CAYMAN ISLANDS

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NATIONAL STANDARDS (2007) CHECKLISTS (REVISED NOV 2009)

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NATIONAL STANDARDS [2007] CHECKLISTS (Revised Nov 2009)

The following is produced for guidance as to the minimum standards to be met by all health care facilities for registration by the Cayman Islands Health Practice Commission.

Key Values

- Patient-Centred Services
- Patient Information
- Management and Personnel
- Accountability
- Consistency
- Safety and Quality Assurance

Core Standards	Outcomes
1.0 Information Provision	Patients receive clear and accurate information regarding their treatment and its likely costs.
2.0 Management and Personnel	Treatment provided to patients is in line with the relevant guidelines.
3.0 Premises and Facilities	Patients receive treatment in premises that are safe and appropriate for that treatment.
4.0 Materials and Equipment	Patients receive treatment using equipment and supplies that are safe and in good condition.
5.0 Quality of Treatment and Care	The treatment and care provided is patient centred. Appropriate policies and procedures are in place to help ensure the quality of treatment and services.
6.0 Records and Information Management	Records are created, maintained and stored to standards which meet regulatory compliance and professional practice recommendations. Patients are assured that all information is managed within the regulated body to ensure patient confidentiality.
7.0 Risk Management Procedures	Patients, staff and persons visiting the registered premises are assured that all risks connected with the establishment, treatment and services are identified, assessed and managed appropriately.
8.0 Research	Any research conducted in the establishment is carried out with appropriate consent and authorization from all patients involved, in line with published guidance on the conduct of research projects.

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HEALTH PRACTICE COMMISSION
National Standards [2007]
Health Care Facilities – Checklist A

A-1.0 Information Provision
The following information shall be prominently displayed and made readily available to the public.

A-1.1 Public Information

1.1.1. Proof of facility and professional registration (displayed)
1.1.2. Hours of operation (displayed)
1.1.3. Services provided by the facility
1.1.4. Current fee schedule

A-1.2 Patient Education

1.2.1 Clinical information, defined as the description of clinical services provided and the types of treatment offered, shall be provided to all clients as outlined by respective Council.

A-1.3 Administrative Information (i.e. management structure)

A-2.0 Management and Personnel

A-2.1 A clear organizational plan shall be established.
A-2.2 A comprehensive operational plan shall be developed and implemented.
A-2.3 There shall be adequate numbers of personnel (Clinical and non-clinical) in keeping with the nature of the business.
A-2.4 Suitably qualified persons shall be employed by the business.
A-2.5 Working conditions shall be in compliance with the Cayman Islands Labour Law (2001 Revision) Part VIII, Sections (59-61)

A-3.0 Premises and Facilities

A-3.1 Structure and Design

3.1.1 The structure and design of the facility shall be in compliance with the Cayman Islands Building Codes ensuring public access to parking, ramps, bathrooms etc.
3.1.2 Accessibility and fire routes shall meet requirements as set out in the Cayman Islands Building Codes and the Fire Brigade Law (1999 Revision).
3.1.3 Facilities design shall be compatible with services offered, e.g. laboratory, diagnostic imaging, and shall ensure quality service delivery.
3.1.4 Premises (internal and external) shall be designed and maintained with the safety of patients in mind and ensure that the patient's privacy and dignity is protected.
3.1.5 Where patients are required to undress, changing room facilities shall enable privacy and dignity.
3.1.6 Indoor air quality shall meet internationally accepted air quality standards.

3.1.6 Ventilation shall be appropriate to the services provided by the facility.
3.1.7 All areas used by patients shall be well lit, internally and externally.
3.1.8 There shall be fail-safe emergency lighting in place.
3.1.9 Emergency contingency plans for major plant failure or loss of utilities such as electricity, gas or water supplies shall be in place.
3.1.10 All task lighting shall be appropriate to facility operations and in good working condition.

A-3.2 Maintenance Programme and Procedures

3.2.1 A comprehensive maintenance programme for the premises and all health care equipment shall be documented and adhered to.
3.2.2 Safe temperatures shall be monitored and maintained for all hot water supplies and the surfaces of heating appliances in all areas.

A-3.3 Waste Management

3.3.1 Waste shall be segregated into clinical and non-clinical items and stored in colour-coded bags and appropriate containers.
3.3.2 Clinical waste shall be labeled to enable it to be traced back to its point of origin.
3.3.3 Clinical waste stored outside the building shall be kept in closed containers clearly labeled as containing biohazardous waste.
3.3.4 The collection, segregation, packaging and disposal of all waste (refuse, garbage, hazardous materials and infectious waste) shall be in compliance with the following Cayman Islands regulations:

a. Dangerous Substances, Handling and Storage Law 2003, Section (12) subsection (1b).
b. Public Health (Garbage and Refuse Disposal) Regulations 2003
c. Public Health (Infectious Waste) Regulations (2002 Revision).

A-3.4 Health and Safety

3.4.1 Fire Safety

3.4.1.1 A fire emergency response plan shall be documented and accessible to all staff.
3.4.1.2 The premises shall be equipped with appropriate, adequate numbers and appropriately positioned fire alerts, detection and fire fighting equipment.
3.4.1.3 All fire safety equipment shall be unobstructed, accessible, regularly serviced and maintained and in good working order.
3.4.1.4 All staff shall be trained in appropriate fire response procedures, and fire drills shall be conducted regularly.

3.4.2 Ergonomics

3.4.2.1 Facility design, layout and equipment selection shall, as far as reasonably practical, minimize the risk of repetitive strain injuries.

3.4.2.2 Procedures for the review and selection of appropriate ergonomic solutions shall be implemented.

3.4.3 A system for the prevention, reporting and investigation of accidents shall be documented and employed.

3.4.4 Hazardous Materials

3.4.4.1 An inventory of all hazardous materials used and/or stored and stock balances shall be maintained.

3.4.4.2 Appropriate personal protective equipment shall be available and accessible, and training on the fit and use of such equipment provided to staff.

3.4.4.3 Procedures for decontamination of surfaces and equipment contaminated by hazardous substances shall be documented and adhered to.

3.4.4.4 The handling, storage, transportation and disposal of hazardous materials shall be in compliance with the Cayman Islands Dangerous Substances Handling and Storage Law 2003, Section (12).

A-4.0 Material and Equipment

A-4.1 Equipment selected and used within the establishment shall be wholly appropriate for the treatment or services provided.

A-4.2 All materials and equipment shall be clean, in good working order and stored in a clean and safe manner.

