Standards for

Long-Term Care Services

Version (1)

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Health Policies and Standards Department

Health Regulation Sector (2025)

ACKNOWLEDGEMENT

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Health Regulation Sector

Dubai Health Authority

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INTRODUCTION

The Health Regulation Sector (HRS) plays a key role in regulating the health sector. HRS is mandated by the Dubai Health Authority (DHA) Law No. (6) of the year (2018) with its amendments pertaining to DHA, to undertake several functions including but not limited to:

- Developing regulations, policies, standards, and guidelines to improve quality and patient safety and promote the growth and development of the health sector;
- Licensure and inspection of health facilities as well as healthcare professionals and ensuring compliance with best practices;
- Managing patient complaints and assuring patient and physician rights are upheld;
- Governing the use of narcotics, controlled and semi-controlled medications;
- Strengthening health tourism and assuring ongoing growth; and
- Assuring management of health informatics and e-health and promoting innovation.

The Standards for Long-Term Care Services aims to fulfil the following overarching Dubai Health Sector Strategy 2026:

- Pioneering a Human-centred health system to promote trust, safety, quality and care for patients and their families.
- Make Dubai a lighthouse for healthcare governance, integration and regulation.
- Leading global efforts to combat epidemics and infectious diseases and prepare for disasters.
- Pioneering prevention efforts against non-communicable diseases.

- Become a global digital health hub.
- Foster healthcare education, research and innovation.
- Strengthening the economic contribution of the health sector, including health tourism, to support Dubai's economy.

EXECUTIVE SUMMARY

Long-term healthcare refers to a range of medical and personal services designed for individuals who require continuous care due to chronic illnesses, disabilities, or aging-related conditions. These services include skilled nursing care, rehabilitation, assisted living, and long-term care, ensuring that residents receive the necessary medical attention and support for daily activities. Depending on the resident's needs, long-term healthcare can be provided in various settings, such as specialised facilities, community-based centres, or private homes. Integrating technology, such as telemedicine and remote resident monitoring, has significantly improved the accessibility and efficiency of long-term care services.

In Dubai, long-term healthcare is undergoing significant development to address the growing demand for specialised medical services, particularly for the elderly, individuals with chronic illnesses, and those in need of rehabilitation or palliative care. The city's long-term care (LTC) sector faces notable challenges due to a rapidly ageing population and a historical underinvestment in elder care services. As of 2023, individuals aged 65 and above make up approximately 1.7% of the United Arab Emirates' total population. While this percentage may seem small, projections indicate a substantial demographic shift, with the number of Emiratis aged 60 and older expected to increase more than six-fold by 2030. This surge highlights the

urgent and growing need for comprehensive LTC services to accommodate the expanding elderly population.

This standard shall be read in conjunction with related UAE laws, DHA standards, policies, manuals, and other relevant documents, including but not limited to:

- UAE Federal Law No. 5 of 2019 on the Subject of Regulating the Practice of the Profession of Human Medicine.
- UAE Federal Law No. 4 of 2016 on the Subject of Medical Liability.
- Federal Law No. (8) of 2023 amending some provisions of Federal Law No. (4) of 2015 concerning the Private Health Facilities.
- UAE Cabinet Resolution No. (20) of 2017, which approves the unified standards for licencing health professionals at the state level.
- Ministerial Resolution No. (14) of 2021 regarding the Patient's Rights & Responsibilities Charter in the United Arab Emirates (UAE) on Charter of Patient's Rights and Responsibilities.
- Ministerial Resolution No. (1448) of 2017 On Adoption of Code of Ethics and Professional Conduct for Health Professionals.
- Decree of the Executive Council No. (49) of 2024 Concerning the Regulation of Practising Health Professions in the Emirate of Dubai.
- Ministerial Resolution 1448 of 2017 concerning the Code of Ethics and Professional Conduct for Health Professionals.
- Unified National Standards for Hospitals (2018).

- Unified Healthcare Professional Qualification Requirements (PQR).
- National Guidelines for Biosafety 2020.
- DHA Manual for Licencing Health Facility.
- DHA Role and Responsibilities of Medical Director Policy.
- DHA Communicable Disease Notification Policy.
- DHA Health Information Assets Management Policy.
- DHA Sentinel Event Notification and Management Standards.
- DHA Referral and Interfacility Transfer policy.
- DHA Health Data and Information Sharing Policy.
- DHA Standards for Medical Advertisement Content on Social Media.
- DHA Standards for Renal Dialysis.
- DHA Standards for Oncology Services.
- DHA Standards for Physiotherapy Services.
- DHA Standards for Home Healthcare Services.
- DHA Standards for Clinical Laboratory Services.
- DHA Standards for Telehealth Services.
- DHA Pharmacy Guideline.
- DHA Guideline for Patient Consent.
- DHA Clinical Guideline for Best Practice in Immunisation.

DEFINITIONS

Activities of Daily Living: Fundamental personal care tasks necessary for everyday living. ADLs include bathing, dressing, grooming, toileting, eating/feeding, and transferring (mobility). Assistance with ADLs is a core service provided by Assisted Living Facilities to help residents who cannot perform these activities independently due to physical or cognitive limitations.

Convalescence Facilities specialized centres that provide care and support to individuals recovering from illnesses, surgeries, or medical procedures that require extended recovery periods. These facilities offer a structured environment where patients can receive medical supervision, rehabilitation therapies, and nursing care tailored to their recovery needs.

