alarms that provide early warnings in situations posing risks to patient safety, along with their locations and usage conditions, are defined to include at least the following:
  - Clinically appropriate settings for alarm signals
  - Conditions under which alarms can be disabled
  - Conditions under which alarm parameters can be modified
  - Individuals authorized to configure alarm parameters
  - Individuals authorized to modify alarm parameters
- » An alarm system management program is developed and implemented for alarm signals that pose risks to patient safety.
- » Criteria for identifying early warning signs of changes or deterioration in the patient's condition and providing the necessary assistance are established and implemented.
  - Patient age is considered when defining criteria, and when and how to request assistance is clearly outlined.
  - Additional assistance is promptly sought if concerns arise regarding the patient's condition.
  - Patients and their families are informed about how to seek assistance if they are concerned about the patient's condition.
  - Employees responsible for managing clinical alarms receive the necessary training.

PC.2.8

The participation of patients and their relatives in the care process is ensured.

- » Practices in care plans include the involvement of patients and their families in the care process.
- » Patients are allowed to perform their independent functions and are encouraged to participate in their own care.
- » Practices performed by the patient or their family are documented in the care plan.
- » The adaptation of the patient and their family to the institution/unit is facilitated.
- » Patients and their families are informed about the rules they need to follow,

meal times, use of phones, methods to reach healthcare professionals, and the process of being informed about the care services provided.

» The entire care team providing services to the patient communicates with the patient and their family in a way that considers their expectations, needs, and values, maintaining a positive dialogue during conversations with the patient and their family.
» In the course of care procedures, the patient and their family are informed by the person performing the procedure about the details of the procedure.
» The patient and their family are informed at the designated frequency and time regarding the progress of care procedures.
» Training is provided to the patient and their family to ensure the continuity of care.
» The training content includes topics such as patient rights, medication usage, considerations during care procedures, discharge education, and other relevant subjects.
» In the case of a risky procedure, the patient is informed about the procedure by the person performing it, and written consent is obtained.
» The spiritual and cultural needs of the patient and their family are considered

PC.2.9

Arragements for the management of patients at risk of harming themselves or others are established.

» Patients receiving inpatient services who are at risk of harming themselves or others are identified and known to the relevant staff.
» The following minimum precautions are taken for patients at risk of harming themselves or others:
  • Patients at high risk of harming themselves or others are observed at the frequency determined by their care needs.
  • If necessary, arrangements are made to ensure that healthcare staff can easily access the patient.
  • The patient's room is made safe from an environmental perspective (e.g., appropriate lighting, avoiding the use of risky furniture, accessories, etc., ensuring windows are secure).
  • In patients where necessary, care-related interventions are determined in collaboration with a psychiatry consultant.
  • For patients who cannot be controlled with the minimum precautions, movement restrictions are applied according to the physician's decision.
» Minimum rules for pharmacological restrictions are defined.
» Whenever possible, the patient is informed about the restriction to be applied, including the reasons for it, when it will end, its importance, etc.
» The privacy of the patient to whom the restriction is applied is ensured.
» If a physical/chemical restraint is applied to the patient;
  • The suitability of the equipment to be used for restraint is evaluated.
  • The materials used for restraint do not prevent the patient from moving or impair circulation.
  • The relevant healthcare professional assesses the skin in the area where the restraint will be applied, both before and during the procedure.
  • The relevant healthcare professional assesses circulation in the area where the

restraint will be applied, both before and during the procedure.
    - The patient's care needs, such as nutrition, elimination, oxygen needs, mobilization requirements, and hygiene, are evaluated while the patient is under restraint.
- » Physical restraint is applied within the framework of the following rules:
    - The decision for physical restraint is made by the physician.
    - The decision for physical restraint is included in the treatment plan, and the plan includes the following details:
    - The date and time when the application begins
    - The intervals at which the application will be monitored
    - The date and time when the application ends
- » The decision regarding the continuation of the restraint is reviewed at least every 24 hours.
- » All assessments are recorded.
- » A care plan is prepared based on the patient's care needs, and necessary care is provided.

Standard 3

PC.3
Arragements for improving clinical quality are established.

PC.3.1
Processes for the development, use, dissemination, and improvement of evidence-based clinical guidelines, protocols, and manuals are defined.

- » The use of nationally and/or internationally recognized, evidence-based, up-to-date clinical guidelines, protocols, and manuals in diagnosis, treatment, rehabilitation, and discharge processes is one of the key factors in improving clinical quality.
- » The processes related to the development, use, dissemination, and improvement of evidence-based clinical guidelines, protocols, and manuals include at least the following topics:
    - Identifying the areas where national and international clinical guidelines, protocols, and manuals will be used
    - Developing/selecting the clinical guidelines, protocols, and manuals to be used
    - Defining the purpose and methods of using clinical guidelines for evaluation, treatment, prognosis, discharge, etc.
    - Determining who will use the clinical guidelines, protocols, and manuals and how they will be used
    - Promoting the widespread use of clinical guidelines, protocols, and manuals
    - Conducting activities such as training, meetings, etc., for the development and improvement of clinical guidelines, protocols, and manuals.
    - The selection of clinical guidelines, protocols, and manuals to be used is carried out by a multidisciplinary committee or council;
- » The selection process is carried out by a multidisciplinary committee or council.
    - Best practice information, shared outcome data, and input from patients and

their families are considered.
- A patient-centered approach is followed, and guidelines connected to improved patient experience are prioritized.

» To monitor the dissemination and implementation of clinical guidelines, protocols, and pathways among practitioners:
- After the guideline is selected and published, activities such as organizing training programs for practitioners and ensuring easy access to the guidelines are carried out.
- Following the implementation of the guidelines, they are reviewed and evaluated at regular intervals in terms of clinical, economic, and patient-based outcomes

PC.3.2
The effective and safe use of evidence-based clinical guidelines, protocols, and manuals is ensured, and awareness-raising and improvement activities for their dissemination are conducted.

» The reliable use and coordination of clinical guidelines, protocols, and manuals are ensured by establishing teams that include relevant field experts for service areas.
» The clinical guidelines, protocols, and manuals to be used in each unit are determined by these teams.
» Unit-based reviews are conducted as part of scientific studies to ensure that guidelines, protocols, and manuals remain up to date.
» The compliance and usage of clinical guidelines, protocols, and manuals are monitored and evaluated, and corrective actions are planned and implemented based on the results.
» Regular informative training sessions for employees using clinical guidelines, protocols, and manuals are planned, implemented, and analysed.

PC.3.3
Indicators for improving clinical quality are identified, and the effectiveness of activities is monitored at regular intervals.

» Indicators related to the clinical guidelines, protocols, and manuals in use are identified and monitored.
» Indicator analysis results are tracked, evaluated, and improvement activities are planned and implemented accordingly. (See: Indicator Management)

Standard 4

PC.4
Arragements for digital health applications used in patient assessment and care processes are established.

PC.4.1
Processes for the use of digital health applications are defined.

» Processes monitored through digital health applications within the institution/ organization are identified.

- Digital health applications include systems such as e-order, e-appointment, telemedicine, clinical decision support systems, artificial intelligence applications, and automated medication distribution systems.

» Rules related to processes managed through digital health applications are defined.

PC.4.2

The safe, effective, and efficient use of digital health applications is ensured.

» Activities related to digital health applications comply with all relevant national arragements, international service standards, and rules within the framework of security and privacy principles.

» Digital health applications are designed and implemented based on existing evidence.

» All studies conducted with stakeholders within the scope of digital health applications are documented.

» The privacy, confidentiality, and security of patient information are ensured.

PC.4.3

The effectiveness of digital health applications is evaluated, implementation monitoring results are reported, and continuous improvement activities are carried out.

» Data monitored through digital health applications is defined, responsible personnel for data monitoring processes are identified, and data is tracked, analysed, and evaluated. Improvement activities based on analysis results are planned and implemented in collaboration with relevant units.

» Employees using digital health applications possess adequate training and experience in relevant applications.

» Necessary training is provided to relevant employees regarding the use of digital health applications.

SECTION 4 HEALTH SERVICES	
Chapter 12 Prevention and Control of Infections (PCI)	
Code	**Standard 1**
PCI.1	Processes and rules for the prevention and control of infections are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
PCI.1.1	A managerial structure for the prevention and control of infections are established, and duties, authorities and responsibilities are defined.
PCI.1.2	A risk assessment is conducted for the prevention and control of infections.
PCI.1.3	Processes for the management of epidemic or rare infections are defined.
PCI.1.4	Education is provided to patients, relatives and employees on the prevention and control of infections.
Code	**Standard 2**
PCI.2	Studies on the prevention and control of infections are carried out within a program.
Code	**Assessment Criteria**
PCI.2.1	A program for the prevention and control of infections are established.
PCI.2.2	Arragements are made regarding isolation measures.
PCI.2.3	Arragements are made regarding infection control bundles.
PCI.2.4	Arragements are made regarding the rational use of antibiotics.
PCI.2.5	Arragements are made regarding the prevention of facility-acquired infections.
Code	**Standard 3**
PCI.3	Monitoring and evaluation studies on infection prevention and control are conducted.
Code	**Assessment Criteria**
PCI.3.1	Indicators for the prevention and control of infections are determined, the effectiveness of the work is monitored at regular intervals and continuous improvement activities are carried out.

Chapter 12: Prevention and Control of Infections (PCI)

General Information

Prevention and control of infections in healthcare institutions/organizations is critical to protect the health of both patients and healthcare workers. Ensuring patient safety is important in terms of protecting healthcare workers, cleaning the clinical environment, preventing outbreaks, improving the quality of patient care, ensuring faster and more effective recovery of patients and reducing costs. The work to be carried out in this area includes a series of practices and protocols to comply with various legal and regulatory standards and offers an evidence-based approach. The standards in this chapter provide guidance to all health institutions and organizations in the prevention and control of infections.

Purpose

The purpose of this chapter:

- Prevent the spread of infections
- Protecting the health of patients, healthcare workers and the public by establishing an effective framework for the control of infections
- To provide a systematic and planned approach to the prevention and control of infections
- To ensure that monitoring and evaluation studies are carried out regularly and the results are used to improve policies and practices for the prevention and control of infections

Objectives

- Patient Safety
- Healthy Work Life

Standard Requirements

Standard 1

PCI.1
Processes and rules for the prevention and control of infections are defined and functioning is ensured accordingly.

PCI.1.1
A managerial structure for the prevention and control of infections are established, and duties, authorities and responsibilities are defined.

» A management structure such as a committee, team, responsible person, etc. is established for the prevention and control of infections, depending on the size of the facility.
» The members in the management structure are determined by considering the relevant country legislation, personnel capacity, patient profile and needs.
» The duties, authorities and responsibilities of the people responsible in the management structure are defined to include at least the following:
  • To create a program for the prevention and control of infections in accordance with the characteristics and conditions of the institution/organization within the framework of scientific principles.
  • To monitor the effectiveness of the activities determined and implemented in the program for the prevention and control of infections, to make decisions on necessary improvement activities and to make recommendations to the management.
  • To ensure coordination of efforts to prevent and control infections.
» People working in the managerial structure are informed about their duties, authorities and responsibilities.

PCI.1.2
A risk assessment for infection prevention and control is carried out.

» All areas of the institution/organization and the services provided are evaluated for infection risk at least once a year.
» Necessary measures are taken against the identified risks, and appropriate changes are made to the infection prevention and control program when necessary based on the assessment results, and its continuity is ensured. (See Risk Management)

PCI.1.3
Processes for the management of epidemic or rare infections are defined.

» Processes for managing epidemics and rare infections include, at a minimum, the following:
  • Early diagnosis
  • Rapid intervention
  • Emergency preparedness plan
  • Controlling the spread of infection
  • Training for patients, relatives and healthcare professionals
  • Activities to inform the public when necessary

PCI.1.4
Education is provided to patients, relatives and employees on the prevention and control of infections.

» Training on infection prevention and control for patients/patient relatives are planned, implemented and their effectiveness evaluated with training management officers.
» Training for employees are planned according to the areas of duty and competence of employees

Standard 2

PCI.2
Studies on the prevention and control of infections are carried out within a program.

PCI.2.1
A program for the prevention and control of infections are established.

» The program for infection prevention and control are created by considering the size of the institution/organization and service delivery areas.
» The program includes at least the following topics:
- Evaluation of health service processes in terms of infection risk
- Surveillance
- Hand hygiene
- Isolation measures
- Infection control bundles
- Prevention and control of infections in specific service delivery areas (dialysis, intensive care, bone marrow transplant unit, immunosuppressive patient rooms, isolation rooms, parenteral nutrition unit, etc.)
- Registration of notifiable diseases in the relevant country's national health/ notification system
- Rational use of antibiotics
- Cleaning, disinfection, sterilization, asepsis, antisepsis
- Air and waterborne infection control measures
- Prevention of infections in facility-related renovation, repair, construction works
- Planning for extraordinary situations such as epidemics, rare infections, etc.
- Prevention of infections in support services such as laundry, kitchen, morgue, warehouse, technical unit, biomedical
- Disposal of waste
- Defining health screenings and immunization procedures to be carried out to protect employees from occupational infections

PCI.2.2
Arrangements are made regarding isolation measures.

» Processes for the management of infected/colonized patients are defined, and patient groups for whom isolation measures will be taken are determined.
» Isolation measures are defined to include standard precautions and situation-specific measures such as respiratory, droplet and contact isolation.

- When determining isolation precautions, accepted national and international guidelines are taken as basis.

» The necessary physical conditions for isolation measures (separate room, sufficient distance between beds, sufficient staff, etc.) are provided.

» In order to ensure application and language unity within the institution/ organization and to benefit from the memorability of visual forms, isolation symbols/cards, etc. stimuli are determined according to the type of isolation.
- In infected/colonized patients, descriptive symbols indicating the applied isolation method are used.
- In line with the administrative structure decision for the prevention and control of infections, the name of the isolation method and the method of application can be used together with the visuals used for the descriptive symbols.
- Relevant healthcare professionals, patients and their relatives are informed about the isolation descriptor and its use.
- Isolation precautions and identifying symbols are applied throughout the service process, including patient transfer.

» Healthcare workers are trained on isolation precautions, adequate personal protective equipment is provided, equipment continuity is ensured, and work is carried out in accordance with isolation precautions

PCI.2.3
Arrangements are made regarding infection control bundles.

» A team responsible for raising awareness about rational antibiotic use, planning and carrying out the necessary studies on the subject are formed, and the duties, authorities and responsibilities of the team are determined.
- Specialists working in the field of infection prevention and control, physicians, nurses, pharmacists, patients and their relatives can be included in this process.

» A rational antibiotic use policy is defined.
- When determining antibiotic use policies, international and, if available, national and/or local guidelines are used, and local resistance data also be taken into account.

» A program is developed and implemented in line with the rational antibiotic use policy.

» A guide is prepared regarding the principles of rational antibiotic use and appropriate antibiotic prophylaxis.
- Training, information activities, etc. are organized to ensure that practices are carried out in accordance with the guideline, and their reflection on clinical practice are monitored (such as monitoring the correct use of antibiotics in surgical prophylaxis).

» Restricted reporting rules are determined and implemented in antibiotic susceptibility test reports.

» Antibiotic use and bacterial resistance are monitored on an institutional basis

PCI.2.4
Arrangements are made to prevent facility-related infections.

» The team responsible for preventing and controlling infections are included in the planning and organization of facility demolition, construction, renovation and

repair, etc.
- » Water and ventilation systems are controlled and evaluated to prevent facility-related infections.
- » Records of inspections are kept.
- » The following processes are monitored in terms of infection prevention and control, and necessary precautions are taken and their continuity are ensured:
- » Cleaning of textile materials used in healthcare provision
- » Procurement, storage, preparation and distribution of food provided to healthcare providers and service users
- » Safe removal and disposal of medical waste generated in healthcare provision
- » End-of-life services, morgue area and operation
- » Ventilation and air filtration systems

Standard 3

PCI.3
Monitoring and evaluation studies on infection prevention and control are conducted.

PCI.3.1
Indicators for the prevention and control of infections are determined, the effectiveness of the work are monitored at regular intervals and continuous improvement activities are carried out.

- » Practices carried out for the prevention and control of infections are monitored on a process and result basis and necessary activities are carried out for continuous improvement.
- » Routine observations and controls, surveillance reports, process and result-based indicators determined for practices are used in monitoring and evaluation studies.
- » Routine observations and controls and surveillance reports are evaluated and recorded in meetings.
- » Indicators to be monitored nationally and internationally are determined and recorded.
- » Indicator results are analyzed, their compliance with the set targets are evaluated, and continuous improvement efforts are carried out.
- » The results obtained are shared with senior management and relevant employees.
- » Employees are informed and trained about their responsibilities regarding infection control and prevention.

SECTION 4 HEALTH SERVICES	
Chapter 13 Medication Management (MM)	
Code	**Standard 1**
MM.1	Processes and rules regarding medication management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
MM.1.1	Processes and policies for medication management are documented.
MM.1.2	A managerial structure for medication management is established.
MM.1.3	Duties, authorities and responsibilities regarding medication management are defined and effective communication is ensured.
MM.1.4	Necessary training is given to relevant employees in all processes involving medication.
Code	**Standard 2**
MM.2	Arrangements are made for the supply, storage and stock management of medications.
Code	**Assessment Criteria**
MM.2.1	Arrangements are made to ensure that the right medication is provided at the right time.
MM.2.2	Medications are stored in accordance with their characteristics and the necessary physical conditions are provided.
MM.2.3	Arrangements are made for the storage of special quality medications.
MM.2.4	Arrangements are made to monitor stock levels and expiry dates of medications.
Code	**Standard 3**
MM.3	Arrangements are made for the request, preparation and transfer of medication.

Code	Assessment Criteria
MM.3.1	Arrangements are made for the medication request process.
MM.3.2	Arrangements are made for the preparation of medications.
MM.3.3	Arrangements are made for the safe transfer of medications.
Code	**Standard 4**
MM.4	Arragements regarding safe medication administration are made.
Code	**Assessment Criteria**
MM.4.1	Arrangements are made regarding the preparation and administration of medications before regulation.
MM.4.2	The medications that come with the patient is checked.
MM.4.3	Arragements are made regarding adverse effects related to medication applications.
MM.4.4	Arrangements are made for the destruction of medications.
Code	**Standard 5**
MM.5	Monitoring and evaluation studies regarding medication management are conducted.
Code	**Assessment Criteria**
MM.5.1	All stages of the processes involving the medication are traceable.
MM.5.2	Indicators for evaluating the performance of processes in which the medication is involved are determined, the effectiveness of the studies are monitored at regular intervals and continuous improvement activities are carried out.

General Information

A medicinal product is a substance or combination of substances that is presented as having therapeutic or preventive properties or is used in humans or administered to humans for the purpose of correcting, improving, changing physiological functions or medical diagnosis by exerting pharmacological, immunological or metabolic effects. Medicines are actively used and a large number of medicines are stored in health institutions and organizations. Medicines need to be managed effectively. Medication management ensures that the right medication is administered in the right dose, to the right patient, at the right time and in an appropriate manner. Incorrect medication use or errors threaten patient and employee safety, prolong treatment processes and cause additional costs. The standards in this chapter guide health institutions and organizations in the effective management of medicines.

Purpose

The purpose of this chapter;

- Minimizing risks to patients and employees in all processes involving medicines.
- To ensure that drug management processes are carried out effectively and efficiently.

Objectives

- Patient Safety
- Healthy Work Life
- Efficacy
- Patient Focused
- Efficiency
- Convenience
- Timeliness
- Continuity

Standard Requirements

Standard 1

MM.1
Processes and rules regarding medication management are defined and functioning is ensured accordingly.

MM.1.1
Processes and policies for medication management are documented.

» Processes related to medication management should cover all service areas where medication is kept and should include at least the following topics:
- Duties, authorities and responsibilities of employees involved in medication management
- Supply of medications
- Storage of medications
- Medication requests
- Transfer of medications
- Preparation of medications
- Medication applications
- Control of the medications that the patients bring
- Use and disposal of remaining ampoules after treatment
- Control of medication-medication, medication-food interactions
- Stability and incompatibility control of parenteral medications
- Procurement, preparation, storage and application processes of total parenteral nutrition solutions and exceptional cases
- Disposal processes of medications that are not in appropriate storage conditions after being diluted, opened or prepared, or whose storage period has expired.
- Use and disposal of remaining ampoules after treatment
- Disposal processes of half-dose psychotropic and narcotic medications
- Disposal processes of half-dose medications and solutions that are found to be incompatible after preparation
- Management of pharmaceutical waste
- Management and request process of high-risk medications
  - Processes for special medications (emergency pediatric medications, medications with similar appearance, psychotropic/narcotic medications, high-risk medications, cytotoxic medications, medications requiring secondary monitoring, medications requiring special techniques/equipment for preparation, concentrated electrolytes, etc.)
- Medication groups with special characteristics are determined by the institution/organization in accordance with the relevant country legislation, and warning mechanisms for the safety of such medications (colored labels, colored or audible warnings on the information system, etc.) are used.
- Adverse effect reports
- Reporting of medication errors and adverse events

» Medication errors and adverse events are reported to the relevant institutions or

organizations in accordance with the relevant country legislation and national/international standards.

» Processes and rules regarding medication management are defined, periodically reviewed and updated with the participation of all stakeholders.
» Rules regarding medication management are in accordance with relevant country legislation, national/international guidelines and practices (e.g. rational medication use).
» An "Antibiotic Usage Control and Antibiotic Prophylaxis Guide" are created for the institution/organization and its implementation is ensured.

MM.1.2
A managerial structure for medication management is established.

» A managerial structure such as a committee, unit, commission, team, etc. is established for the effective execution and coordination of medication management processes.
  • People who will take part in the managerial structure have the necessary qualifications regarding medication management.
  • The management structure is consist of medical doctors, pharmacists, nurses and other relevant health professionals who are responsible for all medication-related activities.
  • The managerial structure must have training, experience and competence in the field related to medication management.
  • The management structure is knowledgeable about current pharmaceutical information and technologies.
  • Has managerial structure, good communication and teamwork skills

MM.1.3
Duties, authorities and responsibilities regarding medication management are defined and effective communication is ensured.

» The duties, authorities and responsibilities of employees involved in all processes of medication management are defined.
» The management structure has an active role in making decisions regarding all processes of the medication.
» Regular audits regarding medication safety are carried out by the management structure, reports are made and improvement activities are carried out.
» Effective communication is ensured between patient-employee and employee-employee at every stage of medication administration

MM.1.4
Necessary training is given to relevant employees in all processes involving medication.

» The medication management training program is designed to ensure that all relevant employees learn the basic information about medication processes.
» The training program has meet the specific needs of different employee groups. (safe medication transfer training for personnel who will transfer medication, safe medication practice training for nurses)
» The training program is compatible with current medication information and technologies.

» The effectiveness of training on medication management is ensured. (See Training Management)

Standard 2

MM.2
Arragements are made for the supply, storage and stock management of medications.

MM.2.1
Arrangements are made to ensure that the right medication is provided at the right time.

» Rules and methods for the medication supply process are determined.
» Annual medication procurement, interim medication procurement and emergency medication procurement are carried out within the framework of a plan.
  • The plan includes processes such as persons who can request medication supply, request method, request evaluation, etc.
» Determining the types and quantities of medications are supplied, the nature of the demands (urgent, routine, priority medication groups, etc.), current stock status and consumption analysis are taken into consideration.

MM.2.2
Medications are stored in accordance with their characteristics and the necessary physical conditions are provided.

» Defined medication storage areas includes pharmacy warehouses and all unit warehouses where medications are kept for more than 24 hours (intensive care, delivery room, emergency room, operating room, home health, ambulance, etc.).
» For safety and security reasons, access to medication stores is restricted to people other than authorized personnel.
» In storage areas, medications are stored under appropriate storage conditions according to their qualities.
  • Arrangements such as air conditioning and light control are made, physical conditions are monitored, and measures are taken to protect the cold chain in refrigerators or cold rooms in extraordinary situations such as power outages.
» The environmental parameters (temperature, humidity) of all defined warehouses are monitored, and in case of non-compliance, remedial action are initiated.
» Materials other than medications, serums or vaccines are kept in medication stores and cabinets reserved for medications.
» Medication boxes are not placed at level with the ground, and the height of the shelf bottoms are at a height where the medications are not be affected by floods or inundations.
» Medication layout plans for warehouses and refrigerators are easy to use, accessible, and plans are kept up to date.
» During the preparation of the layout plan, separate areas are defined for medications with special properties, and medications with similar spelling/reading/appearance are placed away from each other.
» Spoiled or expired medications are stored in designated areas for disposal.
  • Special storage conditions are provided for medications that require a cold

chain (such as vaccines and insulins).
- During the preparation of these medications, temperature controls are made and the cold chain is broken

MM.2.3

Arrangements are made for the storage of special quality medications.

» Examples of special medication groups are given below:
- Emergency pediatric medications
- Medications with similar appearance
- Medications with similar spelling and pronunciation
- Narcotic medications
- Psychotropic medications
- Medications that need to be protected from light
- High-risk medications
- Medications that require special technique/equipment/expertise to prepare
- Concentrated electrolytes
- Medications that should not be used during pregnancy and breastfeeding
- Cytotoxic medications
- Anesthetic medications
- Gases

» Lists for special medication groups are prepared, the lists are available in the area of use and used effectively.

» The placement of emergency pediatric medications, medications with similar spelling, pronunciation and appearance and high-risk medications in cabinets are done in a way that prevents possible errors.

» Warnings (such as colored labeling) for high-risk medications that do not have a warning element in their original packaging and special medications determined by the institution/organization are defined and their use are ensured.

» Necessary preservation measures are taken in all service delivery areas for the safety of narcotic and psychotropic medications, exceptions for preservation are defined, and necessary additional measures are taken.

» Narcotic and psychotropic medications are handed over and recorded.

» Handover records are include at least the following information:
- Which patient, how often and in what dosage
- Date the medication was used
- Who administered the medication
- Who and to whom the amount of medication was delivered
- Signatures of those receiving and delivering

» Narcotic and psychotropic medications are stored in locked areas.

» A record is kept for narcotic medications damaged during storage and transportation.

» Narcotic and psychotropic medications that are destroyed due to expired or spoiled, risky use, etc. are recorded.

MM.2.4

Arrangements are made to monitor stock levels and expiry dates of medications.

» Minimum, critical and maximum stock levels for medications are determined and monitored.

» Warning arragements are in place for deviations in stock levels.
» Medications are monitored in terms of expiration and warning arragements are in place for medications approaching their expiration date. (Visual or audible warnings, labeling etc. via IMS)
» Medication expiration dates are also be checked at regular intervals and randomly by manual methods

Standard 3

MM.3
Arrangements are made for the request, preparation and transfer of medication.

MM.3.1
Arrangements are made for the medication request process.

» The medication request process, rules for the process, and special and exceptional situations (verbal request, urgent request, storage requests, etc.) are defined.
» Authority, method and rules for all request stages are determined in accordance with the country's legislation.
» Medication requests are made in writing or electronically signed by authorized healthcare personnel.
  • Patient-based, treatment-based medication requests are made and approved daily.
    ▪ Requests that are not possible to prepare on a daily basis or are ineffective (such as urgent requests, automatic stop requests, continuous requests, verbal requests), identified, and rules for these situations are defined.
  • Medication orders are also be visible in the IMS pharmacy module.
  • Requests made on paper must include the doctor's information and a wet signature.
  • Medication requests which made electronically include the physician's electronic signature or mobile signature.
    ▪ Requests made with the user password in IMS are used for this purpose without an electronic signature.
    ▪ For electronic storage requests, it is sufficient to assign a user account and password.
  • The medication name is not abbreviated in the requests.
» Medication requests include, at a minimum, the full name of the medication, pharmaceutical form, time of administration, dose, route of administration, duration of administration, medication-medication, and medication-food interactions.
» Written medication orders are written clearly and legibly, and no abbreviations, symbols or icons are used other than those defined in the order. (See Patient Safety Goals)
» Rules for the use of abbreviations are not included in the list are defined.
» Medication orders are evaluated and approved by reviewing the patient's medical history, allergies, medication interactions, and current medication therapy.
» Information and decision support systems that provide medication interaction,

allergy, dosage and current medication information are actively used.
» If there is a doubt or problem with the evaluated request, the healthcare professional who created the request is contacted.
» Rules to be followed in situations where verbal requests are applied is determined. (See Patient Safety Goals)

MM.3.2
Arrangements are made for the preparation of medications.

» Personnel preparing medication have sufficient knowledge, experience and training on the subject.
» Except for storage requests, medications are packaged separately for each patient for medication requests made for patient use.
  • The name of the medication, form, dose and patient information are visible on the package.
  • Packaging is done in a clean and organized environment to avoid mixing of medications.
» Medications that require special techniques/equipment or expertise during preparation (such as chemotherapy medications) are delivered to the application area after preparation under appropriate conditions.
» During preparation, attention is paid to warning signs, expiration dates and identification of divided packages (cut blisters, tablets, etc.).
  • Measures are taken to identify split packages, expiration dates of all prepared medications are checked and claims are confirmed.
  • For medication outputs containing more than one divided package, these medications are packaged and labeled separately.
  • The label contains patient identification parameters and the full name of the medicinal product, pharmaceutical form, dose, time of administration, route of administration and expiry date

MM.3.3
Arrangements are made for the safe transfer of medications.

» Appropriate equipment (medication transport boxes, cold chain trolleys, carrying bags, forklift or pallet transport systems, breakage-preventive filling materials, etc.) are provided for the transfer of medications.
  • The equipment used may vary depending on the amount, type and storage conditions of the medications to be transferred.
» Transfer methods and rules are determined according to the nature, size and material type of the medications, and precautions are taken for special medications such as those with a high risk of breakage, those that need to be protected from light, and require cold chain transfer, etc.
» Arrangements are made for situations such as accidents, spills, breakage or loss of medication during transfer.
» For medications that require a cold chain (such as vaccines and insulins), transfer conditions that will not break the cold chain is provided.
» Relevant employees are given training on the safe transfer of medications, at least on the following topics.

- Correct transfer methods for different types of medications
- Cold chain management and temperature controls
- Protective packaging techniques
- Transfer safety and risk reduction strategies
- Intervention methods in case of hazardous medication breakage
- Filling and keeping transfer records

Standard 4

MM.4
Arragements regarding safe medication administration are made.

MM.4.1
Arrangements are made regarding the preparation and administration of medications before regulation.

» Medications are prepared specifically for each patient, in an appropriate medication preparation environment and within the framework of established rules.
» Medication administrations are performed only by personnel authorized to administer medication (physician, nurse, intern under the supervision of a physician/nurse, etc.).
» Medications are administered after patient identity is verified and treatment information is confirmed. (See Patient Safety Goals)
  - The rules regarding verification are defined by the institution/organization.
  - During medication administration; the identity of the patient, the name and dosage of the medication, and the method, time and duration of administration are verified by the person performing the administration.
» Hygiene rules are followed during medication preparation and administration.
» Medication administration are tracked in nursing records.
  - Nursing records include the name of the medication, dosage, route of administration, time and duration of administration, and the employee who performed the administration.
» Medications administered to the patient are recorded in the patient file.
» After medication administration, the clinical condition of patients are monitored, and any reactions and adverse events are recorded.
» Medication administration for educational purposes is under the supervision of authorized persons.

MM.4.2
The medications that come with the patient is checked.

» Processes and rules for the management of medications brought by the patient are defined.
» Medications brought by the patient are recorded and received, checked and then made available for the patient's use.
  - Medications received from the patient is subject to expiration and physical condition checks.

    - For patients whose stay will be one week or longer, the regular medications they use before admission and their medication use (numbers, times, interactions) are checked by the pharmacist, and if any inconsistencies are detected, the relevant specialist physician for the medication can be contacted.
  - No medication is left with the patient under any circumstances, and the medications brought by the patient are checked during the admission process.
  - The remaining amounts of registered medications received are returned to the patient upon discharge.

MM.4.3
Arragements are made regarding adverse effects related to medication applications.

» The clinical condition of patients are monitored for possible reactions and adverse effects after medication administration.
  - Especially after the first use of any medication and the administration of risky medications, patients are monitored for possible reactions and adverse effects.

» Adverse effects related to medication administration is recorded and reported (pharmacovigilance).

» Processes for adverse effect reporting are defined.
  - The pharmacovigilance officer and responsibilities regarding adverse effect reporting are defined.

» Serious and unexpected adverse effects are reported to the pharmacovigilance officer.

» Serious and unexpected adverse effects are reported to the relevant national authority within 15 days at the latest.

MM.4.4
Arragements are made for the destruction of medications.

» The processes and rules for the disposal of expired, physically altered, spoiled leftover medications and medication waste and their disposal under appropriate conditions are defined. (See Waste Management)

» The disposal of medications is carried out in accordance with the relevant country legislation.

» The name of the destroyed medication, its amount, reason for disposal, method, unit, date, person performing it, etc. are recorded

Standard 5

MM.5
Monitoring and evaluation studies regarding medication management is conducted.

MM.5.1
All stages of the processes involving the medication are traceable.

» Traceability and continuity of all data and information related to the processes in which the medication is involved are ensured.

» All data created during the medication management process is stored in a readable, accessible and secure manner.
» Traceability of medications cover supply requests, request, return, destruction and consumption processes

MM.5.2
Indicators for evaluating the performance of processes in which the medication is involved are determined, the effectiveness of the studies are monitored at regular intervals and continuous improvement activities are carried out.

» Indicators for measuring the effectiveness, efficiency and safety of processes involving medications are determined.
  • Indicators determined for rational medication use, antibiotic use, medication errors, medication interactions, destroyed medications, psychotropic, narcotic medication use, stock tracking, etc.
» Indicator results are evaluated and monitored periodically.
» Improvement activities are carried out according to indicator results.
» Regular training and awareness studies are carried out to develop a culture of traceability and continuous improvement.