A-4.3 Clinical equipment shall be installed, used and serviced in accordance with manufacturer instructions, and shall not be modified and/or used for purposes for which it was not designed without documented advice from the manufacturer.

A-4.4 All stock products used in the establishment shall be used in date in order to ensure that at the time of use they are in optimum condition and within expiry dates.

A-4.5 Sterile supplies shall be in appropriately sealed packaging, stored in a clean area and not beyond the date of expiry indicated on the label/packaging.

A-4.6 Heat, light and/or temperature sensitive items shall be stored in a controlled environment to keep the items in optimum condition.

A-4.7 A planned programme of safe and regular maintenance that conforms to manufacturer recommendations that shall be in place for all equipment. This shall include:

4.7.1 Preventative maintenance

4.7.2 Replacement programme

4.7.3 Recordkeeping

A-5.0 Quality of Treatment and Care

A-5.1 Policies and procedures shall be in place to ensure that the care provided is patient centred.

A-5.2 Ongoing Patient Satisfaction Surveys shall be conducted.
A-5.3 Services offered shall be reasonably accessible, i.e. availability of appointments and shortest possible waiting times.
A-5.4 Information regarding the services provider's scope of practice and availability shall be provided to all clients and prospective clients.

A-6.0 Records and Information Management

A-6.1 All patient records and information shall be stored in a secure manner that ensures confidentiality.
A-6.2 Patient records stored for an extended period as required by legal and professional regulations shall be maintained in an appropriate medium and secure location.
A-6.3 Disposal of patient records shall be carried out in a manner that safeguards the patient confidentiality.
A-6.4 A system for the storage of and restricted access to financial and personnel records shall be maintained.
A-6.5 Operational records (manuals, records, logs, policies, procedures and protocols) shall be maintained and stored in appropriate media.

A-7.0 Risk Management Procedures

A-7.1 A process for the receipt, investigation and resolution of complaints shall be in place.
A-7.2 The establishment shall possess adequate insurance coverage against professional malpractice and public liability, and health insurance for all employees.
A-7.3 An infection control programme shall be in place to prevent infection in patients and employees, and environmental contamination and shall include:-

7.3.1 Use of the universal/standard precautions
7.3.2 Decontamination procedures
7.3.3 Procedures for handling, segregation, containment and disposal of hazardous waste.
7.3.4 Procedures for patient, employee and environmental monitoring.

A-8.0 Research

A-8.1 All approved research applications shall be subject to the following guidelines:-

8.1.1 A clear, ethical process shall be established
8.1.2 All participants, having received all relevant information regarding the study, shall have given written consent prior to enrollment.
8.1.3 Record keeping shall be thorough, appropriate and ensure patient confidentiality.

HEALTH PRACTICE COMMISSION
National Standards
Private Medical Offices – Checklist B

These standards cover a variety of services that are provided by private medical practitioners. They apply to:-

- Private walk-in medical centres where services are provided by a medical practitioner
- Exclusively private medical practitioners
- Agencies that provide medical practitioners to private patients, for example, in the patient's home, hotel or workplace

The Cayman Islands' National Standards for Health Care Facilities shall apply to said establishments.

B-1.0 Minor Surgery

B-1.1 Where minor surgery takes place; it shall be performed in a suitably designed and maintained room.
B-1.2 Walls and floors of minor surgery shall be finished in a material that keeps it free from infection.
B-1.3 A surgical table shall be provided for such procedures.
B-1.4 All health care professionals employed by the establishment shall be trained in basic life support.
B-1.5 Resuscitation equipment shall be available and shall be checked at least weekly.
B-1.6 There shall be procedures for responding to emergencies including arrangements for transfers to hospital.

B-2.0 Resuscitation Equipment

B-2.1 Resuscitation equipment shall be available and easily accessible.
B-2.2 Equipment for resuscitating patients shall include:

- a defibrillator,
- portable oxygen with appropriate valves, mask, metering and delivery system,
- first line resuscitation drugs,
- equipment for securing and maintaining the airway of a patient, and
- equipment necessary for the insertion and maintenance of intravenous infusions.

B-2.3 Resuscitation equipment shall be checked regularly and restocked to ensure all equipment remains in working order and that there are no expired drugs.

B-2.4 Equipment shall be secured from tampering.
B-2.5 All equipment and medication checks shall be recorded and each entry dated and signed.
B-2.6 Equipment shall be cleaned and decontaminated after each use.
B-2.7 All personnel shall be aware of the location of resuscitation equipment.

B-3.0 Operating Theatres

B-3.1 Walls and floors shall be finished in a material that keeps it free from infection.
B-3.2 Operating theatres shall be of sufficient size to accommodate the patient, their escort and all necessary professional personnel.
B-3.3 Support services, including pathology and radiology, shall be provided.
B-3.4 Instruments and equipment shall be received from a sterile services unit.
B-3.5 Full equipment for endotracheal intubation shall be readily available, and there shall be immediate access to spare apparatus in the event of a failure.
B-3.6 There shall be appropriate and effective suction apparatus, which is portable and independently powered.
B-3.7 Whenever artificial ventilation equipment is used, a disconnect alarm shall be used.
B-3.8 There shall be an emergency power supply for the operating theatre in the event of an interruption to the main supply.

B-4.0 Medicines Management

B-4.1 All medicines shall be stored safely, securely and at appropriate temperatures.
B-4.2 Procedures for ordering, receiving, recording and dispensing medicines shall be in place.
B-4.3 All controlled drugs shall be stored in a locked cupboard or cabinet, and shall be accessed by a medical practitioner, pharmacist or registered nurse only.
B-4.4 A controlled drugs logbook shall be maintained and kept in a location near to the storage area for said medicines.
B-4.5 Records containing drug names, brand, batch numbers, expiry dates, quantities and, where relevant, patient's name shall be maintained for the following:

- Received medicines
- Dispensed medicines
- Returned medicines
- Disposed medicines
- Controlled drugs

B-4.6 To ensure the safety of patients and health care personnel anti-neoplastic drugs shall be prepared in a suitable environment by appropriately trained pharmacy personnel only.
B-4.7 Cytotoxic drugs shall be dispensed by suitable trained pharmacists only.
B-4.8 Cytotoxic waste shall be disposed on in puncture resistant, leak proof containers and shall appropriately labeled as ‘Cytotoxic’.

HEALTH PRACTICE COMMISSION
National Standards
Laboratory Services – Checklist C

The following standards apply to all laboratory facilities. The Cayman Islands' National Standards for Health Care Facilities shall apply to such establishments.