End-of-Life Care: Care is given when a patient's condition deteriorates, and death is imminent or expected in the near term. End-of-life care involves an intensive focus on comfort measures, psychosocial/spiritual support, and respecting the patient's wishes regarding life-sustaining treatments. It encompasses the management of the final hours or days of life and the immediate post-mortem support of the family (including bereavement care).

Healthcare Professional: A healthcare personal working in healthcare facilities and required to be licenced as per the applicable laws in the United Arab Emirates.

Hospice Care: A form of palliative care typically focused on the end-of-life stage, where curative or life-prolonging treatments are no longer the priority. Hospice is usually provided when a resident is expected to have limited life expectancy and centres on comfort, dignity, and support in the final phase of life. The term "palliative care facility" in this document encompasses hospice services.

Informed Consent: An agreement or permission accompanied by complete information on the nature, risks, and alternatives of a surgical or interventional procedure before the physician begins the procedure/treatment. Accordingly, the patient or the patient's legal guardian either consents to or refuses treatment.

Interdisciplinary Team: A collaborative team of healthcare professionals and support staff who address the patient's and family's needs together. The team typically includes (at minimum) physicians and nurses and may include allied health professionals such as pharmacists, social workers, psychologists and counsellors. All team members work within their scope of practice to provide comprehensive care.

Licensure: issuing official permission to operate a health facility to an individual, government, corporation, partnership, Limited Liability Company (LLC), or other form of business operation that is legally responsible for the facility's operation.

Life-Threatening / Life-Limiting Illness: Any illness or condition with a high likelihood of causing death in the near future or which significantly impacts the quality of life through severe progressive debility. Examples include advanced cancers, end-stage organ diseases (heart, lung, liver, kidney failure), progressive neurological diseases (e.g. advanced dementia, motor neuron disease), or any condition for which curative treatment is no longer effective or desired.

Long-Term Care (LTC): A broad range of personal care, health care, and supportive services provided on an ongoing basis to people with chronic conditions or functional limitations.

Nursing Home Facilities: A residential facility that provides comprehensive, long-term care for individuals with significant health issues requiring assistance with daily living activities.

Palliative Care: An approach to healthcare that focuses on relieving suffering and improving the quality of life for residents with serious or life-threatening illnesses. Palliative care addresses pain and other distressing physical symptoms, as well as psychosocial and spiritual needs, and may be provided alongside curative treatments. It is appropriate at any stage of a serious illness and is not limited to end-of-life care (though it includes end-of-life support).

Resident: An individual who stays in a long-term care facility designed for people who need ongoing assistance with daily activities and medical care. This individual is unable to live independently due to chronic health conditions, disabilities, or age-related issues.

ABBREVIATIONS

ACHS: Australian Council on Healthcare Standards

ACLS: Advanced Cardiovascular Life Support

ACP: Advance Care Planning

ADL: Activity Daily Living

AED: Automated External Defibrillator

ARTG: Australian Register of Therapeutic Goods

BLS: Basic Life Support

CA-SUTI: Catheter-Associated Symptomatic Urinary Tract Infection

CE: Conformité Européenne

CFs: Convalescence Facilities

DHA: Dubai Health Authority

DNR: Do-Not-Resuscitate

EMS: Emergency Medical Service

EPP: Emergency Preparedness Plan

FDA: Food and Drug Administration

HRS: Health Regulation Sector

IDT: Integrated Interdisciplinary Team

IPC: Infection Prevention and Control

KPIs: Key Performance Indicators

LTCFs: Long-Term Care Facilities

MOHAP: Ministry of Health and Prevention

NHFs: Nursing Home Facilities

PALS: Paediatric Advanced Life Support

PPE: Personal Protective Equipment

SUTI: Symptomatic Urinary Tract Infection

TENS Transcutaneous Electrical Nerve Stimulation

UAE: United Arab Emirates

VAE: Ventilator-Associated Event

1. BACKGROUND

Long-term care (LTC) has evolved as a critical component of healthcare systems worldwide, addressing the needs of individuals who require ongoing medical and personal assistance due to ageing, chronic illnesses, or disabilities. Historically, long-term care was primarily provided informally by family members and community caregivers. However, formalised LTC systems

have become essential with increasing life expectancy, changes in family structures, and the rising prevalence of chronic diseases. The demand for LTC services has grown significantly over the past century, particularly in developing countries where ageing populations require specialised care. Governments and private sectors have responded by establishing nursing homes, assisted living facilities, rehabilitation centres, and home-based care services to meet the diverse needs of individuals requiring long-term support.

Advancements in medical science have also contributed to the expansion of LTC, as improved treatments and early disease detection allow individuals to live longer, often with chronic conditions that necessitate continuous care. As a result, LTC services have shifted from merely custodial care to comprehensive models that integrate medical, rehabilitative, and social support.

In Dubai, LTC is in its growth phase, with efforts underway to establish a robust system that balances affordability, accessibility, and quality of care. Recognising the importance of long-term care, investments are being made in infrastructure, regulations, and digital health solutions to meet the needs of an ageing population. With continued advancements and policy reforms, the future of LTC is expected to focus on patient-centred, technology-driven models that ensure individuals receive the care they need while maintaining their dignity and quality of life.

2. SCOPE

2.1. DHA-licenced healthcare professionals and health facilities provide long-term care services in the Emirate of Dubai.