SECTION 4 HEALTH SERVICES	
Chapter 14 Safe Anesthesia and Surgical Care (ASC)	
Code	**Standard 1**
ASC.1	Arrangements are implemented for safe anesthesia.
Code	**Assessment Criteria**
ASC.1.1	Processes and rules for safe anesthesia practices are documented.
ASC.1.2	Arrangements are made regarding the safety of anesthesia practice.
ASC.1.3	Arrangements are made regarding anesthesia practices outside the operating room.
ASC.1.4	Arrangements are made regarding the safe use of anesthetic medicines and gases.
ASC.1.5	Arrangements are made regarding the safe usage of equipment in anesthesia practices.
Code	**Standard 2**
ASC.2	Arrangements are implemented for safe surgical care.
Code	**Assessment Criteria**
ASC.2.1	Processes and rules for safe surgical care are documented.
ASC.2.2	Arrangements are made regarding the preparation process for surgery.
ASC.2.3	Arrangements are made regarding the surgical application process.
ASC.2.4	Arrangements regarding the safety of tissue samples taken for diagnostic purposes are made.
ASC.2.5	Arrangements are made regarding postoperative patient care.

Code	Standard 3
ASC.3	Arrangements are implemented for operating room processes
Code	**Assessment Criteria**
ASC.3.1	Arrangements are made regarding operating room areas.
ASC.3.2	Arrangements are made regarding ventilation systems.
ASC.3.3	Arrangements are made regarding the continual supply of electrical energy.
ASC.3.4	Arrangements are made regarding the management of medications, materials, and equipment in the operating room.

Chapter 14: Safe Anesthesia and Surgical Care (ASC)

General Information

Safe anesthesia and surgical care are important for ensuring patient safety, minimizing risks during surgical procedures and increasing the effectiveness of medical procedures. The type of anesthesia is decided by the physician according to the surgical procedure and the medical needs of the patient. In order to ensure patient safety and to perform the surgical procedure successfully, there are specific practices and procedures to be followed for the type of anesthesia. Surgical care includes preoperative preparation, surgical application and postoperative processes. It is necessary to implement patient safety procedures and ensure effective communication in all anesthesia and surgical care processes. The standards in this chapter guide healthcare institutions and organizations in the effective and safe management of safe anesthesia and surgical care processes.

Purpose

The purpose of this chapter:

- To ensure that practices comply with patient safety solutions and universal protocols determined by national and international authorities in safe anesthesia and surgical care processes
- To organize operating room conditions to ensure patient and employee safety

Objectives

- Patient Safety
- Patient Focused
- Efficacy
- Effectiveness
- Fairness

Standard Requirements

Standard 1

ASC.1
Arrangements are implemented for safe anesthesia.

ASC.1.1
Processes and rules for safe anesthesia practices are documented.
Safe anesthesia practices encompass all general anesthesia and/or sedation, regional, and local anesthesia applications performed in both the operating room and areas outside the operating room.

- » The processes regarding safe anesthesia practices in and outside the operating room include the stages before, during and after the practice.
- » The rules for safe anesthesia practices both in and outside the operating room include at least the following topics:
  - Pre-anesthesia patient evaluation
  - Safe anesthesia control
    - Use of anesthesia safety checklist
  - During anesthesia patient information and consent
  - Safe use of anesthetic medications and gases
  - Safe use of anesthesia equipment
  - Anesthesia practices outside the operating room

ASC.1.2
Arrangements are made regarding the safety of anesthesia practice.

- » During the pre-anesthesia patient assessment process, the patient is verbally informed by the relevant anesthesiologist about anesthesia applications and patient consent is obtained.
- » Anesthesia Safety Checklist is used to ensure the safety of anesthesia practice and the list is traceable.
- » Control of anesthesia devices, anesthetic drugs and medical gases are ensured.
- » Information on each stage of anesthesia is recorded.
  - The relevant records include information such as anesthetic substance used, type of anesthesia administration, physician administering anesthesia, anesthesia administration and follow-up processes, etc.
  - Records include information on the development of complications.
  - Records of the materials/devices/equipment used in the patient specific to the procedure are kept.

ASC.1.3
Arrangements are made regarding anesthesia practices outside the operating room.

- » The planning, practices, and management of non-operating room anesthesia practices are carried out by a specialist physician who is trained and competent in non-operating room anesthesia practices.
  - The physician responsible for non-operating room anesthesia practices has

completed a training program under the relevant national legislation and is certified.

» The areas where non-operating room anesthesia practices are carried out are defined considering patient safety and the necessary conditions for anesthesia practice are provided in the designated area.
  - Non-operating room anesthesia practice areas include endoscopy, colonoscopy, ERCP, ESWL, MRI, CT, EEG, ECT, interventional radiology, angiography laboratory, brachytherapy, etc.
  - Appropriate monitoring conditions are provided in the area.
  - There is a central medical gas system in the area.
  - The area provides the necessary conditions to intervene in medical emergencies, particularly resuscitation.
    - A crash cart is available, and its contents are determined by the relevant anesthesiologist.
    - A physical environment with easy access to the anesthetized patient is provided.
    - It is for stretcher entry and exit for transfer.
  - A designated waiting area is planned for the patient's relatives, and they are informed about the process.

» There is a recovery area after anesthesia practices outside the operating room.
  - The recovery area is equipped to intervene in emergencies.
  - The patient is closely monitored in the recovery area and follow-up findings are recorded.
  - The rules for patient discharge from the recovery area are determined.

» In non-operating room anesthesia practices, team members (physicians, nurses, anesthesia technicians, operating room technicians, EMTs, etc.) receive regular training on the use of medications, complications, reporting of advers events, and advanced life support.

ASC.1.4

Arrangements are made regarding the safe use of anesthetic medicines and gases.

» The anesthetic drugs and gases to be used are planned according to the patient and procedure, and their dosages are recorded.

» The use of anesthetic medications is daily, stored under appropriate conditions and the preparation date and time are written on the medications.

» Planning is made regarding the monitoring of narcotic drugs.

» Anesthetic gases are filled into appropriate vaporizers.
  - Personal protective equipment is provided during vaporizer filling.
  - The current calibration times of vaporizers are recorded.

» Necessary training is provided to relevant staff regarding the safe use of anesthetic drugs and gases.

» The pressure levels of medical gases are controlled and recorded from the medical gas control panel and the indicator panel on the anesthesia device.

» The backup medical gas cylinders that are integrated into the anesthesia device are checked

ASC.1.5
Arrangements are made regarding the safe usage of equipment in anesthesia practices.

» As part of the safe use of anesthesia devices:
  • Daily controls of the devices are performed at the beginning and end of each day.
  • Periodic maintenance and calibration of the devices are ensured and recorded.
  • A backup anesthesia device is available in case the primary anesthesia device is out of service.
» It is ensured that other devices used in anesthesia practices such as monitor/defibrillator/laryngoscope etc. have backups.
» Necessary training is provided to the relevant employees for the safe use of devices used in anesthesia practices.
» As part of the safe use of anesthesia devices:
  • Daily controls of the devices are performed at the beginning and end of each day.
  • Periodic maintenance and calibration of the devices are ensured and recorded.
  • A backup anesthesia device is available in case the primary anesthesia device is out of service.
» It is ensured that other devices used in anesthesia practices such as monitor/defibrillator/laryngoscope etc. have backups.
» Necessary training is provided to the relevant employees for the safe use of devices used in anesthesia practices

Standard 2

ASC.2
Arrangements are implemented for safe surgical care.

ASC.2.1
Processes and rules for safe surgical care are documented.
The surgical care processes encompass all surgical and interventional procedures performed in the operating room and outside the operating room in the institution/organization.

» The processes regarding safe surgical care encompass the preoperative, intraoperative, and postoperative stages.
» The rules for safe surgical care include at least the following topics:
  • Use of the Safe Surgical Checklist (SSC) (See Patient Safety Goals)
  • Verification of patient identity
  • Informing the patient and obtaining consent before the surgical procedure
  • Preparation process for patients undergoing surgery
  • Safe patient transfer
  • Surgical site marking before the surgical procedure
  • Conducting the surgical procedure
  • Ensuring the safety of tissues taken for diagnostic purposes
  • Postoperative care processes specific to the type of anesthesia and procedure applied

ASC.2.2

Arrangements are made regarding the preparation process for surgery.

» Preoperative preparations for surgical procedures are identified and planned for both elective and emergency surgeries.

» In cases considered to be at risk for bleeding in the preoperative period, planning is made for blood or blood products.
  - Within the scope of this plan, necessary blood or blood products are available in case of need in surgical practice.

» Medicines and materials to be used in surgical procedures are procured and necessary controls are performed.

» Medical devices to be used are made prepared for use.

» Patients and their relatives are informed about the preparations before the surgical procedure and the issues to be considered.

» Controls are performed by healthcare professionals regarding the preparations.

» During the patient evaluation process before surgical, the patient is provided with verbal information about the surgical by the relevant physician, and the patient's consent is obtained.
  - With this information, it is ensured that the patient is informed about his/her disease and treatment; that he/she is informed about the proposed procedure and its risks, by whom, where, and when the intervention will be performed.
  - After the patient is provided with the opportunity to decide entirely of his/her own free will, he/she is provided with the opportunity to accept the proposed surgical or interventional procedure with his/her consent (See Patient Experience).

» The surgical site is marked before the surgical/interventional procedure.
  - Marking is performed by the relevant physician before the patient is taken to the operating room/interventional procedure unit.
  - Marking is performed on conscious patients while they are awake and alert, and during the marking process, the area to be marked is indicated to the patient and/or their relatives.
  - Marking is performed using a method determined by the institution/organization that is clear, understandable, does not confuse, is not easily erasable, and remains intact during the cleaning of the area.
  - Marking is performed on or very close to the area where the surgical/interventional procedure will be conducted and is visible.
  - If procedures are to be performed on multiple areas, all areas are marked.
  - The institution/organization determines the situations where area marking is not required, defines how verification will be conducted in such cases, and records instances where marking is not performed.

» Personal belongings and prostheses are controlled and secured.
  - The process for the delivery of removable prostheses and valuables belonging to the patient before surgery is defined.
  - The process for the protection of the patient's belongings is determined.
  - The final check for non-removable items or prostheses is performed and recorded by the operating room staff.

ASC.2.3

Arrangements are made regarding the surgical application process.

- » Patient identity is verified at all stages of the surgical procedure.
- » All kinds of information about the procedure performed during the surgical procedure, including the name, surname and title of the healthcare professionals who performed the procedure, is traceable.
  - The sterility status of the materials/devices used for the patient in the operating room is traceable.
  - Information about the material/device, patient, practitioners and surgical team is traceable.
  - It is ensured that the operation/interventional procedure notes are written by the relevant physician at the end of the operation/interventional procedure.
  - The operative/interventional procedure note include all details of the procedure and unexpected events/complications.
- » Safe transfer of the patient from the relevant department to the operating room, within the operating room and from the operating room to the relevant department is ensured. (See Patient Care)
  - Before and at the end of the operation/interventional procedure, the patient is transferred to the area to be followed up after the operation/procedure, accompanied by a healthcare professional, paying attention to patient privacy.
- » All records are kept completely and accurately during the surgical procedure.
  - The relevant records include information on the surgical procedure performed, the physician who performed the procedure, the duration of the procedure, other healthcare professionals involved in the procedure, etc.
  - Records of permanent materials/devices/equipment used in the patient specific to the surgical procedure is kept.
  - Records include information on the development of complications.
- » Procedures related to implantable devices/materials to be used in the patient during the surgical procedure is recorded and traceable.
- » Necessary preparations and planning have been made to continue safe surgical practices in case of emergencies (power outage, medical gas outage, etc.) (See Facility Management)
- » Surgical prophylaxis is applied within the framework of rational antibiotic use principles.
- » Trainings on safe surgical practices is provided to relevant employees

ASC.2.4

Arrangements regarding the safety of tissue samples taken for diagnostic purposes are made.

- » Storage conditions of tissue samples taken for diagnostic purposes before and during transfer are defined.
- » After-hours transfer and storage conditions of tissue samples taken for diagnostic purposes is planned.
- » It is ensured that tissue samples taken for diagnostic purposes are taken into the appropriate sample container, labeled correctly and completely (name-surname / ID number / barcode number / acceptance number / region of collection / clinic name and receiving physician, etc.) and transferred appropriately.

» The processes of delivery of tissue samples taken for diagnostic purposes to the relevant laboratory is recorded and traceable.
» In order to ensure the safety of tissue samples taken for diagnostic purposes; the person responsible for the transfer is determined and the necessary training is provided.

ASC.2.5
Arrangements are made regarding postoperative patient care.

» In the postoperative period, arrangements are made for care processes specific to the type of anesthesia and procedure applied.
» The patient is closely monitored during the postoperative period, and the observation findings are recorded.
  • The patient is assessed using national/international scoring systems after the surgery/interventional procedure, and the care process is planned based on this assessment.
» Rules regarding the patient's transfer from the operating room, recovery unit, and/or intensive care unit after surgery are determined.
» A healthcare professional accompanies patient transfer.
» Records related to the patient are maintained at every stage, and patient information and records transferred to the next stage are provided safely.
» Necessary training is given to relevant employees regarding surgical patient care

Standard 3

ASC.3
Arrangements are implemented for operating room processes.

ASC.3.1
Arrangements are made regarding operating room areas.

» Patient and personnel entrances and exits to the operating room is separate.
» Operating room areas is planned to consist of at least 3 different sections (free area, clean area, sterile area) and the rules to be followed in the areas and in the transition between areas is determined.
  • The free area is the non-sterile area where patients, personnel and equipment are allowed to enter the operating room in a controlled manner. Non-operating room attire is worn.
  • The clean area includes the support rooms required for surgical practice. It covers the physical space between the sterile area and the free area. It includes storage areas for clean materials and devices and corridors leading to sterile rooms. Staff and patients is present in this area. Staff wear surgical attire and use appropriate equipment for face and hair.
  • The sterile field includes operating rooms and hand washing and scrubbing areas. It is mandatory to wear surgical clothing and cover hair and face with appropriate equipment.
  • Waiting areas for patients' relatives (which will not disrupt health care and ensure effective information of patients' relatives) are created at a suitable distance from the operating room.

  - These areas are ergonomic and comfortable.
  - Processes for patients' relatives to receive information are defined.
  - Digital screens etc. is hung where patient information is tracked.
- » Operating rooms are of a size and sufficiency that will not prevent the surgical team from dressing sterile, the patient from being covered sterile and the anesthesia team from working.
- » In the operating room; it is ensured that the floor, ceiling and wall surfaces are smooth, that there are no cracks on the surfaces, and that the door, window and wall joints are smooth and free of protrusions.
- » The materials to be used on the walls, ceiling and floor of the operating room have antibacterial properties suitable for disinfection and cleaning.

ASC.3.2
Arrangements are made regarding ventilation systems.

- » The ideal temperature and humidity rates of the operating areas is determined and controlled.
- » Temperature and humidity are individually adjustable in each operating room.
- » HEPA filtered ventilation system is used in sterile areas.
- » In operating rooms, airflow is from the sterile area to the free area (positive pressure airflow).
- » Operations such as orthopedics, prosthesis surgeries, open heart surgery, which are at high risk for surgical site infection, are performed in rooms where laminar air flow is used.
- » Ventilation systems provide at least 15 filtered air changes per hour, of which at least 3 (20%) is with fresh air.
- » Periodic measurements are made to determine the number of particles in the operating room and the results is evaluated by those responsible. How to proceed in case of non-compliance is defined.
- » Records of current measurements are kept.
- » The ventilation system is regularly maintained, filters is changed in the periods deemed necessary, and filter change times are recorded
- » Records of current measurements are kept.
- » The ventilation system is regularly maintained, filters is changed in the periods deemed necessary, and filter change times are recorded.

ASC.3.3
Arrangements are made regarding the continual supply of electrical energy.

- » In case of a power outage in the operating rooms, there are a sufficient number of sockets connected to uninterruptible power sources to meet the energy needs until the generator is activated.
- » Medical devices that not interrupt the surgical process are connected to these sockets.
- » Maintenance of uninterruptible power supplies are carried out periodically within a plan.
  - Maintenance documents are traceable.
- » Alternatives are planned in case uninterruptible power supplies also fail.

ASC.3.4

Arrangements are made regarding the management of medications, materials, and equipment in the operating room.

- Medication management in operating room areas are under the control of the institution/organization pharmacist.
- For continuity of service in device management, there is a plan on how the operation will continue in case of possible device failure.
- Positioning is ensured that there will be no loss of time in accessing drugs, materials and devices in the operating room.
- Plans for the management of the devices used in the operating room is established.
- All devices is inventoried and periodic maintenance and calibration is ensured.
- Technical controls of the devices are performed before the operation and equipment and tools suspected to be faulty not be used.
- Sterile materials accepted to the operating room is checked (such as expiry date, strength of the package, color change of the indicator in the package).
- The process for the acceptance of materials (prosthesis etc.) brought to the operating room by the company etc. is defined.
- Storage conditions are provided for sterile materials used in the operating room

SECTION 4 HEALTH SERVICES	
Chapter 15 Blood and Blood Component Management (BCM)	
Code	**Standard 1**
BCM.1	Processes and rules for the management of blood and blood components are defined and appropriate functioning is ensured.
Code	**Assessment Criteria**
BCM.1.1	Processes and rules for the management of blood and blood components are documented.
BCM.1.2	A managerial structure is established for the safe execution and coordination of processes for blood and blood components, and duties, authorities and responsibilities are defined.
BCM.1.3	A risk assessment is made for the management of blood and blood components, and necessary measures are taken for the identified risks.
Code	**Standard 2**
BCM.2	Arrangements are made for the management of the procurement/donation process of blood and blood components.
Code	**Assessment Criteria**
BCM.2.1	Operating rules regarding the procurement/donation process of blood and blood components are documented.
BCM.2.2	Arrangements are made for the medical questioning and evaluation of the donor and the acceptance or rejection of the donation.
BCM.2.3	Arrangements are made to ensure patient safety during the donation process.
Code	**Standard 3**
BCM.3	Arrangements are made for the preparation, storage, transfer and disposal of blood and blood products.
Code	**Assessment Criteria**
BCM.3.1	Processes for the preparation of blood and blood components are documented.

BCM.3.2	Measures are taken for the preservation of blood and blood components.
BCM.3.3	Safe transfer of blood and blood components is ensured.
BCM.3.4	Rules for the disposal of blood and blood components are determined.
Code	**Standard 4**
BCM.4	Safe transfusion of blood and blood components is ensured.
Code	**Assessment Criteria**
BCM.4.1	Rules for the ordering of blood and blood components are determined.
BCM.4.2	Measures are taken to ensure patient safety during the transfusion process.
BCM.4.3	Reactions developing due to transfusion process are monitored.
BCM.4.4	Traceability of blood and blood components is ensured and unexpected/ unwanted effects are monitored.

General Information

Blood and blood components are used in healthcare organisations to meet specific needs in different clinical situations. The management of blood and blood components is a complex process starting from donor-related processes and covering procurement, ordering, testing, processing, storage and transfusion stages. In addition, monitoring blood and blood components from the donation process and managing them in accordance with safety standards ensures the safety of both patients and employees. In this respect, this chapter provides guidance to healthcare institutions/organisations in the effective management of blood and blood components.

Purpose

The purpose of this chapter;

- To ensure the safe execution and coordination of processes for blood and blood components
- To take the necessary measures to ensure safety for patients, donors and employees during the preparation, storage and transfer of blood and blood components
- To ensure patient safety at all stages of the transfusion process.

Objectives

- Patient Safety
- Efficacy
- Effectiveness
- Convenience

Standard Requirements

Standard 1

BCM.1
Processes and rules for the management of blood and blood components are defined and appropriate functioning is ensured.

BCM.1.1
Processes and rules for the management of blood and blood components are documented.

- Processes and rules for the management of blood and blood components include at least the following topics:
- Blood and blood component procurement process management
- Blood and blood component request process management
- Safe storage, preparation and transfer of blood and blood components
- Return and rejection criteria for blood and blood components
- Principles and procedures for the disposal of blood and blood components
- Obtaining patient consent for the procedure before transfusion
- Verification of patient identity during transfusion processes
- Monitoring of patients during transfusion
- Identification and follow-up of patients with transfusion-related reactions
- Management of quality control studies of the tests performed in the transfusion centre
- Transfusion practices in clinical emergencies
- Preparation of blood products for specific indications (such as paediatric use)
- Identification, notification and monitoring of potentially infectious donors (HIV, HCV or HBV)
- Equipment handling, cleaning, maintenance and calibration
- Training of relevant employees on the management of blood and blood components

BCM.1.2
A managerial structure is established for the safe execution and coordination of processes for blood and blood components, and duties, authorities and responsibilities are defined.

» Depending on the size of the institution/organisation, a managerial structure (committee, team, relevant manager for centres, etc.) is established for the management of donation processes.
» The duties, authorisations and responsibilities of those involved in the managerial structure are defined.
» Those responsible for the donation process are identified and responsibilities are defined

BCM.1.3
A risk assessment is made for the management of blood and blood components, and necessary measures are taken for the identified risks.

» A risk assessment is carried out before each application regarding the preparation and application processes of blood and blood components and necessary measures are taken for the identified risks.

Standard 2

BCM.2
Arrangements are made for the management of the procurement/donation process of blood and blood components.

BCM.2.1
Operating rules regarding the procurement/donation process of blood and blood components are documented.

» The rules of operation for the procurement of blood and blood components include the following topics according to the role of the institution/organisation:
- Informing the donor about the donation processes and obtaining their consent
- Identification, medical enquiry and assessment of the donor
- Collection and preparation of blood and blood components from the donor
- Procurement from another centre and transfer to transfusion centre
- Donation criteria for whole blood and apheresis blood products

BCM.2.2
Arrangements are made regarding the medical inquiry and evaluation of the donor and the acceptance or rejection of the donation.

» The donor's medical inquiry and evaluation are made by a physician and recorded.
» Permanent and temporary rejection criteria for the donor are determined.
» In cases of donor rejection, feedback is given to the donor.
» Donor acceptance-rejection processes are ensured to be monitored.

BCM.2.3
Arrangements are made to ensure patient safety during the donation process.

» Procedures and process tracking algorithms are developed for donor safety management during the donation process.
» Donation and apheresis procedures are performed under the responsibility and supervision of a physician, and the donor is monitored for possible complications.
» In areas where donation procedures are performed, at least the following physical arrangements are made to ensure patient safety:
» Appropriate ventilation, temperature and humidity conditions are provided.
» Compliance of relevant personnel with hand hygiene rules is checked during donation reception and storage.
» A call system to enable the donor to access the staff when necessary is present.
» Appropriate equipment for safe transplantation is available for donor

complications.
» Emergency response kit is present

Standard 3

BCM.3
Arrangements are made for the preparation, storage, transfer and disposal of blood and blood products.

BCM.3.1
Processes for the preparation of blood and blood components are documented..

» The processes involved in the preparation of blood and blood components include the following aspects:
  • Preparation and labeling of donor blood and blood components
  • Tests for donor blood and blood components
» ABO-Rh determination, HBsAg, Anti-HCV, Anti-HIV (minimum microelisa method is used) and Syphilis (VDRL) tests are performed.
» In case of conflicting results, there are defined procedures to resolve the situation, to prevent the use of blood and blood components with repeatedly reactive results in the screening test for treatment, and to store or dispose of these components in a separate environment.
» Confirmatory tests are performed in case of positive microbiological tests.
» In case of positive results in confirmatory tests, the donor is informed and guided about the necessary actions to be taken.
» Other immunohematologic tests of the recipient are performed.
» Cross-comparison tests are performed for blood and blood components.
» Stages related to additional procedures such as preparation, filtering, irradiation, washing of blood and blood components are recorded.
» Labeling of blood and blood components is done in accordance with the relevant country legislation and international arrangements.
» At least the following information is included on the label of blood and blood components accurately and completely:
  • Component name
  • International number of the component (ISBT No)
  • Name of the service unit
  • ABO blood type
  • Rh -D Group
  • Date of collection and expiration of the blood component
  • Microbiology test results
  • Storage temperature
  • Name, composition and volume of anticoagulants and additional solutions
» Blood and blood component checks are performed under the responsibility of two health workers

BCM.3.2
Measures are taken for the preservation of blood and blood components.

» Blood and blood components are stored under appropriate conditions.

» Storage conditions of blood and blood components are designed to maintain optimal viability and function of blood components during storage.
  • Proper storage conditions are ensured at the transfusion center, during transfer and before administration to the patient.
» The temperature of blood cabinets, freezers and shakers is monitored and recorded.
  • There are warning systems for situations where appropriate temperature conditions are not met.
» Procedures for making blood and blood components ready for use is determined and each stage is controlled and recorded.
» Expiration dates of blood and blood components are monitored.
» Critical stock level is determined for blood and blood components.
» Blood samples taken from donors and patients are stored under appropriate conditions and time.
  • Donor and recipient witness samples are stored in at least two separate containers below -30°C for at least 18 months.
» Inventory of devices for the management of blood and blood components is kept, and periodic maintenance and calibrations are performed. (See Material and Device Management)

BCM.3.3
Safe transfer of blood and blood components is ensured.

» Blood and blood components are transported by systems that have been validated to maintain ambient temperature for the maximum prescribed time.
  • Transfer containers that can maintain the storage temperature are used for the transfer of blood and blood components within/out of the institution/ organization.
  • The transfer temperature is monitored during transfer and can be traced retrospectively.
» The transfer of blood and blood components is performed by personnel who have received relevant training.
» Transfer containers are easy to clean and usable.
» The time blood and blood components leave the transfusion center is recorded

BCM.3.4
Rules for the disposal of blood and blood components are determined.

» Rules for the disposal of blood and blood components and witness samples, donor and patient samples are determined.
» Products that are found not to meet the storage and transfer conditions shall be recorded and taken and destroyed according to the determined destruction procedures and principles.
» Records shall be kept on the destroyed blood and blood components

Standard 4

BCM.4
Safe transfusion of blood and blood components is ensured.

BCM.4.1
Rules for the ordering of blood and blood components are determined.

- » Rules for requesting blood and blood components before planned procedures and in emergencies are determined.
- » At least the following information is included in the request form:
  - Patient's name and surname
  - Date of birth
  - Gender
  - Protocol number
  - Department of treatment
  - Blood type
  - Diagnosis
  - Indication for transfusion
  - Transfusion history
  - Group of the blood or blood component to be prepared
  - Type and quantity of blood or blood component to be prepared
  - Prompt date
  - The time when the blood will be administered
  - Patient's history of pregnancy, transfusion and transfusion reaction
  - Requirement for additional processing (irradiation, filtration, washing, etc.)
  - Physician stamp and signature
- » The blood request form is filled out appropriately and completely.
- » In case of a cross-match test, the blood request form and the blood sample taken from the patient are labeled and sent to the transfusion center.
- » All blood and blood component orders are made electronically

BCM.4.2
Measures are taken to ensure patient safety during the transfusion process.

- » Procedures for pre-transfusion controls, follow-ups during transfusion and post-transfusion follow-ups and notifications are defined.
- » Before starting transfusion, the physician must inform the patient or relatives about transfusion and obtain their consent.
- » Requests for blood and blood components are written in the treatment plan by the physician.
- » The departure time of blood and blood components from the center and the time of arrival at the clinic are recorded and the time is tracked.
- » Information about the blood or blood components to be administered to the patient before transfusion is checked by two healthcare professionals (physician, nurse) in the relevant clinic.
  - At least the following information is reviewed in the controls to be made:
    - Patient's blood type

- Group of the blood or blood component received by the department
- Presence of a label indicating that microbiology tests have been performed and the results are negative
- Dates of collection and expiration of the blood component
- Ensuring that the requested and delivered blood component is the same component
- Presence of observational non-compliance such as leakage, discoloration in the blood and blood component bag
- Change in product color, presence of clots/particles
- Cross-match testing and conformity of test results
- Numerical or alphabetical description of the donor
- Storage-storage temperature
- Volume, weight, number, etc. measurement information of blood and blood components

» The patient's identity information is checked before starting transfusion.
» The first 15 minutes of transfusion is performed slowly and patients are carefully monitored for vital signs and allergic reactions during transfusion.
» All records of the transfusion process are kept and traceable

BCM.4.3
Reactions developing due to transfusion process are monitored.

» The structure and responsibilities responsible for monitoring transfusion reactions are defined.
» An algorithm for the management of transfusion reactions is created; in case of any transfusion reaction, issues such as which intervention will be performed and who will be notified are defined.
» Transfusion reactions that develop in the patient are monitored, necessary intervention is performed and recorded.

BCM.4.4
Traceability of blood and blood components is ensured and unexpected/unintended effects are monitored.

» In transfusion processes; processes for traceability of blood and blood components and follow-up of unexpected/unwanted events are defined.
» Within the scope of transfusion processes of blood and blood components, the necessary system infrastructure is created to ensure traceability.
» Starting from the donation process; unexpected/unintended effects in terms of the use of blood and blood components in all processes are monitored and reported to the national notification system (See Adverse Event Reporting).
» Risk assessment is conducted for transfusion processes and necessary improvement activities are carried out for the identified risks.

SECTION 4 HEALTH SERVICES	
Chapter 16 Cleaning, Disinfection and Sterilization Services (CDS)	
Code	**Standard 1**
CDS.1	Processes and rules regarding cleaning and disinfection services are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
CDS.1.1	Processes and rules regarding cleaning and disinfection services are defined, and functioning is ensured accordingly.
CDS.1.2	Responsible individuals for cleaning and disinfection services are determined, and their responsibilities are defined.
CDS.1.3	A risk assessment for cleaning and disinfection is conducted, and a cleaning and disinfection plan is established.
CDS.1.4	Arrangements for the cleaning and disinfection of areas, floors, and environmental surfaces are implemented.
CDS.1.5	Arrangements for the cleaning and disinfection of materials and devices are in place.
CDS.1.6	Arrangements for the control of cleaning and disinfection procedures are in place.
CDS.1.7	Necessary training is provided to relevant employees regarding cleaning and disinfection services.
Code	**Standard 2**
CDS.2	Processes and rules regarding high-level disinfection are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
CDS.2.1	Processes and rules regarding high-level disinfection are defined, and functioning is ensured accordingly.
CDS.2.2	Areas where high-level disinfectants are used are identified, and necessary arragements are implemented.
CDS.2.3	Medical devices requiring high-level disinfection are identified, and specific arragements for their operation are established.
CDS.2.4	Arrangements for the preparation, application, monitoring, and disposal of high-level disinfectants are implemented.
CDS.2.5	Necessary training is provided to relevant employees regarding high-level disinfection.

Code	Standard 3
CDS.3	Processes and rules regarding sterilization services are defined, and functioning is ensured accordingly.
Code	**Assessment Criteria**
CDS.3.1	Processes and rules regarding sterilization services are documented.
CDS.3.2	Physical and functional arragements for the Central Sterile Services Department (CSSD) are implemented.
CDS.3.3	Arrangements for the collection and washing processes of contaminated materials are established.
CDS.3.4	Arrangements for packaging and loading processes are implemented.
CDS.3.5	Arrangements to ensure the effectiveness of the sterilization process are established.
CDS.3.6	Arrangements for the storage of sterile materials are implemented.
CDS.3.7	Arrangements for the traceability of the sterilization process are established.

General Information

Defining and controlling the processes for cleaning, high-level disinfection and sterilization services is important to ensure patient and employee safety. It guides healthcare institutions and organizations in defining and monitoring cleaning practices in all areas where healthcare services are provided, defining and monitoring high-level disinfection application areas and applications, defining areas, applications and practitioners within the scope of sterilization services and ensuring traceability in terms of evidence regarding time, device, method, practitioner and control parameters at every stage of sterilization processes.

Purpose

The purpose of this chapter:

- To ensure that cleaning and disinfection, disinfection and sterilization of instruments and materials used for medical purposes are carried out within the framework of evidence-based guidelines and nationally and internationally accepted practices
- Prevent and control infections

Objectives

- Patient Safety
- Healthy Work Life

Standard Requirements

Standard 1

CDS.1
Processes and rules regarding cleaning and disinfection services are defined, and functioning is ensured accordingly.

CDS.1.1
Processes and rules for cleaning and disinfection services are documented.

» Processes regarding cleaning and disinfection services include at least the following topics:
  - Policies for cleaning and disinfection
  - Responsible individual and their duties regarding cleaning and disinfection
  - Areas characterised by infection
  - Cleaning and disinfection of areas, floors, and environmental surfaces (method, frequency, detergents, equipment, etc.)
  - Cleaning and disinfection in cases of contamination with blood and body fluids or incidents causing potential contamination
  - Cleaning and disinfection of used cleaning equipment
  - Cleaning and disinfection of materials and devices (method, frequency, detergents, equipment, etc.)
  - Monitoring of cleaning and disinfection procedures

» The compliance of determined rules for the cleaning and disinfection of areas, floors, and surfaces is approved by the infection control committee

CDS.1.2
Responsible individuals for cleaning and disinfection services are determined, and their responsibilities are defined.

» Responsible individuals and their duties for the monitoring of cleaning and disinfection are defined, and the control method and intervals are determined.
  - The area, cleaning materials to be used, the responsible individual, the application methods, and how and by whom the effectiveness of the applications will be monitored are determined.

CDS.1.3
A risk assessment for cleaning and disinfection is made and a cleaning and disinfection plan is created.