C-1.0 Administrative

C-1.1 Operations

1.1.1 There shall be documented organizational procedures including, but not limited to, the following:
- Standard Operating Procedures
- Staff Orientation
- Training
- Safety Practices
- Fire Safety
- Hazardous Materials Management including emergency procedures for controlling spills
- Equipment Maintenance Programme
- Disaster Preparedness

1.1.2 Procedure manual shall be available and accessible to all employees, and shall be reviewed and updated at least annually.

1.1.3 All training and service records shall be maintained for 3 years, and made available in the event of an external audit.

C-1.2 General Safety

1.2.1 Safety inspections shall be conducted regularly and findings documented. Inspection records shall be maintained for 3 years.

1.2.2 There shall be a qualified first aid officer on site.

1.2.3 First aid kits shall be available, accessible, adequately stocked and in a prominent location.

1.2.4 Emergency equipment (emergency showers, eyewash facilities, fire fighting) shall be tested and inspected on a regular basis.

1.2.5 A system for reporting and recording all incidents and accidents shall be in place.

1.2.6 Personal protective equipment necessary for the protection of employees from hazards associated with laboratory operations shall be available and accessible at all times.

1.2.7 Storage and consumption of food and/or drink in the laboratory area is strictly prohibited.

1.2.8 Mouth pipetting is prohibited.

1.2.9 All public advisory signs, e.g. "no Smoking", "Biohazard", shall be of a reasonable size print, prominently displayed, and bearing internally recognized logos where appropriate.

1.2.10 Security measures shall be in place to restrict unauthorized access to laboratory areas.
1.2.11 All corridors shall be free from obstructions.
1.2.12 Emergency telephone numbers shall be prominently displayed throughout the laboratory, and beside or on all telephones.
1.2.13 Emergency evacuation procedures shall be in place, and drills conducted regularly.

C- 1.3 Structure and Layout

1.3.1 Layout of work area is suitable for the tasks undertaken
1.3.2 All work surfaces are non-permeable and free from defects.
1.3.3 Adequate hand washing facilities shall be available, accessible, and in working order.

C 1.4 Human Resources

1.4.1 Professional staff shall be registered with the Health Practice Commission.
1.4.2 Staff shall receive orientation upon initial assignment to the laboratory, and any additional training deemed necessary for work in that environment.
1.4.3 Training records shall be maintained for 3 years.

C-2.0 Fire Safety

C-2.1 Procedures

2.1.1 Fire safety procedures, including alarm activation, evacuation and equipment shutdown, shall be documented, and available and accessible to employees.
2.1.2 Fire safety training shall be conducted for all new employees, and at regular intervals.
2.1.3 Fire drills shall be conducted at least biannually.
2.1.4 Laboratory floor plan illustrating emergency evacuation routes shall be prominently posted.
2.1.5 All staff shall participate in annual fire safety training, which includes, but is not limited to, facility evacuation procedures and the use of fire extinguishers.
2.1.6 If the laboratory classified as “ordinary hazard” is not protected by an automatic extinguishing system, it shall be separated from surrounding health care areas and from exit access corridors by fire barrier walls and assemblies (doors, windows) with a minimum 1-hour-fire-resistant rating.
2.1.7 Equipment (open system) that release ignitable vapours into the ambient workspace shall be operated at least 5 feet from stored combustible materials unless separated by 1-hour-fire-resistive construction. Closed systems shall be provided with audible and visual alarms for low liquid level, and high vapour levels.

C-2.2 Exits

2.2.1 Laboratory size in excess of 100 sq. ft. shall have at least two (2) exit access doors remote from each other, one of which must open directly onto a means of egress. The other door may open into another room, providing 1-hour-fire-resistant rating construction separates the two areas.
2.2.2 Travel distance between any point in the lab and an exit door shall not exceed 75 ft.
2.2.3 Corridors shall be maintained clear and unobstructed at all times.
2.2.4 Corridors used for transporting patients, and representing access to an exit shall not be less than 96 inches in clear unobstructed width.
2.2.5 All exit signs shall be illuminated and clearly visible.
2.2.6 Fire-resistant rated doors shall not be held open by any means other than an automatic release device.

C-2.3 Fire Protection System

2.3.1 Fire alarms shall be installed, audible throughout the laboratory, and tested and serviced at regular intervals.
2.3.2 Fire detection devices, i.e. thermal/smoke detectors, shall be free from defects, and unobstructed at all times.
2.3.3 All fire suppression equipment shall be regularly maintained.
2.3.4 Where an automatic fire suppression system exists, it shall be connected to the facility fire alarm system.
2.3.5 Portable fire extinguishers shall be suitable for the particular hazard, available, accessible, and inspected annually with proof of inspection attached.
2.3.6 Fume hoods shall be vented to discharge above the roof.

C-3.0 Flammable and Combustible Liquids

C-3.1 General

3.1.1 Standard operating procedures relating to safety and health considerations shall be followed.
3.1.2 Staff shall receive orientation and any relevant training upon initial assignment to the laboratory.
3.1.3 Chemical inventory shall be maintained, reviewed and updated at regular intervals, and a list provided to the Cayman Islands Fire Service.
3.1.4 Reference material on hazards, safe handling, storage and disposal of flammable and combustible liquids, including but not limited to Material Safety Data Sheets (“MSDS”) received from the chemical supplier shall be available and accessible.
3.1.5 All containers shall be appropriately labeled.

C-3.2 Safety

3.2.1 All hazardous chemicals shall be handled and used with care and knowledge of the hazardous properties both individually and in combination with other materials with which they come in contact.
3.2.2 Controls ensuring appropriate facilities and procedures are available for receiving, storing, use and disposal of hazardous chemicals shall be in place.

C-3.3 Storage and Use

3.3.1 Storage containers shall be appropriate and approved for that purpose.
3.3.2 Chemicals shall not be stored in fume hoods.
3.3.3 Glass containers shall be transported within the laboratory in safety carrying devices.
3.3.4 Total volume of hazardous liquids shall not exceed 2 gallons per 100 feet.
3.3.5 Reliable stock inventory system shall be in place. Quantities of hazardous liquids for disposal shall be included in the total inventory.
3.3.6 Refrigerators used for the storage of chemicals shall be appropriately labeled and used exclusively for that purpose.
3.3.7 Flammable and combustible liquids shall not be stored or transferred from one vessel to another in any exit corridor.
3.3.8 Flammable and combustible liquids shall not be positioned near any heat source.
3.3.9 Transfer of chemicals from bulk stock to smaller containers shall be made with fume hoods having a velocity of at least 100 ft. per minute.
3.3.10 Appropriate personal protective equipment shall be worn when handling chemicals.