3. PURPOSE

3.1. This standard provides a comprehensive framework for delivering medical and clinical services in long-term care settings, ensuring minimum quality and safety standards for all healthcare professionals and facilities.

4. APPLICABILITY

4.1. All healthcare professionals and health facilities provide long-term care services in the Emirates of Dubai.

5. STANDARD ONE: REGISTRATION AND LICENSURE PROCEDURES

5.1. All health facilities providing long-term care services shall adhere to the laws of the United Arab Emirates (UAE) and Dubai regulations.

5.2. Health facilities aiming to provide long-term care services shall comply with the DHA licensure and administrative procedures available on the DHA website: https://www.dha.gov.ae.

5.3. licenced health facilities opting to add long-term care services shall submit an application through the Sheryan platform to obtain permission to provide the service.

5.3.1. This applies to all health facilities within the Emirate of Dubai.

5.4. LTCFs shall operate only under the following DHA-approved facility types:

5.4.1. Convalescence Facilities,

5.4.2. Nursing Homes Facilities,

5.4.3. Palliative care and hospice facilities,

5.4.4. Addiction Treatment and Rehabilitation Centres.

5.5. LTCFs shall display the facility licence publicly at the central administrative office or main entrance.

5.6. Please refer to the DHA manual for licencing health facility.

6. STANDARD TWO: HEALTH FACILITY REQUIREMENTS

6.1. LTCFs shall ensure that facility infrastructure and layout meet the minimum design and safety requirements established by the DHA Health Facility Guidelines and UAE federal/local regulations.

6.2. LTCFs shall promote a non-institutional, homelike, culturally appropriate environment supporting resident well-being.

6.3. LTCFs shall comply with the Dubai Universal Design Code to ensure full accessibility for residents with mobility limitations or disabilities.

6.4. LTCFs shall provide specialised areas for varying levels of care dependency, including:

6.4.1. Dementia care,

6.4.2. Rehabilitation,

6.4.3. Palliative care.

6.5. LTCFs shall adopt an efficient spatial layout (e.g., linear, L-shaped, quadrant) to facilitate zoning of care, public, staff, and support areas.

6.6. LTCFs shall integrate infection prevention and control design features, including zoning for clean/dirty areas and proper air handling systems.

6.7. LTCFs shall incorporate dedicated spaces to accommodate various levels of resident dependency (e.g., low, medium, high), including specialised areas for dementia care, rehabilitation, and palliative services.

6.8. General Facility Design and Functional Planning:

6.8.1. Public and Administrative Areas

a. This zone shall be easily accessible to visitors and staff while remaining separated from clinical and resident living areas to preserve privacy and security. This includes, but is not limited to:

i. Main Entrance & Airlock

- The Main entrance shall be weather-protected and equipped with CCTV/intercom access control for security.
- Entrance shall be designed to allow ambulances and visitors easy access without obstruction.
- Entry airlock shall be provided with a minimum area of 10 m².

ii. Reception/ Clerical

- A reception desk shall be located near the entrance for efficient delivery service.

iii. Waiting Areas

- Separate waiting areas for male and female visitors shall be provided, each with a minimum size of 10 m².

iv. Meeting Room

- At least two rooms, each with a minimum area of 14 m², shall be provided for family consultations or intake interviews.

v. Consult/ Exam Room

- Ideally located near entrances for initial assessments, with a minimum of 14 m².

vi. Administrative Offices

- Each office shall be sized between 12 to 20 m², depending on the specific needs of the administrative functions.

vii. Public Amenities:

- Public toilets easily accessible from the main entrance and other commonly used public areas.
- All public toilets shall be accessible to individuals with disabilities, including adequate space for wheelchair manoeuvring and fixtures for ease of use.

6.8.2. Resident Living Areas (by dependency level)

a. Dedicated wings or areas shall be established for residents requiring varying levels of care, including:

i. Independent living,

ii. Assisted living,

iii. High-dependency or skilled nursing care.

b. LTCFs shall have a minimum capacity of 25 beds and shall not exceed a maximum capacity of 30 beds.

c. Each resident's room shall ensure privacy, comfort, and adequate space for essential furniture and mobility aids, including but not limited to the following:

   i. LTCFs should provide at least 20% single bedrooms, although a higher percentage is preferred for privacy and infection control.

   ii. Residents' rooms recommended to be single occupancy to ensure privacy, dignity, and infection control.

   iii. Each room shall have a minimum size of 18 to 25 m², providing sufficient space for necessary furniture, medical equipment, and mobility aids.

   iv. LTCFs shall provide at least one larger room, measuring a minimum of 28 m², specifically designed to accommodate residents with special needs, such as those requiring bariatric care.

   v. Ventilator-capable rooms equipped with ceiling-mounted service pendants shall be provided in high-dependency care areas to accommodate residents with complex medical needs.

   vi. Class N (negative pressure) isolation rooms shall be mandatory, provided at a ratio of one room per every 30 beds (±2 beds).

vii. Each isolation room shall have a minimum area of 18 m² to adequately manage residents requiring isolation for infectious conditions.

viii. Isolation rooms may be combined with bariatric care rooms, resulting in isolation bariatric rooms measuring a minimum of 28 m², to support residents who require simultaneous isolation and specialized bariatric care.

ix. Each isolation room shall include a dedicated anteroom to facilitate proper donning and doffing of personal protective equipment (PPE) and maintaining infection control protocols.

x. Double-occupancy rooms are allowed, but shared rooms must not exceed 2 beds per room.

xi. Nurse Call System and Resident's Safety Fixtures shall be installed in all resident rooms.

d. Each resident's room shall have a directly accessible ensuite bathroom, including but not limited to the following:

i. Each bathroom shall have a minimum area of 4 to 6 m² to support safe and independent use.

ii. Bathrooms shall be fully accessible, featuring non-slip flooring, strategically placed grab bars, and adequate manoeuvring space for wheelchairs and mobility aids.

iii. Fixtures shall be installed at accessible heights, and design shall ensure ease of use for residents with varying physical abilities.