» A risk assessment for cleaning and disinfection of areas, floors, and environmental surfaces is performed.
  - Areas related to cleaning and disinfection are categorized based on the following risk levels:
  - Low-risk areas: Standard cleaning procedures are sufficient in non-patient contact areas such as registration and archives, etc.
  - Moderate-risk areas: Cleaning with a general surface disinfectant is done in care areas used by individuals who do not have infectious diseases and patients with a low risk of developing infections. Dry cleaning methods or

dust-generating procedures such as vacuuming are avoided. In cases of contamination with blood or body fluids, disinfection is performed after cleaning.
    - High-risk areas: In isolation rooms where infectious patients are present, a one-step process with a detergent/disinfectant solution or a two-step process involving cleaning followed by disinfection is performed, and separate cleaning equipment is maintained
    - Very high-risk areas: In protective isolation rooms, operating rooms, intensive care units, neonatal units, hemodialysis units, and transplant units, where patients are at high risk of developing infections, a one-step or two-step cleaning and disinfection process, as described above, is performed, and separate cleaning equipment is maintained.
    - Environmental surfaces are classified as "critical" and "non-critical." Surfaces frequently touched by hands, such as door handles, bed rails, keyboards, bed control panels, light switches, and non-invasive medical devices like blood pressure monitors, ECG machines, and stethoscopes, are considered critical surfaces. Equipment with a relatively low risk of microorganism transmission, such as walls, ceilings, shelves, and radiators, is classified as non-critical surfaces.
- » Based on identified risks, a cleaning and disinfection plan covering all areas of the facility is developed. This plan includes, at least the following elements:
    - On the basis of area and surface;
    - Risk level
    - Cleaning and disinfection materials and equipment to be used
    - Frequency and rules for cleaning and disinfection
    - Individual responsible for performing cleaning and disinfection procedures
    - Methods and frequency of insect control

CDS.1.4
Arrangements for the cleaning and disinfection of areas, floors, and environmental surfaces are implemented.

- » Necessary supplies, equipment, and personal protective gear for cleaning and disinfection are provided.
- » The personal protective equipment to be used by the staff performing cleaning and disinfection procedures is determined.
    - Employees is trained on the use of protective equipment
    - Continuous use and supply of protective equipment is ensured.
- » Cleaning and disinfection procedures are carried out from less contaminated areas to more contaminated areas, from top to bottom, and from the farthest point from the door towards the door.
- » The area to be cleaned-disinfected is ventilated.
- » Movement in the area undergoing cleaning and disinfection is stopped or minimized.
- » In high-risk areas outside the operating room, in addition to daily cleaning, floors and all high-touch surfaces (e.g., bedside tables, monitor and ventilator surfaces, meal tables, work desks, faucet handles, door handles, and bed rails) are disinfected at least once a day and whenever contamination occurs.

- Operating room areas are cleaned and disinfected before the first case in the morning, between cases, and at the end of the day.
- Buckets and cleaning cloths in different colors are designated according to the risk level of the area, floor, and surfaces.
- Cleaning with a neutral detergent is sufficient for non-critical surfaces. However, the main concern is the contamination of water in the cleaning bucket during use. For this reason, the detergent water is changed between patient beds and whenever it becomes soiled.
- Critical surfaces undergo thorough effective cleaning and disinfection. If there is no visible contamination, disinfection is performed in a single step using a detergent-disinfectant product.
- The room is cleared as much as possible before cleaning, and waste is removed.
- In the disinfected patient room, the exposure time of the disinfectant solution is observed, and activities that disrupt air circulation are avoided. The patient is not brought into the room during this period.
- The disinfectant is selected based on its rapid antimicrobial effect. After cleaning, detergent residues are removed to ensure effective disinfection.
- The areas for placing clean/soiled cloths and other materials on the cleaning cart are determined as standard.
- The solutions to be used, along with their concentrations and contact times, are documented in writing on the cleaning cart and in the preparation unit. Preferably, an automatic dosing system is used.
- Cleaning and disinfection of cleaning equipment (cleaning trolley, mop handle, buckets, etc.) and disposable materials (disposable wipes, cloths, mops, etc.) is carried out in line with the relevant national/international guidelines.
- Decontamination procedures following exposure to blood, body fluids, or contamination due to accidents are conducted based on national and international guidelines.
- When terminal disinfection methods (e.g., hydrogen peroxide, UV) are applied, documentation is provided regarding the equipment, application areas, operators, usage procedures (e.g., evacuation of patient rooms), and maintenance requirements.
- It is ensured that cleaning is visibly performed before disinfection

CDS.1.5
Arrangements for the cleaning and disinfection of materials and devices are in place.

- Materials and devices are classified into at least three groups based on infection risk levels (e.g., critical, semi-critical, and non-critical).
  - Critical: Devices that come into contact with organs, tissues, or blood undergo sterilization or high-level disinfection.
  - Semi-critical: Devices that come into contact with mucous membranes or non-intact skin undergo high-level or intermediate-level disinfection.
  - Non-critical: Devices that come into contact with intact skin undergo low-level disinfection.
- Disinfection and sterilization methods are defined according to risk levels.
  - High-level disinfection is considered sufficient for semi-critical medical

devices; however, sterilization is preferred for devices that can be sterilized by any sterilization method.

» Devices and materials requiring disinfection are determined.
» The level of disinfection, the disinfectant to be used, and the application guidelines are determined according to the material being disinfected.
» The lids of containers containing disinfectants are kept closed.
» Preparation and expiry dates are labeled on containers used for preparing disinfectants.
» Disinfectants are used in accordance with the manufacturer's recommended concentration and contact time, and the contact time is monitored.
» Disinfectants are disposed of properly.
  • The disposal process for disinfectants is established based on national and international guidelines, manufacturer recommendations, and relevant country arragements.
» The implementation of disinfection procedures within the framework of the determined rules is monitored by the relevant responsible persons.

CDS.1.6
Arrangements for the control of cleaning and disinfection procedures are in place.

» Cleaning of all indoor and outdoor areas and disinfection processes carried out in the health institution/organisation are regularly controlled.
» In accordance with the cleaning and disinfection plan, the availability of necessary materials and equipment in the usage areas is checked.
» Evidence of cleaning effectiveness is retrospectively traceable.
  • The method, frequency, and responsible individual for monitoring cleaning effectiveness are defined depending on the applied method (e.g., fluorescent marking, ATP testing, or microbiological methods), the results are recorded and are retrospectively traceable.

CDS.1.7
Necessary training is provided to relevant employees regarding cleaning and disinfection services.

» Training programs for staff involved in cleaning and disinfection services include at least the following topics:
  • Cleaning rules for general areas
  • Cleaning protocols based on the determined risk level of areas
  • Features of the use of cleaning agents
  • Communication among employees
  • Communication with patients and their relatives
  • Use of personal protective equipment (PPE)
  • Actions to be taken in case of exposure to cleaning agents (e.g., splashes into the eyes, skin contact)
  • Structural issues that compromise cleaning and disinfection effectiveness and the need to report these to responsible individual
  • Use of disinfectants
    ▪ Considerations for ensuring disinfectant effectiveness
    ▪ Use of personal protective equipment
    ▪ Ventilation conditions

- Actions to be taken in case of accidents
- Reporting situations that compromise disinfection effectiveness
- Storage conditions for disinfectants

Standard 2

CDS.2
Processes and rules regarding high-level disinfection are defined, and functioning is ensured accordingly.

CDS.2.1
Processes and rules regarding high-level disinfection are documented.

» Processes and rules related to high-level disinfection include at least the following topics:
  - High-level disinfection policy
  - Responsible individuals and responsibilities for high-level disinfection
  - High level disinfection areas
  - Preparation, application, monitoring, and disposal of high-level disinfectants
  - Evaluation of the effectiveness of disinfection practices

CDS.2.2
Areas where high-level disinfectants are used are identified, and necessary arragements are implemented.

» Areas of high-level disinfectant use is carefully planned according to need, and random use is avoided.
» For endoscope decontamination, there is an area consisting of at least two rooms, a dirty area where decontamination is performed and a clean area where decontaminated endoscopes are stored.
  - In cases where it is not possible to provide two rooms, the workflow is adjusted from dirty to clean.
» Closed decontamination systems are preferred.
» A handwashing sink is present in the endoscopy decontamination area.
» An eye-wash station is available for use in case of splashes.
» Proper ventilation conditions are provided in areas where high-level disinfectants are used.
  - Ventilation system which is capable of ensuring fresh air exchange per hour in the working areas is provided. The ventilation system is separate from the general system and the air exchange can be monitored.

CDS.2.3
Medical devices requiring high-level disinfection are identified, and specific arragements for their operation are established.

» Medical devices to be subjected to high-level disinfection are determined according to their risk status, type and type. Random use of high-level disinfectants are avoided.
» Appropriate cleaning, disinfection and/or sterilization rules are followed when preparing endoscopes for reuse.

- The methods to be applied when preparing for reuse is determined according to the risk status of the endoscopic procedures and the type and type of endoscopes.
- In terms of risk, endoscopic procedures are categorized as high and moderate risk.
- High-risk devices are medical devices used in procedures where the skin is punctured and sterile cavities are entered (arthroscopes, laparoscopes, etc.).
- These devices are sterilized before use according to the manufacturer's instructions after appropriate cleaning procedures.
- High-level disinfection not be performed on high-risk rigid endoscopes (arthroscopes, laparoscopes, cystoscopes, etc.).
- Accessories used in endoscopic interventions that penetrate tissue (forceps, syphincteretomes, polypectomy sines, cyclerotherapy needles, cytology brushes, etc.) are sterilized before use.
- Moderate-risk devices are classified as semi-critical instruments used in procedures involving intact mucous membranes (e.g., colonoscopes, gastroscopes).
- These devices undergo high-level disinfection before use, with reprocessing carried out in the endoscope decontamination area.
- Guidelines for pre-treatment, cleaning, rinsing, high-level disinfection, final rinsing, drying, and storage of endoscopic devices are aligned with national and international standards.
- Proper physical conditions need to be ensured to achieve effective high-level disinfection of endoscopic devices.
- Endoscopy decontamination areas where manual decontamination is performed have at least two sinks—one designated for washing and brushing contaminated endoscopes and the other for rinsing.
- The material from which the sink is made is resistant to chemicals and easy to clean.
- The sink is large enough to fully accommodate an endoscope along with its insertion and light guide tubes without causing damage (minimum 42 cm).
- Both hot and cold water supply is available at the sink.
- A separate handwashing sink is also provided.
- In endoscope disinfection with disinfectors, the endoscope is placed in the disinfector after all the cleaning steps up to the disinfection process are applied.
- If automatic endoscope washer-disinfector devices are used for washing and disinfection, there are preferably two doors and all channels of the endoscope can be connected to the device in contact with water, detergent and disinfectant.
- The endoscope is not removed before the disinfector cycle is completed, and the drying and storage steps are completed properly as in manual disinfection.
- The disinfection container is large enough to accommodate the endoscopes without damaging them.
- The lids of the containers containing disinfectants are closed during use.
- Duration and device records of all cycles made with disinfectors are kept.
- Endoscopes are hung in a vertical position for drying and kept clean after drying.
- The employees who perform the cleaning, disinfection and sterilisation of endoscopic devices are trained on the subject.
- The fundamental principles of disinfection practices, products that are selected

for intended levels of disinfection, and application methods are defined in accordance with international standards and evidence-based studies.

» All operations are carried out according to the recommendations of the endoscope manufacturer and the standard application document, including leakage test, pre-washing, brushing, main washing, rinsing, disinfection and storage.

» Decontaminated endoscopes are not stored in transport cases; they are stored vertically in closed cabinets, preferably equipped with HEPA-filtered drying systems.

» The storage period of decontaminated endoscopes is validated, or if endoscopes are not used on the same day, they undergo re-decontamination at the beginning of the following day.

CDS.2.4

Arrangements for the preparation, application, monitoring, and disposal of high-level disinfectants are implemented.

- High-level disinfectant is prepared in a clean container with clean water, using a measuring device, at the concentration recommended by the manufacturer.
- The minimum effective concentration (MEC) of the high-level disinfectant is checked at specified intervals using indicators and recorded.
- A timer is used for the disinfection duration, and the contact time recommended by the manufacturer is followed.
- In case of manual disinfection, the MEC test of the high-level disinfectant is performed regularly as defined in the written document and recorded.
- If an automatic endoscope washer-disinfector is used, the device cycle outputs are recorded.
- High-level disinfectants are disposed of appropriately.
- The disposal process of high-level disinfectants is determined in accordance with national and international guidelines, manufacturer recommendations, and relevant country arragements.
- After the ineffective disinfectant is disposed of, the disinfectant container is washed, a new disinfectant is prepared, and no additions are made.
- Traceability of high-level disinfection processes is ensured.
- Necessary materials, equipment, and personal protective equipment appropriate for high-level disinfection processes are present.
- All personal protective equipment required during the process is defined and kept available in the area.

CDS.2.5

Necessary training is provided to relevant employees regarding high-level disinfection.

» Awareness training is provided to relevant employees on the importance and responsibility of high-level disinfection.

» Endoscope decontamination applications are carried out by qualified employees trained on the subject

Standard 3

CDS.3
Processes and rules regarding sterilization services are defined, and functioning is ensured accordingly.

CDS.3.1
Processes and rules regarding sterilization services are documented.

- Processes and rules related to sterilization services include at least the following topics:
- Control of pre-sterilization unit processes
- Physical area arrangement of the sterilization unit
- Process control in sterilization services
- Necessary equipment, working conditions, and rules related to the services provided
- Instruments;
- Transfer to the unit
- Washing
- Transport to the preparation and control area
- Counting and inspection
- Packaging, sterilization, and storage
- Maintenance of sterility until transfer to the area of use
- Control of washing, packaging, and sterilization effectiveness
- Daily cleaning and periodic maintenance of instruments used in washing, packaging, and sterilization processes
- Course of action to be followed in cases causing service disruption (e.g., power outages, water cuts, equipment failures)
- If sterilisation service is procured, the scope of controls, control intervals and responsible person
- Sterilization process of non-inventory sets and materials
- Conditions of use of reusable medical devices and materials
- If there are reusable medical devices and materials, processes related to them is defined.
- Single-use critical medical devices are not re-sterilized.
- A single-use medical device is a device manufactured by the producer for use on a single patient and for a single procedure.
- Preparing these medical devices for reuse and reusing them poses significant risks to patient safety.
- Arragements preventing the reuse of single-use critical medical devices are established.
- Determined measures related to sterilization services in extraordinary situations (e.g., disasters, facility-related issues, gas leaks in devices).
- Processes for instant sterilisation application, if any
- In which cases the instantaneous sterilisation method is to be used
- Flash sterilisation is used in cases where there is not enough time to sterilise medical devices and materials by standard pressurised saturated steam method and is not used as a routine sterilisation method.

- Which medical devices and materials the sterilisation program will cover
- Points to be considered before use to the patient after leaving the steriliser
- Informing employees
- Monitoring the cycles with chemical and biological indicators in accordance with the instant sterilisation programme
- Recording the entire process
- Traceability of sterilisation processes
- Control of processes after the sterilisation unit
- Processes and rules regarding sterilisation services are determined in line with the relevant national and international guidelines.
- Necessary training is provided to the relevant employees for the processes related to sterilisation services

CDS.3.2
Physical and functional arragements for the Central Sterile Services Department (CSSD) are implemented.

- Physical space in the MSU is planned according to the steps of the process. Dirty, clean, sterile and support areas is defined and physically separated.
- Dirty area This is the area where medical device acceptance and washing processes are applied.
- Clean area The area where control, maintenance, packaging and loading into the sterilization device are performed.
- Sterile area Areas where sterile material is removed from the device, delivery parameters are evaluated and stored.
- Support areas: Employee dressing rooms, restrooms, rest room, training room, administrative office, textile folding area, etc.
- Appropriate temperature and humidity ranges is determined according to the areas, and temperature and humidity is monitored continuously.
- All surfaces in the MSU is easy to clean and disinfect. For example. There is no cracks on the surfaces, jointless materials is used, there is no surfaces wrapped with fabrics, plasters, etc., if a ceramic surface is used, the surface is large, etc.
- In the sterilization unit, the air flow is from the sterile area to the clean area and to the dirty area.
- The ventilation system provides at least 10 filtered air changes per hour.
- Any method to create air turbulence not be used.
- The ventilation system ensure that air flows out of the sterile storage area at positive pressure and measurement records is traceable. Ex. Automation system, technical service records, pressure measurements of the ventilation device, creation of two-door corridors in area passages, etc. Records that give this information about ventilation
- Systems such as water, lighting, uninterruptible power supply are established to ensure that the safety and efficiency of sterilization processes are maintained.
- Routine checks of systems such as water, lighting, uninterruptible power supply are carried out by competent technical staff.
- In the MSU, the final rinse water of washing disinfectors, water used in thermal disinfection and water used in steam sterilizers is demineralized.
- Processes and control intervals for measuring the quality of demineralized water is defined.

- The conductivity of the water is measured and recorded every day.
- To prevent microbiological contamination, storage of demineralized water in large quantities are avoided, the temperature of the water is controlled and the storage area is cleaned regularly.
- In the MSU, the final rinse water of the washing disinfectors and the water going to the steam sterilizers is demineralized water obtained by reverse osmosis.
- The conductivity of this water is below 15 microsiemens and the conductivity is recorded every day.
- Necessary lighting levels are determined according to the characteristics of the work areas.
- All devices in the MSU is connected to an uninterruptible power supply.
- Equipment to ensure hand hygiene (such as sinks, liquid soap, hand sanitizers) is available at transition points between dirty, clean and sterile storage areas.
- The employee performs hand hygiene at the entrance to the area, when leaving the dirty area, in the clean area before touching the tools with bare hands, before touching the packaged material, before touching the package of sterile material.
- Ergonomic working conditions for workers at the MSU is defined and observable (such as adjustable stools and tables).
- Chapticle-forming activities in a clean and sterile area is avoided (presence of cardboard boxes, folding textiles, cutting sponges, etc.).
- Rules regarding the placement, storage and delivery of sterile materials in the sterile storage area is determined.
- Storage conditions in sterile areas is created in a way that does not prevent air circulation and ensures that the sterility of the material is maintained.
- Clean room criteria (ISO Class 8) is met in the sterile area and the number of air changes, air validation measurement tests is performed and evaluated once a year and improvements is made if there is nonconformity.
- Entry to the sterile storage area is controlled and non-sterile materials and medical devices not be in this area.
- Daily maintenance and controls of pressurized steam autoclaves is carried out.
- Vacuum leakage test is performed for pressurized steam autoclaves.
- If the vacuum leakage is less than 1 millibar/minute, it is done once a week.
- If more than 1 millibar/minute, it is done every day.
- If the vacuum leakage exceeds 1.3 millibars/minute, the device is stopped.
- Vacuum leak test results is traceable.
- Bowie-Dick test is performed and recorded every day when the device is empty and before starting the sterilization process.
- Safety measures is taken for ethylene oxide.
- The ethylene oxide sterilizer is located in a separate section, with the necessary warning symbols on the entrance door and controlled access to the room.
- In the ethylene oxide sterilization room, there is fresh air exchange at least 20 times per hour and the pressure is kept lower than the surrounding areas. The pressure difference is continuously monitored with audio and visual warning systems.
- The device work with 100% ethylene oxide, the cartridge not be activated manually, it automatically fill into the chamber within the device.
- Cartridges is stored in a special closed metal container.

- There is a warning system that is able to detect gas in the environment.
- Gas masks and protective clothing is available at the entrance of the sterilization unit to be used in case of alarm.
- Materials sterilized with ethylene oxide sterilizer is ventilated for an appropriate period of time.
- Ingredients;
- At least 8-10 hours in the device's own boiler
- Outside the device, it is ventilated for an additional 12 hours to two weeks, taking into account criteria such as the structure of the material, intended use, lumen thinness, lumen length, and the fact that it will be left in the body.
- The waste gases from the ethylene oxide sterilizer is discharged through an independent chimney to ensure environmental safety.
- In the presence of devices capable of neutralizing the waste gas, there is no need for an independent chimney. In this case, the ethylene oxide content of the waste gas is measured at regular intervals and necessary measures is taken.

CDS.3.3
Arrangements for the collection and washing processes of contaminated materials are established.

- Rules for receiving, washing, and monitoring the washing effectiveness of sterilizable materials are defined in accordance with national and international guidelines.
- Dirty materials are counted upon receipt, and the name, quantity, originating unit, date and time of arrival, and details of the person delivering and receiving the materials are recorded.
- System records made using barcode methods with QR codes for instrument use are acceptable.
- Equipment, chemicals, and physical parameters (such as temperature, concentration, and cycle parameters if machines are used) for washing are compatible with the items to be decontaminated.
- The process for monitoring washing effectiveness is include at least the following control steps:
- Cycle reports from washing machines are assessed after each wash. For devices that do not provide output, external physical control methods are applied.
- In addition to the control of physical outputs, one of the following controls is applied at least once a week.
- Electronic control systems displaying temperature time parameters
- Control with washing indicators
- Protein residue tests are carried out at least once every two weeks.
- Chemical and microbiological control of demineralised water is carried out at least once every six months.
- The washing control also covers instruments with lumen in use.
- Processes related to the maintenance and cleaning of washing areas and devices are defined.

CDS.3.4
Arrangements for packaging and loading processes are implemented.

- Packaging rules are determined in accordance with national and international guidelines.
- Materials are delivered to the clean area with a material list.
- The package contents are checked for cleanliness, integrity, and damage, and necessary maintenance procedures are applied.
- The packaging process is carried out in the clean area.
- Textile materials are packaged in a separate area from other materials.
- Materials used for packaging are compatible with the sterilization method to be applied, ensuring the effectiveness of sterilization and the safe storage of sterile packages.
- Rules for loading packages into the sterilization device are defined, and excessive or crowded loading that reduce sterilization efficiency is avoided.

CDS.3.5
Arrangements to ensure the effectiveness of the sterilization process are established.

- TThe methods and processes to be followed by the unit for monitoring sterilization effectiveness (such as parametric validation, biological validation, routine use of chemical and biological indicators) are defined.
- Competency tests for validation are routinely conducted at least once a year. Additionally, competency tests are repeated in the following situations:
-
- Major repairs, such as sensor replacement in the sterilizer
- Changes in the sterilization process (e.g., increase in vacuum depth, changes in the number of pre-vacuums, etc.)
- Changes in load or loading method (according to the reference load used in the competency tests)
- Changes in packaging material or method (e.g., transition from single-use packaging material to containers)
- If the parametric validation method has been decided and parametric validation is conducted at least once a year, chemical or biological control results are not required for product delivery. Product delivery is made based on routine physical control results (such as Bowie-Dick test, vacuum leak test, and cycle charts).
- If biological validation has been performed, cycles are monitored with biological indicators. In cases requiring repetition of competency tests, the sterilizer is put back into use only after three consecutive negative biological indicator results have been obtained.
- The installation and operational competency of sterilizers are proved by the manufacturer.
- An indicator is used on each package to distinguish between processed and unprocessed packages.
- If the unit is defined as the routine monitoring of sterilization effectiveness through internal chemical indicator application, a chemical indicator with suitable properties for the package content is placed in each package according to the nature of the contents.

- Chemical indicators are not required in sterilization packages containing a maximum of 5 non-luminous instruments or 10 sponges/pads, provided the following conditions are met:
- Regular maintenance, repair, and calibration of the steam sterilizer are performed
- Bowie-Dick test and vacuum leak test results are positive
- Load control tests are performed and result positively in every cycle involving such packages
- If the unit is defined biological indicator application for routine monitoring of sterilization effectiveness, the application is carried out at a minimum according to the following rules:
- The frequency and rules for biological indicator use are determined according to the sterilization method:
- If parametric product delivery is not possible in steam pressure sterilization, biological indicators are used at least once a week and in every load containing implants.
- Each cycle of ethylene oxide sterilisation
- Each cycle of formaldehyde sterilisation
- Each cycle of H2O2 sterilisation
- After the first installation cycles and major repairs of the devices, use is started after three consecutive negative results.
- Biological indicator results are recorded.
- A positive control test is performed for each different production series of the indicator.
- If the biological indicator result is positive, the materials delivered since the last negative result are recalled, sterilised again, and if the materials are used in patients, the relevant patients are monitored by the infection control committee. Maintenance controls of the device are carried out and its use is permitted after three negative biological controls.
- The biological indicator incubator is calibrated within the specified intervals and when necessary.
- In validation competency tests, measuring devices in parametric validation and biological indicators in biological validation are placed at the points determined by the autoclave manufacturer as ‘difficult points’ in challenging test systems and the results are evaluated by an expert. These measurements are repeated three times with the autoclave empty and fully loaded with the most difficult load. All results are recorded

CDS.3.6
Arrangements for the storage of sterile materials are implemented.

- Sterile materials are stored in the sterile storage area.
- The ventilation system is designed to ensure that air flows out of the sterile storage area with positive pressure. There is no direct contact with the outside air.
- In sterile material storages, the material shelves are at least 30 cm above the floor, the distance to the ceiling is at least 50 cm after the material is placed on the top shelf, and at least 5 cm in front of the wall for air circulation.
- Sterile storage racks are easy to clean, allowing free circulation of air around the stored product.

» Materials leaving the sterile warehouse are not accepted to the warehouse without being sterilised again, even if the package is not opened.
» Sterile materials coming out of the sterile warehouse to the areas are stored appropriately (suitable drawer cabinet etc.) in the application areas.
» Sterile materials are labeled with identifying information, including the sterilization device used, the employee performing the sterilization, the sterilization date, and the shelf life.
» The shelf life of sterile materials is determined by considering factors such as the number of packaging layers, packaging materials, other protective factors (e.g., closed boxes, dust covers, transport trolleys), and storage location.

CDS.3.7
Arrangements for the traceability of the sterilization process are established.

- At each stage of sterilisation processes (receipt, washing, packaging, sterilisation, storage, transfer to the area of use); there are records of time, device, method, practitioner and control parameters.
- Records related to sterilization process provide at least the following information:
- Performance tests that verify the effectiveness of washing and thermal disinfection.
- Post-cycle inspection of packs for moisture and exposure band
- Indıcator control results if sterilisation efficiency is monitored by chemical and biological indicators
- Sterilised on which date, by which method and in which cycle
- Maintenance, repair, and calibration records for sterilization devices.
- Cycle records of the device.
- Test results for the device (such as vacuum leak test, Bowie-Dick test)
- When and by whom it was received and delivered
- At which stage and by whom the process is applied
- Records of quality control procedures conducted during processing.
- Descriptive information about the sterile material is also available in the patient file and it is recorded which material is used for which patient.
- The records of the materials used for the patient are accessed retrospectively.
- There are also records of materials in outpatient clinics, small intervention areas, dental units, etc.

SECTION 4 HEALTH SERVICES	
Chapter 17 Laboratory Services (LS)	
Code	**Standard 1**
LS.1	Processes and rules related to laboratory services are defined, and operations align accordingly.
Code	**Assessment Criteria**
LS.1.1	Processes and rules related to laboratory services are documented.
LS.1.2	Laboratory service delivery areas are identified, and necessary physical conditions are ensured for these areas.
LS.1.3	An informative guide related to laboratory services is prepared.
LS.1.4	A healthy working environment in the laboratory is established.
LS.1.5	The control and safe use of reagents, materials, devices, and equipment used in laboratory services are ensured.
LS.1.6	Arragements for reporting and managing adverse events in laboratory services are established.
LS.1.7	Arragements for the use of point-of-care testing devices are established.
LS.1.8.	Necessary training is provided to relevant personnel for laboratory services.
Code	**Standard 2**
LS.2	Control of pre-analytical processes is ensured.
Code	**Assessment Criteria**
LS.2.1	Arragements for sample and test requests are established.
LS.2.2	Arragements for sample collection are established.
LS.2.3	Arragements for sample transfer are established.
LS.2.4	Arragements for the acceptance and rejection of samples in the laboratory are established and traceable.
LS.2.5	Arragements for samples accepted into the laboratory are established.
LS.2.6	Arragements for identity verification in pre-analytical processes are established.

Code	Standard 3
LS.3	Control of analytical processes is ensured.
Code	**Assessment Criteria**
LS.3.1	Control of analytical processes is ensured.
LS.3.2	Quality control activities for laboratory tests are conducted.
Code	**Standard 4**
LS.4	Control of post-analytical processes is essential.
Code	**Assessment Criteria**
LS.4.1	Arragements for the interpretation and reporting of laboratory results are established.
LS.4.2	Laboratory result reporting times are determined, and timely reporting of results is ensured.
LS.4.3	Arragements for the storage and archiving of analysis samples, excess biological material, test data, and results are established.
Code	**Standard 5**
LS.5	Traceability of laboratory service processes is ensured.
Code	**Assessment Criteria**
LS.5.1	All stages of laboratory service processes are traceable.
LS.5.2	Arragements for information management in laboratory service processes are established.
LS.5.3	Arragements for tests conducted through external resources are established.
Code	**Standard 6**
LS.6	Monitoring and evaluation activities for laboratory services are conducted.
Code	**Assessment Criteria**
LS.6.1	Indicators for evaluating the performance of laboratory services are determined, the effectiveness of operations is monitored regularly, and continuous improvement activities are carried out.

General Information

This chapter covers the following medical laboratories that are established, licensed, and have operating permits in accordance with national/international arragements and standards:

- Medical biochemistry laboratory
- Medical microbiology laboratory
- Medical pathology laboratory
- Tissue typing laboratory
- Genetic Disorders Evaluation Center

A medical laboratory refers to laboratories where biological materials are examined for the evaluation of patients, monitoring of the diagnosis and treatment process, with results reported, interpreted when necessary, and recommendations for further examination included.

While auditing/implementing this chapter:

- The licensing of medical laboratories, national laws and arragements that form the basis for the operating permit, national standards, and rules that need to be followed are considered.
- The laboratory's license, permit documents, working hours, services obtained from external laboratories, institutions and organizations served, personnel list, laboratory layout, medical devices and examination lists approved by the laboratory specialist, lists of chemicals and reagents, appointment and assignment documents, diplomas, licenses, and specialty certificates, along with any relevant training certificates, are checked for currency.
- The laboratory's biosafety level compliance is checked. The medical microbiology laboratory complies with at least "biosafety level 2" conditions, and other medical laboratories comply with at least "biosafety level 1" conditions. According to international arragements, medical laboratories working with microorganisms in risk groups 3 or 4 comply with "biosafety level 3" or "biosafety level 4" conditions, respectively.
- The term "sample" used throughout this chapter also includes biological material

Purpose

- The physical conditions are structured to ensure the appropriate delivery, storage, analysis, and proper reporting of test results for patient samples, and to create a healthy working environment for laboratory personnel.
- In non-laboratory processes, ensuring test safety involves correctly and effectively informing healthcare professionals involved in the testing process and ensuring access to the necessary documentation.
- The accuracy and reliability of laboratory results are ensured by controlling the processes from test request to sample analysis.
- Patient safety is ensured through the continuity of quality improvement activities in laboratory analytical processes.
- Test results are used for patient benefit and patient safety is ensured.
- Traceability of testing processes is ensured to obtain data for the analysis and improvement of laboratory processes.

» Quality activities conducted in the laboratory are converted into a measurable format to identify, monitor, and ensure continuous improvement in areas that require enhancement.

Objectives

» Patient Safety
» Effectiveness
» Efficacy
» Efficiency

Standard Requirements

Standard 1

LH.1
Processes and rules related to laboratory services are defined, and operations align accordingly.

LH.1.1
Processes and rules related to laboratory services are documented.

» The laboratories providing services are defined, and the processes related to these laboratories include at least the following topics:
  - Physical Conditions
  - The physical conditions required for licensing are in place.
  - The physical conditions and layout of medical laboratories align with the appropriate biosafety level.
  - The support areas of medical laboratories are organized to form a functional unity with the technical area.
- General Working Principles of the Laboratory
  - Pre-analytical processes
  - Analytical processes
  - Post-analytical processes
- Risk management
- Disaster and emergency management
- Quality, external quality control programs, and program providers
- Duties and responsibilities of personnel
- Identification of units and centers sending samples
- Service procurement
- Information systems, data protection, and storage
- Rules for the confidentiality and security of records related to forensic cases and forensic reports
- Laboratory safety
- Management of materials and equipment in the laboratory
- Management of medical waste in the laboratory
- Definition of intra-departmental and inter-departmental consultations in the pathology laboratory
- Definition of the intraoperative consultation process in the pathology laboratory
- IMS used in medical laboratories, clinical decision support systems, and artificial intelligence applications in medical laboratories.

LH.1.2
Laboratory service delivery areas are identified, and necessary physical conditions are ensured for these areas.

» Areas for the acceptance of samples, pre-analysis preparation, analysis, and post-analysis storage and archiving processes are established, and the necessary physical conditions for these areas are provided.
- The laboratory includes a sample acceptance area/unit.

- Physical areas for sample preparation and testing processes are identified.
- Areas for storing residual samples after testing under appropriate conditions are designated.
- A suitable archive area for histopathological samples is established.
- The pathology laboratory includes an archiving area for slides, blocks, and reports.
- Temperature and humidity monitoring occurs in the area, and paraffin blocks are stored at temperatures not exceeding 25°C.

LH.1.3
An informative guide for laboratory services is prepared.

» The guide for informing healthcare professionals includes at least the following topics:
  - Tests performed in the laboratory
  - Which samples are suitable for which tests
  - Tests requiring pre-processing and the rules related to these tests
  - Rules for sample collection
  - Rules for sample transfer and laboratory acceptance
  - Test methodology
  - Information on reporting and interpreting results
  - Test-specific explanations, if necessary

» The guide remains up-to-date and accessible in departments providing healthcare services.

» Relevant healthcare professionals receive information about the use of the guide.

LH.1.4
A healthy working environment in the laboratory is established.

» A laboratory safety guide is created for procedures related to physical, chemical, and biological sources in the laboratory.

» Working conditions align with the defined biosafety level.

» Laboratory safety complies with facility management and infection prevention and control programs.

» Processes for laboratory cleaning, cleaning and disinfection of medical devices are defined, and operational arragements are established.

» Emergency response kit, fire extinguisher tube and flame extinguishing blanket suitable for the existing hazards are available.

» A decontamination area and/or neutralization materials suitable for risks such as chemical exposure and similar injuries are provided, and measures are taken for their effective use.

» Personal protective equipment suitable for chemical, radioactive, or potentially infectious risks is available to protect employee health and ensure occupational safety.