C-3.4 Disposal

3.4.1 Disposal of flammable and combustible liquids shall be in accordance with the Cayman Islands Department of Environmental Health regulations.
3.4.2 Procedures for disposal shall be documented and accessible to all employees.

C-3.5 Emergencies involving Hazardous Chemicals

3.5.1 Accidental release measures and spill clean up procedures shall be in place and documented.
3.5.2 Spill kits shall be appropriate to the chemical and shall be located in the area of use.
3.5.3 Staff shall be trained in spill clean up procedures.

C-4.0 Compressed Gases

C-4.1 Staff shall have knowledge of hazards associated with the transportation, storage and use of compressed gas cylinders.
C-4.2 Cylinders shall be stored in well-ventilated rooms or enclosures.

C-4.3 Material Safety Data Sheets shall be available and accessible.
C-4.4 At least 20 ft. shall be maintained between gas cylinders and flammable/combustible materials.
C-4.5 Cylinders not attached to any piped system shall be kept in racks or secured in place.
C-4.6 The number of reserve cylinders within the general laboratory work areas shall not exceed 1 weeks' working supply.
C-4.7 Where a manifold compression system exits the cylinders shall:

- Be in a separate room having at least 1-hour-fire-resistant construction and adequate ventilation, or
- Be located outside the building and connected to the lab equipment by permanently installed piping system.

C-4.8 Pressure regulators shall be compatible with the gas for which they are used.
C-4.9 Gas lines are leak-tested regularly, and findings documented.
C-4.10 If a system is to be converted for the use of a different gas the following must take place:

i. Inspection for suitability for proposed gas
ii. Purged with an inert gas
iii. Cleaned when oil, grease or other readily oxidized materials are present
iv. Pressure testing of the cylinder/system in accordance with the appropriate system.

C-5.0 Biological Safety

C-5.1 Waste

5.1.1 Contaminated waste procedures are in place and adhered to.
5.1.2 Sharps shall be disposed of in leak-and-puncture-resistant containers.
5.1.3 Disposal procedures shall be in accordance with the Department of Environmental Health's regulations.

C-5.2 Cabinets

5.2.1 Biosafety cabinets shall be available, in working order, and inspected and certified annually.
5.2.2 Hoods shall be vented externally, and in reasonable distance from the air handling vents.

C-5.3 Safety

5.3.1 Work surfaces shall be decontaminated in accordance with established and documented procedures.
5.3.2 Safety procedures in the event of a hazardous biological incident shall be in place, and acknowledged by all employees.
5.3.3 Appropriate personal protective equipment is available.

C-6.0 Emergency Procedures

C-6.1 Emergency procedures shall be in place for potential incidents involving chemical, biological, fire, meteorological or topological incidents.

C-6.2 Staff shall receive initial and refresher training in emergency procedures and personal preparedness.

C-6.3 Showers/Eye wash Stations

6.3.1 Emergency showers shall be provided in the work areas for immediate emergency use.
6.3.2 Showers shall be controlled by a non-automatic shut-off device.
6.3.3 Fixed eye baths shall be designed and installed to avoid injurious water pressure, i.e. 1.5L or 0.4 gallons of water delivered per minute.
6.3.4 Showers and eye baths shall be activated weekly and inspected annually.

C-7.0 Electrical and Equipment Safety

C-7.1 Switches and power leads shall be intact and in working order.
C-7.2 Electrical panels and receptacles are covered and intact.
C-7.3 Residual current devices shall be installed in distribution boards where required.
C-7.4 Where electrical outlets are in use within 6 ft. of water Ground Fault Circuit Interrupters shall be installed/in place.
C-7.5 Access doors to high voltage areas shall be appropriately and clearly identified.
C-7.6 Emergency stop switches shall be clearly labeled and accessible.
C-7.7 Spacing of equipment shall be in accordance with manufacturer recommendations.

C-8.0 Quality Assurance

C-8.1 Standard Operating Procedures for all tests performed shall be documented and accessible.

8.1.1 Specimen shall not be accepted and processed without:
- A request form complete with the physician's name
- Appropriate labeling
- Unique patient identifier, and
- Patient information, i.e. date of birth, gender

8.1.2 Accessioning procedures shall be in place.
8.1.3 Tests reports shall be easily retrievable, and stored in a manner that maintains patient confidentiality.

8.1.4 Quality control testing shall be performed and documented for all tests.

C-8.2 Routine maintenance programme including but not limited to daily checks and instrument calibration shall take place.

C-8.3 Reagents and solutions shall be marked with opened, reconstituted and/or expiry dates.

C-8.4 Decontamination procedures for equipment including written confirmation of decontamination prior to servicing are in place.

C-8.5 Procedures shall be documented and followed in the event of:

- Inappropriate specimen labeling
- Absence of a request form
- Compromised specimen
- Rejected specimen
- Storage and retrieval of specimen

HEALTH PRACTICE COMMISSION
National Standards
Pharmacy Premises – Checklist D

The following minimum standards have been established for any establishment involved in the stocking, preparation and dispensing of pharmaceuticals. The Cayman Islands' National Standards for Health Care Facilities shall apply.

D-1.0 General Appearance and Registration

D-1.1 The exterior of the premises shall be kept clean and in good state of repair.
D-1.2 Floor coverings, ceilings, windows, walls, shelves and work surfaces shall be clean and regular cleaning schedules shall be in place.
D-1.3 The shop area shall be clean, tidy and uncluttered.
D-1.4 Registration certificates for the establishment and all dispensing personnel shall be prominently displayed.

D-1.5 All labels on dispensed medicines shall be mechanically printed and shall contain the following:

a. patient's name
b. name and address of the dispensing person or establishment
c. date of dispensing
d. name of product
e. directions for use
f. relevant warning, e.g. "Keep out of reach of children"
g. date of expiry
h. batch number/prescription number

D-1.6 A suitable and hygienic method of counting tablets/caplets shall be in place.
D-1.7 The process of obtaining patient/client information including patient's name, age and relevant medical and medication history shall ensure patient confidentiality.
D-1.8 Procedures for the detection, recording and reporting of adverse events, medication errors, defects in product quality and counterfeit products shall be in place and shall be subject to regular internal audits and review.
D-1.9 A clear policy and procedure shall be in place for the purchasing of medicines.

D-2.0 Operations

D-2.1 Procedures for dispensing medicines shall be in accordance with international regulations and the code of practice of the local regulatory body ensuring correct and correctly labeled medicines are delivered to patients.