6.8.3. Resident Activity and Social Spaces

a. LTCFs shall provide dedicated spaces for communal activities, socialisation, dining, and therapy to foster a homelike and engaging environment for residents. These spaces shall be designed to support both independent and group activities, including but not limited to the following:

i. Dining Area with an adjacent Pantry/Servery to serve meals to residents.

- The dining room shall be designed to seat all ambulatory residents with a minimum of 2 m² per resident for dining spaces.
- An adjacent pantry/servery kitchen with a minimum of 10–15 m² shall be provided for efficient meal service.

ii. Lounge and Activity Areas, including quiet and active zones, are designed to provide relaxation, recreation, and social interaction spaces.

- Gender-segregated spaces, such as separate lounges for male and female residents, shall be provided where culturally required.
- Quiet lounge areas with a minimum of 20–40 m² shall be provided for relaxation.

- Active recreation rooms with a minimum of 25–40 m² shall be available for group activities.
- At least one lounge or activity area shall open directly to a secure garden/courtyard for outdoor access.
- Prayer rooms or designated corners for religious practices shall be provided, ensuring privacy for spiritual activities.

iii. Rehabilitation Spaces

- A therapy gym with a minimum of 40–50 m² shall be provided to accommodate rehabilitative therapy, physical activity, and exercise.
- Activities of Daily Living (ADL) practice kitchens and bathrooms with a minimum of 12 m² each shall be available for functional rehabilitation and independence training.

iv. Outdoor Spaces (Garden/Outdoor Area)

- A secure outdoor courtyard/garden with a minimum of minimum 100–150 m² shall be provided for resident use.
- The outdoor area shall include seating, shaded spaces, and pathways for residents with mobility aids, promoting outdoor activity and relaxation.

v. Resident Laundry (optional for independence) may be included to promote independence for residents capable of managing their laundry, with at least one laundry room per floor.

6.8.4. Clinical and Support Areas

a. Clinical and support areas shall be designed for quality care delivery, infection control, and operational efficiency.

b. These areas shall be strategically located to ensure accessibility while minimising cross-contamination and facilitating adequate care provision, including but not limited to the following:

i. Clean Utility Room:

- A dedicated room for storing and managing clean supplies, sized at a minimum of 12 m².

ii. Dirty Utility Room:

- A room for the handling and disposal of soiled materials, sized at least 14 m², located separately from clean areas to avoid cross-contamination.
- It shall include facilities for soiled linen storage and waste disposal.

iii. Medication Room:

- A room with appropriate medication storage, including controlled substances, ensuring secure access and compliance with safety regulations.
- The room shall be sized around 10–14 m² and equipped with a lockable cabinet for controlled substances.

iv. Resuscitation Bay:

- A designated area for emergency care near high-dependency residents' areas, with space for resuscitation equipment and an emergency cart.
- The space shall be accessible and visible from the staff station.

v. PPE Storage and Disposal Room:

- A room designed to store PPE and facilitate safe disposal of contaminated items.
- It shall be located close to resident's care areas and sized appropriately for the facility's needs.

vi. Staff Office, Station & Handover Room:

- Centralised stations with a minimum of 12–18 m² with sub-stations as needed.
- The station shall be visible to care areas, with space for monitoring equipment and residents' records.

- Each staff room shall be sized between 10 to 15 m², depending on staffing levels and shift requirements.

vii. Equipment & General Stores:

- Separate storage areas for equipment and supplies, including linen, mobility aids, and therapeutic equipment.
- The linen store shall be at least 10–12 m² to accommodate the facility's needs and storage for mobility aids and general equipment shall be easily accessible for staff.

viii. Central Bathing/Assisted Bathing Suite:

- An optional area for residents requiring assistance with bathing, providing a safe, supportive environment for bathing needs.
- This room shall be equipped with appropriate lifting devices and space for caregivers. It shall be sized to 20–24 m² if provided to accommodate specialised equipment.

6.8.5. Staff Support Areas

a. LTCFs shall provide dedicated spaces for staff support, rest, and administrative functions to promote operational efficiency and staff well-being.

b. A staff lounge area shall be provided with a minimum size of 15 to 20 m².

c. The lounge shall include a kitchenette and seating and be conveniently located during breaks and shift transitions.

d. Staff toilets and showers shall be separate for males and females.

e. Each facility shall include lockers for secure storage of personal belongings.

6.8.6. A staff call and duress alert system shall be installed at all key care points, including:

a. Resident's care zones,

b. Interview and consultation rooms,

c. Staff support areas.

6.9. LTCF design shall assure residents' and staff's safety.

6.10. All standalone LTCFs shall be accredited within twenty-four (24) months of obtaining their licence. Accreditation certificates shall be uploaded to the Sheryan platform.

6.11. A grace period of twenty-four (24) months from the date of publishing this document shall apply to standalone existing standalone LTCFs to obtain accreditation.