» Lighting and noise levels in the laboratory are measured periodically, and improvements are made in case of non-compliance.

» Vaccination of personnel is ensured based on the biological materials or tests being handled.

» An eyewash station, equipment, and emergency shower are available in the

technical area of the laboratory.

» Labeling or marking using nationally or internationally recognized symbols is applied to devices, equipment, or instruments to address potential hazards and risks.

» Appropriate ventilation or climate control systems are installed to prevent the spread of chemical, toxic, or infectious agents. (Examples: Biosafety cabinets, fume hoods, ventilation systems, etc.)
  • The biosafety cabinet in the microbiology laboratory is at least Class 2 level.

» The security of biological agents, biological materials, medicines, radioactive materials are ensured and measures are taken to prevent the misuse, destruction and theft of patient information.

» Maintenance and controls of protective devices and equipment in the laboratory are performed regularly and recorded.

» In the pathology laboratory, measurements are conducted under appropriate conditions using a xylene and formaldehyde measurement device with a suitable detector or measurement capability and a valid calibration certificate, and the measurement results are recorded.

LH.1.5

The control and safe use of reagents, materials, devices, and equipment used in laboratory services are ensured.

» Storage and preservation processes for materials are defined according to their types.

» Access to defined material storage areas and all unit storage areas where medical consumables are kept for more than 24 hours is restricted to authorized personnel only.

» Materials are stored and recorded in storage areas according to their characteristics.
  • Materials are stored under appropriate temperature and humidity conditions according to their types.
  • A cold storage room or an adequate number of refrigerators is available for reagents and other chemicals requiring low-temperature conditions, and the temperature and humidity levels of these areas are monitored.
  • Storage areas are cleaned at regular intervals, and records are maintained.

» A device management file containing at least the following information exists for each test device in the laboratory:
  • User manual etc.
  • Calibration records for the test or device, if available (calibration plans, acceptance criteria, calibration intervals, and result documents)
  • Quality control results, if available
  • Device maintenance forms (daily, weekly, monthly, etc.)
  • Company contact information
  • User training certificates

» Temperature monitoring is conducted for devices such as incubators, freezers, water baths, and refrigerators.

» Rules regarding the use of tissue tracking solutions and water baths in the pathology laboratory are established.

- Tissue tracking solutions are replaced at regular intervals based on quality controls such as section quality and tissue fixation, depending on the laboratory's workload.
- Individuals responsible for solution changes are identified.
- Water changes and cleaning of the water bath occur at least once a day.
- Records of water and solution changes are maintained.
- Responsible personnel receive training on water and solution changes.

LH.1.6
Arrangements for reporting and managing adverse events in laboratory services are established.

» Errors and near-miss adverse events occurring in laboratory processes are monitored, analyzed, and necessary improvements are implemented. (See: Adverse Event Reporting)
- The monitoring of errors and near-miss adverse events occurring in laboratory processes utilizes the relevant national tracking system, if available. (e.g., Laboratory Error Classification System, etc.)

» In the pathology laboratory, nonconformities identified regarding clinical outcomes are categorized and analyzed under the following headings based on their impact on the patient:
- No impact on the patient
- Minimal impact
- Minor harm
  - Diagnosis delay
  - Causing unnecessary diagnostic interventions (such as blood analysis, radiological examination)
  - Causing a delay in treatment
  - Application of unnecessary treatment that does not cause morbidity
- Moderate harm
  - Causing unnecessary diagnostic interventions that lead to moderate morbidity
  - Causing unnecessary treatment interventions that lead to moderate morbidity
- Major damage
  - Causing unnecessary diagnostic interventions that result in organ function loss/damage/failure
  - Causing unnecessary treatment interventions that result in organ function loss/damage/failure
- When major damage occurs, root cause analysis is conducted as soon as possible and necessary improvements are made.
- Categorized nonconformities are evaluated regularly within the laboratory, and necessary improvement actions are identified.

LH.1.7
Arrangements for the use of point-of-care testing devices are established.

» Point-of-care testing devices (POCT) refers to a kit, device, or test that can be carried or temporarily brought to the patient's location or clinic without requiring

a permanent and specific area. These devices measure parameters outside the laboratory, such as blood glucose, blood gases, electrolytes, urine strip tests, streptococcus antigen, cardiac enzymes, coagulation parameters, and C-reactive protein.

» POCTs used in the institution/organization are defined in a traceable manner.
  • To ensure traceability, an inventory containing the unit where the devices are used, the unit device responsible, device number, device type, brand, and model information is created.
» The responsible laboratory unit, individuals, and their responsibilities for the maintenance and cleaning of the POCT are defined.
» Quality control work processes for the POCT are defined.
  • Quality control tests are recorded.
  • Corrective and preventive actions are initiated if nonconformities are found in the quality control results.
» Employees using the POCT receive training on at least the following topics.
  • Considerations to be made during the preanalytical, analytical, and postanalytical stages of the tests to be performed
  • Evaluation of calibration and quality control results
  • Cleaning and maintenance of the device
» All test results performed on the POCT are recorded in the patient's file.

LH.1.8

Necessary training is provided to relevant employees for laboratory services.

» Training for laboratory services includes at least the following topics:
  • Laboratory safety
  • Internal quality control
  • External quality control
  • Safe use of materials and devices
  • Information security
  • Testing process
  • Sources of error
  • Emergency preparedness and response for incidents that may lead to chemical, biological, and physical hazards
  • Ethical values

Standard 2

LH.2

Control of pre-analytical processes is ensured.

The pre-analytical process covers the period from the clinician's test request to the acceptance of the sample in the laboratory. Ensuring quality in pre-analytical processes is the responsibility of not only laboratory staff but also the requesting clinician and all healthcare workers involved in the process

LH.2.1

Arragements for sample and test requests are established.

» Rules for test requests are defined.
» During the request, the physician responsible for the patient's clinical process

provides all requested information about the patient.
» Clinical information related to the patient that will contribute to clinical interpretation is provided.
» Information about previous pathology results is provided to the pathology laboratory.

LH.2.2
Arragements for sample collection are established.
» Rules for sample collection are defined.
» In cases where the patient must collect their own sample, proper sample collection information is provided.
» The date and time of sample collection are recorded accurately.
» The request, sample collection, and acceptance or rejection of the sample are registered as separate stages in the Laboratory Information System (LIS) and visible to authorized users.
» Relevant personnel receive training on the sample collection process

LH.2.3
Arragements for sample transfer are established.
» Rules for sample transfer are defined.
» The transfer container to be used, transfer method (manual methods, pneumatic system, etc.), appropriate sample position, transfer temperature, and similar factors are defined.
» Maximum acceptable transfer times for samples are determined.
» Samples are sent to the pathology laboratory within the specified timeline and stored under appropriate conditions outside working hours.
» Clinician responsible for ordering tests are informed about the conditions for sending biopsies requiring special processing to the pathology laboratory.
» Relevant personnel receive training on carrying out sample transfer with the correct method and within the specified time.
» In cases of outsourcing:
  • The patient or their relatives are informed that the test will be performed in another medical laboratory.
  • Samples are collected at the healthcare facility that made the test request and sent to the medical laboratory where the service will be provided.
  • The contractor company ensures the appropriate transfer of the collected samples and delivery of the result reports to the healthcare institution/ organization receiving the service

LH.2.4
Arragements for the acceptance and rejection of samples in the laboratory are established and traceable.
» Acceptance and rejection criteria for samples are determined.
» Acceptance or rejection of samples is recorded.
» Records include at least:
  • Date and time
  • Department that sent the samples

- Who accepted or rejected the samples
- If rejected, the reason for rejection

» This information is traceable in the Laboratory Information System (LIS).

» The process for sample rejection is defined.

- Reasons for rejection are analyzed monthly, and corrective and preventive actions are initiated if necessary.
- In case of sample rejection, feedback about the process is provided to the clinical responsible as soon as possible, either electronically or verbally.
- In the pathology laboratory, before rejecting samples that do not meet the acceptance criteria, samples outside the definite rejection criteria are evaluated by the responsible pathology physician and examined under suboptimal conditions for the benefit of the patient.

» Relevant employees receive necessary training on how acceptance and rejection procedures are carried out.

LH.2.5

Arragements for samples accepted into the laboratory are established.

» Areas where samples accepted into the laboratory are stored before analysis are defined, and samples are stored under appropriate conditions.

» Arragements for pre-analysis preparation of samples are made, and relevant personnel receive training on this.

- Rules for pre-analysis preparation of samples are defined based on each test, and relevant personnel receive training on this.
- Example: Waiting time before centrifugation, centrifugation process, considerations when placing tubes in the centrifuge, selection of correct centrifugation time and force, centrifugation temperature, re-centrifugation of samples, etc.

LH.2.6

Arragements for identity verification in pre-analytical processes are established.

» Stages in pre-analytical processes where identity verification is required (such as sample collection, sample acceptance) and how verification will be carried out at these stages are determined.

Standard 3

LH.3

Control of analytical processes is ensured.

The analytical process covers the period from sample analysis to result approval.

LH.3.1

Test processes from sample analysis to result approval are defined.

» Work processes for each test are defined to include at least the following information:

- Cleaning, maintenance, repair, and calibration processes for devices used in the test process
- Preparation and control of kits and/or materials to be used
- Test calibrations, internal and external quality assessment activities

- Algorithms for the test execution process
- Rational laboratory practices
- Approval of results

» Any changes in the test execution process are documented and the documents revised. Training on the prepared documents and revisions is provided to employees

LH.3.2
Quality control activities for laboratory tests are conducted.

» Quality control activities for laboratory tests are conducted under the responsibility of the laboratory specialist to ensure the reliability of the laboratory process, test if the results are appropriate for the intended purpose, and maintain control.

» The quality control method and working period, based on nationally or internationally recognized guidelines, depend on the type of test.

» Internal quality control activities for laboratory tests are carried out.

- Internal quality control processes for laboratory tests and the responsibilities related to these processes are defined.
  - For each test performed in the laboratory, the internal quality control method, control materials, usage intervals, and who will apply, evaluate, and approve them are defined.
- For internal quality control tests, control samples such as positive, negative, normal, low, or high pathological control sera are used, depending on the type of test.
- Samples used in internal quality control are treated in the same process as patient samples and processed with the same methods.
- Results of internal quality control activities and who reviewed them are recorded. The records include the date and time and the corrected test result to ensure traceability.
- In the Microbiology Laboratory, internal quality control activities are performed for manual tests (culture, serology) and equipment (microscope).
- In the Pathology Laboratory, pathological samples are evaluated periodically for processes such as section quality, tissue identification, tissue tracking, section thickness, knife marks, and staining quality by the responsible technician and recorded.
- The evaluation performed by the technician is reviewed and approved by the specialist physician.
- In the Pathology Laboratory, quality control studies of tests performed with special techniques (histochemical, immunohistochemical, FISH and molecular pathology tests) are performed, records is kept and archived.
- Training on the internal quality control process is provided to employees.

» External quality assessment activities for laboratory tests are conducted.

- The external quality control program is a comparison program conducted to evaluate, compare, and identify areas for improvement in the test results and performance of the medical laboratory.
- The external quality assessment processes for laboratory tests and the responsibilities related to these processes are defined.

- For tests performed in the laboratory, the external quality assessment method to be applied, control materials to be used, evaluation intervals within the program, and who will apply, evaluate, and approve them are defined.
- For tests included in the external quality assessment program, work is done according to the conditions required by the program, and when inappropriate results are obtained, necessary improvement actions are taken.
- The external quality assessment test sample goes through the same process as routine patient samples and is tested with the same methods.
- If evaluation results are unsuitable, necessary improvement actions are taken according to the root cause analysis of the issues.
- Results of external quality assessment activities, who evaluated them, the source of the problem (if any), and the improvement actions taken are recorded.
- The laboratory participates in external quality control programs for tests defined by the national public authority, and the results are recorded. Participation in external quality control programs is documented.
- A medical laboratory providing services to another medical laboratory informs the receiving laboratory of the documentation and results of participation in external quality control programs for tests determined by the national public authority.
  - In case of service procurement, documents are kept. (See: Management and Organization)

» Test methods to be validated and verified and the processes related to implementation are defined.

- Method validation and verification is a set of activities carried out to determine the conditions under which the test methods applied in the laboratory provide the desired performance during routine use, test if they provide results suitable for the intended purpose, and keep them under control.
- Method validation and verification activities follow national and international guidelines and protocols.
- In cases where standard methods and validated methods (such as CE or FDA approved) are used, full validation is not required.

» Measurement uncertainty fo r quantitative tests is evaluated.

- Measurement uncertainty is evaluated to assess the results, make decisions based on measurement results, compare measurement results, determine compliance with limit values, and demonstrate the performance of the testing laboratory.
- If the calculated measurement uncertainty analysis result is not suitable for the intended purpose, either a method change or necessary improvements to the method are applied to achieve the desired level of uncertainty.
- Measurement uncertainty data for tests are accessible when necessary.

Standard 4

LH.4
Control of post-analytical processes is essential.

LH.4.1
Arragements for the interpretation and reporting of laboratory results are established.

» Patient result reports and the information that are included in the reports contain at least the following details, taking into account national and international standards and test-specific requirements:
  - Health institution/organization/laboratory name
  - Name of the laboratory where the test was performed
  - Laboratory license or activity permit number
  - Patient's first and last name
  - Name, surname, and diploma registration number of the requesting physician
  - Date and time of the request
  - Name of the specimen and the test
  - Type of specimen (Pathology Laboratory)
  - Body part where the specimen was taken (Pathology Laboratory)
  - Preliminary diagnosis of the clinician (Pathology Laboratory)
  - Clinical information related to the patient that will assist clinical interpretation (Pathology Laboratory)
  - If available, the number written on the cassette (Pathology Laboratory)
  - Number of pieces and blocks taken from the material (Pathology Laboratory)
  - Result of the examination (Pathology Laboratory)
  - Date and time of specimen collection
  - Date and time the specimen was accepted by the laboratory
  - Unit of the result value
  - Reference range/value or decision limits
  - Date and time the result was approved

» The report format is designed in a dynamic way, where limitations related to the incoming sample and the laboratory expert's comments can be added if necessary.

» Arragements are made for the reporting of antibiotic sensitivity tests (restricted and commented antibiotic reporting) in the Microbiology Laboratory.

» Abbreviations are not used in patient result reports in the Pathology Laboratory.

» If auxiliary methods such as histochemistry, immunohistochemistry, Fluorescence In Situ Hybridization (FISH), or molecular tests were used to reach the diagnosis in the Pathology Laboratory, their results and interpretations are included in the pathology report.

» In pathology reports for patients diagnosed with cancer in the Pathology Laboratory, all clinically significant and pathological parameters that can be obtained through pathological examination are included, with respect to prognosis and treatment.

» Processes for intra-departmental and inter-departmental consultations in the Pathology Laboratory are defined to cover at least the following topics:

- Consultation request
- Transfer of the specimen in external consultations
- Reporting the consultation result

» Consultation requests and result notifications in the Pathology Laboratory are made with defined standard forms.
- Arragements are made for the evaluation of important and specific cancer cases by at least one different pathologist within the department.
- External consultation results are organized as an additional report.
- The archived material to be sent for external consultation is re-evaluated before being sent and is transmitted along with the consultation form.
- External consultation results and laboratory results are compared, and if there is a discrepancy between the two, a re-evaluation is done to investigate the reasons.

LH.4.2
Laboratory result reporting times are determined, and timely reporting of results is ensured.

» Result turnaround times are determined by the institution/organization management, considering conditions, needs, and scientific requirements.
» While determining result turnaround times, emergency tests, off-hours, weekends, and official holidays are also considered.
» In the Pathology Laboratory, for specimens other than immunohistochemistry, histochemistry, decalcification, new piece collection, and new section situations, the reporting time for 80% of the specimens should not exceed 10 days. If any of the above additional procedures occur, one day is added to the reporting time for each procedure.
» Patients and relevant staff are informed about result turnaround times.
» When a delay occurs in result turnaround time for any reason, the method of informing is determined.
» In intraoperative consultations (frozen section) in the Pathology Laboratory, the communication of results is done within the established rules and recorded immediately.
» 90% of intraoperative consultations are reported within 20 minutes after arrival at the laboratory.
» Result turnaround times is measured at regular intervals, evaluated, and necessary improvements are made.
» Arragements are made for the effective and safe communication of panic/critical values and diagnoses. (See: Patient Safety Goals)

LH.4.3
Arragements for the storage and archiving of analysis samples, excess biological material, test data, and results are established.

» Rules are determined for the storage and archiving of samples and isolates whose test processes are completed, in accordance with biosafety arragements and storage conditions.
» Excess biological materials from post-study tests are stored under suitable conditions in pre-designated areas for at least 24 hours.

- Control samples for biological materials analyzed with ethanol or toxic alcohol are stored under appropriate conditions for at least 1 year.

» Rules are defined for the storage and archiving of processed tissues, blocks, slides, and analysis samples in the Pathology Laboratory.
- An archiving area is provided for slides, blocks, and reports.
- Blocks are stored at a temperature not exceeding 25°C.
- In the Pathology Laboratory, after the report is issued, sampled tissues are preserved for at least one month, slides for at least ten years, and blocks for at least twenty years.

» In the medical laboratory, device test calibration results are preserved for at least one year, and internal and external quality control evaluation results are kept for at least five years.

» In the medical laboratory, physical reports and records are kept for at least thirty years, and electronic records are stored indefinitely with backups.

Standard 5

LH.5
The traceability of laboratory service processes is ensured.

LH.5.1
All stages of laboratory service processes are traceable.

» The sample and test are traceable in the pre-analysis, analysis, and post-analysis processes.

» The following minimum records are found in the Laboratory Information System (LIS) regarding the test process:
- Patient's first and last name
- Patient's age
- Patient's gender
- Protocol number
- Request date and time
- Name, surname, and department of the requesting physician
- Sample type
- If necessary, the body part where the sample was taken
- Date and time the sample was taken
- Date and time the sample was accepted by the laboratory and by whom
- Device or method used for the test
- If applicable, test repetition and results
- Date and time the result was approved
- Name, surname, and diploma registration number of the staff and laboratory expert who approved the result

» In the Pathology Laboratory, the sample is traceable in the pre-analysis, analysis, and post-analysis processes.
- All documents, preparations, blocks, and remaining tissue samples related to the patient are marked with a non-removable and distinct label, text, or preferably a barcode, indicating the ownership of the sample.

LH.5.2
Arragements for information management in laboratory service processes are established.

- Authorization is made regarding access to records related to laboratory service processes.
- In the laboratory, necessary infrastructure is provided for the use of hardware, computers, or electronic systems, delivering analysis reports to the physician or user, recording, storing, sending data, and ensuring access to the data again.
- Providers of Laboratory Information Systems (LIS) and clinical decision support systems to be set up in the laboratory should have active records in the relevant country's health authority registration system, if applicable.
- Systems established for data management in the medical laboratory is operated in compliance with the Personal Data Protection Law.
- The Laboratory Information System (LIS) is protected against any external access and data tampering. (See: Information Management System)
- The LIS operation and user manual is documented by the installing company.
- Updates of the LIS and its modules is carried out with the permission of the medical laboratory experts.
  - After the update, validation processes are completed before the system goes live to prevent disruption in laboratory operations.
  - Backups of older versions of the system is kept ready for use.
- All medical records, including test results, charts, and images within the IMS, are backed up and archived.
- Necessary administrative and technical measures are taken against any potential physical, magnetic, or electronic interference, tampering, or misuse targeting the records in the IMS.
  - All medical records, including test results, graphs, and images in the LIS, is backed up and archived.
  - Necessary administrative and technical measures is taken against potential physical, magnetic, electronic interventions, or abuses of records in the LIS.
- Necessary measures are taken to prevent changes to forensic case records and forensic reports after the physician following the case enters data or approves the forensic report, except for the physician handling the case, in terms of confidentiality and security.
- In case of an error in the total test process, corrections are made only by the medical laboratory expert, provided the reason is documented. Changes are recorded and log entries are kept.
- The medical laboratory supervisor or authorized individuals have access to forensic case records.
  - If forensic records or reports are requested by official authorities, the test report sent is marked as a "copy" and certified.
  - Responsibility for these reports lies with the medical laboratory unit supervisor and the responsible manager.

LH.5.3

Arragements for tests conducted through external resources are established.

» When medical laboratory services are provided through outsourcing, the following points are followed:
  - Tests worked through outsourcing are integrated with the Laboratory Information System (LIS).
  - In the result reports, the name and address of the outsourced medical laboratory, the name and surname of the physician who performed the evaluation are included, and the report is approved by the responsible medical laboratory expert.
  - The medical laboratory expert who signs the report is primarily responsible for the final results of the reports.
  - The responsibilities of both the receiving and providing medical laboratories in the outsourcing process are defined

Standard 6

LH.6

Monitoring and evaluation activities for laboratory services are conducted.

LH.6.1

Indicators for evaluating the performance of laboratory services are determined, the effectiveness of operations is monitored regularly, and continuous improvement activities are carried out.

» Indicators for measuring the effectiveness, efficiency, and safety of laboratory services are determined.
» For this purpose, the following indicators are specified:
  - Rate of Rejected Samples in Clinical Laboratory Tests
  - Rate of Incorrectly Identified Samples in Clinical Laboratory Tests
  - Rate of Lost Samples
  - Rate of Samples Collected Again
  - Contamination Rate in Blood Cultures
  - Contamination Rate in Urine Cultures
  - Number of Nonconformities in External Quality Control Studies
  - Number of Nonconformities in Internal Quality Control Studies
  - Panic Value Reporting Rate
  - Rate of Results Not Provided on Time
  - Rate of Incorrect Reporting in Clinical Laboratory Tests
» Data is analyzed within the intervals determined according to the characteristics of the indicator.
» Based on the analyses of the indicators, necessary improvement activities are planned and implemented.
» Regular training and awareness activities are conducted to develop a culture of traceability and continuous improvement

SECTION 4 HEALTH SERVICES	
Chapter 18 Radiology, Nuclear Medicine and Radiation Oncology Services (RNR)	
Code	**Standard 1**
RNR.1	Processes and rules for radiology, nuclear medicine and radiation oncology services are defined and proper functioning is ensured
Code	**Assessment Criteria**
RNR.1.1	Areas where radiology, radiation oncology and nuclear medicine services are provided are defined.
RNR.1.2	Processes and rules for radiology, nuclear medicine and radiation oncology services are documented.
RNR.1.3	Arragements are made for areas where radiology and radiation oncology services are provided.
RNR.1.4	Arragements are made for areas where nuclear medicine services are provided.
Code	**Standard 2**
RNR.2	Monitoring and evaluation studies are conducted for radiology, radiation oncology and nuclear medicine services.
Code	**Assessment Criteria**
RNR.2.1	Works on radiology, radiation oncology and nuclear medicine services are carried out within a program.
RNR.2.2	Protective measures are taken for patients and their relatives in areas where radiology, radiation oncology and nuclear medicine services are provided.
RNR.2.3	Protective measures are taken for employees in areas where radiology, radiation oncology and nuclear medicine services are provided.
Code	**Standard 3**
RNR.3	Arragements are made to ensure radiation safety.
Code	**Assessment Criteria**
RNR.3.1	Indicators for radiology, radiation oncology and nuclear medicine services are determined, the effectiveness of the work are monitored at regular intervals and continuous improvement activities are carried out.
RNR.3.2	Periodic field assessments of radiology, radiation oncology and nuclear medicine services are conducted and reports are shared with the committee and senior management.

General Information

Radiation safety in diagnostic and therapeutic procedures performed with radiation emitting and producing devices is a necessity that is ensured not only for patients exposed to dose but also for the health of personnel working in this environment and the environment. For this reason, the use of radiation in health services is managed with utmost care. Safe environments are provided for employees, patients and their relatives, and environmental protection measures are taken. Health institutions and organizations must take the necessary safety measures to protect themselves from the negative effects of radiation and manage their processes in accordance with international safety standards. This chapter is a guide for health institutions and organizations in terms of ensuring the safety of radiation elements used during the provision of health services.

Purpose

The purpose of this chapter is:

- To ensure that radioactive substances and radiation-producing devices are used safely and effectively in diagnosis and treatment services and that measures are taken to reduce radiation exposure of patients/patient relatives and employees.

Objectives

- Patient Safety
- Efficacy
- Convenience
- Healthy Work Life
- Timeliness

Standard Requirements

Standard 1

RNR.1
Processes and rules for radiology, nuclear medicine and radiation oncology services are defined and proper functioning is ensured.

RNR.1.1
Areas where radiology, radiation oncology, and nuclear medicine services are provided are defined.

» Areas where radiology, radiation oncology and nuclear medicine services are provided and where devices emitting ionizing radiation are located are up-to-date licenses (licenses, certificates, etc.) issued by authorized institutions and organizations in accordance with the country's legislation.

» Areas where radiology, radiation oncology and nuclear medicine services are provided using ionizing radiation are defined and the areas are classified according to radiation levels.

- Areas where devices containing ionizing radiation sources are located are defined as ionizing radiation areas and examples of these devices are given below:
  - Computerized tomography device
  - Mammography device
  - Tomosynthesis device
  - Bone-mineral densitometry device
  - Fixed/mobile X-ray device
  - Angiography device
  - Fixed/mobile scopy
  - Fluoroscopy
  - Extracorporeal Shock Wave Lithotripsy (ESWL)
  - Endoscopic Retrograde Cholangiopancreatography (ERCP)
- When defining the area, special situations are considered (For example; operating rooms where the scopy device is used are considered as controlled areas only when the device is in use).

RNR.1.2
Processes and policies for radiology, nuclear medicine, and radiation oncology services are documented.

» Processes and rules for radiology, nuclear medicine and radiation oncology services include the following at a minimum:

- Scope of radiology services (medical imaging and interventional radiology) and nuclear medicine services for examination and treatment Areas where radiology, radiation oncology and nuclear medicine services are provided.
- Radiation safety program
- Devices emitting ionizing radiation and areas where these devices are located.
- Diagnostic and treatment procedures using radioactive substances.
- Uninterrupted service provision in the fields of radiology, radiation oncology or

nuclear medicine
- Qualifications of employees working in radiology, radiation oncology and nuclear medicine services
- Measures to ensure the safety of the source and its safe use in areas where radioactive sources are present (such as brachytherapy, blood irradiation, nuclear medicine)
- Radiology, radiation oncology and nuclear medicine services provided through outsourcing (See Outsourcing Management)

RNR.1.3
Arragements are made for areas where radiology and radiation oncology services are provided.

» In areas where the radiation source is fixed, shielding is applied.
» In areas where the radiation source is fixed, appropriate ventilation conditions are provided.
» In areas where there is a radioactive source (such as brachytherapy, blood irradiation, nuclear medicine), necessary precautions are taken to ensure the safety of the source and its safe use.
» The doors of the imaging unit are kept closed during radiation applications.
» Warning signs are placed in radiation areas and high magnetic fields.
» Adequate ventilation conditions are provided to protect against cryogenic gases that cool the magnets in MRI devices.
» All devices and materials in high magnetic fields are suitable for the area.
» Entrance and exit to controlled areas are controlled.
» Ambient measurements are monitored in supervised areas.
» Waiting rooms are outside the controlled areas.
» Only authorized healthcare personnel and the patient/relative accompanied by this employee is allowed to enter the high magnetic field area, and the patient/relative is informed about the entrance rules.
» Arragements are made regarding the precautions to be taken in possible accidents that may endanger radiation safety.
  - Regional and institutional measures to be taken in cases of radiation-related accidents, injuries, contamination, and fallout, as well as intervention methods and intervention teams, are determined.
  - Accidents, injuries, contamination, fallout situations related to radiation and the way of intervention are recorded within the scope of occupational health and safety.
  - A decontamination process for the scattering and spillage of radioactive material during work is determined.
» In areas where portable scopy devices are used, precautions to be taken during the active use of the device is determined.
» Radiology services provided through Outsourcing are compliant with SAS (See Outsourcing Management)
» In operating rooms where scopy devices are available, a sign or description determined by the institution is used to warn employees during the active use of the device.
» Areas are arranged for the patient to rest and, if necessary, to be monitored after

an interventional or contrast imaging procedure.
» In radiation areas, radiation/radioactivity level measurements are made at certain intervals.

RNR.1.4
Arragements are made for areas where nuclear medicine services are provided.

» A separate area (SPECT, PET, SPECT/CT, Inpatient Treatment Unit) is created for each device used in nuclear medicine services, and physical arrangements are made in the areas in line with the relevant country legislation.
» A preliminary preparation room is available for patients and physical arrangements are made.
» There are single-person waiting rooms for patients receiving radionuclide treatment and a radioactive patient toilet in the rooms.
» There is a separate room with radioactive waste accumulation containers, a locked door and a warning sign for the temporary storage of radioactive solid waste before discharge.
» A waste tank system separate from the existing sewage system is available for liquid radioactive waste in inpatient treatment institutions where radionuclide treatment services are provided.
» Rooms with ionizing radiation source devices are not used for any other purpose.
» A fume hood system is available in areas where the radiation source is located, and rules are defined for the use of these areas.
» Arragements are made regarding the measures to be taken in possible accidents that may endanger radiation safety.
  • Regional and institutional measures to be taken in cases of radiation-related accidents, injuries, contamination, and fallout, as well as intervention methods and intervention teams, are determined.
  • Accidents, injuries, contamination, fallout situations related to radiation and the way of intervention are recorded within the scope of occupational health and safety.
  • A decontamination process for the scattering and spillage of radioactive material during work is determined.
» The entry of radioactive material into the compartment and the radioactivity level at the time of entry is measured and recorded.
» The entry of radioactive material into the compartment and the radioactivity level at the time of entry is measured and recorded.

Standard 2

RNR.2
Monitoring and evaluation studies are conducted for radiology, radiation oncology and nuclear medicine services.

RNR. 2.1
Works on radiology, radiation oncology and nuclear medicine services are carried out within a program.

- » A "Radiation Protection Program" is established in accordance with the relevant country legislation for radiology, radiation oncology and nuclear medicine services.
- » Within the scope of the Radiation Protection Program, a structure responsible for the management of processes in the presence of at least two of the radiology, nuclear medicine and radiation oncology applications using ionizing radiation sources are established and responsibilities are defined.
  - In other cases, a radiation safety officer is designated.
  - The management structure in question must perform the following activities at a minimum:
    - Reducing risks arising from medical irradiation practices in the institution
    - Making plans for the measures to be taken
    - Making decisions to monitor radiation sources and evaluate them within the framework of patient and employee safety and monitoring the implementation of the decisions taken
    - Reporting and monitoring the nonconformities identified arising from the practices and the necessary improvement activities to the unit managers, committee and senior management
    - Making indicator monitoring
    - Evaluating the notifications received from department/unit managers

RNR.2.2
Protective measures are taken for patients and their relatives in areas where radiology, radiation oncology and nuclear medicine services are provided.

- » The patient and, if necessary, the patient's relative made to use radiation protection equipment appropriate to the nature of the procedure performed.
  - Rules for the use of radiation protection are determined for the patient and their relatives.
  - Radiation protection (radiation protection apron, thyroid protection, gonad protection, lead equivalent glasses, etc.) is available in different sizes according to the patient profile.
- » Within the scope of measures to reduce radiation exposure, only the patient who will be scanned and, if necessary, an accompanying person is allowed into the imaging room.
- » Necessary measures are taken to apply the right procedure (right medication and dose, right material, right method, etc.) to the right patient (See Patient Safety Goals)
- » Necessary measures are taken to prevent repeated X-rays, imaging protocols are

created, and relevant employees are trained on this subject.

» In areas where radiation applications are performed, arrangements are made to prevent external entry into the area during the procedure.
» Necessary arrangements are made within the scope of country legislation for patients receiving radionuclides.
» Before any nuclear medicine application, the patient and the patient's relative is informed in writing about the examination to be performed, the radiation dose that may be received, the risks and benefits, and the points to be considered.
» An informative document is prepared for the patient and the relative who uses radioactive drugs, including the points to be considered for the protection of the people in the environment and the family from radiation.
» The discharge of the patient after radionuclide treatment is made according to the amount of activity remaining after the application and the dose rate.
» When a patient receiving radionuclide, therapy is discharged; information about the patient, the radionuclide administered, the amount of activity they received and the amount of activity remaining at discharge is recorded. Arrangements are made for patients and relatives who pose a risk of radiation exposure due to their particular condition.
  • Rules to be followed for pregnant and potentially pregnant patients are determined.
    - Questions regarding pregnancy and suspected pregnancy is made separately during the request process and during the application process.
    - If medical radiation is required for pregnant women and those who may be pregnant, they are informed about the effects of the imaging on the fetus, their consent is obtained, and the procedure is carried out by taking protective measures.
  • Issues to be considered when imaging pediatric patients are determined, measures are taken to reduce exposure, and repeat imaging is minimized.
    - Necessary and adequate dose adjustments are made, considering the body weight and irradiation area of pediatric patients.
» The time the patient is actively receiving radiation is recorded.
  • Target values for exposure times are determined on a transaction basis and monitored periodically.
  • If the average time is above the target value, necessary improvement work is done.
» Before specific procedures (angiography, radiotherapy, radionuclide therapy and imaging, etc.), patients are informed about any issues that need to be taken into consideration regarding the procedure, and the healthcare professional checks whether these issues are followed.
  • In order to effectively provide information about specific radiological examinations and interventions that require preparation (angiography, ESWL, IVP, etc.), a procedure-specific informative document is created.
» Arrangements are made to ensure patient comfort and privacy at every stage of radiology, radiation oncology and nuclear medicine services.
  • There is an arrangement to protect patients' valuables.
  • A privacy-friendly room or cabin is available for patients to prepare.
  • Clean sheets, aprons, etc. are available for patients to use.