2.1.1 All prescriptions and dispensed medicines shall be checked by a pharmacist, and initialed.
2.1.2 All dispensed medicines shall be given out by a registered pharmacist, dispensing pharmacist or pharmacy technician.
2.1.3 There shall be a standardized and endorsed record of all changes made to prescriptions.
2.1.4 Verbal advice to patients shall be done in a professional manner and in a private area to ensure patient confidentiality.
2.1.5 Verbal or written information regarding the dispensed medicine shall be provided to all patients to ensure the maximum benefit is derived from the treatment.

D-2.2 All labels on dispensed medicines shall be mechanically printed and shall contain the following:

a. patient's name
b. name and address of the dispensing person or establishment
c. date of dispensing
d. name of product
e. directions for use
f. relevant warning, e.g. "Keep out of reach of children"
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D-2.6 A clear policy and procedure shall be in place for the purchasing of medicines.

D-3.0 Facilities and Equipment

D-3.1 The establishment shall provide equipment and supplies to carry out its professional and administrative functions.
D-3.2 Adequate and appropriate facilities shall be provided for the storage, safeguarding, preparation and dispensing of drugs.
D-3.3 Premises shall be secure at all times.
D-3.4 The dispensing area shall be clearly identified and access shall be restricted to authorized personnel only.
D-3.5 Dispensary fixtures and fittings including shelves and work surfaces shall be adequate for the purpose for which they are intended.
D-3.6 Surfaces shall be impervious to dirt and moisture, and free from defects.
D-3.7 Adequate seating shall be provided for clients and staff.

D-3.8 A private, quiet area, which safeguards patient confidentiality, shall be available for the counseling of clients.
D-3.9 Sinks shall be clean, and shall have hot and cold water supplies.
D-3.10 The size and layout of the dispensary shall be sufficient to allow effective communication, workflow and safety.
D-3.11 Refrigerators shall be clean, defrosted, in good state of repair, and shall be used for no other purpose than the storage of medicines.
D-3.12 Refrigerator temperatures shall be between 2 and 8 degrees Celsius (35.6-46.4 Fahrenheit), and a written record of daily minimum and maximum temperatures shall be maintained, available and accessible.
D-3.13 A record of refrigerator defrosting dates shall be maintained.
D-3.14 The facility shall have emergency power supply in the event of main supply failure.
D-3.15 All equipment shall be maintained in good working condition and shall be serviced at regular intervals as recommended by the manufacturer.

D-4.0 Medicines Stock, Containers and Storage

D-4.1 Adequate supplies of medicines and devices shall be maintained to meet the needs of the patients.
D-4.2 Any area where medicines are stored shall be periodically checked.
D-4.3 Stock medicines shall be stored appropriately, i.e. in their original boxes, no loose blisters, no mixed batches and in an organized fashion.
D-4.4 Medicines shall be stored in conditions (humidity, temperature etc.) recommended by the manufacturer.
D-4.5 Adequate date checking procedures shall be in place.
D-4.6 Dispensing containers shall be stored in a clean environment and kept free of dust and other contaminants.
D-4.7 Medicines shall be dispensed in child-resistant closures unless otherwise requested. All such requests shall be recorded.
D-4.8 All unwanted, i.e. expired, patient returned and incorrectly, prepared stock, shall be appropriately marked and separated.
D-4.9 All dispensed medicines awaiting collection shall be identifiable within the controlled drug cabinet.
D-4.10 Repackaged medicines (from breaking bulk containers) shall be supplied or sold from establishments with appropriate licences and registration.
D-4.11 Stock audit system with running balances shall be in place.

D-5.0 Controlled Drugs

D-5.1 Staff involved in handling and supply of controlled drugs shall be registered health care professional, and adequately trained.
D-5.2 Standard Operating Procedures for the handling and supply of controlled drugs shall be used.

D-5.3 Procedures for detection, recording and management of untoward incidents involving controlled drugs shall be in place.
D-5.4 All controlled drugs are correctly labeled.
D-5.5 Controlled drug register is maintained in accordance with international regulations.
D-5.6 A record of all patient-returned controlled drugs shall be maintained.

D-6.0 Hazardous Materials

D-6.1Chemicals shall be stored and labeled in accordance with local government regulations.
D-6.2 Procedures for accidental release and spill clean up shall be in place, and shall be in compliance with the Public Health (Infectious Waste) Regulations (2002 Revision) Section (15).

D-7.0 Recordkeeping

D-7.1 A system of recordkeeping and book-keeping shall be established and implemented for accountability and quality assurance.
D-7.2 The following actions shall be accurately recorded in a standardized format, readily accessible to staff, and audited at regular intervals.

7.2.1 Prescriptions received
7.2.2 Stored and sold poisons
7.2.3 Sales of veterinary medicines
7.2.4 Dispensing errors, i.e. errors picked up during the dispensing process
7.2.5 Clinical interventions/significant events

D-7.3 All records shall contain drug or chemical name, brand, batch number, expiry dates, quantities, strength, prescription or label reference and, where relevant, patient's name.

D-8.0 Waste Disposal

D-8.1 Procedures for collection, segregation, and safe disposal of the following shall be in place:

- hazardous waste
- returned medicines
- expired pharmacy stock, and

shall be in compliance with the regulations set out by the following Cayman Islands Dangerous Substances Handling and Storage Law (2003).

D-8.2 Disposal of pharmaceuticals shall be in accordance with the department o Environmental Health ("DEH") Standard Operating Procedures:-

a. A list of drugs and/or chemicals for disposal shall be provided to the DEH.
b. Establishment shall make an appointment with the DEH for delivery of items for disposal.
c. Items shall be contained in red plastic bags indicating that contents are biohazardous.
d. A witness from the establishment shall be present during the incineration of the items.
e. A certificate of disposal listing the disposed items and date of disposal shall be issued to the establishment.

D-8.3 Staff shall be trained in waste management procedures, and appropriate protective equipment shall be readily available and accessible.
D-8.4 Sensitive documents, such as prescriptions, shall be appropriately packaged, identified, and delivered to the DEH for incineration.

D-9.0 Information Sources

D-9.1 To ensure patient safety at all times current information and reference resources shall be maintained.
D-9.2 A reliable system for the notification of drug alerts and subsequent management shall be implemented.

HEALTH PRACTICE COMMISSION
National Standards
Diagnostic Imaging Services – Checklist E

The following are requirement for registration and licensure as a Diagnostic Imaging Service provider. The Cayman Islands' National Standards for Health Care Facilities shall also apply.