6.11.1. Accreditation shall be for the long-term care services by an International Society for Quality in Health Care External Evaluation Association (ISQua EEA) approved entities, including but not limited to:

a. Joint Commission International (JCI).

b. Accreditation Canada – Qmentum Long-Term Care Accreditation.

c. CARF International (Commission on Accreditation of Rehabilitation Facilities).

d. Australian Council on Healthcare Standards (ACHS) -Residential Care Accreditation

6.12. LTCFs shall maintain accurate and complete employee personnel records, including training records. Such records shall be maintained and kept confidential.

6.13. LTCFs shall develop the following policies and procedures but not limited to:

6.13.1. Resident's identification

6.13.2. Resident's acceptance criteria

6.13.3. Resident's assessment and admission.

6.13.4. Resident's education, communication and informed consent.

6.13.5. Resident's health records, confidentiality and privacy as per DHA policy for health information assets management

6.13.6. Infection control measures and hazardous waste management

6.13.7. Incident reporting

6.13.8. Emergency and disaster preparedness

6.13.9. Residents and staff safety.

6.13.10. Resident's discharge/transfer.

6.13.11. Medication management and pharmacy services as per DHA guidelines for pharmacy.

6.13.12. Verbal and/or telephone communication among caregivers

6.13.13. Reporting critical diagnostic test results

6.13.14. Care of high-risk residents and safety protocols

6.13.15. Pain management

6.13.16. Fall prevention and management.

6.13.17. Pressure ulcer prevention and management.

6.13.18. Restraint and seclusion use and monitoring.

6.13.19. End-of-life care and advance directives.

6.13.20. Handover communication

6.13.21. Addressing unusual delays in diagnostic and/or treatment services

6.13.22. Clinical practice guidelines, clinical pathways and/or clinical protocols

6.13.23. Scope of services, credentialing, and privileging of staff

6.13.24. Utilisation of telehealth and remote monitoring

6.13.25. Resident's and family/caregiver involvement in care

6.13.26. Abuse and neglect prevention policies.

6.13.27. Community integration

6.13.28. Grievance procedures

6.13.29. Violence against staff/ zero tolerance

6.14. LTCFs shall provide documented evidence of the following, but not limited to:

6.14.1. Transfer of critical/complicated cases when required.

6.14.2. Interdisciplinary decision-making and management of residents'

6.14.3. Clinical laboratory services

6.14.4. Equipment maintenance services

6.14.5. Laundry services

6.14.6. Medical waste management as per Dubai Municipality (DM) requirements

6.14.7. Housekeeping services.

6.15. LTCFs shall maintain a charter of resident's rights and responsibilities posted at the premises entrance in two languages (Arabic and English).

7. **STANDARD THREE:** HEALTHCARE PROFESSIONALS REQUIREMENTS

7.1. Long-term care professionals delivering long-term care services shall hold an active DHA licence per the Unified Professionals Qualification Requirements (PQR) and work within their scope of practice.

7.1.1. For more information, refer to the DHA Manual for Licencing Healthcare Professionals

7.2. LTCFs shall have a medical director who supervises the professional staff, is responsible for the services provided in the long-term care facility and establishes the services' policies and procedures.

7.2.1. Please refer to the DHA policy regarding the roles and responsibilities of medical directors.

7.3. The Privileging Committee and/or Medical Director of the health facility shall privilege the physician aligned with his/her education, training, experience, and competencies. The privilege shall be reviewed and revised at regular intervals.

7.4. HPs with the privilege of providing long-term care shall comply with the following requirements:

7.4.1. Licensure: HPs shall hold a current and valid medical licence issued by DHA.

7.4.2. Continuing Professional Development (CPD):

a. Healthcare professionals are required to complete ongoing CPD relevant to their speciality and the services they provide.

i. Physicians require forty (40) CPD hours annually to renew their licence.

ii. Nurses require twenty (20) CPD hours annually to renew their licence.

iii. Allied Healthcare require ten (10) CPD hours annually to renew their licence.

b. The training may cover key topics including, but not limited to:

i. Chronic disease management

ii. Pain management

iii. Dementia care and communication.

iv. Support for residents with learning disabilities.

v. Trauma-informed care.

vi. Cultural competency and diversity.

vii. Wound care management.

viii. The prevention, detection, and reporting of elder abuse.

7.4.3. Clinical Competence: healthcare professionals shall demonstrate clinical competence in the long-term care services they are privileged to provide.

7.4.4. Adherence to Protocols: healthcare professionals shall comply with the health facility's established clinical protocols, guidelines, and policies, ensuring consistency and quality in residents' care.

7.4.5. Documentation: healthcare professionals shall maintain accurate and thorough documentation of all residents' encounters, treatments, and communications, adhering to legal and ethical standards.

7.4.6. Emergency Preparedness: healthcare professionals shall be prepared to manage emergencies effectively, with a clear understanding of protocols for urgent situations that may arise during long-term care.

7.4.7. Ethical Standards: healthcare professionals shall uphold ethical standards in practice, including obtaining informed consent, respecting residents' autonomy and confidentiality, and demonstrating effective communication and interpersonal skills in all interactions.