» In radiology, radiation oncology and nuclear medicine services, the patient's care needs are assessed before and after diagnostic/treatment procedures, and processes for care and treatment are defined.
» Arrangements are made to control access and reduce noise exposure in areas where MRI applications are performed.
  • Entry and exit rules for areas where MRI is performed is defined.
  • Healthcare personnel, cleaning and transportation personnel are trained regarding entry and exit rules.
  • Medical equipment (oxygen cylinder, defibrillator, monitor, stretcher) used in the MRI room and taken into the imaging room with the patient is compatible with MRI.
  • Patients, relatives and employees with devices such as pacemakers, metallic heart valves, stents and cochlear implants that are not MRI compatible, are not allowed into the imaging room.
  • There are no coins, metal devices or objects on or near the patient at the entrances to the MRI room.
  • There are arragements for areas where interventional or contrast imaging procedures are performed.
    - Healthcare personnel performing interventional or contrast imaging procedures receive training in CPR (Cardio Pulmonary Resuscitation) and allergic reactions.
    - In interventional or contrast imaging areas, an emergency intervention kit is readily available.

RNR.2.3
Protective measures are taken for employees in areas where radiology, radiation oncology and nuclear medicine services are provided.

» It is ensured that employees use radiation protection equipment.
» It is determined by which method, by whom and at what minimum dose the controls for radiation protection will be performed.
» Radiation protection controls are performed at least once a year and when necessary, and the control results are approved by a radiologist.
  • It is determined in which cases non-routine controls are performed.
» Arrangements are made for employees to use individual dosimeters.
  • Dosimeter results are monitored and shared with employees.
  • Dosimeter results are evaluated and improvement efforts are made when necessary.
  • The individual dosimeter usage requirement of employees in operating rooms where scopy is used is determined.
» Health screenings are performed for employees working in radiology, radiation oncology and nuclear medicine services. (See Healthy Work Life)
» Working conditions of employees who pose a risk of radiation exposure due to their special conditions are arranged to ensure employee safety

Standard 3

RNR.3
Arragements are made to ensure radiation safety.

RNR.3.1
Indicators for radiology, radiation oncology and nuclear medicine services are determined, the effectiveness of the work is monitored at regular intervals and continuous improvement activities are carried out.

- All stages of processes related to radiology, radiation oncology and nuclear medicine services are traceable.
- Indicators related to radiology, radiation oncology and nuclear medicine services are determined and monitored.
- Data is analyzed at intervals determined according to the characteristics of the indicator.
- As a result of the analysis made regarding the indicators, necessary improvement activities are planned and implemented.
- The results obtained are shared with the senior management and relevant employees.

RNR.3.2
Periodic field assessments of radiology, radiation oncology and nuclear medicine services are conducted and reports are shared with the committee and senior management.

SECTION 4 HEALTH SERVICES	
Chapter 19 Emergency Department Services (EDS)	
Code	**Standard 1**
EDS.1	Processes and rules related to emergency department service processes are defined, and operations align with these.
Code	**Assessment Criteria**
EDS.1.1	Emergency department service delivery areas are defined.
EDS.1.2	Processes and rules for emergency depart-ment services are documented.
EDS.1.3	If an emergency department is not availab-le, processes for providing emergency he-alth services are defined.
EDS.1.4	Necessary training for staff related to emer-gency department service processes is pro-vided.
Code	**Standard 2**
EDS.2	Arrangements are made for the areas where emergency services are provided.
Code	**Assessment Criteria**
EDS.2.1	Arrangements that facilitate access to the emergency department are made.
EDS.2.2	Arrangements for reception, consultation, guidance, and registration services are ma-de.
EDS.2.3	Arrangements specific to the operation of areas designated for providing emergency department services are made.
EDS.2.4	Access to service delivery areas related to the emergency department is facilitated.
EDS.2.5	Arrangements for expanding the emergency department in cases such as disasters, epi-demics, or major accidents are made.
EDS.2.6	Arrangements for medications, supplies, and devices required in the emergency depart-ment are made.
EDS.2.7	Arrangements to ensure safety in the emer-gency department are made.

Code	Standard 3
EDS.3	Arrangements related to patient care in the emergency department are made.
Code	**Assessment Criteria**
EDS.3.1	Arrangements for prioritizing patients (triage) applying to the emergency department are ma-de.
EDS.3.2	Arrangements for examination, intervention, treatment, consultation, and observation pro-cesses in the emergency department are made.
EDS.3.3	Algorithms for the diagnosis, treatment, and follow-up of critical patient groups served in the emergency department are created.
EDS.3.4	Safe patient transfer is ensured in all service processes in the emergency department.
EDS.3.5	Arrangements related to patient admission, transfer, and discharge from the emergency department are made.
EDS.3.6	Arrangements are made to ensure effective communication in emergency service proces-ses.
Code	**Standard 4**
EDS.4	The traceability of processes related to emergency services is ensured, and monitoring and evaluation studies are conducted.
Code	**Assessment Criteria**
EDS.4.1	All stages of emergency service processes are traceable, performance indicators are determined for performance evaluation, and continuous improvement activities are carried out.

Chapter 19: Emergency Department Services (EDS)

General Information

Emergency services include medical services provided in the emergency department for the intervention or treatment required to protect patients from disability or death in cases of sudden illness, accident, injury, etc. Emergency services have to meet the increasing demands in sudden health shocks and disasters such as epidemics and disasters where extraordinary situations develop as well as situations that occur in the ordinary process. Emergency services have sufficient physical infrastructure, qualified human resources, materials and devices in order to provide quality service in order to ensure patient and employee safety in ordinary and extraordinary processes. The standards in this chapter provide guidance for the provision of emergency services in ordinary and extraordinary processes.

Purpose

The purpose of this chapter:

- To ensure that emergency services are provided in a suitable area
- To ensure patient and employee safety in all processes from patient admission to discharge in the emergency department
- To evaluate the effectiveness of the services provided in the emergency department and to ensure continuous improvement

Objectives

- Efficacy
- Patient Safety
- Effectiveness
- Healthy Work Life

Standard Requirements

Standard 1

ASH.1
Processes and rules related to emergency department service processes are defined, and operations align with these.

ASH.1.1
Emergency department service delivery areas are defined.

- » Areas for providing emergency department services are defined in compliance with relevant national arragements.
- » General areas for intervention and treatment based on patients clinical conditions are determined within the emergency department.
- » At a minimum, the following areas are present:
  - A reception area planned according to the volume of applications
  - Waiting areas
  - Decontamination area
  - Examination areas
  - Intervention areas
  - Resuscitation area
  - Observation areas
- » Additional areas for emergency interventions related to specific patient groups, such as gynecology, ENT, ophthalmology, psychiatry, orthopedics, or other special needs, are defined based on the patient profile served in the emergency department.
- » Personal hygiene areas, dressing rooms, and rest areas are allocated for staff.

ASH.1.2
Processes and rules for emergency department services are documented.

- » Emergency department service processes cover all stages from patient admission to discharge.
- » At a minimum, they include:
  - Structural arrangements of the emergency department
  - Patient admission to the emergency department
  - Triage
  - Examination, intervention, diagnosis, and consultation processes
  - Observation process
  - Medication management
  - Material and device management
  - Admission, referral, and discharge processes
  - Information sharing with patients and their relatives
  - Management of poisoning cases
  - Management of forensic cases
  - Coordination processes with other institutions and organizations within emergency health services
  - Risk management in the emergency department

    - Disaster and emergency management
- » Chemical, Biological, Radiological, and Nuclear (CBRN) precautions and approaches for exposed patients
- » Critical patient groups are determined based on the institution's characteristics, and diagnostic and treatment algorithms are prepared for these groups.
- » Responsibilities related to emergency department processes are assigned, and duties, authorities, and responsibilities are defined.

ASH.1.3
Necessary training for staff related to emergency department service processes is provided.

- » If no emergency department exists, processes for providing emergency health services are defined according to the type and scope of services provided.
- » These processes include initial evaluations, application of initial treatments, and referral processes in emergencies.
    - Protocols for providing emergency health services are created for healthcare institutions without an emergency department.
    - These protocols comply with national and international emergency health service standards and are prepared in a manner that is easily understood and accessible to employees.
- » Initial evaluations align with triage principles, and staff have the necessary training to effectively conduct this process.
    - Initial treatments are administered promptly according to emergency protocols, and staff receive training in basic and advanced life support and regularly practice these skills.
    - Referral processes are conducted safely and quickly, ensuring the complete transfer of the patient's medical information.
    - These treatments follow emergency protocols.
    - Employees receive training in basic and advanced life support and regularly practice these skills.
- » Patients who are stabilized or require more advanced treatment are referred to an appropriate healthcare institution.
    - The referral process ensures safety and speed, with the complete transfer of the patient's medical information.
    - Collaboration and coordination with other healthcare institutions, ambulance services, and emergency management units ensure the effective delivery of emergency health services.
- » Employees providing emergency health services regularly receive training on emergency management, initial treatment, and referral processes. Awareness is raised about appropriate actions during emergencies, and drill scenarios are organized if necessary.
    - Training programs are repeated periodically, and updated protocols are shared with employees.
- » All equipment and medications necessary for effective emergency health service delivery are regularly checked, updated, and maintained in full availability.
    - Emergency kits, defibrillators, oxygen cylinders, and other required equipment are always kept ready and undergo regular maintenance.

» Emergency plans are integrated with those of other institutions, and joint drills are conducted.

ASH.1.4
Necessary training for staff related to emergency department service processes is provided.

» Training plans for emergency department employees include topics such as basic life support, advanced life support, triage, emergency intervention protocols, medication management, material and device management, communication, empathy, and crisis management.
  • Training incorporates both theoretical and practical applications and is prepared based on evidence-based guidelines.
  • Expert trainers contribute to these training programs.
» The effectiveness of training is regularly evaluated, and feedback is used for improvements.
  • Employee participation and success in training are recorded, and periodic refresher training sessions are planned.
» Training materials are based on current scientific resources and are supported with visual and interactive content.
  • Training materials are also accessible through online platforms.
  • Training effectiveness is enhanced using training videos, simulation software, and interactive e-learning modules.

Standard 2

ASH.2
Arrangements are made for the areas where emergency services are provided.

ASH.2.1
Arrangements that facilitate access to the emergency department are made.

» Signs and signposts facilitating access to the emergency service are present around and inside the institution/organization, and these signs are visible and helpful for guidance.
  • The placement of signs and signposts is at strategic points, and the size and color contrast of the signs are considered to make them prominent.
» Directions are present starting from outside the campus, including main roads, intersections, and road forks, all the way to the emergency service entrance.
  • Direction signs and signposts are suitable for night vision.
» Access to the emergency service from other units and buildings within the institution/organization is facilitated.
» The size and lighting of the emergency service entrance sign are easily visible from outside the institution/organization.
» Ambulance entrances are arranged to allow ambulances to quickly and safely transfer patients.
  • Ambulance entrances are wide enough for vehicles to easily approach and maneuver.

» Emergency service entrances are covered to prevent adverse weather conditions.
» They provide protection from adverse conditions such as rain, snow, and excessive sunlight.
» They are made of durable and long-lasting materials.
» Adequate parking space is allocated according to the capacity and density of the emergency service.
  • Parking areas are illuminated.
  • The safety of parking areas is ensured both day and night.
  • Parking spaces reserved for patients with special needs are available

ASH.2.2
Arrangements for reception, consultation, guidance, and registration services are made.

» Reception, consultation, and guidance services are planned and provided according to the structure and capacity of the emergency service.
» Staff planning for reception, consultation, guidance, and registration services considers factors such as the structure of the emergency service, average case status, etc.
» A team capable of effectively providing reception services is formed.
  • The team consists of experienced staff in the emergency service area, with high communication skills and the ability to work effectively under stress.
  • The team includes staff familiar with different languages and cultures, and good coordination is ensured among team members.
  • Arrangements are made to provide staff who know foreign languages and sign language when necessary.
» Reception staff is located in a suitable area close to the emergency service entrance, and the first person to see the patient is the reception staff.
» Reception, consultation, and guidance services are provided 24/7 without interruption.
» Staff working in reception, consultation, guidance, and registration services receive regular training on patient rights, patient satisfaction, and communication skills.
  • Training aims to keep staff knowledge and skills continuously updated.
  • Training includes simulations and practical applications.
» Rules are determined regarding the registration of patients admitted to the emergency service in the HIS.
» Procedures are determined for the admission of patients whose identity information cannot be accessed.
» Arrangements are made for the effective execution of patient registration procedures in disasters and emergencies.

ASH.2.3
Arrangements specific to the operation of areas designated for providing emergency department services are made.

» Emergency service delivery areas are arranged considering safety, observability, simplicity, flexible modular structure, privacy, and confidentiality principles.
» Service areas are designed using modular structures that can be easily rearranged when necessary.

- » Equipment and materials used in service delivery are always accessible and in working condition.
- » Adequate waiting areas for patient relatives are available according to the capacity of the emergency service, and these areas provide comfort in terms of climate control, ventilation, and lighting.
  - Waiting areas offer comfortable seating arrangements, beverage vending machines, information screens, and free internet access.
- » Arrangements are made to facilitate access for individuals with special needs.
- » Ergonomic and comfortable resting areas for staff are created, and facilities such as personal hygiene areas, kitchen facilities, and quiet working corners are available

ASH.2.4

Access to service delivery areas related to the emergency department is facilitated.

- » Transition connections are available to provide easy access from the emergency service to all other relevant areas.
  - Transitions accelerate patient and staff mobility and increase the effectiveness of emergency services.
  - Direct and short-distance transition routes are planned between the emergency service and critical areas such as intensive care, operating rooms, radiology, and laboratory, and clear and distinct direction signs are used.
  - Signs are prepared using national/international standard symbols and color codes and supported by digital screens when necessary.
- » Access to departments where patient transfers are more frequent is planned with patient safety and comfort in mind, and transfer routes are wide and barrier-free to allow stretcher passage.
- » Light, ergonomic, and easy-to-use transfer equipment (stretchers, wheelchairs, and other transport equipment) is preferred for patient transfers.
- » Special arrangements are made to prioritize the use of elevators in emergencies.

ASH.2.5

Arrangements for expanding the emergency department in cases such as disasters, epidemics, or major accidents are made.

- » An emergency action plan is prepared to quickly and effectively increase the capacity of the emergency service in cases of disasters, epidemics, major accidents, etc.
  - The emergency action plan includes additional areas that can be used, additional materials and equipment procurement, staff assignments, and logistical arrangements.
  - Structures such as temporary tents, prefabricated buildings, or quickly assemblable modular units are quickly deployable when necessary.
- » Necessary equipment and materials such as intensive care beds, ventilators, and portable monitors are planned and procured in advance within the scope of the emergency action plan.
  - Equipment and materials are kept ready at the points specified in the emergency action plan and checked at regular intervals.
- » Coordination and cooperation with other health institutions/organizations, local

governments, and emergency response teams are ensured in emergencies.
» Joint studies are conducted with other institutions/organizations in emergency scenarios and drills, and communication protocols are clarified.
» The emergency action plan is shared with relevant staff, and they are informed about it.
» Regular training and drills are conducted to increase staff knowledge levels and ensure the effective implementation of the plan

ASH.2.6
Arrangements for medications, supplies, and devices required in the emergency department are made. (See Medication Management - Material and Device Management)

» Medications, materials, and devices required in the emergency service are determined and kept in relevant areas.
» Medications, materials, and devices required in the emergency service are determined according to the service class, intervention, and treatment processes.
» The list of medications, materials, and devices is created by emergency service staff and regularly updated.
» The continuity of medications, materials, and devices is ensured, and they are kept ready for use.
» Lists of medications to be kept in emergency service areas and emergency medication carts are prepared, and periodic quantity and expiration date tracking is conducted and recorded.
» A layout plan for existing equipment in the emergency service is available, and the layout plan is prepared in accordance with the arrangement of the emergency service area and designed to facilitate quick access for staff.
» An inventory of all devices is available, and periodic maintenance and calibrations are planned.
» Storage areas of sufficient size to meet the needs are planned.
  • Medications, materials, and devices are safely and orderly stored in storage areas.
  • Storage areas are designed to provide appropriate conditions such as temperature and humidity control and are regularly inspected.

ASH.2.7
Arrangements to ensure safety in the emergency department are made.

» A risk assessment is conducted to ensure safety in emergency services, and necessary measures are taken within a plan.
  • Emergency action plans and risk management plans are prepared, regularly reviewed, updated, and communicated to all staff.
  • Comprehensive analyses regarding life and property safety are included in risk analyses, and security personnel and emergency staff are trained accordingly.
  • Training is repeated at regular intervals, annually, and staff knowledge levels are updated.
» An adequate number of security personnel is employed according to the size of the emergency service, and the continuity of security services is ensured.
  • Security personnel are positioned at strategic points within the emergency

service area to monitor all sections and respond quickly if needed.
    - The turnover rate of emergency service security personnel is tracked, and measures are taken to keep the turnover rate low.
    - The job satisfaction and working conditions of security personnel are regularly evaluated, and motivation-enhancing measures are implemented.
- » Safety measures such as security cameras, emergency buttons, and monitoring systems are in place in the emergency service.
    - In applications such as camera placement, patient and staff privacy is respected.
    - The security and confidentiality of records are ensured, and records are quickly accessible when needed.
    - Records are stored in compliance with national data protection legislation and are backed up at regular intervals.
- » Regular meetings and feedback mechanisms are in place to gather staff opinions and suggestions, and staff are involved in decisions, solutions, and implementations.
- » Improvement activities are monitored, and management and staff actively participate in these activities. The results of these activities are regularly reported, and their effectiveness is evaluated.

Standard 3

ASH.3
Arrangements related to patient care in the emergency department are made.

ASH.3.1
Arrangements for prioritizing patients (triage) applying to the emergency department are made.

- » Patients applying to the emergency service are prioritized (triage) based on the urgency of their condition and their need for immediate treatment. Intervention and treatment priorities are determined according to this prioritization.
- » The triage system ensures that patients receive the fastest and most effective treatment.
- » A color-coding system (red, yellow, green, black) is used for the triage process.
- » A triage area is provided in accordance with the relevant country legislation, and area definitions are made.
    - Privacy is maintained in the triage area.
    - Patients are assessed in a safe and comfortable environment.
- » The treatment priorities of patients applying to the emergency service are determined by a healthcare worker trained in triage, and the patient is quickly and safely transferred to the relevant area based on the urgency of their condition and needs.
- » The management of patients whose condition changes after triage and who need to be moved between areas is defined.
- » Patients and their relatives applying to the emergency service are informed about the triage process. This information helps them understand the process and

makes the waiting period more comfortable.

» Informative posters and brochures about the triage process are available in the emergency service waiting areas, and informative videos are displayed on digital screens.

ASH.3.2

Arrangements for examination, intervention, treatment, consultation, and observation processes in the emergency department are made.

» Patients admitted to the emergency service are assessed by a physician, who takes their medical history, performs a physical examination, and determines the necessary tests and treatments.
  - During the medical history and physical examination process, the patient's medical history, current complaints, and vital signs are systematically recorded.

» Protocols are established for processes that may require medical and/or surgical intervention, and interventions are carried out in accordance with these protocols.

» A plan defining consultation processes in the emergency service is in place, and records related to consultation processes are regularly maintained.

» Patients under observation during intervention, diagnosis, or treatment procedures are monitored by healthcare staff.

» Patients under observation receive safe and effective healthcare services.
  - Observation rooms are planned to allow healthcare staff to monitor patients.
  - Patients under observation are regularly monitored, and records related to the observation process are fully maintained.
  - Each bed has bedside monitors and a bedside panel connected to the medical gas system.
  - Arrangements are in place to allow patients to easily reach healthcare staff when needed.

» Procedures are defined for the intervention and reporting process of poisoning cases.
  - Records are kept and notifications are made to the relevant authorities in accordance with the relevant country legislation.

» Procedures are defined for forensic cases in accordance with the relevant country legislation.
  - Forensic cases are handled in accordance with the defined procedures.
  - Record-keeping and reporting processes for forensic cases are defined, and coordination with relevant organizations is ensured.
  - Relevant healthcare staff receive training on forensic cases.

» A plan is established for the management of unaccompanied patients

ASH.3.3

Algorithms for the diagnosis, treatment, and follow-up of critical patient groups served in the emergency department are created.

» Critical patient groups served in the emergency service are determined based on the institution/organization and patient profile.
  - Critical patient groups include conditions that are frequently encountered in the emergency service and require rapid intervention, such as cardiac

emergencies, trauma patients, poisonings, acute respiratory failure, stroke, severe infections (sepsis), and pediatric emergencies.

» Planning is done to determine intervention and treatment priorities for critical cases, and algorithms are created to define treatment and intervention flows.
  - These algorithms aim to increase patient safety and treatment effectiveness and cover all stages from diagnosis to treatment and follow-up.
  - The procedures to be performed and the precautions to be taken at each step are clearly specified.
  - Algorithms can be designed using dynamic and adaptable systems (decision support, artificial intelligence technologies, etc.) that can be updated and adapted according to the patient's condition. These systems can provide recommendations based on the patient's changing clinical condition.
  - Algorithms are presented in digital or printed formats for easy access by healthcare staff.
  - Healthcare staff receive regular training to effectively use the algorithms, and their usage is monitored.
  - Data analytics are used to evaluate the effectiveness of the algorithms and continuously improve them. Feedback mechanisms analyze healthcare staff experiences and patient outcomes, and algorithms are updated accordingly.
» A multidisciplinary approach is adopted for the diagnosis, treatment, and follow-up of critical patient groups.
  - Experts from different specialties collaborate to manage the patient's entire treatment process.
  - Multidisciplinary team meetings are held to create joint treatment plans for critical patient groups.
» Digital patient tracking systems are used for the follow-up of critical patient groups. These systems monitor patients' treatment processes and provide automatic alerts when necessary. Patient tracking systems are integrated with mobile applications to inform healthcare staff and patient relatives.

ASH.3.4
Safe patient transfer is ensured in all service processes in the emergency department.

» Measures are taken to ensure patient safety and privacy during all stages of patient transfer, from admission to discharge in the emergency service.
» All equipment used in patient transfer processes is regularly checked for safety and maintenance, and necessary precautions are taken to prevent patients from falling, getting injured, or being exposed to other dangers during transfer.
» Patient transfers are carried out with the accompaniment of healthcare staff.
» Healthcare staff responsible for transfer processes have the necessary knowledge and skills appropriate to the patient's condition and carry all necessary medical equipment during transfer.
» Information about the patient's medical history, diagnosis, intervention, treatment, and follow-up is fully and accurately communicated to the department to which the patient is transferred.
» Operation protocols, including emergency scenarios related to patient transfer, are established. These protocols ensure that all healthcare staff use the same

methods and that patient safety is protected at every stage.
» Mobile applications and communication systems are developed for patient transfer processes.
» These systems allow healthcare staff to quickly and effectively exchange information.
» Mobile applications provide real-time information about the patient's condition and transfer details and can guide necessary medical interventions during transfer.
» Equipment used in patient transfer processes is supported by technological innovations. For example, smart stretchers and patient monitoring devices are used to continuously monitor the patient's condition during transfer.

ASH.3.5
Arrangements related to patient admission, transfer, and discharge from the emergency department are made.

» The admission of patients to the clinic is carried out in a coordinated manner according to a plan.
  • Before the patient's admission, communication is established with the clinic, and room preparations, necessary equipment, and staff arrangements are made.
  • Information about the patient and necessary medical documents are fully and accurately communicated to the department where the patient is admitted.
» Referral procedures for patients who have received initial intervention, are stabilized, and are decided to be referred to another institution are carried out according to a plan.
  • Coordination is established with the institution to which the patient is referred before referral procedures, and referrals are made by ambulance.
  • The suitability of ambulances or transport vehicles used for patient transfer is ensured.
  • Information about the patient's condition, interventions performed, and diagnosis/treatment procedures is fully and accurately communicated during patient handover.
» Discharge procedures from the emergency service are carried out according to a plan.
  • Records related to the discharge process are maintained, and information documents prepared for discharged patients are given to the patient/patient's relative.
» Procedures are prepared for patients who leave the emergency service without a physician's permission or refuse treatment, and relevant staff are informed about the procedures.
» The legal rights of patients who refuse treatment and the responsibilities of the institution are clearly defined.

ASH.3.6
Arrangements are made to ensure effective communication in emergency service processes.

» Patients and their relatives are informed about all stages of emergency services,

especially waiting times.
  - Positive communication is established with patients and their relatives using clear, understandable, and straightforward expressions.
- » Patients or their relatives are correctly informed, either verbally or in writing, about the points to be considered regarding admission, referral, and discharge procedures.
  - Information documents given to patients are clear and detailed; points to be considered during the patient's treatment process are clearly stated.
  - The information helps patients manage their home care process correctly and safely.
  - The information includes detailed instructions on post-discharge care, medication use, dietary recommendations, and what to do in case of an emergency.
- » Emergency service staff receive training to improve their communication skills.
  - Training programs include topics such as active listening, body language, communication during crises, and empathy with patients and their relatives, and staff are enabled to communicate effectively and empathetically with patients and their relatives.
  - Training is repeated at regular intervals

Standard 4

ASH.4
The traceability of processes related to emergency services is ensured, and monitoring and evaluation studies are conducted.

ASH.4.1
All stages of emergency service processes are traceable, performance indicators are determined for performance evaluation, and continuous improvement activities are carried out.

- » All processes from the application of patients to the emergency service to their discharge are traceable.
- » Traceability includes data related to the patient on the HIS and all physically maintained records.
- » Real-time data is provided to help healthcare staff make quick decisions.
- » Patient data is analyzed when necessary, and improvement activities are carried out.
- » Indicators are determined and monitored according to the service profile of the emergency service by the institution/organization.
- » Indicator results are evaluated, monitored, and continuous improvement activities are carried out.
- » Improvement activities are monitored and management and employees are actively involved in these activities. The results of these activities are regularly reported and their effectiveness evaluated.

SECTION 4 HEALTH SERVICES	
Chapter 20 Health Services Requiring Specialized Planning (RPS)	
Code	**Standard 1**
RPS.1	Processes and rules for health services that require specialized planning are defined and appropriate functioning is carried out accordingly.
Code	**Assessment Criteria**
RPS.1.1	Patient groups and service areas requiring specia-lized planning are identified and relevant service processes and rules are documented.
RPS.1.2	Arrangements are carried out for service delivery processes specific to patient groups and service areas that require special planning.
RPS.1.3	Special planning is required for patient groups and service areas, and appropriate physical environ-ment conditions, materials, devices, and equipment are provided.

General Information

The planning, delivery, and management of health services requiring special planning are of particular importance. Patient groups requiring special planning demand individual and holistic approaches beyond standard treatment protocols. These patient groups stand out in the healthcare system due to their high risk, complex treatment processes, and resource requirements, necessitating careful monitoring, comprehensive evaluation, and specialized treatment plans. Developing appropriate strategies for these groups not only improves individuals' health outcomes but also supports the sustainability of the healthcare system. Therefore, prioritizing the needs of these groups is key to providing quality and equitable healthcare services. This chapter serves as guidance for institutions in the delivery of health services requiring special planning.

Purpose

The purpose of this chapter:

- To ensure the planning, organization, execution, and provision of an effective service delivery environment for special planning-required health services.

Objectives

- Patient Safety
- Efficacy
- Convenience
- Timeliness
- Fairness

Standard Requirements

Standard 1

RPS.1
Processes and rules for health services that require specialized planning are defined and appropriate functioning is carried out accordingly.

RPS.1.1
Patient groups and service areas requiring specialized planning are identified and relevant service processes and rules are documented.

» Specific patient groups and service areas are determined according to the service scope of the institution/organization.
» Although not limited to the patient groups and service areas below, examples of special patient groups and service areas are given below for guidance.
  • Pediatric Intensive Care Unit (PICU)
  • Geriatric patients
  • Pediatric patients
  • Neonates
  • Palliative care patients
  • Immunosuppressed patients
  • Patients in labor
  • Psychiatric patients
  • Patients with a history of neglect/abuse
  • Forensic patients and incarcerated patients
  • Patients undergoing chemotherapy and/or radiotherapy
  • Patients with burns
  • Patients in the terminal stage of illness
» Processes and rules for patient groups and service areas requiring specialized planning include at least the following topics:
» Identification of responsibilities and accountable staff
» Determination of the qualifications and number of staff involved in service delivery
» Planning of service processes
» Keeping records of implementations
» Monitoring and evaluation of service quality
» Quality improvement efforts

RPS.1.2
Arrangements are carried out for service delivery processes specific to patient groups and service areas that require special planning.

» Customized services are planned for special patient groups and service areas that require special planning.
» The treatment and care of special patient groups comply with the relevant national arragements and include professional standards and evidence-based practices (such as clinical guidelines).
» The assessment, care, treatment, and follow-up of special patient groups are

planned, implemented, and documented according to patient needs.
- The treatment and care practices for special patient groups are carried out with a multidisciplinary approach.
- Treatment and care plans, along with medical practices, are reviewed in periodic meetings to ensure alignment with treatment protocols.
- Treatment options such as medical therapy, surgical interventions, and rehabilitation are determined, while supportive care strategies, including nutritional plans, physical activity recommendations, and lifestyle modifications, are established.
- Psychosocial support, counselling, and guidance services are provided.

RPS.1.3
Special planning is required for patient groups and service areas, and appropriate physical environment conditions, materials, devices, and equipment are provided.
- The physical conditions of areas where the care, treatment, and follow-up of special patient groups are provided are designed to meet their needs.
- Materials, devices, and equipment used for the care of special patient groups are suitable for patient needs.
- The physical environment conditions and necessary materials, devices, and equipment specific to special service areas comply with the relevant national arragements.
- Maintenance, repair and calibration of devices and equipment for the care of specific patient groups are performed in a timely manner

SECTION 5
Support Services

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SECTION 5 SUPPORT SERVICES	
Chapter 21 Facility Management and Hospitality Services (FMH)	
Code	**Standard 1**
FMH.1	Processes and rules regarding facility management are defined and proper functioning is ensured.
Code	**Assessment Criteria**
FMH.1.1	Processes and rules for the facility management research are documented.
FMH.1.2	A structure responsible for the planning and coordination of activities related to facility management is established.
FMH.1.3	Risks related to facility management are identified and necessary measures are taken.
FMH.1.4	Arrangements are made for the continuity and safe use of basic facility resources.
FMH.1.5	Arrangements are made to facilitate access to different service units in the facility settlement area and depart-ments within the facility.
FMH.1.6	Arrangements are made for emergency exits.
FMH.1.7	Arrangements are made for the elderly and individuals with special needs.
FMH.1.8	Arrangements are made for the safe use of lifts, escalators and belts.
FMH.1.9	Arrangements are made to prevent facility-related falls.
FMH.1.10	Exterior facade and landscaping of the building is done.
FMH.1.11	Building tours and technical site visits are made for phys-ical condition and functioning.
FMH.1.12	Necessary trainings are given to the relevant employees about the processes related to facility management.
Code	**Standard 2**
FMH.2	Arrangements are made for hotel services.

Code	Assessment Criteria
FMH.2.1	In all areas where services are provided, arrangements are made to ensure the needs, ergonomics and comfort of patients and their relatives.
FMH.2.2	Arrangements are made for patient rooms, examination rooms and waiting areas.
FMH.2.3	During the medical care process, arrangements are made for patients to have easy access to health personnel when necessary.
FMH.2.4	Arrangements are made for personal cleaning areas.
FMH.2.5	Arrangements are made for baby care and breastfeeding rooms.
FMH.2.6	Arrangements are made to ensure the safety of life and property of patients / relatives and employees.
FMH.2.7	Arrangements are made for catering services to be pro-vided to patients / relatives and employees.
FMH.2.8	Arrangements are made for laundry services.

General Information

Facility management is the process of optimising and supporting human resources and business processes through physical infrastructure in order to improve the performance of the organisation. Facility management ensures the efficient use of buildings, equipment and other physical resources to improve operational performance and the effective delivery of services. In this respect, this chapter is a guide for health institutions and organisations to manage their physical infrastructure and facilities effectively and efficiently.

Purpose

The purpose of this chapter is:

- To create the necessary infrastructure and physical conditions for continuous, safe and easily accessible service provision for patients, relatives and employees
- To ensure that patients, relatives and employees are in a safe and comfortable environment in the facility
- To ensure the safety of life and property of patients, relatives and employees
- To ensure that patients, relatives and employees receive effective and safe food service by taking into account their wishes, needs, expectations and values

Objectives

- Efficacy
- Patient Safety
- Patient Focused
- Timeliness
- Continuity
- Healthy Work Life

Standard Requirements

Standard 1

FMH.1
Processes and rules regarding facility management are defined and proper functioning is ensured.

FMH.1.1
Processes and rules for the facility management research are documented.

- » Processes for facility management include at least the following topics;
- » Administrative structure, duties, authorisations and responsibilities related to facility management
- » Processes related to the determination of the current status of the health facility (infrastructure, etc.)
- » Improvement processes
- » Security and continuity of basic plant resources and alternative resources
- » Access to facility services
- » Facility security

FMH.1.2
A structure responsible for the planning and coordination of activities related to facility management is established.

- » A managerial structure (committee, team, relevant manager for centres, etc.) is established to ensure the planning and coordination of facility management activities.
  - The competence of the people working in the managerial structure is appropriate to the capacity and scope of the organisation.
  - The duties, authorities and responsibilities of the employees within the managerial structure are defined.
- » Responsible persons for facility management are identified and their responsibilities are defined.

FMH.1.3
Risks related to facility management are identified and necessary measures are taken.

- » Risks related to facility management are identified and assessed to cover all service areas including building exterior and landscaping.
- » The current physical condition and functional service efficiency of the facility are assessed at regular intervals and when necessary.
- » Necessary improvement activities are carried out for the results of current situation determination and risk analysis.

FMH.1.4
Arrangements are made for the continuity and safe use of basic facility resources.
The scope of basic facility resources includes electricity, water, natural gas, heating, cooling, medical gas, etc.