E-1.0 Technical Personnel

E1.1 Diagnostic Imaging ("DI") examinations shall be performed by an imaging specialist or a technologist or technician who has current registration with the Health Practice Commission.

E-2.0 Facility

E-2.1 The facility shall provide detailed space for the following functions:

a. Administration
b. Patient waiting area
c. Patient change area
d. Patient washrooms
e. Clerical staff
f. Facility procedures
g. Processing
h. Imaging storage
i. Storage

E-2.2 The facility shall have a properly controlled temperature for the following:
a. Staff and patient safety
b. Film processing
c. Equipment function

E-2.3 The facility should have a wheelchair accessible washroom.
E-2.4 The facility shall have adequate ventilation in all areas.

E-3.0 Medical Records

E-3.1 Medical images shall be identified with the following:
a. Patient name – last name, first name
b. Second patient identifier (e.g. personal health number) and/or date of birth
c. Facility site name

d. Date of examination (where possible, the month should be clearly identified)
e. Medical images should include the following: The technologist/technician initials and the time of the examination

E-3.2 Images may be exchanged for one health professional to another. A copy of the final report shall accompany the exchange.

E-3.3 Master Envelope

3.3.1 The master envelope shall be labeled with the following:

a. Patient name and identification number;
b. Second patient identifier (e.g. personal health number) and/or date of birth.
c. The master envelope should be labeled with the facility name/site.
d. Images and reports shall be stored together in the master envelope.

E-3.4 Diagnostic Reports

3.4.1 Report of the interpretation of imaging procedures shall include the following:

a. Name of the patient and a second patient identifier (e.g. personal health number, date of birth, facility identification number)
b. Name of the requesting practitioner
c. Name of the facility/site where examination was performed
d. Name or type of examination
e. Date of examination
f. Date of dictation or transcription, and time when appropriate, with explanation for unusual delays
g. Pertinent findings
h. Pertinent clinical issues raised in the request for the examination. For example, to rule out a fracture, the report states: “there is no evidence of fracture”
i. Comparative information with previous examinations when appropriate
j. Conclusion or diagnosis – a precise diagnosis whenever possible or differential diagnosis when appropriate
k. Recommendations for follow-up and additional DI studies when appropriate
l. A copy of the final report shall accompany the exchange of relevant radiographic examinations from one health professional to another health professional.

E-3.5 Retention of Medical Records

3.5.1 The following are considered minimum requirements for the retention of records. Individual circumstances may warrant extended periods of retention. (e.g. Lung Fibrosis Programme). In these cases, the relevant legislation shall apply.

a. X-ray films/images (adults) 5 years

b. X-ray films/images (minors) 5 years or 2 years after the age of majority, whichever is longer.
c. Mammography films 5 years or 10 years if there are no intervening studies.
d. Archived digital images (adults) 10 years
e. Archived digital images (minors) 10 years or 2 years after the patient's eighteenth birthday, whichever is later.
f. Bone Densitometry 10 years.
g. Quality Control Records/Documentation 2 years except Bone Densitometry which is 5 years
h. Repeat/Reject Analysis Records 2 years
i. Accession Records/Day Sheets 2 years
j. Equipment Maintenance Records 2 years
k. Incident Reports 10 years

E-4.0 Quality Assurance

E-4.1 All diagnostic imaging facilities shall have in place a quality assurance programme that will limit radiation exposure to the patient, the public, and equipment operators while at the same time optimize image quality.
E-4.2 The quality assurance programme shall assess, document and implement changes. Quality assurance programmes will vary depending on the facility size, and scope of practice. The programme at a minimum should include:

a. a process to evaluate staff performance
b. a schedule of quality control procedures and a preventative maintenance programme to ensure adequate performance of equipment;
c. a schedule of quality control procedures to ensure the production of optimum quality radiographs with minimum exposure of the patient to radiation;
d. a process to ensure the service needs of patients are being met;
e. a process to ensure the needs of referring physicians are being met;
f. a process to monitor all aspects of safety including radiation safety;
g. a process to review incidents and avenues for implementation of change where areas for improvements are identified.

E-5.0 Calibration of Equipment

E-5.1 Facilities containing DI equipment shall comply with minimum radiographic standards. Standards and control limits may vary for different types of equipment, and manufacturer's recommendations shall be considered. The frequency of calibration is dependent on workload and volumes (procedure counts).
E-5.2 Not withstanding paragraph 5.1, all DI equipment will be calibrated and certified annually by an appropriately certified Biomedical Technologist.

E-6.0 Quality Control

E-6.1 Facilities shall have a schedule for quality control procedures.
E-6.2 All quality control shall be documented.
E-6.3 Corrective action shall be taken if results are not within control limits as delineated by the manufacturer.

E-7.0 Preventative Maintenance

E-7.1 Facilities shall have a preventative maintenance schedule for each piece of equipment.
E-7.2 Manufacturer's recommendations regarding frequency and procedures shall be considered.
E-7.3 All preventative maintenance records shall be retained for a minimum of 2 years.

E-8.0 General Safety

E-8.1 Safety inspections shall be conducted regularly and findings documented. Inspection records shall be maintained for 3 years.

E-8.2 There shall be a qualified first aid officer on site.

E-8.3 First aid kits shall be available, accessible, adequately stocked and in a prominent location.

E-8.4 Emergency equipment (emergency showers, eye wash facilities, fire fighting) shall be tested and inspected on a regular basis.

E-8.5 A system for reporting and recording all incidents and accidents shall be in place.

E-8.6 Personal Protective Equipment necessary for the protection of employees from hazards associated with DI operations shall be available and accessible at all times.

E-8.7 Storage and consumption of food and/or drink in the DI area is strictly prohibited.

E-8.8 All public advisory signs, e.g. 'No Smoking'. 'Biohazard', shall be of reasonable size print, prominently displayed, and bearing internally recognized logos where appropriate.

E-8.9 Security measures shall be in place to restrict unauthorized access to DI areas.

E-8.10 All corridors shall be free from obstruction.

E-8.11 Emergency telephone numbers shall be prominently displayed throughout the DI area, and beside or on all telephones.

E-8.12 Emergency evacuation procedures shall be in place, and drills conducted regularly.