7.5. Long-term care services may be provided by an interdisciplinary team of healthcare professionals, including but not limited to the following:

7.5.1. Physician

7.5.2. Registered Nurses, Assistant Nurses or Specialised Nurses

7.5.3. Physiotherapist and Physiotherapist Assistant

7.5.4. Occupational Therapist

7.5.5. Clinical Dietitian

7.5.6. Respiratory Therapist

7.5.7. Speech Therapist /Speech & Language Pathologist

7.5.8. Clinical psychologist

7.5.9. Podiatrists

7.5.10. Audiologists

7.5.11. Clinical Social Worker

7.6. LTCFs shall ensure adequate staffing levels to meet care demands while maintaining consistent service quality.

7.7. LTCFs shall ensure defined minimum nurse-to-resident staffing ratios according to the level of care dependency:

7.7.1. Low-dependency residents: 1 licenced nurse to 12 residents during the day shift; 1:20 during the night shift.

7.7.2. Moderate-dependency residents: 1 licenced nurse to 8 residents during the day shift; 1:12 during the night shift.

7.7.3. High-dependency residents or residents receiving palliative care: 1 licenced nurse to 4 residents during the day shift; 1:6 during the night shift.

7.8. LTCFs shall ensure that all healthcare professionals provide care within their scope of practice.

7.9. LTCFs shall ensure that appropriate professionals are always on duty to diagnose, plan, supervise, and evaluate residents' care.

7.10. LTCFs shall employ registered nurses with at least two years of experience in long-term care.

7.11. LTCFs shall ensure a 24/7 nursing presence in the facility.

7.12. LTCFs shall require all professionals to maintain valid Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) certifications.

7.13. LTCFs admitting paediatric residents shall require designated healthcare professionals to maintain valid Paediatric Advanced Life Support (PALS) certification.

8. **STANDARD FOUR:** RESIDENTS' CARE

8.1. LTCFs shall admit residents only after appropriate clinical screening confirms that their care needs align with the facility's mission, scope of services, and available resources.

8.2. LTCFs that cannot meet the identified care needs shall refer the resident or assist in identifying appropriate alternative services.

8.3. In emergency situations, LTCFs shall provide stabilizing care before arranging safe transfer to a higher-level facility.

8.4. Residents' selection criteria

8.4.1. LTCFs shall admit residents who are medically stable and meet at least one additional category of eligibility criteria.

8.4.2. Medical Stability:

a. Residents must be medically stable and not in need of acute hospital care.

8.4.3. Medical and Extended Care Needs:

a. Residents shall require prolonged medical or rehabilitative services beyond what is feasible at home.

b. Residents shall need 24-hour nursing care and daily physician visits.

c. Residents shall have chronic conditions needing continuous care and supervision (e.g., advanced neurological disorders, end-stage organ failure, severe arthritis).

d. Residents shall depend on medical equipment (e.g., oxygen therapy, feeding tubes, and catheters) that require skilled nursing.

e. Residents shall require palliative or end-of-life care with specialised support.

8.4.4. Cognitive and Functional Dependency

a. Residents with significant impairment in Activities of Daily Living (ADLs) shall require assistance with essential tasks (e.g., bathing, dressing, eating, toileting, transferring).

b. Residents with dementia or Alzheimer's disease shall require structured supervision.

8.4.5. Behavioural and Psychological Criteria

a. Severe aggression or self-harm behaviours.

b. Severe psychosis requiring structured care.

8.5. Residents' Assessment and Care Planning

8.5.1. LTCFs shall ensure that a qualified physician assesses the residents face-to-face before admission.

8.5.2. LTCFs shall implement clear and structured admission protocols applicable to adults, adolescents, and paediatric residents.

8.5.3. LTCFs shall develop medical care plans in collaboration with the treating physician, interdisciplinary team, resident, and family where appropriate.

8.5.4. LTCFs shall conduct a comprehensive medical history, physical examination, assessment of the level of impairment, medications, and drug allergies, and evaluation of the condition's impact on their ADLs.

8.5.5. LTCFs shall use validated clinical tools to support objective admission decisions, such as:

a. Barthel Index – for assessing performance in basic activities of daily living (ADLs).

b. Functional Independence Measure (FIM) – for evaluating physical and cognitive disability and determining care needs.

c. Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA) – for residents with suspected cognitive impairment.

8.5.6. LTCFs shall incorporate routine mental health and cognitive screening using tools such as, but not limited to:

a. Geriatric Depression Scale (GDS) – for mood screening in elderly residents.

b. Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA) – for cognitive function evaluation.

8.5.7. LTCFs shall develop and implement strategies to prevent and manage responsive behaviours.

a. Strategies shall address behaviours such as aggression, wandering, agitation, and resistance to care.

b. Approaches shall be evidence-based (e.g., Gentle Persuasive Approach, Montessori Methods for Dementia, person-centred behavioural care).

c. Staff shall receive regular training in non-pharmacologic behaviour support techniques, de-escalation methods and communication skills for residents with cognitive or psychiatric conditions.

8.6. Discharge, Referral, Transfer and Follow-Up.

8.6.1. LTCFs shall develop and implement discharge plans and referral processes based on residents' readiness.

8.6.2. LTCF shall designate staff member in the resident's medical record who is accountable for the coordination of internal and inter-facility transfers.

8.6.3. LTCFs shall have an MOU or collaboration with a hospital to facilitate emergency transfers and referrals.

8.6.4. LTCFs shall ensure continuity of care during transfer, with a qualified healthcare professional accompanying the resident.