» Arrangements for the continuity and safe use of basic facility resources are made within the plans defined by the managerial structure in accordance with the relevant country legislation and the service area of the institution/organisation.
» Uninterrupted service of basic facility resources is ensured and their capacities are determined within the scope of current legislation and requirements.
» Necessary tests and analyses for basic plant resources are carried out in certain periods, alternative resources that can be used in case of interruption, capacity and conditions of use of resources are determined.
» Maintenance and controls of electrical systems, health institution/organisation transformers, generators, uninterruptible power supplies are carried out at regular intervals and recorded.
  • Generators have approval certificates obtained from authorized institutions in line
» Arrangements are made to ensure patient and employee safety for the use of electrical sockets and sockets.
  • Electrical sockets are fixed, no moving extension cables etc. are used in the working areas, which may create a risk of falling and cause fire.
  • Sockets located low in common use areas and sockets accessible to children in units serving pediatric patients have socket protection.
» Lighting systems are of sufficient illumination power and quality that will not pose an accident risk for patients, relatives and employees.
» Arrangements are made for the safe use of water tanks.
  • The tank is made of stainless steel, chrome nickel, concrete and similar materials that will not change the properties of water, and the inner surface of the water tanks in concrete structure is covered with a suitable material.
  • The lid of the tank is locked and sealed.
  • The warehouse door are only opened and closed by warehouse attendants and authorised personnel.
  • Warehouses are away from heat sources, not exposed to direct sunlight.
  • The tanks are regularly maintained, emptied and cleaned at least once a year.
  • Water samples are taken from the tanks at least twice a year and bacteriological and chemical analyses are performed.
  • Chlorine measurements are made at least once a week in water tanks and at the end points of the water network.
» Arrangements are made for water systems used in dental units.
  • Suction hoses used in dental units are equipped with an arrangement to prevent the return of contaminated fluids back into the unit (antiretraction valves).
  • If distilled water is used in dental units, rules for cleaning distilled water tanks are defined.
  • The maintenance of the water systems used in dental units is carried out regularly and within the plan.
» Arrangements are made for the safe use of sanitary facilities.
  • In the event of an interruption in the mains water supply for any reason, the water requirement is met by activating the existing backup water resources.
  • Wastewater installation is checked at intervals and methods determined by the institution/organisation in terms of impermeability, and improvement activities

are organised for the problems identified.
- Control and proper drainage of rainwater is ensured.
- Regular checks are carried out to ensure that fire water can be used continuously and at the appropriate pressure.

» Medical gas systems are maintained and controlled, pressure (bar) values of medical gases such as oxygen, nitrogen, vacuum and air etc. are checked and recorded daily.
- Pressure changes in the medical gas system are monitored by auditory and visual warning system.
- There are backup systems to be used in case of low pressure.
- Gases are stored according to their type.
- Areas where medical gas systems are located are well ventilated with open air.
- The closed ventilation ducts of the areas where the medical gas system is located are not connected to the ventilation ducts of other departments or buildings.

» Arrangements are made for compressed gas cylinders.
- All compressed gas cylinders, including portable gas cylinders, are fixed individually or in containers.
- Compressed gas cylinders delivered to the institution / organisation by the manufacturer have a certificate.
- Compressed gas cylinders are checked for fullness and tightness.
- Gas cylinders are stored according to gas types, separated from flammable gases and oxidising agents.
- Filled and empty gas cylinders are preferably not stored in the same area Distinctive signs/labelling are used in the storage area.

» Arrangements are made for the control and maintenance of ventilation and air conditioning systems.
- Air filtration systems are monitored for the prevention of infections and necessary measures are taken.
- Maintenance and control of the central ventilation system and air conditioning systems are carried out at specified intervals, and measures are taken for the problems identified.
- For systems located in closed areas, the daily temperature of the space is monitored and recorded.
- Ventilation systems in defined specialised areas (intensive care units, negative pressure rooms, operating theatres, etc.) are connected to an uninterruptible power supply.
  - If ventilation systems in specialised areas are designed to be supplied from the generator, the use of uninterruptible power supply is not mandatory, and feeding with the generator is considered appropriate.
- Maintenance and performance tests of ventilation systems using HEPA filters are carried out at regular intervals.
- At least the following performance tests are applied to the ventilation system:
  - HEPA filter conformity (sealing test)
  - Air flow rate and air velocity measurement
  - Determination of pressure differences and air flow directions between sterile areas

        - Measurement of system efficiency (re-cleaning)
        - Particle measurement
    - The reference devices used in the performance measurement of ventilation systems comply with the relevant country legislation and international standards.
- Pressure vessels such as autoclaves, steam boilers, compressors, steam turbines, heating boilers, etc. are regularly maintained and annual inspections are carried out.
    - Pressure vessels are checked before the first use and at each change of location, and a document showing that they are installed correctly and operate safely is issued.
    - Periodic controls of pressure vessels are carried out.
    - Checks are repeated in cases such as changes in the way pressure vessels operate, accidents, natural events or prolonged non-use of the equipment.
    - Personnel in charge of using the equipment are given training on the risks that may arise from the use of this equipment and ways of protection.
- Backup systems are installed against critical failure situations that may occur in basic plant resources. The managerial structure determines the risk areas to be covered by these systems.
- Personnel using the equipment in the main plant resources are trained on the risks and protection methods that may arise from the use of the equipment.
- The building is secured against dangerous elements (hose, lightning strike, fire, flood, etc.) that may come from the external environment.

FMH.1.5
Arrangements are made to facilitate access to different service units in the facility settlement area and departments within the facility.

- The necessary physical and functional arrangements for easy access to different service units in the facility settlement area and to the departments within the facility are made in accordance with the relevant country legislation, covering at least the following issues.
    - Direction signs and services
        - There are adequate and up-to-date direction signs in the entire campus and building, including polyclinic, building and floor entrances and the health facility garden.
        - Direction signs are readable and functional.
        - How and in what form referral services will be provided is planned and implemented in advance.
    - Waiting areas used by patients and their relatives
    - Comfort and safety of patient rooms
    - Air conditioning of common areas (polyclinics, clinics, waiting areas, etc.)
    - Exit ramps, stairs, elevators, toilets, bathrooms, parking areas, etc. throughout the facility for priority patients and people with special needs, the elderly, and those who need assistance due to their illness.
    - Environmental arrangements (parking lot, landscaping, etc.)
- General sketches showing main service units are located at building entrances.
- At floor entrances or elevator exits, there are floor sketches showing the location,

emergency exit doors and fire extinguishers/stations.

» The facility has a layout plan positioned close to the entrance gates to the residential area.
» Signs and directional signs are placed on the streets and avenues around the health facility to facilitate access to the facility.
» There are directional signs indicating the location of the emergency room at the entrance of the health facility.

FMH.1.6
Arrangements are made for emergency exits.

» Arrangements for emergency exits are made within the scope of the relevant country legislation.
» There are emergency exit signs.
  • Emergency exit signs are capable of being seen in the dark.
  • Signs are placed in a way that they can reach exits from every point of the institution/organization.
  • Other signs and boards are not obstructing the view of exit signs.
  • Employees are trained on the functional use of signs and plaques.
  • Arragements are made for emergency exits.
  • Emergency exits are shown on facility plans.
  • There are no obstacles in emergency exits.
  • Emergency exit doors have panic bars on the inside.
  • Emergency exit stairs are equipped with emergency lighting lamps that are activated in the event of a power outage.
  • Emergency exits are suitable for patient transfer by stretcher.
  • There are vehicles such as stretchers that can transfer patients from emergency exit stairs.

FMH.1.7
Arragements are made for the elderly and individuals with special needs. Patient Experience.

» Elderly and special needs individuals;
  • They are provided with priority service in examination, diagnosis and treatment procedures.
  • Support is provided to individuals who need assistance in reaching health service areas.
  • Facilitating arrangements are made for transportation to departments within the facility.
    ▪ Exit ramps, grab bars, elevators, braille alphabet, voice warning systems, wheelchairs, auxiliary personnel, etc.
    ▪ Functional arrangements for visually impaired patients to find directions and ensure their transportation within the facility
    ▪ Priority patient signs during examination
  • Considering the number of patients in the relevant departments, there is a sufficient number of stretchers and wheelchairs of appropriate quality.
  • Arrangements are made for them to be able to sit in polyclinic areas with priority.

- Parking areas, sinks, toilets, rooms and bathrooms are arranged for the use of individuals with special needs.
- In case of emergency, planning is made for their evacuation from the health facility.

FMH.1.8
Arrangements are made for the safe use of lifts, escalators and belts.

» Elevators, moving staircases and lines are registered by authorized institutions.
» An inventory list of elevators (including dumbwaiter elevators), escalators and walking walkways are created.
» Elevator (including elevators) escalators and bands is numbered.
» Maintenance, repair and periodic checks of elevators, escalators and moving staircases are carried out within the scope of the relevant country legislation.
- According to the conformity control that is carried out at least once a year by the Type A inspection body, there is an up-to-date periodic control (conformity certificate) document.
- Periodic inspections of elevators are carried out at least once a year by authorized institutions or organizations.
- Periodic control results are evaluated in four groups: perfect (green color), slightly defective (blue), defective (yellow color) and unsafe (red color).
- Coloured information labels are attached to visible parts of elevator cabins.
- The use of an elevator that is determined not to be safe as a result of follow-up inspection is allowed.
- The elevator identification number, label color scale and inspection date in the inspection report are compatible with the information on the label.
- Intermediate maintenance of elevators are done.
- Elevators has a working help call system.

FMH.1.9
Arrangements are made to prevent facility-related falls.

» In order to prevent falls for patients, relatives and employees, facility-related risks are determined, and precautions are taken on a departmental and area basis according to the identified risks. See. Patient Safety Goals
» All incidents of falls and near-misses falls are reported to the adverse event reporting system.
» Corrective and remedial actions are taken regarding the actual and near-miss fall incidents.

FMH.1.10
Exterior facade and landscaping of the building is done.

» The following minimum precautions are taken for the building exterior and landscaping.
- The exterior of the facility is constructed in a way that does not endanger the life and property of patients, relatives and employees, and precautions are taken against the identified risks.
- The exterior of the building is well-maintained.
- There is an arrangement that ensures controlled vehicle entry and exit.

- There is parking place for employees and patients/patient relatives.
- Vehicle parking areas are designated with lines.
- The facility layout and its surroundings are appropriately illuminated.
- For waste generated in the facility settlement area, waste bins are provided in appropriate locations and in appropriate numbers, depending on the type of waste.
- Green areas are arranged around the facility and well-maintained sitting areas are provided.

FMH.1.11
Building tours and technical site visits are made for physical condition and functioning.

» A team is formed for building tours and technical site visits.
- The team is formed considering the size of the institution/organization and the diversity of services.
- The team is including relevant employees such as an occupational health and safety specialist, a biomedical field specialist, a hotel services manager, etc.
- There are at least one person from senior management on the team.
- Building tours and technical site visits are conducted at least quarterly and as needed.
- Records of building tours and technical site visits are kept, and an action plan is prepared for activities targeting identified non-conformances or areas open to improvement and submitted to the administrative structure for facility management.
  - Decisions taken by the administrative structure within the scope of the action plan is reported to the senior management.
  - Corrective and remedial actions are initiated for the nonconformities detected, and all evaluations and adjustments made is traceable.
  - Processes for job tracking control is defined.

FMH.1.12
Necessary trainings are given to the relevant employees about the processes related to facility management.

» Necessary training is provided to relevant employees regarding the processes related to facility management, considering occupational groups and occupational health and safety legislation.

Standard 2

FMH.2
Arrangements are made for hotel services.

FMH.2.1
In all areas where services are provided, arrangements are made to ensure the needs, ergonomics and comfort of patients and their relatives.

» Ventilation, air conditioning and lighting conditions in all areas where services are provided is complied with current national and international standards.

- » Noise control is provided in service delivery areas.
- » Service delivery areas are waiting areas where patients can sit and rest when needed.
- » Mandatory areas of use such as stairs, elevators, toilets, bathrooms, parking areas are arranged in such a way as to consider the needs of patients and relatives of patients (for example, the elderly, children, individuals with special needs).
- » There are no elements that threaten patient safety in service delivery areas.
- » There are arrangements for baby care and breastfeeding rooms in polyclinic areas.
- » Before and after procedures such as endoscopy, chemotherapy, radiotherapy, etc. arrangements are made for the patient to wait, rest, or meet their needs such as toilet, bath, etc.

FMH.2.2

Arrangements are made for patient rooms, examination rooms and waiting areas.

- » Patient rooms are arranged to ensure the comfort of patients and their relatives and should have the necessary equipment accordingly.
  - Appropriate ventilation and lighting conditions are provided in patient rooms.
  - Necessary personal furniture are provided in patient rooms.
  - Sink, bathroom and toilet areas are available in patient rooms and necessary and sufficient materials for personal hygiene is available in these areas.
  - Patient beds are positionable.
  - Patient beds are at appropriate size for adult and child patients and they have high quality that ensures patient safety.
  - Patient rooms have armchairs/sofas/beds that can be positioned so that companions can rest.
- » There is a bedside panel connected to the medical gas system at the head of each patient bed.
  - Bedside panel checks are performed at regular intervals and recorded.
- » Examination rooms are equipped with medical service processes such as examination tables, examination tools and equipment appropriate to the relevant branch, etc.
- » Examination rooms are clean and have appropriate ventilation, air conditioning and lighting conditions.
- » The doctor's name, surname, field of expertise (if any) and title are displayed at the entrance to the examination rooms.
- » Arrangements are made to ensure hygiene conditions in examination rooms.
  - Personal cleaning supplies such as a sink, liquid/foam soap, paper towels and alcohol-based hand antiseptics are available.
  - The examination table cover is disposable.
- » Necessary personal protective equipment is available in examination rooms.
- » Examination rooms have arrangements to ensure patient privacy.
- » Patients are admitted to examination rooms in order, according to a set system.
- » Waiting areas have seating areas of appropriate quality and quantity, depending on patient potential.
- » Waiting areas are clean.
- » Appropriate ventilation and lighting conditions is provided in the waiting areas.

FMH.2.3
During the medical care process, arrangements are made for patients to have easy access to health personnel when necessary.

» In areas where patients receive inpatient healthcare services during the medical care process, there is a nurse call system connected to the bedside.
» All bathrooms and toilets used by inpatients have a nurse call system/be accessible and the patient and/or patient's relatives are trained on its use.
» Regular maintenance and checks of the nurse call system is performed.

FMH.2.4
Arrangements are made for personal cleaning areas.

» The doors of personal hygiene areas such as bathrooms, toilets and sinks throughout the facility are designed to be easily accessible in case of emergency.
» Personal cleaning areas are equipped with a system such as emergency call/ alarm etc. to provide access in case of emergency.
» Cleaning of personal hygiene areas are done according to a plan, in accordance with the nature of the area.
» Cleaning materials are kept in personal hygiene areas.
  • In personal cleaning areas, liquid or foam soap, paper towels, toilet paper and bagged trash cans are provided.
  • It is ensured that the materials used for personal cleaning comply with hygiene conditions.

FMH.2.5
Arrangements are made for baby care and breastfeeding rooms.

» In baby care and breastfeeding rooms;
  • Materials and furniture without sharp edges are used.
  • No toys are kept.
  • The baby changing area has railings and it is clean.
  • There is a sink, soap and paper towels.
  • Air conditioning is provided.
  • There are posters and brochures that encourage breastfeeding and explain proper breastfeeding

FMH.2.6
Arrangements are made to ensure the safety of life and property of patients / relatives and employees.

» There is a defined plan for the uninterrupted maintenance of protection, surveillance, inspection and control services against all kinds of threats, dangers and destruction such as sabotage, theft, looting and assault against the facility.
» Risk analyses covering all areas and sections of the facility are conducted to ensure the safety of life and property, and necessary improvement work are carried out as a result of the analyses.
  • The notification process for incidents that threaten life and property safety are defined.
» There are security guards and security equipment such as security cameras and alarm systems in designated areas of the facility.

- 24-hour security service is provided.
- The working areas, working hours and job descriptions of security guards are determined within a plan.
- The general usage areas of the facility is monitored with security cameras, and a camera tracking system are installed for this purpose.
  - The rules regarding how, by whom, where, and under what conditions camera monitoring will be conducted, as well as the keeping and storage of records are defined.
  - For example, issues such as whether video recording is sufficient in the areas of use or whether audio recording is necessary is determined.
  - The field of view of the camera monitoring system covers areas other than the areas where the patient is examined and treated, considering patient and employee privacy.
  - Camera recordings are accessible only to those identified by senior management.
  - The retention periods of camera recordings are determined in accordance with the relevant country legislation.
  - Cameras are positioned to see all areas of the facility; there are no blind spots that is allowed to cause security gaps. The process for received patient relics and lost and found items are defined

FMH.2.7
Arrangements are made for catering services to be provided to patients / relatives and employees.

» At a minimum, the following arrangements are made in areas where kitchen services are provided.
- All sections in the kitchen service area, such as storage, food preparation, dish washing areas, etc. are arranged in separate areas and in accordance with the work flow to prevent cross-contamination.
- The ceiling, floor and walls of all areas where kitchen services are provided are suitable for washing and disinfection.
- The floor is made of material that prevents slipping and falling.
- Cold storage facilities have the ability to be opened from the inside or must have a warning system that can notify the outside from the inside.
- The suitability of storage conditions is traceable.
- Arrangements are made for air conditioning in the kitchen.
- Arrangements are made to prevent kitchen odors from mixing with facility service areas.
- Arrangements are made to protect kitchen areas from animals and pests.
- Kitchen waste is disposed of in a hygienic and environmentally friendly manner in accordance with the relevant country legislation.
- A food preparation area is designated in relevant clinics for infant and child patients.

» Rules for the safe supply of food is determined to cover at least the following:
- Qualities to be sought according to food types
- Quality control criteria
- Supplier acceptance and evaluation criteria

- Minimum documents and requirements for the transportation and delivery of food

» Storage conditions (such as temperature, storage time, packaging conditions (if any), placement rules on shelves and cabinets) are defined according to food types.
- Level placement are done in food warehouses.
- Materials other than food are kept in food warehouses.
- Products in the warehouse are placed separately in food groups to prevent contact with the floor and walls.
- When storing produced and purchased foods, recommended consumption dates are followed effectively.

» Production and expiry dates of raw, semi-cooked and cooked products are recorded.

» Products in the warehouse are placed separately in food groups to prevent contact with the floor and walls.

» In food storage, expiration dates are tracked effectively.

» Arragements are made for the preparation of food.
- Food preparation areas is separated from other areas (food storage areas, areas where dirty materials are washed, etc.).
- Foods are prepared hygienically in food-friendly and clean areas.
- Rules regarding food hygiene are defined, and processes such as washing vegetables and fruits are implemented in line with these rules.
- Garbage areas are located away from food preparation areas.
- Necessary environmental conditions are provided to ensure effective personal hygiene of kitchen staff.
- Consumables, utensils and equipment used in food preparation are properly cleaned or disinfected.
- Materials that come into contact with food are sanitary properties.
  - The counters where food is chopped is separate for meat, fish and vegetables, and the cutting boards on which these foods are chopped is separate.
  - All kitchen tools and equipment used in the preparation and distribution of meals is cleaned and disinfected.
- All workers wear appropriate protective equipment such as masks, caps, gloves and foot wear.
- Meals are prepared in line with the patients care needs and nutritional treatments, considering their cultural and spiritual values.
- Employees with special dietary needs for treatment purposes are identified and provided with food services appropriate to their diet.
- In order to perform the necessary analyses in cases of possible food poisoning, reference samples are taken from the prepared foods, a sufficient number of samples are taken for analysis from each type of food prepared, and each sample is stored under appropriate conditions for 72 hours.
- The compliance of prepared menus, standard meal recipes and weight lists with the guidelines published by the relevant country health authorities are checked.

» Foods are distributed according to their types, paying attention to the temperature, presentation and hygiene rules of the food.

- Between cooking and serving, food is kept at the appropriate temperature, covered, for an appropriate time and place.
- Processes for the transportation of foods prepared outside the institution/ organization and the rules for the operation of these processes are defined.
- Foods are transported in suitable containers in a transport vehicle suitable for the temperatures at which they will be served, so that they do not mix with each other and do not contaminate the interior of the vehicle.
- The internal temperatures of distribution vehicles are monitored and recorded.
- Food transport vehicles and other equipment and materials used in transportation and distribution are cleaned and disinfected (including the areas where they are stored).
- Procedures for cleaning and disinfection of transport vehicles and containers are recorded.
- Transport vehicles and their containers are used to transport any other substance.
- Foods are covered during transport.
- Foods are served at appropriate serving temperatures.
- Hygiene rules are observed when serving meals (serving meals with separate serving spoons, etc.).
- Personnel distributing food wears appropriate work clothes and appropriate protective equipment such as bonnets, gloves and masks.

» Health screenings of all employees working in food services are carried out periodically, and actions to be taken in case a problem that threatens food safety is detected are defined.
- A suitable area is created for the temporary storage of food waste, and dietician control are provided in the food chain processes.
- How food waste is used according to its type (composite fertilizer, animal shelters, etc.) is defined.
- The amount of food thrown away as household waste is monitored.
- Improvement work is carried out to reduce the amount of food thrown away.
- At least the following training are given to kitchen and service personnel and repeated at regular intervals:
- Hygiene training for food safety
- Content of diet meals
- Portioning of meals

FMH.2.8
Arrangements are made for laundry services.

» The processes related to the collection, transportation, separation, washing, ironing, distribution and storage of all textile products used in the facility for cleaning, as well as the regulation of the laundry environment are defined.
» Laundry items are transported with closed systems.
» In facilities that carry out transportation with containers;
- The cleaning of the containers is carried out daily.
- The vehicles used for transporting laundry are described as dirty and clean.
- Rules regarding the use of equipment are determined, and cleaning, maintenance, repair and control of the equipment are ensured.

  - In facilities that use automatic systems for transportation, the chimneys of the system is cleaned.
  - Relevant employees are given training on the use of the equipment at regular intervals.
- » Laundry has sufficient space for washing, drying, ironing and storage, and dirty and clean laundry areas are kept separate from each other.
- » Laundry floors and walls are suitable for washing and disinfection.
- » Temperature and humidity controls are performed to ensure the safety, ergonomics and comfort of employees, and appropriate ventilation, noise and lighting conditions are provided.
- » In areas where laundry is stored, appropriate conditions regarding temperature and humidity values are provided.
- » If laundry services are provided outside the institution, dirty laundry collection and clean laundry distribution areas are separated.

SECTION 5 SUPPORT SERVICES	
Chapter 22 Information Management System (IMS)	
Code	**Standard 1**
IMS.1	Processes and rules related to the information management system are defined, and operations align with these.
Code	**Assessment Criteria**
IMS.1.1	Processes and rules related to the information management system are documented.
IMS.1.2	Individuals responsible for the information management system are identified, and duties, authorities, and responsibilities are defined.
IMS.1.3	Electronic access to patients' health records is provided at national and institutional levels.
IMS.1.4	Modules within the information management system are integrated.
IMS.1.5	Operations performed on the information management system are traceable.
IMS.1.6	Arragements are established for all computers used within the information management system.
IMS.1.7	Necessary support is provided to ensure the effective-ness and continuity of the information management system.
IMS.1.8	Updated information regarding servers is recorded.
IMS.1.9	Training is provided to employees to ensure effective use of the information management system.
Code	**Standard 2**
IMS.2	Arragements are made to ensure information security.
Code	**Assessment Criteria**
IMS.2.1	Necessary measures are taken to ensure information security and protect personal data.
IMS.2.2	Risks related to the information management system are identified and analyzed.

IMS.2.3	The security of the server rooms is ensured.
IMS.2.4	Security measures are taken for access from external environments to internal areas.
IMS.2.5	Measures are taken to ensure the security of the server.
IMS.2.6	Measures are taken to ensure the security of the database.
IMS.2.7	Arragements are made for backing up the data on the information management system.
IMS.2.8	Arragements are made for error reporting and resolution processes.
IMS.2.9	The information management system and infrastructure are adapted to technological innovations and require-ments.

Chapter 22: Information Management System (IMS)

General Information

Information management systems are fundamental structures in healthcare institutions that allow access to information related to patients or employees. It is crucial that this information is accurate, complete, understandable, accessible when needed, and reliable for the safety of patients and employees. This chapter serves as a guide for healthcare institutions in ensuring the effective and secure use of information management systems and the security of information..

Purpose

The purpose of this chapter:

- To ensure that medical and personal information related to patients or employees is accurately, timely, and securely recorded, stored, and made fully accessible to authorized individuals when needed.

Objectives

- Efficacy
- Timeliness
- Patient Safety
- Continuity
- Healthy Work Life

Standard Requirements

Standard 1

IMS.1
Processes and rules related to the information management system are defined, and operations are carried out accordingly.

IMS.1.1
Processes and rules related to the information management system are documented.

» Information to be used within the information management system (IMS) is defined, and methods and rules for them are determined, considering the institution's needs and critical processes.
» The IMS policy is regulated within the framework of the relevant country's legislation.
» The IMS, for its effective and secure use, should include at least the following topics:
  • Physical and technological measures
  • Information security
  • Information privacy
  • Information continuity and procedures to be applied when the IMS is offline
  • Access to external information sources
  • Authorization (including tracking of newly hired and departing staff)
  • Remote access
  • Continuity and security of technical and support infrastructures
  • Integration with subsystems and higher systems that make up the IMS (e.g., SIMS, LIMS, PACS, telemedicine, e-health, Medula, web, and applications created by higher institutions)
  • Measures against cyberattacks and breaches
  • Backup
  • Information technology destruction method
» The IMS is structured to allow employees to access the information they need to perform their duties effectively and in a timely manner.
» When sharing information with external users, attention is given to share the requested specific data and information at the required frequency and in the specified format.

IMS.1.2
Individuals responsible for the information management system are identified, and duties, authorities, and responsibilities are defined.

» The individuals responsible for the IMS are identified, and their duties, authorities, and responsibilities are defined.
» Regular assessments are conducted by those responsible to determine the current status of information management, risks in the processes are identified, and necessary corrective and preventive actions are initiated. Those responsible ensure:

- Coordination of processes related to the IMS
- Necessary work is done regarding information security
- Current status assessment of the IMS is performed
- Risks in the processes related to the IMS are identified, and necessary corrective and preventive actions are initiated.

» Role groups related to the information management system (e.g., doctors, nurses, secretaries) and their authorities are defined.
- Employees are informed about their authority levels.
- Information and authority levels are recorded.
- Employees performing the same duties are assigned the same authority groups.
- Processes for granting and revoking authority for newly hired and departing employees are defined.

» The authorities defined for role groups and users are periodically reviewed and updated in case of job changes, departures, etc

IMS.1.3
Electronic access to patients' health records is provided at national and institutional levels.

» Integration with the national health database (e-health) from the IMS examination screens is ensured. *

» Access to patients' past medical records at the institution is provided through the IMS.

* The national or international health databases used are allowed to vary depending on the country and local legislation.

IMS.1.4
Modules within the information management system are integrated.

» In the IMS, modules determined by the institution for different service processes are created and integrated.

» Help information regarding the use of modules on the IMS is available

IMS.1.5
Operations performed on the information management system are traceable.

» All information collected in the IMS is tracked for historical reference to ensure information continuity.

» Audit trails are ensured for historical traceability.
- Correction and cancellation records performed on the IMS are traceable.
- A separate read-only database or table is available.
- In the database or tables, users who log into the system, the actions they perform, changes made to system settings, system messages, and errors are recorded by log monitoring software.
- Only individuals authorized as administrators in the information system can access these databases or tables.

IMS.1.6
Arragements are established for all computers used wit-hin the information management system.

» All computers used within the scope of the IMS are included in the domain.
» An up-to-date inventory of computer hardware and software are created. Operating system and anti-virus software on user computers are kept up to date.
» Different VLANs are created for wireless network connections to which guest users connect.

IMS.1.7
Necessary support is provided for the effectiveness and continuity of the information management system.

» A software-hardware support unit providing 24-hour uninterrupted service is available in the institution.
» The up-to-date contact information of the software-hardware support unit staff is available in the relevant department.
» Malfunctions and downtime in the information management system are recorded along with their causes.
» Necessary improvement actions are taken for identified interruptions and malfunctions in the system.
» The date and time of when errors occurred, when the notification was made, and when the error was resolved are recorded.
  • The content of the error, solution methods, and duration are traceable.

IMS.1.8
Updated information regarding servers is recorded.

» The up-to-date information about the servers in the institution includes at least the following:
  • Server name
  • Location
  • IP address
  • Type (Physical/Virtual)
  • Main function (Web, Database, Email, etc.)
  • Applications and services running on it
  • Operating system and version
  • Responsible person and contact information
  • Hardware details (brand, model)
  • Warranty status (Yes/No) - (if yes) related company and contact information

IMS.1.9
Training is provided to employees for the effective use of the information management system.

» Training for the effective use of the information management system is planned and implemented based on employees' needs.
» Employees are informed about updates related to the information management system applications

Standard 2

IMS.2
Arragements are made to ensure information security.

IMS.2.1
Necessary measures are taken to ensure information security and protect personal data.

- The minimum following matters are defined regarding information security and the protection of personal data:
  - Access and authorization control
  - Physical and environmental security management
  - Communication security
  - Information security breach management
  - Protection of personal data
- There is a confidentiality agreement for the IMS responsible individuals and users.
- Access to records containing all personal and medical information about patients and employees, whether written or electronic, is restricted through authorization, and access from external sources is controlled.
  - Within the scope of authorization, the information users can access, the time, and the method are defined.
- Measures are taken against unauthorized access to the IMS, and connected computers are monitored for unauthorized access tracking.
- Employees are provided with awareness training on information security and the protection of personal data.

IMS.2.2
Risks related to the information management system are identified and analyzed.

- Risk analysis for physical hazards, software and hardware issues, information security, information privacy, protection of personal data, and user errors is conducted every six months and updated when necessary.
- Improvement actions are initiated based on identified risks.
- Necessary measures are taken to ensure that software problems do not disrupt data integrity and cause data loss, and test reports (restore, data integrity, etc.) are kept.

IMS.2.3
The security of the server rooms is ensured.

- An independent system room is allocated for servers and network devices.
- Access to the system room is controlled.
  - A camera system is available.
  - The door of the system room is access-controlled.
  - Records of personnel entering and exiting the room are kept.
  - Entry of unauthorized personnel is prevented.
- Necessary measures are taken against water-related hazards.
  - The system room has good insulation against water.

- The room does not contain installations such as taps, radiators, or wastewater that could cause flooding.

» Necessary measures are taken against fire hazards.
- A gas-based fire suppression system (such as Halon, FM 200, CO2) is available.
- The safety of the electrical system is ensured.
- Furniture and materials that could facilitate the spread of fire are not present.
- Personal protective equipment is kept available in case gas-based fire suppression systems are activated.
- Training is provided to ensure necessary precautions for employee safety during the fire suppression process.

» There is an uninterruptible power supply specific to the system room, independent from other uninterruptible power supplies in the institution, and the power supply have the capacity to provide the necessary time to safely shut down the physical servers (at least 30 minutes). Ideal temperature (18-22 °C) and humidity levels (%45- %70) are maintained, checked regularly, and redundant air conditioners with humidity control are available.

» An alert system is in place to notify system administrators in case of unusual conditions such as fire, smoke, ambient temperature changes, or flooding.

IMS.2.4
Security measures are taken for access from the external environment to the internal environment.

» The conditions for access from the external environment to the internal environment and the individuals who can access are defined.

» All individuals who can access institutional data through physical or information systems as part of a service agreement sign a confidentiality agreement.

» A corporate confidentiality agreement is signed with all companies that can access institutional data via physical or information systems.

» Access from the external environment to the internal environment is recorded

IMS.2.5
Measures are taken to ensure the security of the database.

» Operating systems running on servers, service server software, and protection software like antivirus are required to be up-to-date.

» The software and hardware maintenance of servers is to be performed by authorized individuals within the timeframes determined by the manufacturer.

» Servers are to be located behind a firewall.

» According to the current Health Information Network (HIN) architecture, in institutions/organizations without a firewall, servers are to be placed in a separate VLAN from end users and medical devices.

IMS.2.6
Database security measures are to be taken.

» Database operations that require audit logs are to be identified, audit logs are kept, and they are available for monitoring by the institution/organization management when necessary.

- Audit logs related to system login users, actions performed, changes made to system settings, system messages, and errors are recorded by the software.
- The contact details of the responsible persons for the database are available.
- The passwords used by users to connect to the interface are stored in an encrypted form.
- Users are informed before any intervention is made to the database.
- A system is established to track changes and deletions in data in case of unauthorized or erroneous interventions from internal or external sources.

IMS.2.7
Arragements are made for backing up data on the information management system.

- Backup processes are defined to include the storage and protection of data, as well as data recovery test plans.
- Backups are performed at least 3 times a day, including one full backup and two incremental backups.
- Backup files are stored in an environment outside the server where the information management system (IMS) operates.
- Backups are performed in environments such as external storage, portable storage media, or a backup server running on the network.
- The backup media are stored in a physically separate area from the IMS's operating area, ideally in a different building.
- Data are stored offline indefinitely by the responsible institution/organization, as specified in the backup policy.
- Data recovery tests are conducted every six months and monitored by the institution/organization management.
  - Backup restoration and whether data loss occurs are checked.
  - Tests are recorded.
  - Improvement efforts are started when necessary

IMS.2.8
Arragements are made for error reporting and resolution processes.

- Software and hardware errors related to the IMS are reported, and the method for addressing errors is defined.
- The following minimum information related to reported errors is recorded:
  - The date and time when the error occurred
  - The date and time when the report was made
  - The content of the error
  - The date and time when the error was resolved
- Errors encountered, solution processes, and the time to resolve the error are recorded, and these records are available for tracking in case similar errors occur.
- Actions to ensure that work is not disrupted until the error is resolved are defined on a department basis.

IMS.2.9
The information management system and infrastructure are adapted to technological innovations and requirements.