E-9.0 Fire Safety

E-9.1 Procedures

9.1.1 Fire safety procedures, including alarm activation, evacuation and equipment shutdown, shall be documented, and available and accessible to employees.
9.1.2 Fire safety training shall be conducted for all new employees, and at regular intervals.
9.1.3 Fire drills shall be conducted at least bi-annually.
9.1.4 Radiology activity floor plan illustrating emergency evacuation routes shall be prominently posted.
9.1.5 All staff shall participate in annual fire safety training which includes, but is not limited to, facility evacuation procedures and the use of fire extinguishers.
9.1.6 If the Radiology activity classified as 'ordinary hazard' is not protected by and automatic extinguishing system it shall be separated from surrounding health care areas and from exit access corridors by fire barrier walls and assemblies (doors, windows) with a minimum 1-hour-fire-resistant rating.
9.1.7 Equipment (open system) that release ignitable vapours into the ambient workspace shall be operated at least 5 ft. from stored combustible materials unless separated by 1-hour-fire-resistive construction. Closed systems shall be provided with audible and visual alarms for low liquid level, and high vapour levels.

E-9.2 Exits

9.2.1 Radiology activity size in excess of 1000 sq. ft. shall have at least two (2) exit access doors remote from each other, one of which must open directly on to a means of egress.
9.2.2 The other door may open into another room, providing 1.hour-fire-resistant rating construction separates the two areas.

9.2.3 Travel distance between any point in the lab and an exit door shall not exceed 75 feet.
9.2.4 Corridors shall remain clear and unobstructed at all times
9.2.5 Corridors used for transporting patients, and representing access to an exit shall not be less than 96 inches in clear, unobstructed width.
9.2.6 All exit signs shall be illuminated and clearly visible.

9.2.7 Fire-resistant rated doors shall not be held open by any means other than an automatic release device.

E-9.3 Fire Protection System

9.3.1 Fire alarms shall be installed, audible throughout the DI activity, and tested and serviced at regular intervals.
9.3.2 Fire detection devices, i.e. thermal/smoke detectors, shall be free from defects, and unobstructed at all times.
9.3.3 All fire suppression equipment shall be regularly maintained.
9.3.4 Where an automatic fire suppression system exists it shall be connected to the facility fire alarm system.
9.3.5 Portable fire extinguishers shall be suitable for the particular hazard, available, accessible, and inspected annually with proof of inspection attached.

E-10.0 Manuals

E-10.1 DI facilities shall have current and comprehensive manuals in place. Policy statements shall be consistent with the goals of the organization and shall reflect any published standards of the HPC and other medical organizations. Their extent should reflect the complexity and extent of the procedures performed.

E-10.2 There shall be documented organizational procedures including, but not limited to, the following:

a. Standard Operating Procedures
b. Staff Orientation
c. Training
d. Safety Practices
e. Fire Safety
f. Hazardous Materials Management including emergency procedures for controlling spills
g. Equipment Maintenance Programme
h. Disaster Preparedness

E-10.3 All policies/procedures shall initially be signed by the Medical Director. In private facilities policies shall be signed by the administrator.

E-10.4 Subsequently, all policies/procedures shall be reviewed annually and signed by the Medical Director or the administrator designate.

E-10.5 Any changes in the interim shall be initialed by the Medical Director or administrator designate.

HEALTH PRACTICE COMMISSION
National Standards
Outpatient Ambulatory Care – Checklist F (*by Dr. Neville Ballin, October 2005 – note detail under section entitled "hospital" on page 31 is specific to Hospital theatres only)*

This standard applies to outpatient ambulatory care where any form of anaesthetic, including local and/or sedation anaesthetics are as follows:

It must be categorically stated that the standard of care provided to patients must be of a high standard irrespective of whether the service is provided in or out of hospital. As a general principle, these guidelines should apply to ALL facilities that administer anaethesia in any form.

The standards outlined are the minimum standards guidelines to be applied in any given circumstances. All efforts should be made to equip and staff the areas to exceed that stated minimum standards.

GENERAL GUIDELINES

a. There must be personnel trained in the administration of the anaesthetic and in the treatment of complications

b. The areas must have adequate space and lighting

c. There must be adequate trained personnel available to help during the procedure and to help in the event of any complication.

d. There should be adequate equipment and medications available for resuscitation in the event of a problem.

e. Regular drills should be conducted in order to ensure that the staff is fully aware of the location and the status of resuscitative equipment.

f. There should be an established line of communication to a hospital or specialist service for transfer and further treatment of a patient in the event of a problem.

g. Equipment used for monitoring and anaesthesia is of a specialized nature. Arrangements must be in place for regular inspection, servicing and calibration of equipment.

h. Medical gases, (oxygen, nitrous oxide) should be available in adequate quantities and stored in the appropriate way.

WHERE LOCAL ANAESTHETICS AND NO SEDATION IS GIVEN:
In addition to the applicable general guidelines.

The Minimal Standards to be applied are:

a. Person should be trained in the administration of local anaesthetics. They should also be trained in the recognition and treatment of adverse reactions associated with its administration.

b. A readily available assistant should be present.

c. Blood pressure equipment should be available, not necessarily an automated system, but at least a sphygmomanometer and stethoscope.

d. There should be an easily accessible resuscitation kit comprising of at minimum: Adrenaline, Hydrocortisone, antihistamine, benzodiazepine, and atropine.

e. Equipment for gaining intravenous access should be available.

f. Oxygen should be available

g. Suction equipment with the appropriate tubing, connectors and large bore suction end (Yankhaur).

CONSCIOUS SEDATION

This is defined as minimally depressed levels of consciousness that retains the patient's ability to independently and continuously maintain an airway and responds appropriately to physical stimulation and verbal command. This can be induced by:

a. Oral administration of a single sedative drug
b. Nitrous oxide and oxygen
c. Combination of oral sedative drug and nitrous oxide and oxygen
d. Parenteral administration of sedative drug (intravenously, intramuscularly, subcutaneously, submucosally, or intranasally)

In addition to the applicable general guidelines stated above –

The minimum standards to be applied are:
The standards applicable to local anaesthetic and no sedation administration PLUS:

a. There should be a MINIMUM of TWO persons, one of whom should be trained in the administration of and the recognition and management of the adverse effects of conscious sedation.
b. At least one person should be ACLS trained.

c. Oxygen in adequate amounts, at least two “E” size cylinders, and oxygen delivery systems, must be available.
d. Presence of a readily accessible resuscitation kit with a minimum of: Adrenaline, Hydrocortisone, atropine, antihistamines, and the antidote for any of the medications used, e.g. Naloxone, Flumazanil.

e. Self-inflating resuscitation system (Ambu-bag) with appropriate face masks, oropharyngeal airways and endotracheal tubes.

f. Laryngoscope and an assortment of blades.

g. Patient to be monitored with a Pulse Oximeter and Non Invasive Blood Pressure Monitor (“NIBP”) during the procedure.

h. A signed consent should be obtained.

i. Pre-operative assessment to be done

j. Recovery area to be designated.

k. Documented discharge criteria be established

l. Intravenous access must be present

DEEP SEDATION

This is defined as a depressed state of consciousness accompanied by a partial loss of protective reflexes, including the inability to respond purposefully to verbal commands. Deep sedation must only be performed by a registered dentist/practitioner who has undergone a prescribed formal course of training in anaesthesia relevant to his/her specialty.