8.6.5. LTCFs shall adhere to the DHA Policy For Patient Referral And Interfacility Transfer.

8.6.6. LTCFs shall discharge residents based on the following criteria and complete the "Discharge Plan" documentation:

a. The established goals and objectives for care have been met.

b. The resident's family or legal guardian refuses services or no longer desires services.

c. The resident's condition has changed, and the provider's resources are such that the required care or services are beyond the scope, type, or quantity the provider can provide.

d. The resident's family or legal guardian is no longer able or willing to cooperate with the established Care Plan.

e. LTCFS shall ensure that the resident's family can adequately accommodate and meet the resident's needs at home.

8.7. Caregiver Education and Discharge Preparation

8.7.1. Long-term care facilities shall provide structured education and training to family members or legal caregivers before the discharge of residents. This training shall include, but not be limited to:

a. Medication administration and side effect monitoring

b. Wound care techniques (if applicable).

c. Use and maintenance of medical equipment (e.g., oxygen therapy, feeding tubes).

d. Transfer and mobility assistance.

e. Emergency response protocols at home.

8.7.2. LTCFs shall document caregiver training in the resident's health record.

8.7.3. LTCFs shall ensure that families receive written instructions and contact information for follow-up support.

8.8. Emergency Management

8.8.1. LTCF shall have a comprehensive emergency management plan, ensuring the facility's preparedness for various emergency scenarios.

8.8.2. The emergency management plan shall include, but is not limited to:

a. Procedures for handling medical emergencies, such as cardiac arrest, respiratory distress, and severe allergic reactions.

b. Protocols for natural disasters, fires, and other environmental emergencies.

c. Evacuation plans for residents in case of emergencies that require relocation.

d. Communication strategies to ensure timely coordination with emergency services and healthcare facilities.

8.8.3. LTCFs shall train staff regularly through drills and simulations.

8.8.4. LTCFs shall maintain adequate medical supplies and equipment for emergency care.

8.8.5. LTCFs shall meet the minimum mandatory Emergency Medications requirements per DHA emergency medication policy in Hospital categories.

8.8.6. LTCFs shall document and review all emergency incidents to improve response strategies.

9. **STANDARD FIVE**: RESIDENTS' SAFETY

9.1. Medical health record

9.1.1. LTCFs shall ensure the confidentiality of medical records, allowing access only under legally prescribed circumstances.

a. For more information, please refer to Standards for Consent and Access Control.

9.1.2. LTCFs shall maintain accurate, comprehensive, and easily retrievable health records for all residents.

9.1.3. LTCFs shall maintain an updated list of all active and inactive long-term care residents within the facility's records management system.

9.1.4. LTCFs shall maintain electronic medical records (EMR) for residents' documentation in compliance with the DHA Health Data Quality Policy. EMRs shall include, but not be limited to:

a. Residents' Identification Data: All relevant identification information.

b. Admission Records: Signed admission agreement, general and specific consent forms (including consent/refusal for resuscitation/DNR), initial assessments, and initial care plan.

c. Medical History: Past medical and surgical history, immunisations, allergies, previous treatments, and any advanced directives or living wills noted.

d. Physician Orders: All current and past orders for medications, treatments, diets, and activity levels. Changes shall be documented, with discontinued orders dated and signed.

e. Medication Documentation: Documentation of all administered medications, doses, times, and initials of administering staff. PRN medication records shall include reason and observed effect.

f. Progress Notes: Regular narrative entries by physicians and nurses, documenting residents' condition, care provided, significant changes, incidents, physician/family communication, and interventions.

g. Assessments and Care Plans: Completed assessment forms (initial and periodic), updated care plans, and records of interdisciplinary review with signatures and dates.

h. Therapy Notes: Evaluation and progress reports from physiotherapy, occupational therapy, or other rehabilitative services.

i. Consultation Reports: Records of external consultations, lab test results, imaging reports, and dental or specialist visits.

j. Monitoring Charts: Records of ongoing monitoring (e.g., vital signs, blood glucose, intake/output, repositioning schedules) maintained and filed appropriately.

k. Risk Assessments: A section for documenting risk assessments (e.g., falls, pressure ulcers) and associated management plans.

l. Consent Forms: A copy of the signed general consent form, with regular updates, as necessary.

m. Legal Documents: Guardianship papers, power of attorney, court orders, and signed DNR forms, as applicable.

n. Discharge Records: Summary of discharge or death, including date, reason, destination, key information sent with the resident, or, in the case of death, time of death, cause (if known), and release documentation.

9.1.5. LTCFs shall document medical records electronically within 24 hours of a resident encounter, authenticated by electronic or computer-generated signature.

9.2. General and Informed consent

9.2.1. LTCFs shall obtain general and informed consent from the resident or the resident's legal guardian before initiating long-term care services.

9.2.2. In cases where the resident lacks full decision-making capacity (e.g., under 18 years of age or cognitively impaired), LTCFs shall obtain consent from a relative up to the fourth degree, in accordance with UAE law.

9.2.3. LTCFs shall ensure that designated and trained HPs are responsible for informing residents and obtaining documented general and informed consent prior to the initiation of long-term care services.

9.2.4. LTCFs shall maintain a copy of the signed general and informed consent in the resident's health record, which shall be readily available for review by DHA inspectors at any time.

9.2.5. Informed residents' consent shall be written and include the following:

a. Nature and purpose of the treatment.

b. Expected benefits and potential risks.

c. Alternatives to the proposed treatment include the option of not receiving treatment.

d. Potential consequences of refusing treatment.

e. Residents' rights and responsibilities.

f. Specialised consent forms are required for specialised services like dialysis, IV therapy, etc.