SECTION 5 SUPPORT SERVICES	
Chapter 23 Records Control and Archive Services (RCA)	
Code	**Standard 1**
RCA.1	Processes and rules regarding the control of medical and administrative records are defined and appropriate functioning is ensured.
Code	**Assessment Criteria**
RCA.1.1	Processes and rules for the control of medical and admi-nistrative records are documented.
RCA.1.2	Responsible persons for the control of records are identi-fied and their duties, authorities and responsibilities are defined.
RCA.1.3	Arrangements are made for the preparation and use of medical and administrative records.
RCA.1.4	Rules for information privacy and security in access to records are defined.
RCA.1.5	A standard plan for the definition and content of patient files is established.
RCA.1.6	Arrangements are made for electronic records.
Code	**Standard 2**
RCA.2	Processes and rules regarding archive services are defined and proper functioning is ensured.
Code	**Assessment Criteria**
RCA.2.1	Processes and rules for archive services are documented.
RCA.2.2	Arrangements are made for the storage of patient files in the archive section.

Chapter 23: Records Control and Archive Services (RCA)

General Information

Keeping medical and administrative records created by health institutions and organizations regularly and archiving them securely is one of the cornerstones of quality and effective service delivery. These records ensure rapid access to the necessary information at every stage of patient care and administrative processes, ensure that services are carried out effectively and efficiently, support the diagnosis and treatment process, and reduce the workload of employees. Maintaining records securely protects patient privacy and strengthens transparency and accountability in service delivery. This chapter guides health institutions and organizations in the effective management of records.

Purpose

The purpose of this chapter:

- To ensure that medical and administrative records are created effectively, accurately and in a timely manner, stored securely with a systematic archiving system, and that all kinds of information and documents related to the care process can be accessed in a timely manner.

Objectives

- Patient Safety
- Efficacy
- Effectiveness

Standard Requirements

Standard 1

RCA.1
Processes and rules regarding the control of medical and administrative records are defined and appropriate functioning is ensured.

RCA.1.1
Processes and rules for the control of medical and administrative records are documented.

» Processes for the control of medical and administrative records include at least the following:
- Determination of registrations
- Collection of registrations
- Classification of records
- Use of registrations
- Access to records
- Maintaining records
- Ensuring the continuity of records
- Renewal of registrations when necessary
- Destruction of records

» Applications for the control of medical and administrative records can be manual or electronically carried out directly through the Information Management System (IMS).
- Processes for the control of medical and administrative records are defined in accordance with the nature of the applications (manual-electronic).

RCA.1.2
Responsible persons for the control of records are identified and their duties, authorities and responsibilities are defined.

» Those responsible for the planning, coordination and execution of processes related to the control of medical and administrative records are identified, and their duties, authorities and responsibilities are defined to cover the relevant processes

RCA.1.3
Arrangements are made for the preparation and use of medical and administrative records.

» Preparation, use, destruction and modification of records are carried out in accordance with predefined processes and are traceable.
» Records are easily accessible and maintained in a manner that protects them from unauthorized alteration.
» Records are legible.
» Records are periodically reviewed in line with defined processes.
» Standardized diagnosis and procedure codes are used for records and consistent use of approved symbols and abbreviations is ensured throughout the institution/

organization.

» Records retention periods are determined and all records are accessible during the retention period.

» Traceability of changes made to records is ensured.

- Both original and revised records and files can be tracked, including the date of modification, time of modification, changes made, and the identity of the personnel who made the changes.

RCA.1.4

Rules for information privacy and security in access to records are defined.

» Rules for information privacy and security when accessing records include at least the following:

- Authorization for access to all electronic and printed records
- Obligation of employees authorized to access records to keep information confidential
- Confidentiality of records
- Process to be followed in case of breach of confidentiality and privacy
- Retention conditions and durations of printed records not stored in the IMS

RCA.1.5

A standard plan for the definition and content of patient files is established.

» All medical records of outpatients and inpatients can be accessed electronically or in printed media with the same fixed file number.

» A standard file content is determined for patient files:

- The minimum information and documents to be included in the files are defined according to the needs of the institutions/organizations within the scope of the relevant country legislation.
- File contents may vary by department and type of hospitalization.

» Patient files contain at least the following information about the patient.

- Name and surname
- Date of birth
- Gender
- Contact information (address, telephone, etc.)
- Marital status
- Education status
- Current or previous occupation
- Whether the patient has authorized someone else to access medical records related to him/her, and if so, the contact information and degree of closeness of the person

» Patient files are checked for completeness and recorded before archiving.

RCA.1.6

Arrangements are made for electronic records (See Information Management System).

» Data security and confidentiality are ensured in electronic records.

» Electronic records are standardized in a specific format.

» Electronic records are kept in accordance with the relevant country legislation

and international standards.

» Regular checks are made to ensure that records are accurate, complete and up-to-date.

» The status of records and security breaches are recorded and reported to senior management.

» Employees are trained on arragements regarding electronic records.

Standard 2

RCA.2
Processes and rules regarding archive services are defined and proper functioning is ensured.

RCA.2.1
Processes and rules for archive services are documented.

» The processes and rules for archival services include at least the following:
- Archive plan
- Authorization for access to the archive
- Delivery of files to the archive, control and acceptance of the content
- Placement of accepted files in the archive
- Unarchiving files
- Protection, storage and destruction of files placed in the archive
- Management of forensic case files

» Responsible for the planning, coordination and execution of processes related to archive services is determined; duties, authorities and responsibilities are defined to cover the relevant processes.

» A traceable archive plan is created to ensure easy access to patient files

RCA.2.2
Arrangements are made for the storage of patient files in the archive section.

» Measures are taken to protect the files in the archive.
- Archive environment temperature and humidity are monitored and records are taken.
- Air conditioning is done.
- Measures are taken against pests, theft, fire and floods.

» Archive entry and exit is kept under control.

» Document/record entry and exit records are kept in the archive.

» There is a unit archive in clinics and polyclinics according to the needs of the institution/organization.
- Unit archive locations are defined and working systems are organized in accordance with the general archive operation

SECTION 5 SUPPORT SERVICES	
Chapter 24 Material and Equipment Management (MEM)	
Code	**Standard 1**
MEM.1	Material management processes and rules are defined, and the operation is carried out accordingly.
Code	**Assessment Criteria**
MEM.1.1	Material management processes and rules are documented.
MEM.1.2	Responsible individuals for material management are identified, and their duties, authorities, and responsibi-lities are defined.
MEM.1.3	Arrangements for identifying and procuring materials are made.
MEM.1.4	Arrangements for the storage and inventory control of materials are made.
MEM.1.5	Arrangements for the safe transfer of materials to units are made.
Code	**Standard 2**
MEM.2	Processes and rules for the management of hazardous materials are defined, and the operation is carried out accordingly.
Code	**Assessment Criteria**
MEM.2.1	Processes and rules for the management of hazardous materials is documented.
MEM.2.2	Responsible individuals for the management of hazardous materials are identified, and their duties, authori-ties, and responsibilities are defined.
MEM.2.3	An inventory of hazardous materials is created.
MEM.2.4	Arragements for the management of hazardous materi-als are made.
Code	**Standard 3**
MEM.3	Device management processes and rules are defined, and the operation is carried out accordingly

Code	Assessment Criteria
MEM.3.1	Device management processes and rules are documented.
MEM.3.2	The persons responsible for device management are identified, along with their duties, authority, and responsibilities.
MEM.3.3	The traceability of devices is ensured.
MEM.3.4	Arragements for the safe and efficient use of medical devices are established.
MEM.3.5	Arragements for the usage process and quality control activities of Point-of-care testing devicess are established.
MEM.3.6	Arragements for medical devices identified as unsuitable for use or with limited usage decisions, based on test, control, and calibration results, are established.
MEM.3.7	Arragements for device malfunction reporting and repair are established.
MEM.3.8	Arragements for reporting adverse events related to medical devices are established.

Chapter 24: Material and Equipment Management (MEM)

General Information

Effective management of materials and devices in healthcare institutions and organizations is important to ensure uninterrupted, safe and quality healthcare service delivery and smooth operational flow. Ensuring the availability and availability of materials and devices in the required area, time and quantity is essential for the sustainability of service delivery. Effective management of supplies and devices minimizes waste, reduces costs, prevents stock outages and ensures sustainable use. This chapter provides guidance to health institutions and organizations for the effective management of materials and devices.

Purpose

The purpose of this chapter:

- To ensure the timely procurement, safe use and effective stock management of materials, devices and hazardous substances, taking into account patient and employee needs.

Objectives

- Efficacy
- Productivity
- Convenience
- Timeliness
- Healthy Work Life

Standard Requirements

Standard 1

MEM.1
Material management process and rules are defined, and the operation is carried out accordingly.

MEM.1.1
Material management processes and rules are documented.

» Processes and rules for materials management include at least the following topics:
- Identification of material needs
- Material requests/demands
- Procurement of materials
- Material receipt and acceptance processes
  - The delivery and storage of documents such as warranty certificates, user manuals, etc., provided by the manufacturers for the safe use of materials.
- Storage of materials
- Material request, preparation, and transfer
- Rules for the withdrawal, storage, and return conditions of unsuitable materials
- Safe use of materials
- Creation of a plan for material replacement and updates when necessary
- Monitoring the service life of materials
- Cleaning and disinfection processes specific to materials
- Methods for intervention in hazardous situations arising during material use
- Materials requiring special qualifications, special storage conditions, or specific technical/expertise for use
- Malfunction and repair processes for materials
- Management processes for decommissioning materials
- Indicators related to material management

MEM.1.2
Responsible individuals for material management are identified, and their duties, authorities, and responsibilities are defined.

» Responsibilities for planning, coordinating, and executing material management processes are determined, and tasks, authority, and responsibilities are defined in a way that covers the relevant processes.

MEM.1.3
Arrangements for identifying and procuring materials are made.

» The processes for the determination of the need for and procurement of materials are defined to include at least the following issues:
- The process of determining the need for materials
- Persons authorized to request materials
- Demand method

- Evaluation of requests by management
- Preparation of technical specifications
- Determining the procurement method
- Evaluation process of bids
- Supply of materials
- Control of procured materials
- Receiving the materials from the supplier and putting them into service
- Assessment of compliance with contracts with suppliers

» The need for materials is determined on the basis of service units.
» The required amount of materials is calculated based on the institution's previous years' data and the service capacity it plans to provide.
» Necessary measures are taken to ensure the provision of the correct materials at the right time for the effective delivery of services.
» Rules and methods for material procurement requests are defined.
  - The individuals who can request material procurement, the request method, the evaluation of requests, and the procurement process from the supplier are defined.
» The minimum, critical, and maximum stock levels of routinely used, urgent, or mandatory materials are determined and monitored.
» While making evaluations for identifying the needs in determining the types and quantities of materials to be procured, procurement requests, consumption analyses, and the planned service capacity are considered.
» The processes related to all stages, from the submission of material requests to their use in departments, are traceable through the Information Management System (IMS).
» Critical materials are determined based on the scope of services of the organization/institution.
  - Measures and action plans to prevent disruption of services in case these materials cannot be procured are determined.

MEM.1.4
Arrangements for the storage and inventory control of materials are made.

» Materials are stored under appropriate storage conditions based on their characteristics.
» The storage layout plans for materials are determined, and the plans are kept updated.
» The floor-to-ceiling height of the material warehouses is determined to be appropriate, and safety measures for earthquake, flood, electricity leakage, etc. are determined.
» The cleaning of material warehouses is determined to be carried out at regular intervals, and records are determined to be kept.
» Materials are determined to be stored under appropriate temperature and humidity conditions according to their type and characteristics, and, when necessary, real-time measurable and traceable temperature-humidity monitoring systems are determined to be used.
» Sterile consumable materials are determined to be stored under appropriate conditions.

- The expiration date tracking procedures for stored materials are determined to be carried out electronically.
- Materials are determined to be monitored for product defects and adverse effects, and if identified problems exist, they are determined to be communicated to the notification system defined by the relevant national authority.
- The tracking and reporting of unexpected effects and defective products in medical consumable materials are determined.
- Access to defined material warehouses and all unit warehouses where medical consumables are stored for more than 24 hours is restricted to authorized personnel only.
- An accepted method for inventory tracking (such as FIFO, LIFO, etc.) is determined and applied in the stock control process of materials.
- The minimum, critical, and maximum stock levels are determined and monitored based on factors such as the usage amounts of materials in previous periods and the nature of the services provided.

MEM.1.5
Arrangements for the safe transfer or materials to units are made.

- Appropriate transfer rules based on the characteristics of the materials are determined for the safe transfer of materials to the units, and the necessary equipment for safe transfer is provided.
- Measures are determined to prevent issues such as dropping, breaking, tearing, spilling, and misuse during the transfer of materials from the warehouses to the units.
- Special and hazardous materials for transfer are determined, and employees responsible for transferring these materials are trained in safe transfer procedures.
- The delivery of materials to the units is determined to be recorded.

Standard 2

MEM.2
Processes and rules for the management of hazardous materials are defined, and the operation is carried out accordingly.

MEM.2.1
Processes and rules for the management of hazardous materials are documented.

- The processes related to the management of hazardous materials are determined to include at least the following topics:
  - The safe transportation, storage, and use of hazardous materials
  - Actions to be taken in case of exposure to hazardous materials
  - Actions to be taken in case of hazardous material spills
  - Safety information related to hazardous material

MEM.2.2
Responsible individuals for the management of hazardous materials are identified, and their duties, authorities, and responsibilities are defined.

» The responsible person(s) for the management of hazardous materials are determined, and their duties, authorities, and responsibilities are defined to cover the relevant processes.

MEM.2.3
An inventory of hazardous materials is created.

» The inventory of hazardous materials is determined to include at least the following information:
  - The commercial name, brand, active ingredient, and form (liquid, powder, crystal, etc.) of the hazardous material
  - The usage method and expiration date
  - Storage conditions
  - Substances it interacts with
  - Methods of intervention in case of fire
  - Methods of intervention in case of contact
  - Locations where it is used and stored
  - Transportation method
  - Disposal Method
  - Symbols indicating the hazardous material class

» The inventory is available in the warehouse and usage areas.

MEM.2.4
Arrangements for the management of hazardous materials are made.

» Hazardous materials are labeled with symbols indicating their hazardous material class, and the name of the material and the symbol representing its class are present on the label.
» Users are trained on the symbols representing the hazardous material class.
» The radioactivity value and measurement date of radioactive materials are recorded and are traceable.
» Stock control of hazardous materials is conducted.
» The safe transportation, use, and disposal of hazardous materials are ensured.
» Necessary personal protective equipment and antidotes for potential hazards are available, and response and treatment methods for each incident or hazardous material are known by the response teams.

Standard 3

MEM.3
Device management processes and rules are defined, and the operation is carried out accordingly.

MEM.3.1
Device management processes and rules are documented.

» Processes for device management include at least the following topics:

- Authorization of requests for devices, determination of needs and evaluation of requests
- Supply of devices
- Receipt and acceptance of devices
- Delivery and storage of documents such as warranty certificates, user manuals, etc. given by the manufacturer companies for the safe use of the devices
- Establishing a plan for replacing and updating the devices when necessary
- Monitoring the lifetime of devices
- Safe use of devices
- Methods of intervention in dangerous situations that occur during the use of devices
- Device-specific cleaning and disinfection processes
- Methods of intervention in dangerous situations that occur during the use of the device
- Devices of special quality, special storage conditions or devices that require special technique/expertise to use
- Maintenance, adjustment and calibration of instruments
- Fault notification and repair processes of devices
- Management processes related to decommissioning of devices
- Indicators for device management

» Rules for the withdrawal, storage, reuse, decommissioning and return of non-compliant devices is defined.
  - In the event that medical devices are taken out of use (if any), notification is made to the tracking system defined by the relevant country authority.

» The amount of devices needed is calculated by taking into account the data of the institution/organization in previous years and the service capacity it plans to provide.

» Necessary measures is taken to ensure that the right devices are provided at the right time in order to provide the service effectively.

» In determining the devices to be procured and their quantities, procurement demands, consumption analyses and the service capacity planned to be provided is taken into consideration while evaluating the needs.

» Transactions related to all processes from device requests to their use in departments are traceable.

» Critical devices are determined based on the scope of service of the institution/organization.
  - Measures and action plans are determined to prevent service disruptions in case these devices cannot be procured

MEM.3.2
The persons responsible for device management are identified, along with their duties, authority, and responsibilities.

» The individuals responsible for planning, coordinating, and executing the processes related to device management are determined, and their duties, authorities, and responsibilities are defined to cover the relevant processes.

MEM.3.3
The traceability of devices is ensured.

» Devices have an inventory both across the institution/organization and by department; the inventory includes at least the following information:
  - The name of the device
  - The identifying number of the device (biomedical number or asset number)
  - Serial number
  - Brand
  - Department where the device is located
» Devices have a device card/label, which includes at least the following information:
  - The identifying number of the device (biomedical number or asset number)
  - The department where the device is located
» The inventory of medical devices (if applicable) is traceable through the system defined by the relevant national authorities.

MEM.3.4
Arrangements for the safe and efficient use of medical devices are established.

» Processes related to the maintenance, repair, adjustment, testing, inspection, and calibration of medical devices are defined and monitored within a plan.
  - Maintenance, repair, adjustment, and calibration of medical devices are performed according to company recommendations, institution/organization needs, and usage frequency as determined.
» The test, inspection, and calibration report for medical devices that have undergone calibration includes at least the following information:
  - The name and contact details of the institution
  - Information about the authorization certificate, if applicable
  - Descriptive information about the institution/organization where the medical device is located
  - The location, name, brand, model, identity, and serial number of the medical device that has undergone testing, inspection, and calibration
  - The test, inspection, and calibration procedures performed on the medical device, measurement values, results, measurement uncertainty, and the standards and criteria followed for these procedures
  - The name, brand, model, serial number, calibration date, certificate number, and location of the device, hardware, software, and accessories used for testing, inspection, and calibration
  - The name, surname, and signature of the individuals who performed and approved the test, inspection, and calibration
  - The location, date, and validity period of the test, inspection, and calibration
  - Environmental conditions of the location where the test, inspection, and calibration were performed, including temperature, pressure, humidity, and similar information
  - The report number for the test, inspection, and calibration
  - The training certification details of the personnel who performed the calibration
  - The signature of the institution/organization personnel overseeing the entire process during testing, inspection, and calibration work conducted through service procurement.

- » Medical devices subjected to calibration testing have a calibration label, which includes at least the following information:
  - Descriptive information about the calibration company
  - Device identification number
  - Calibration date
  - Calibration validity period
  - Calibration certificate number
- » Calibration labels for devices that pass, partially pass, or fail calibration are color-coded differently.
- » Continuous technical support is provided for the efficient use of devices.
- » Personnel receive necessary training for using the devices.
- » The physical and technical infrastructure for the safe and efficient use of the devices is appropriately established.
- » Appropriate materials and equipment are used to ensure the devices operate efficiently and safely.
- » Costs and service outputs produced by medical devices are monitored, and the efficiency of the devices is evaluated.
- » Rules related to the cleaning, disinfection, and sterilization of devices are defined, and intervention methods for potential hazardous situations during device use are determined.
- » Protective equipment, safety usage information, and manuals for devices are accessible in usage areas.

MEM.3.5
Arrangements for the usage process and quality control activities of Point-of-care testing devicess are established.

- » POCTs (Health and Biomedical Technology Devices) used in the institution/organization are identified and tracked in a traceable manner.
  - For this purpose, an inventory is created containing information such as the unit where POCTs (Health and Biomedical Technology Devices) are used, unit device responsible person, device number, device type, brand, and model.
- » Responsibilities related to the maintenance and cleaning of POCTs (Health and Biomedical Technology Devices) are defined.
- » Quality control activities are carried out for POCTs (Health and Biomedical Technology Devices)
  - Quality control test results are recorded.
  - Corrective and preventive actions are initiated if any non-conformity is detected in the quality control results.
- » Employees using POCT (Health and Biomedical Technology Devices) are trained on at least the following topics:
  - Considerations for pre-analytical, analytical, and post-analytical phases of tests
  - Evaluation of calibration and quality control results
  - Cleaning and maintenance of the device
- » All test results performed on POCT (Health and Biomedical Technology Devices) are recorded in the patient's file.

MEM.3.6
Arrangements for medical devices identified as unsuitable for use or with limited usage decisions, based on test, control, and calibration results, are established.

- » The processes for maintenance, repair, and recalibration of medical devices found unsuitable for use are defined.
  - The process of how service delivery will be maintained during the period until the maintenance, repair, and recalibration of medical devices determined not suitable for use are defined.
- » The functions of the device, which is decided to have limited use, identified as unsuitable in the test, control, and calibration results, are not used.
  - The functions that should not be used are made traceable on the device by the employees.

MEM.3.7
Arrangements for device malfunction reporting and repair are established.

- » Rules regarding device malfunction reporting and repair processes are defined.
- » Malfunctions in devices are reported as soon as possible.
- » Device malfunctions, along with malfunction reports and repair processes, are recorded.
- » In case of a malfunction, the device is taken out of service, and a malfunction warning is present on the device.

MEM.3.8
Arrangements for reporting adverse events related to medical devices are established.

- » The responsibilities and accountable individuals for reporting undesirable and unexpected events related to medical devices are defined.
- » Reports are made to the system defined by the relevant national authority (if applicable).
- » Relevant employees are informed about reporting adverse events related to medical devices.

SECTION 5 SUPPORT SERVICES	
Chapter 25 Waste Management (WM)	
Code	**Standard 1**
WM.1	Processes and rules related to waste management are defined, and the operations are carried out accordingly.
Code	**Assessment Criteria**
WM.1.1	Processes and rules related to waste management are documented.
WM.1.2	Waste management responsibles are assigned, and du-ties, authorities, and responsibilities are defined.
WM.1.3	Waste segregation at the source, collection, transporta-tion, temporary storage, and reduction are ensured.
WM.1.4	Practices to mitigate the effects of climate change are implemented.
WM.1.5	Training is provided to employees regarding waste ma-nagement.

General Information

Healthcare institutions and organizations produce a significant amount of waste during the service delivery process. Improper segregation, collection, transportation, temporary storage, and disposal of waste cause serious health issues and environmental damage, so the management of waste generated from healthcare services is important. This chapter guides healthcare institutions and organizations in managing waste effectively and minimizing environmental impacts..

Purpose

» The purpose of this chapter is to ensure that waste does not harm human and environmental health throughout the process, from its generation to its delivery to the authorized disposal entity..

Objectives

» Patient Safety
» Healthy Work Life
» Patient Focused

Standard Requirements

Standard 1

WM.1
Processes and rules related to waste management are defined, and the operations are carried out accordingly.

WM.1.1
Processes and rules related to waste management are documented.

» Waste management processes include at least the following topics:
- The source, quantity, and types of waste
- Segregation of waste at the source
- Reduction of the amount of waste generated
- Regular recording of information related to the amount of waste generated
- Proper collection and transportation of waste
- Collection frequency and rules
- Equipment and vehicles used for transporting waste
- Cleaning and disinfection of collection equipment
- Use of temporary storage areas and storage of waste
- Cleaning and disinfection of temporary storage areas
- Protocol with the relevant institution/organization for the receipt, transportation, and disposal of waste
- Precautions to be taken against accidents that occur during the collection and transportation of waste, and actions to be taken in case of an accident
- Training of personnel responsible for waste collection and transportation
- Responsible parties in the waste management process
- Routes to be followed by waste transportation vehicles
- Mitigation of the effects of climate change

WM.1.2
Waste management responsibles are assigned, and duties, authorities, and responsibilities are defined.

» A management structure (committee, team, center managers, responsible persons, etc.) consisting of at least one person from the institution/organization management and individuals trained in waste management is established.

» The duties, authorities, and responsibilities of employees in the management structure are defined.

WM.1.3
Waste segregation at the source, collection, transportation, temporary storage, and reduction are ensured.

Segregation of Waste at the Source

» Waste is separated at source in at least the following categories:
- Domestic waste

    - General waste
    - Packaging waste
    - Medical waste
    - Infectious/medical waste
    - Pathological waste
    - Sharp waste
  - Hazardous waste
    - Hazardous chemical wastes
    - Cytotoxic, genotoxic and cytostatic drugs and wastes
    - Amalgam waste
    - Pharmaceutical waste
    - Wastes containing heavy metals
    - Vegetable oil waste
    - Pressure vessels
  - Radioactive waste

» Waste bins appropriate for the types of waste are available.
» Waste bins are checked at regular intervals for content suitability.
» When positioning waste bins, the distance from the waste sources and ease of use are considered.
» International warning signs and labels identifying the waste are placed on the waste bins.

Collection and Transportation of Waste

» A risk assessment is made for waste collection and transportation, and necessary precautions are taken against potential accidents. (See: Risk Management)
» Waste is collected by personnel trained for this task, according to its types.
» The clothing of personnel assigned to waste collection and transportation is appropriate.
» Waste collection and transportation procedures are carried out in accordance with the route designated by the institution/organization, ensuring that they are as far away as possible from areas with high foot traffic.
» Waste collection equipment with suitable specifications is used.
» Waste bags are transported with suitable, easily cleanable equipment within the institution/organization.
  - Descriptive information about the unit where waste bags are collected is available.
  - Bags are filled up to a maximum of ¾ capacity, their contents are not compressed in any way, their openings are tightly sealed, and complete leak-proofing is ensured.
  - The bags not be reused under any circumstances.

Temporary Storage of Waste

» Waste is collected in containers or temporary storage areas.
  - Containers or temporary waste storage facilities with suitable sizes and specifications are available according to the institution/organization size and waste capacity.

- The temporary waste storage facility meets the minimum requirements specified according to the relevant country's arragements.
- The temporary waste storage area is covered and constructed to protect the waste from all external factors.
- The floor and walls of the temporary medical waste storage area are covered with a solid, impermeable material that does not retain microorganisms or dirt, and it is easy to clean and disinfect, with adequate lighting in the storage areas.
- An passive ventilation system is available in non-refrigerated temporary medical waste storage areas.
- The door of the temporary medical waste storage area is orange, with the visible black-colored "International Biohazard" symbol and the black-colored "CAUTION! MEDICAL WASTE" label, and the door is always clean and painted.
- The temporary waste storage area is constructed to prevent any animals from entering.
- The interior and doors of the temporary waste storage area are designed so that the responsible personnel can work comfortably, and waste can be easily unloaded, stored, and loaded.
- The temporary waste storage area is not located near areas with high foot traffic, such as the institution/organization's entrance/exit, or food storage, preparation, and sales areas.
- The temporary waste storage area is cleaned and disinfected using appropriate disinfectants.
- Cleaning materials, special clothing and protective equipment, medical waste bags, containers, buckets, and bins are kept near the storage area.
- The temporary waste storage area is not used for any purpose other than the temporary storage of waste.
- Security measures are taken against all emergencies such as fires in the temporary waste storage area, and unauthorized persons are not allowed to enter.
- Absorbent materials are kept in the temporary waste storage area to prevent spills or leaks.
- The doors of the temporary waste storage area are kept closed and locked when not in use, and the lids open outward.

» Containers have at least the following features:

- Containers are made of stainless metal, plastic, or similar materials, have wheels, lids, and lockable lids.
- The external surfaces of the containers have the "International Biohazard" symbol and the "CAUTION! MEDICAL WASTE" label.
- Containers have the capacity to hold at least two days' worth of medical waste from the healthcare facility.
- Containers are placed within the healthcare facility boundaries, away from areas with high foot traffic such as entrances, exits, sidewalks, and food storage, preparation, and sales areas, and do not receive direct sunlight.
- The lids of the containers are kept locked, and unauthorized persons are not allowed to open them.
- Containers are disinfected using appropriate disinfectants after the waste is unloaded.

- Containers are not used for any purpose other than the temporary storage of medical waste.

» Waste is stored without exceeding the maximum waiting times specified for each waste type.
- Medical waste is stored in the temporary medical waste storage area or container for no more than 48 hours.
- If the temperature inside the temporary medical waste storage area does not exceed +4°C and the capacity is suitable, the waiting time can be extended up to one week.

» Waste is stored separately without mixing in the temporary waste storage area.
» Stored waste is delivered to the authorized entity for final disposal and is recorded.

Waste reduction:
» Waste segregation audits are conducted at regular intervals, and the results are analyzed.
» An action plan for waste reduction is in place, and the plan's progress is monitored.

WM.1.4
Applications to reduce the effects of climate change are implemented.
» Strategies are defined within the scope of waste management and recycling activities to reduce the effects of climate change.
- In this context, the following practices are implemented:
- Recycling and reuse
- Composting
- Low waste strategies
- Energy recovery
- Waste segregation awareness
- Zero waste programs, etc.

» The use of environmentally friendly chemicals is encouraged to minimize the use of harmful chemicals.
» Support is provided for social responsibility projects aimed at reducing the effects of climate change.

WM.1.5
Training is provided to employees regarding waste ma-nagement.
» The personnel responsible for waste management receive training covering at least the following topics.
- Obligations and administrative sanctions within waste management
- The importance of the environment and the consequences of environmental pollution
- Waste types causing environmental pollution and waste types originating from institutions/organizations

» Training is given to employees in the units where waste is produced, covering at least the following topics.
- Waste types and the separation of waste according to their types

- Use of waste collection equipment
- Collection, transportation, and temporary storage of waste
- Health risks caused by waste, possible injuries and diseases
- Precautions to be taken in case of accidents or injuries

SECTION 6
Disaster and Emergency Management

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SECTION 6 DISASTER AND EMERGENCY MANAGEMENT	
Chapter 26 Disaster and Emergency Management (DEM)	
Code	**Standard 1**
DEM.1	Arrangements are made regarding disaster and emergency management processes.
Code	**Assessment Criteria**
DEM.1.1	An administrative structure for disaster and emergency management is established and duties, authorities and responsibilities are defined.
DEM.1.2	Risk assessment for disaster and emergency management is made.
DEM.1.3	Disaster and emergency plan is created.
DEM.1.4	Emergency plan sketches are available.
DEM.1.5	Arrangements are made for evacuation in disasters and emergencies.
DEM.1.6	Arrangements are made for earthquake.
DEM.1.7	Arrangements are made for fire.
DEM.1.8	All employees are trained on disaster and emergency plan and drills are conducted.
Code	**Standard 2**
DEM.2	Arrangements are made for emergency warning systems.
Code	**Assessment Criteria**
DEM.2.1	Warning systems for emergencies are established.
DEM.2.2	Persons responsible for the management of emergency warning systems and their responsi-bilities are identified.
DEM.2.3	Response team(s) for emergencies are identified.
DEM.2.4	Necessary medicines and equipment to be used in response to emergencies are identified and their continuity is ensured.
DEM.2.5	Records of interventions are kept.
DEM.2.6	Trainings on emergency warning systems are provided and drills are conducted.

Chapter 26: Disaster and Emergency Management (DEM)

General Information

Disaster and emergency management is critical to make health institutions and organizations resili-ent and durable in crisis situations and to ensure continuity of service delivery. Effective disaster management includes preparedness, response, recovery and mitigation strategies that enable health facilities to operate under adverse conditions, protect patients and staff, and ensure continuity of service. The standards in this chapter guide health institutions and organizations in the effective management of disasters and emergencies.

Purpose

The purpose of this chapter:

- To ensure that people and physical elements are not harmed or the damage they will suffer is minimized in cases requiring disasters or emergency medical intervention to be encountered in health institutions and organizations
- To ensure the fastest and most effective response to emergencies such as respiratory or cardiac arrest, risk/action of infant or child abduction, risk/attempt of violence against employees, fire or CBRN accidents that is encountered in health institutions and organizations
- To ensure patient, patient relatives, employee and environmental safety against CBRN hazards.

Objectives

- Healthy Work Life
- Patient Safety

Standard Requirements

Standard 1

DEM.1
Arrangements are made regarding the disaster and emergency management process.

DEM.1.1
An administrative structure for disaster and emergency management is established and duties, authorities and responsibilities are defined.

» A managerial structure that plans and ensures the implementation of measures for mitigation, prevention, response and recovery for natural and man-made disasters and emergencies that the institution/organization is allowed to face is established.
  - The governance structure includes at least one person from the management of the institution/organization.
  - Meetings are held at regular intervals by the governance structure and records of the meeting is kept.

» Job descriptions of the personnel involved in the disaster and emergency management structure is made and their authorities and responsibilities is arranged to include at least the following subjects:

» Risk assessment for disaster and emergency management
  - Drills
  - Trainings to be received by employees
  - Keeping emergency records
  - Initiation of corrective and remedial actions when necessary

» Employees to be assigned in case of disaster and emergency is identified together with their substitutes and their responsibilities is defined.

DEM.1.2
Risk assessment for disaster and emergency management is made.

» A risk assessment is made for disaster and emergency management, including at least the following topics;
  - Fire
  - Earthquake
  - Sel
  - Landslides
  - Epidemics
  - Acts of terrorism
  - Migration
  - Industrial explosion
  - Radiological, nuclear and chemical accidents
  - War
  - Cyclone (typhoon, hurricane)
  - Hose
  - Volcanic eruption
  - Lightning strike
  - Digital terror, etc.

» During risk assessment; events requiring possible / extraordinary intervention, , first aid and evacuation and the characteristics of the region where the institution / organization is located is taken into consideration.
» For the measures to be taken for disasters and emergencies, possible situations are identified, the dangers that emergencies pose are analyzed and necessary remedial measures are planned.

DEM.1.3
Disaster and emergency plan is created.