In addition to the applicable general guidelines outline above –
The minimal standards to be applied are:

All of the standards applicable to conscious sedation PLUS:

a. Written preoperative instructions to be given to the patient or responsible person.
b. A signed consent must be obtained.
c. The anaesthetic and monitoring equipment used must be checked and serviced and conform to current standards for functional safety.
d. Patient information during the procedure must be recorded in the patient’s notes.
e. The patient must not be left unattended during the administration of sedation/anaesthetic.

f. The practitioner must have undergone training and have certification in post-graduate anaesthesia practice, relevant to his/her specialty.
g. Defibrillator and facility for ECG monitoring should be available.
h. The assistant should be trained to Basic Life Support level.

HOSPITALS

It is essential that certain core standards of monitoring must be used whenever a patient is anaesthetized. These standards should be uniform irrespective of duration or location of anaesthesia.

Generally, anaethesia is independently performed by a doctor/nurse anaesthetist who has undergone formal training and is registered to practice in the Cayman Islands. The **specialist who will assume the medical responsibility for the** patient must supervise, directly or indirectly. The level of supervision will depend on the level of training and experience of the anaesthetist, and will be at the discretion of the specialist anaesthetist.

These core standards are:

a. The anaesthetist must be present throughout the conduct of an anesthetic.
b. Monitoring devices must be attached before induction of anaesthesia and their use continued until the patient has recovered form the effects of anaesthesia.
c. The same standards of monitoring apply when the anaesthetist is responsible for a local anaesthetic or sedative technique for an operative procedure.
d. All information provided by monitoring devices should be recorded in the patient's notes.
e. The anaesthetist must check all equipment before use. All alarm limits must be set appropriately. Infusion devices and their alarm settings must be checked before use. Audible alarms must be enabled when anaesthesia commences.
f. Some monitoring devices are **essential** and must be immediately available during anaesthesia. If a monitoring device deemed essential is not available and anaesthesia continues without it, the anaesthetist must clearly state in the notes the reasons for proceeding without the device.
g. Additional monitoring may be necessary as adjudged by the anaesthetist.
h. Only a brief interruption of monitoring is acceptable if the recovery area is immediately adjacent to the operating theatre. Otherwise monitoring should be continued during transfer to the same degree as any other intra or inter hospital transfer.

ESSENTIAL MINIMAL MONITORING DEVICES DURING THE CONDUCT OF AN ANAESTHETIC

1. Non-invasive Blood Pressure Monitor
2. Pulse Oximeter
3. Electrocardiograph

ADDITIONAL MONITORS (These should be available for use if required)

1. End tidal carbon dioxide monitor
2. Nerve stimulator
3. Temperature measurement
4. Anaesthetic vapor analyzer
5. Oxygen monitor to measure inspired oxygen concentration

POSTOPERATIVE

1. There should be a recovery room or designated recovery area.
2. If the anaesthetist is not going to recover the patient; there should be a dedicated trained recovery room nurse,
3. In addition to **CLINICAL** observation of the patient, the **minimum** of monitoring devices should be a pulse oximeter and a Non-Invasive Blood Pressure Monitor.
4. Additional monitors e.g. ECG should be available if required.

EQUIPMENT

Failure of anaesthetic equipment may lead to serious consequences. It is important that is regularly serviced, and that there is documentation of any breakdowns and repairs carried out.

ASSISTANCE FOR THE ANAESTHETIST

No anaesthetic is to begin with only the anaesthetist present. There must be an assistant, which can be a dedicated anaesthetic technician, or a designated nurse. After induction and stabilization of the patient, the assistant may help in other areas, BUT MUST be readily available to assist the anaesthetist in the event of an emergency.

DISCHARGE CRITERIA

Patients can be discharged following conscious sedation or general anesthesia when they satisfy the following criteria:
a. Patient is fully conscious and oriented in place and time.
b. All vital signs are stable.
c. Patient is ambulant.
d. Patient must be discharged in the care of a responsible adult.
e. Patient must be advised not to drive or operate sensitive machinery for a period of 24 hours.
f. Written discharge instructions should be given to the patient or responsible person prior to the procedure.

STORAGE OF MEDICAL GAS CYLINDERS

Medical gas cylinders contain gas at high pressures; uncontrollable release of the gases can cause mechanical hazards (e.g. the cylinder falling over and cracking open). This could result in lethal consequences.

a. Cylinders must never be left without some form of physical support e.g. cylinder cart, cylinder stand or chained to a wall.

b. Oxidizing gases e.g. oxygen and nitrous oxide must not be stored with any flammable gas, liquid or vapor.

c. Cylinders in storage and in use must be prevented from reaching a temperature of 54 degrees Celsius (130 degrees Fahrenheit). At this temperature, the "pop off" pressure for the burst disk may be reached activating the safety system, releasing gas. This temperature can be reached by storing the cylinders in the direct sun.

OXYGEN NO SMOKING OR OPEN FLAMES

D. Small leaks will inevitable occur with any gas source. There must be adequate ventilation to prevent build up of medical gases in the confines of the storage area.

CHECKLIST FOR INSPECTION

a. Trained personnel

b. Adequate space and lighting appropriate for the procedures

c. Adequate supply of oxygen with appropriate pressure regulator

d. Adequate supply of medical gases appropriate for the facility. (e.g. Nitrous oxide, Medical Air)

e. Presence of readily accessible resuscitation equipment including manual resuscitator (Ambu-bag) oxygen tubing, masks, and oropharyngeal airways.

f. Presence of a functioning laryngoscope and blades.

g. Presence of readily accessible resuscitation drugs.

h. Presence of monitoring equipment, appropriate for the facility e.g. Blood pressure monitors, Pulse Oximeter, ECG monitor and Defibrillator.

i. Evidence of documentation of pre and post operative guidelines.

j. Presence of suitable serviced anaesthesia delivery system.

k. Presence/evidence of a recovery area.