» A Disaster and Emergency Plan is prepared for disasters and emergencies, including at least the following topics:
  • Identified risks
  • Protective measures
  • Control
  • Early diagnosis and detection
  • Triage
  • Management of clinical services and resources (patient care, human resources, medical devices, ambulance services, archives etc.)
  • Evacuation of the facility
  • Alternative areas to use
  • Supply of materials to be used
  • Inventory of disaster and emergency supplies
  • Organization with institutions to cooperate with, etc.
» Disaster and emergency plan is updated every year and necessary approvals are obtained from the relevant authority.
» Planning is made to implement the remedial measures determined for disasters and emergencies.
  • Planning is carried out under the leadership of the management and responsibility of the determined managerial structure.
  • The plan covers all stages of the disaster management process (mitigation, preparedness, response and recovery).
  • Planning includes at least the following topics:
    ▪ Determination of activities to prevent and mitigate structural and non-structural hazards within the framework of risk analysis
    ▪ Planning necessary preventive investments and activities
    ▪ Budgeting of investments and activities
    ▪ Making response plans for possible disasters and emergencies
    ▪ Continuous review of whether the measures and practices developed serve the purpose
    ▪ Determining the duties and responsibilities of employees in disasters and emergencies within the framework of the incident command system and sharing them with employees
    ▪ Planning the return to normalcy after disasters and emergencies
    ▪ Identifying and planning investments that will facilitate the management of disasters and emergencies (retrofitting, reconstruction, mitigation of non-structural hazards, emergency warning systems, alternative communication systems in emergencies, etc.)

» Although necessary remedial measures are taken for possible emergencies (natural disasters, etc.), it also be planned in advance what is done in case of situations that require extraordinary intervention and struggle.

DEM.1.4

» General emergency plan sketches showing the main service units are available at building entrances.
» Floor emergency plan sketches are available at floor entrances or elevator exits.
» Emergency plan sketches contain at least the following information:
  • Places where emergency equipment is located (equipment to be used for fire extinguishing, etc.)
  • Locations of the emergency response kit
  • Emergency exit routes, gathering places and places with warning systems
  • Contact numbers of necessary institutions/organizations for first aid, emergency medical intervention, rescue and fire fighting
» Employees are informed about emergency plan sketches.

DEM.1.5

Arrangements are made for evacuation in disasters and emergencies.

» A facility evacuation plan is prepared for disasters and emergencies, including at least the following topics:
  • Transfer of patients to safe places
  • Temporary relocation sites
  • Staff reinforcement
  • Traffic flow and safety
  • Patient monitoring systems
  • Emergency lighting (portable generator, flashlights, etc.)
  • Organization of alternative sources of electricity, water, heating and communication
» A facility evacuation drill is conducted at least once a year with the participation of employees.
  • The facility evacuation drill covers the evacuation of all service delivery areas, including administrative and support services.
  • Video recordings of drills are available.
  • A drill report is prepared.
  • Necessary improvements are made for nonconformities identified during the exercise.
  • Exercise objectives are determined and repeated until a successful exercise is realized.
» Equipment, materials, escape routes (directional signs and signs) and evacuation places (such as fire escapes, emergency evacuation elevators) necessary for the safe evacuation of patients and employees from the facility are available.

DEM.1.6

Arrangements are made for earthquakes.

» Arrangements for earthquake are planned in line with risk assessment.
» High cabinets, coolers, all kinds of tools and equipment that risk patient and

employee safety by tipping over or scattering during shaking is properly secured.
- All kinds of equipment such as oxygen cylinders, transportation vehicles, stretchers, wheelchairs are placed/parked and fixed in a way that will not harm patients and employees and will not block escape routes.
- Heavy or bulky equipment such as refrigerators and photocopiers are fixed to the floor and/or wall.
- Medical devices that pose a risk are fixed.
- In medical consumables and pharmaceutical warehouses, large volume materials are placed on lower shelves and shelves are arranged in a way to prevent materials from falling.
- Objects are placed on shelves according to their weight, from heavy to light (with heavy objects on the lower shelves).
- Natural gas is cut off automatically during shaking.
- Radioactive materials are stored in armored protective containers.
- Employees are given earthquake awareness trainings.

DEM.1.7
Arrangements are made for fire.
- The facility is configured in accordance with the country legislation on fire.
  - Compliance with relevant legal arragements are assessed by authorized institutions.
  - Improvement activities are carried out for the nonconformities detected.
- The equipment to be used during fire intervention, rules for the safe use of this equipment, signs and directions for the fire situation are defined.
- Tools and equipment such as fire hydrants, fire extinguishers, fire extinguishers, fire hoses to be used for the first response to fire are placed in accordance with the defined rules, and information (plans, instructions, etc.) are provided for their location and use.
- In case of possible fire, emergency warning system calls and interventions are recorded to include at least the following information:
  - When the emergency warning call was made
  - How the intervention is carried out
  - The outcome of the intervention
  - Information on the notification of the incident to the fire brigade and the intervention processes of the fire brigade
  - Fire brigade report
- Analyses are made for the records kept and the results obtained from the implementation are monitored periodically.
- There is a functional fire detection system that covers all areas of the facility, is not affected by power outages and can address.
- The effectiveness of the central extinguishing systems used is checked at regular intervals.
- An effective fire extinguishing system is established by taking into account the capacity of the institution/organization and the effectiveness of the method to be used, and the methods to be used on the basis of area or unit is defined.
- Emergency plan sketches have markings indicating fire extinguishers.
- Fire extinguishers are fixed.

» Appropriate fire extinguishers are used according to the characteristics of the area or unit.
» Fire extinguishers are checked, general maintenance and powder changes are made.
» The equipment in the fire cabinet is in working order.
  • The fire hose is undamaged.
  • The fire hose comes easily when pulled.
  • Valves open easily.
» Precautions are taken against fire on building roofs.
» Roof entrances and exits are controlled, the roof area is clean, there is no equipment, materials, etc. and electrical cables that pose a fire hazard, or they are insulated so as not to pose a fire risk.

DEM.1.8
All employees are trained on the disaster and emergency plan and drills are conducted.

» All employees is given at least the following trainings and drills is carried out within the scope of the disaster and emergency plan:
  • Basic disaster awareness
  • Use of fire extinguishers and hoses (practical)
  • Reducing non-structural risks (YORA)
  • CBRN (Chemical, Biological, Radioactive and Nuclear Events)
  • Radiation protection
  • Disaster and emergency triage
» Drills (tabletop and practical) is conducted at least once a year.
» Records related to the exercise are kept, the results of the exercise are evaluated and necessary remedial measures is taken.
» Employee participation in relevant trainings and drills are encouraged and ensured.

Standard 2

DEM.2
Arrangements are made for emergency warning systems.

DEM.2.1
Warning systems for emergencies are established.

» At least the following emergency warning systems are established for timely response to emergencies:
  • Respiratory arrest or cardiac arrest
  • Risk/act of infant/child abduction
  • Risk/act of violence against health workers
  • Fire
» Emergency warning systems are inclusive, visual and auditory, taking into account the size of the institution/organization and the provision of services in different buildings.

» Emergency warning systems are created in a way to inform the employees of the institution/organization, to ensure effective and fast communication, and to prevent panic with a short and clear message.
» Records and practices related to emergency warning systems are traceable.

DEM.2.2
Persons responsible for the management of emergency warning systems and their responsibilities are identified.

» The persons responsible for the management of emergency warning systems are determined taking into account the structure and type of the organization.
» The responsibilities of designated persons include at least the following topics:
  • Trainings to be given to employees
  • Organizing drills
  • Monitoring of relevant records
  • Initiation of corrective and remedial actions when necessary
  • Following the relevant country legislation and making necessary arrangements accordingly

DEM.2.3
Response team(s) for emergencies are identified.

» Emergency response teams (for each shift in institutions/organizations working in shifts) are formed for the purpose of the emergency warning system.
  • The respiratory arrest or cardiac arrest team meet at least the following requirements:
    ▪ The team includes at least one physician and one health worker.
    ▪ The physician and health worker is trained in CPR.
    ▪ In cases where there are not enough personnel to form a team outside working hours, it is determined how the emergency intervention will be carried out.
  • Emergency response teams in case of fire are designated for each shift in institutions/organizations working in shifts.
» It is determined how the relevant employees will intervene when an emergency code warning is issued, and how department and institution/organization-based measures will be implemented.

DEM.2.4
The necessary medicines and equipment to be used in response to emergencies are identified and their continuity is ensured.

» Which medicines and equipment will be needed according to the purpose of the emergency intervention is determined in advance and kept ready for use.
  • Usage status is traceable and maintained.
» An emergency response kit is created by defining the medicines and equipment that is available for respiratory arrest or cardiac arrest.
  • The emergency response kit include at least laryngoscope set and spare batteries (for child and adult), balloon-valve-mask system, masks in different sizes, oxygen hose and masks, intubation tube (child and adult SECTIONs), auxiliary airway tools (laryngeal mask, airway or combi tube etc.), injectors,

personal protective equipment etc.
- Equipment such as defibilators, aspirators, oxygen cylinders, etc. used for emergency intervention is defined in which areas they will be located and how they will be brought to the scene.
- The drugs that are included in the emergency response kit is determined according to the needs of the department and the patient portfolio.
- Stock levels of medicines and materials in the emergency response kit are determined and monitored.
- Expiry dates of medicines and materials are monitored.
- Emergency response kit is kept available.

DEM.2.5
Records of interventions are kept.

» Interventions in emergency situations are recorded to include at least the following information:
  - When the emergency warning call was made
  - Information on the person/incident being intervened
  - Which interventions were performed
  - Where(s) the intervention took place
  - How long it takes for the team to reach the intervention site
  - Who is in the intervention team
  - Outcome of the intervention
  - Information on the process of reporting the incident to the judicial authorities

» Analyses are made for the records kept, the results obtained from the implementation is monitored periodically and necessary improvement studies are carried out.

DEM.2.6
Trainings on emergency warning systems are provided and drills are conducted.

» Trainings to be given to all employees on the importance of the emergency warning system and how to implement it are planned.

» Drills for the application of emergency warning systems is conducted at least twice a year, one of which are table-top.

» Records of drills are kept, drill results are evaluated and corrective and remedial actions are initiated when necessary.

» Exercise objectives are set and repeated until a successful exercise is realized.


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SECTION 7
Climate Change and Sustainability

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SECTION 7 CLIMATE CHANGE AND SUSTAINABILITY	
Chapter 27 Climate Change and Sustainability (CCS)	
Code	**Standard 1**
CCS.1	Arrangements are made to address climate change and service sustainability.
Code	**Assessment Criteria**
CCS.1.1	A plan to combat climate change and ensure sus-tainable care is developed.
CCS.1.2	Environmentally friendly arrangements are made for the use of resources.
CCS.1.3	Activities are carried out to raise awareness on combating climate change and ensuring sustainable care.
CCS.1.4	Arrangements are made to monitor and improve efficiency.

Chapter 27: Climate Change and Sustainability (CCS)

General Information

Sustainability in healthcare refers to an approach that balances environmental, economic and social factors in order to maintain the availability and quality of healthcare services for future generations. The requirements for combating climate change and ensuring sustainable care includes important steps to ensure that the organization contributes to combating climate change and provides sustainable healthcare services. Effective implementation of these requirements will help the organization to reduce its environmental impact and provide health care that is more sensitive to society and nature.

Purpose

The purpose of this chapter:

- To contribute to the reduction of environmental impacts by setting standards for combating climate change to ensure sustainability in health services and effective implementation of these standards in institutions/organizations.

Objectives

- Efficiency
- Efficacy
- Effectiveness
- Continuity

Standard Requirements

Standard 1

CCS.1
Arrangements are made to address climate change and service sustainability.

CCS.1.1
A plan to combat climate change and ensure sus-tainable care is developed.

» A plan for combating climate change and ensuring sustainable care is developed by a structure under the leadership of managerial levels and with the participation of stakeholders, including at least the following points:
- Measure the use of material and environmental resources, including the use of energy, water, natural gas, vehicle fuels and other natural resources, and prepare action plans to reduce their use.
  - The institution/organization have practices to reduce carbon footprint and greenhouse gas emissions.
- Exemplary studies is conducted by evaluating the activities carried out within the scope of social responsibility.
  - A system that monitors and reports the carbon footprint of the institution/organization is established, targets is set to reduce greenhouse gas emissions and these targets is monitored regularly.
  - Necessary improvements is made in line with the monitoring results.

CCS.1.2
Environmentally friendly arrangements are made for the use of resources.

» Arragements on energy efficiency and management are put in place.
- The institution/organization have a system to monitor and manage energy consumption in order to increase energy efficiency.
- Arrangements are made for the use of renewable energy sources.
- Arrangements are made for the use of energy-saving technologies.

» Waste management and recycling activities in the organization is carried out within the scope of combating climate change and ensuring sustainable maintenance (See Waste Management)

» Arrangements are made for green infrastructure and buildings in the institution/organization.
- Sustainable building standards are complied with in the construction of new buildings and renovation of existing buildings of the institution/organization.
- Increasing the green areas of the institution/organization and ecological landscaping practices are encouraged.
- Designs that increase the energy efficiency of buildings and ensure the use of natural light and ventilation are adopted.

» Arrangements are made for sustainable supply chain in the institution/organization.
- Selection of suppliers that meet environmental sustainability criteria is encouraged.
- Reusable products are preferred over disposable materials and

environmentally friendly materials are used.
    - The purchase and consumption of local and organic products are encouraged.
- » Water use and consumption is managed effectively.
    - There is a system to monitor and manage water consumption in order to save water.
    - The use of water-saving devices and water recovery systems are encouraged.
- » The organization effectively manage climate change emergencies.
    - Preparedness plans for emergencies caused by climate change are established and regularly updated.
    - Necessary infrastructure and procedures are developed to increase the capacity of the institution/organization to adapt to climate change.

CCS.1.3
Activities are carried out to raise awareness on combating climate change and ensuring sustainable care.

- » Training programs are organized on a regular basis to raise awareness and engagement on combating climate change and ensuring sustainable care, including at least the following topics
    - Health impacts of climate change
    - Energy and water savings
    - Waste management and sustainable practices
    - Green building standards
- » Awareness raising activities on combating climate change and ensuring sustainable care are organized throughout the institution/organization.
    - Awareness activities are carried out on specific days such as World Environment Day, World Health Day, World Water Day.
    - The use of public transportation, bicycle and pedestrian routes for employees and visitors are encouraged.
- » Cooperation is established with stakeholders such as non-governmental organizations, universities, other health institutions and organizations, etc. to combat climate change and ensure sustainable care.
- » Arrangements are made to prevent unnecessary use of health services.

CCS.1.4
Arrangements are made to monitor and improve efficiency.

- » Responsible persons are identified for efficiency studies, including at least the following points;
    - Coordination and monitoring of efficiency-related activities
    - Coordination and monitoring of data collection and analysis activities and improvement activities
    - Defining the methods to be used in productivity measurement
    - Preparation of reports and submission to senior management
- » A plan for efficiency measurements are established.
- » Site-specific measurement periods is determined and results analyzed at least annually.
- » Areas for productivity measurement and measurement methods are defined.

» At a minimum, efficiency measurements are made on the following topics:
  - Medicine
  - Medical Consumables and Supplies
  - Investigation and Diagnostic Services
  - Human Resources
  - Energy Use
  - Facility Utilization (such as clinics, operating rooms, intensive care units, laboratories and warehouses)
  - Medical Device
  - Time Management
  - Budget
» Current scientific methods such as statistical analysis, ratio analysis, regression analysis, data envelopment analysis are used for productivity measurement and analysis.
» At least once a year, current situation analyses are conducted for each efficiency-related topic and a report is prepared and submitted to the senior management.
» Improvement activities are planned in line with the results of the analysis of productivity measurements and the effectiveness of the activities is evaluated.

SECTION 8
Performance Measurement and Quality Improvement

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SECTION 8 PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT	
Chapter 28 Indicator Management (IM)	
Code	**Standard 1**
IM.1	Processes and rules regarding indicator management are defined and functioning is ensured accordingly.
Code	**Assessment Criteria**
IM.1.1	Processes and rules regarding indicator management are documented.
IM.1.2	Duties, authorities and responsibilities regarding indicator management are defined.
IM.1.3	Indicators for performance measurement are determined and monitored.
IM.1.4	Indicator cards are created to monitor the determined indicators.
IM.1.5	Indicator data is collected accurately and in high quality using appropriate methods.
IM.1.6	Relevant employees are trained regarding indicator management.
Code	**Standard 2**
IM.2	The effectiveness of indicator management is ensured.
Code	**Assessment Criteria**
IM.2.1	Indicators are analyzed and necessary improvement studies are carried out.
IM.2.2	Indicator data, targets and results are sent to relevant information management systems.

Chapter 28: Indicator Management (IM)

General Information

Indicator is defined as a tool that is used to measure and evaluate a specific situation, process or result, and that provides simple and effective presentation of complex information. Indicators are measurable elements that allow monitoring and evaluation of service processes, especially administrative, financial and medical processes, of healthcare institutions/organizations, and reflect the performance of healthcare service processes. By effectively managing indicators, healthcare institutions/organizations can identify areas that need improvement, monitor them and develop applications in this regard. In addition, , indicators is able to contribute to achieving targets by providing information to health institutions/organizations and make it possible to make comparisons. This chapter provides guidance to all healthcare institutions/organizations in the effective management of indicators.

Purpose

The purpose of this chapter is:

- To evaluate and monitor the performance of processes related to service delivery, especially administrative, financial and medical processes, through indicators and ensure continuous improvement of quality.

Objectivess

Although they vary according to the nature of the indicators, the general targets are as follows;

- Efficacy
- Effectiveness
- Efficiency

Standard Requirements

Standard 1

IM.1
Processes and rules regarding indicator management are defined and functioning is ensured accordingly.

IM.1.1
Processes and rules for indicator management are documented.

» Processes and rules for indicator management are include at least the following:
  - Indicators to be monitored
  - Data collection process
  - Data analysis
  - Post-analysis improvement efforts

IM.1.2
Duties, authorities and responsibilities regarding indicator management are defined.

» Processes for monitoring indicators are coordinated by the quality management structure; roles, authorities and responsibilities are defined within the framework of indicator management processes.

» Active participation of all relevant employees and units in indicator management processes are ensured.

IM.1.3
Indicators for performance measurement are determi-ned and monitored.

» The institution/organization is determined and monitor indicators within the scope of the SAS Indicator List as part of the quality improvement system (See SAS (accreditation standards in healthcare) Indicator List)

» Indicators are determined by senior management in coordination with the Quality Management Structure.
  - When determining indicators, issues such as the institution/organization's service area, areas open to improvement compared to previous indicator results, etc. are taken into account.

» The monitoring process of these indicators included in the measurement systematic is carried out in a way to cover the results of implementation and improvement activities.

» The institution/organization is also determine new indicators outside the SAS Indicator List to support continuous improvement efforts.
  - Indicators determined outside the SAS Indicator List is valid, reliable, applicable, acceptable and measurable.
  - The monitoring process of these indicators included in the measurement systematics are carried out in a way that includes the results of implementation and improvement activities.

» The monitoring process of the determined indicators are carried out in a way that

includes the results of the implementation and improvement activities.
    - The institution/organization evaluate the indicators it has determined in terms of their contribution to improvement efforts and define rules such as monitoring frequency, termination of monitoring, etc.
    - Indicators are monitored throughout the institution/organization and at the relevant unit/service level, in accordance with their purpose.
- » The institution/organization shares at least 5 of the results related to the indicators it has determined, openly to the public via its corporate website.

IM.1.4
Indicator cards are created to monitor the determined indicators.

- » Indicator cards are created to include at least the following points;
    - Brief definition of the indicator
    - Purpose
    - Process to which it relates
    - Calculation method/formula
    - Target value
    - Data source
    - Data collection and analysis period
    - Persons responsible for the collection, monitoring, evaluation and analysis of data related to the indicator
    - Parties with whom the results will be shared
    - Special considerations regarding the indicator
- » Indicator cards are regularly updated and continuously improved.
- » Indicator target values are determined by taking into account national/ international criteria and guidelines.

IM.1.5
Indicator data is collected accurately and in high qua-lity using appropriate methods.

- » Processes for data collection are defined.
- » Data sources to be used for indicators are defined.
- » To ensure the reliability and accuracy of indicator data, an effective data collection method is used.
    - Data collection method and period are determined according to the characteristics of the indicator.
    - Information management system infrastructures or existing national/ international data systems are preferably be used.

IM.1.6
Relevant employees are trained regarding indicator management.

- » Training on indicator management include at least the following topics:
    - Purpose and importance of the indicator
    - Data collection method and period
    - Target value determination
    - Data analysis method

- Reporting processes and improvement studies
- Data entry into information systems (practical training, simulation, etc.)

» Training is recorded and traceable.

Standard 2

IM.2
The effectiveness of indicator management is ensured.

IM.2.1
Indicators are analyzed and necessary improvement studies are carried out.

» In order to evaluate the indicator results, the analysis method for the indicators monitored within the institution/organization are determined.
- Indicators are analyzed using statistical methods in a way that will produce results that will improve service quality.
- Simple statistical techniques can be used for analysis, as well as advanced statistical methods, depending on the purpose.

» Necessary improvement work is carried out by taking into account the analysis results.

» Analysis results are shared with senior management and relevant unit employees.

IM.2.2
Indicator data, targets and results are sent to relevant information management systems.

» Indicator data, targets and results are sent to the TÜSKAnet Indicator Management System at specified periods for each indicator.

» Information management systems are used for every possible indicator, and measures are taken to obtain accurate and high-quality data.


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Definitions

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SAS


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Adverse Effect: The unintended and harmful effects arise from the usage of a medicine in accepted normal dosages.

Adverse Event: Events that affect the safety of patient, relatives, employees or the other people in the health institution.
Adverse events related to patient safety; drug safety, surgical safety, transfusion safety, facility safety, radiation safety, issues such as information security can occur.
Adverse events related to employee safety; stab wounds, facility safety, radiation safety, occupational infections, issues such as contact with blood and body fluids, violance against employee can occur.

Analytical Process: The test results of the analysis of the samples until the approval process.
Anamnesis: It is the medical history of a patient obtained from the questions asked to the patient to diagnose the disease.

Antibiotic Susceptibility Test: The test performed in order to determine bacterium produced from samples taken from a living donor is sensitive to which antibiotics and to which concentrations of them.

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 institution's mission and vision with corporate goals and objectives.

Biological Validation: It is the 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, is 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 is placed in the compelling package and this package is 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 is repeated in three consecutive tests, both on the empty sterilizer and at full load with each load type. Biological validation is complete if it is verified that no living spores remain in all cycles. Since the product will be delivered according to the results of the biological control, a biological indicator is used in each load and if there is no growth, the material are delivered.

Blood Product: Therapeutic products derived from human blood or plasma.

Calibration: A number of processes correlating between the values which a measuring device or measuring system show and known values of measured ones under certain circumstances.

Definitions

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 Form: 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.

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 refered 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.

Donor: The person giving whole blood or blood components.

Early Warning Scores: These are the scores consisting of physiological parameters developed to recognize the deteriorating patient in the earliest period and to gain time for the necessary intervention.

Emergency Health Services: They are all of the services that is given to the patient in ER in

order to prevent death or disability in case of sudden sickness, accident, injury or suchlike. Equivalent Dose for Radiation: It is the dose obtained when the dose absorbed, according to the type and energy of the radiation, by a tissue or organ is multiplied by the radiation weighting factor, and it is expressed in Sievert (Sv).

External Document: Document not prepared by the institution itself, but benefited from the realization of the activities.

External Quality Assessment Programme: Their performance is evaluted in comparison with the analytical laboratories in certain ranges programs.

E**xternal Quality Assessment Test Sample:** External quality assessment prepared under the program and the value of the external quality assessment Office if unknow by the participants, sent to participating laboratories test sample at regular intervals.

Facility Management: For health institution 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.

Feedback: Term means opinion, suggestion, request or complaints about service provision obtained from patient, patient relatives, institution employees or community via convenient tools such as surveys, phone calls, etc…

Flash Sterilization: It is the process of washing and drying medical devices in the of use in emergency situations and sterilizing them in a short time using a special program in steam autoclaves without being packaged.

Form: Document prepared for filling write the desired data or information.
Fresh Whole Blood: Whole blood waited less than 24 hours

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 organisation wants to reach in the long term.

Governance: Refers to a multi-actor, participatory, and interactive management process that goes beyond the traditional single-actor understanding of administration. In this sense, it provides a comprehensive framework that not only involves decision-making but also defines how, by whom, and in what manner decisions are made.

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.

Definitions

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.
Health Service Related Infection: Infections which doesn't exist or isn't in incubation period at admission and which emerged in a health institution/organisation or another health institution during health service provision. Infections that emerge related to the service provision at institution after discharge and occupation related infections of employees at institution are also in this category.

Heavy Metal Containing Wastes: The wastes containing mercury, cadmium, lead included in tools and equipment such as thermometer, blood pressure measuring device and panels for radiation protection in medical applications such as the treatment and diagnosis in units.
Hemovijilans: It is a number of following process which will involve drawing blood and giving it to the recipient and which will be able to provide a safer and more effective use of side effects, adverse events and blood products along the chain including the continuation of the process.

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 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.

Hospitality Services: In the health institution, except of the scope of medical services, they are services offering the accommodation, 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.

Household Waste: Non-contaminated wastes, which is mainly originated from kitchen, garden, and administrative units

Indication: It is a term, which refers that situations, in which is 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.

Infection Control Bundles: These are checklists prepared to ensure that proven useful infection measures are applied in bundles according to the clinical situation, rather than individually.

It is important to ensure full compliance with control bundles and to be applicable and auditable for each patient 24 hours a day, seven days a week. The basic principles in all bundle applications are defined as the unnecessary use of invasive instruments, hand hygiene during daily medical practices, compliance with the rules of asepsis and antisepsis, and the termination of the use of invasive devices as soon as possible.

Infectious Waste: Laboratory cultures and cultural inventories of infectious agents such as all kinds of body fluids and human tissues, organs, placenta, fetus, 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.

Inpatients: They are the patients stay procedures and necessary diagnostic and therapeutic procedures. Patients who are under observation in the emergency department, with hospitilization procedure for a day (chemotherapy, radiation therapy, physical therapy, patients are given dialysis services, etc.) and necessary follow-up as the result of a special procedure (monitoring of the patient for a while with endoscopic sedation, etc.) are included to inpatiens.

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.)
Internal Quality Control: The process is working the results of measurements with known samples top check the expected performance.

Isolation Precautions: Activities carried out and measures toprevent transmission of apathogen microorganism from person to person, from person to envoirment or vice versa. Limitations: It is providing control of the physical activities against risk of giving harm to self or others of the patient.

Limited Antibiotic Reporting: Within the stated conditions, elective reporting the results of antibiotic susceptibility test performed within the determined frame of international rules. The results related to the drugs which are needed to state are reported.

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.

Measurement Uncertainty: A parameter that characterizes the dispersion of the values that could correspond with the measured values, defines the actual value of the quantity being measured around the range can be found.

Medical Gas: Gas that is produced and packed to be used in anesthetic processes or diagnosis and treatment interventions.

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 institution's being, it's philosopy with provided products and services that lays down their unique differences and separate them from other health institutions.

Morbidity: incidence of disease

Mortality: incidence of death

Narcotic Medicine: These are medicines that are like morphine and has painkiller specifications, natural, semi artificial and artificial and these 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.

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 stay procedures but with necessary diagnostic and therapeutic procedures.

Outsourcing: It means that the health service provider receives some services from an institution or organization other than the health institution through a contract, protocol or public-private cooperation method

Panic/Critical Value: Values of result that requires clinical laboratory testing, may pose a risk to the health of the patient, the patient's physician as soon as possible to inform and

advanced diagnostic, therapeutic and / or prophylactic medical intervention.

Particle: Solid or liquid particles, usually microscopic in size, found in an environment.

Pathogen Microorganism: Microorganisms that cause infectious diseases

Pathological Waste: Tissues, organs, body parts, human fetal arising as a result of surgical intervention.

Parametric Validation: It is the process validation based on the measurement of the physical parameters of sterilization. Product delivery is made according to the measurement results of critical parameters (parametric product delivery). The test charts obtained with the reference load are compared with the cycle chart in each cycle to determine whether there is a deviation and the product is delivered by interpreting the daily Bowie-Dick and weekly vacuum leak results. In this case, the necessity of using chemical and biological indicators (except Bowie-Dick and Exposure indicators) in routine controls is eliminated. In order to be able to deliver parametric products, it is obligatory to perform proficiency tests at the steam sterilizer at installation (installation validation) and at the start of operation (operation and performance validation) and to be repeated once a year (performance requalification).

Patient Care: It encompasses all services provided to patients during the period from their admission to the healthcare institution until their discharge, including post-discharge monitoring.

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 achievemant of steps, what, when, why and document that shows how to do it.

Postanalitytical Process: They are the processes that held after the analysis from the approval of the results.

Postoperative Period: The period after surgical operation

Postpostanalytical Process: It states that interpretation of results in order to ensure patients benefit, determining the needs of additional test, and hence giving the right decisions for the patient's diagnosis treatment or follow-up about laboratory to provide information and guidance support.

Preanalytical Process: After the last sampling test order to the patient until analysis, samples transfer, the adoption of the laboratory sample, covers all the stages including the storage and preparation of analysis.

Preoperative Period: The period before surgical operation

Prepreanalytical Process: the patient process to test request.

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.

Products Obtained by Apheresis: Blood products which is obtained decomposing whole blood by the help of automatic devices after the blood is taken out of vein.
Products Obtained from Whole Blood: The products obtained as a result of processing the whole blood.

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.

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 cause physical addiction when used for a long time.

Quiet Room: It is a room designed to prevent the patients to harm themselves in the psychiatric emergency room.
Radioactive Waste: Waste including radioactive material such as fluids left from radiation therapy or laboratory research; contaminated glassware, packaging or paper; open radionuclides and feces and urine of patients who are treated or examined, sealed radioactive sources.

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

Reference Range: Reference to certain individuals in a population for a test of the minimum

and maximum range of values obtained.

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 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 child, surgery, 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 institution/organisation.

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 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.
Surveillance: It is the systematic observation made on how the certain diseases occur and spread.

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

Transfusion Center: A unit which is not entitled to draw blood from the blood donor except in an emergency, crossmatching the obtained blood and blood component for transfusion ve preparing the required tests for the use of patients.

Transfusion Reactions: Adverse effects in the receiver during or after the transfusion of blood and blood components.

Transfusion: Tansfusion of whole blood or blood component to the patient in need due to health problem.

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 country 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.

Virulence: Ability of a pathogen (bacteria, virus etc.) to cause a disease

Vision: Expressing that health institution hoping 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.

Whole Blood: Blood which was taken in a sterile bag containing anticoagulant preservative liquid from a donor and wasn't decomposed.

Abbreviations

IMS: Information Management System. Trained users and devices connected to the computer through a network of institutions, every effort is made to perform (clinic, laboratory, radiology, pharmacy services ect), with electronic software to maintain the record.

SAS: Standards of Accreditation in Health

Table of Changes for SAS Outpatient Health Services Set– v2/2025 (Detailed)

During the reaccreditation process for the SAS Outpatient Health Services Set-v2/2025, based on all feedback received regarding the Standards, ISQua principles, and reviews of the international literature, changes have been made in areas requiring major revisions to the Standards, and the has been revised to consist of 8 sections, 28 chapters, 79 standards, and 351 assessment criteria.

Click here to view all significant changes made to the dimensions, sections, Standards, Assessment Criteria, Standard requirements, and indicators included in the Reaccredited SAS Outpatient Health Services Set– v2/2025.


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Indicator List

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TÜSKA SAS Outpatient Health Services Set (v2/2025) Indicator List

No	Indicator Name
1	Target Achievement Rate
2	Rate of Completion of Corrective and Improvement Activities (CIA)
3	Rate of Adverse Event Reporting per Employee
4	Staff Training Participation Rate
5	Implementation Rate of Planned Training Courses
6	Employee Satisfaction Rate
7	Staff Turnover Rate
8	Injury Rate from Cutting/Piercing Tools
9	Rate of Exposure to Blood and Body Fluids
10	Incidence of Violence Against Employees
11	Completion Rate of Employee Health Checks
12	Patient Satisfaction Rate
13	Patient Fall Rate
14	Hand Hygiene Compliance Rate
15	Hand Antiseptic Consumption Rate
16	Adverse Effect Incidence Rate
17	Medication Error Incidence Rate
18	Number of Drug Interactions Observed
19	Rate of Medicines Disposed Of
20	Proportion of Blood and Blood Products Destroyed (Adapted)
21	Rate of Correctly Completed Blood and Blood Product Tracking Forms (Adapted)

22	Mortality Rate
23	Number of Repeat X-rays
24	Waiting Times in Radiation Areas
25	Number of Imaging Procedures Performed on Pregnant Patients and Those with Suspected Pregnancy
26	Proportion of Rejected Samples in Clinical Laboratory Tests
27	Proportion of Incorrectly Identified Samples in Clinical Laboratory Tests
28	Rate of Lost Samples
29	Rate of Samples Requiring Re-collection
30	Panic Value Reporting Rate
31	Rate of Results Not Provided on Time
32	Incorrect Reporting Rate for Clinical Laboratory Tests
33	Safe Surgery Checklist (SSC) Usage Rate
34	Successful Pregnancy Rate Following Artificial Insemination and IVF Procedures
35	Rate of Use of Psychotropic and Narcotic Medicines in A&E Departments
36	Patient Referral Rate
37	Number of Days with Equipment Failures
38	Average Response Time to Facility-Related Issues
39	Average Response Time for Information Management System Failures
40	Duration of Information Management System Downtime
41	Average Response Time for Equipment Failures
42	Equipment Failure Rate
43	Fulfilment Rate for Information Management System Revision Requests
44	Compliance Rate with the Target Response Time in the Emergency Code Alert System

45	Proportion of Patient Files Delivered to the Archive on Time
46	Proportion of Complete Patient Files
47	Average Length of Patient Stay
48	Sustainability Training Participation Rate
49	Waste Reduction Rate
50	Recycled Waste Rate
51	Share of Total Accrued Revenue from Laboratory Expenditure
52	Share of Medicines and Medical Consumables Expenditure in Service Revenue
53	Share of Staff Expenditure in Service Accrued Revenue
54	Budget Balance Index

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