9.2.6. LTCFs shall ensure that the informed consent process is communicated clearly in a language and manner the resident (or legal representative) can understand, respecting cultural and literacy considerations.

9.2.7. For further information, refer to DHA Guidelines for Patient Consent.

9.3. Incident Reporting

9.3.1. LTCFs shall implement a safe mobility and transfer protocol to prevent injuries and support resident independence. LTCFs shall ensure the Medical Director reviews medication errors or adverse events.

9.3.2. The LTC management team shall report Medication Errors, sentinel events or adverse drug reactions to the Health Regulation sector (HRS), as per DHA Pharmacy Guidelines and DHA Standards For Sentinel Events Notification And Management In Health Facilities.

9.3.3. LTCFs shall ensure that the Medical Director reviews all incidents involving harm or risk to staff, implements a support system, and initiates a corrective improvement plan to prevent recurrence.

9.3.4. For further information, refer to DHA Standards For Sentinel Events Notification And Management In Health Facilities

10. **STANDARD SIX**: RESIDENTS RIGHTS AND RESPONSIBILITIES

10.1. LTCFs shall uphold the rights and responsibilities of residents in accordance with DHA regulations and the UAE Patients' Bill of Rights.

10.2. LTCFs shall ensure that all residents are informed of their rights and responsibilities upon admission and regularly thereafter, using language and formats that are understandable to the resident and/or their legal guardian.

10.3. LTCFs shall ensure that all residents are treated with dignity, compassion, and respect at all times.

10.4. LTCFs shall prohibit discrimination against residents based on age, gender, nationality, religion, language, socioeconomic status, disability, or health condition.

10.5. LTCFs shall ensure that care is culturally appropriate, sensitive to religious beliefs, and services align with UAE customs and traditions.

10.6. LTCFs shall provide residents with complete and timely information regarding their condition, treatment options, associated risks, and expected outcomes.

10.7. LTCFs shall ensure access to interpretation services for residents with language or communication barriers.

10.8. LTCFs shall protect the confidentiality of each resident's personal and medical information in accordance with UAE Federal Law No. (2) of 2019 on health data protection.

10.9. LTCFs shall provide private spaces for consultation, examination, and treatment unless medically contraindicated.

10.10. LTCFs shall safeguard resident information against loss, unauthorised access, or misuse.

10.11. LTCFs shall involve residents and their families in all decisions concerning care, including acceptance, refusal, or withdrawal of treatment.

10.12. LTCFs shall inform residents of their rights related to end-of-life decisions, including resuscitation status and the option to forgo life-sustaining treatments.

10.13. LTCFs shall ensure that residents and families understand how clinical information and decisions will be communicated.

10.14. LTCFs shall ensure residents have the right to privacy, personal possessions, and protection from any form of abuse, neglect, or exploitation.

10.15. LTCFs shall allow residents to retain and use personal belongings with appropriate protection against loss or damage.

10.16. LTCFs shall facilitate resident communication with family and the outside community unless clinically restricted for safety reasons.

10.17. LTCFs shall provide care and services aimed at helping residents achieve and maintain their highest level of physical, social, and functional ability, consistent with the facility's mission.

10.18. LTCFs shall maintain a transparent process to receive, investigate, and resolve residents' and family complaints and conflicts regarding care and services.

10.19. LTCFs shall permit residents and/or families to meet collectively as an organised group to raise concerns and discuss matters related to care and services.

10.20. For further information, please refer to Ministerial Resolution No. (14) of 2021 on Patient Rights and Responsibilities.

11. STANDARD SEVEN: INFECTION PREVENTION AND CONTROL REQUIREMENTS

11.1. LTCFs shall strictly adhere to DHA Health Facility Guidelines (Part D – Infection Control).

11.2. LTCFs shall establish and maintain an infection prevention and control (IPC) program designed to minimise the risk of infection transmission among residents, healthcare personnel, and visitors.

11.3. LTCFs shall develop and enforce policies regarding resident isolation procedures, immunization protocols, sterilization of reusable equipment, and management of single-use items.

11.4. LTCFs shall implement IPC measures to address infection risks associated with:

11.4.1. Clinical procedures

11.4.2. Waste and laundry handling.

11.4.3. Foodservice hygiene

11.4.4. Expired and contaminated supplies

11.5. LTCFs shall develop and enforce policies related to the following:

11.5.1. Resident isolation procedures

11.5.2. Immunisation protocols

11.5.3. Sterilisation of reusable equipment

11.5.4. Management of single-use items

11.6. LTCFs shall appoint an Infection Control Coordinator, who shall report directly to the Medical Director or Nursing Director.

11.7. LTCFs shall ensure that IPC policies are clearly documented, reviewed regularly, and integrated into the facility's overarching policies and procedures.

11.8. LTCFs shall ensure the availability of clearly labelled and appropriately located medical waste bins, general waste bins, and sharps containers in all resident care areas to facilitate proper segregation and safe disposal.

11.9. LTCFs shall designate a medical waste storage area that is secure, ventilated, and compliant with Dubai Municipality hazardous waste handling and storage regulations.

11.10. LTCFs shall contract with a licenced medical waste management company, in compliance with Dubai Municipality regulations, to handle the collection, transport, and destruction of infectious materials.

11.11. LTCFs shall provide sufficient personal protective equipment (PPE) such as gloves, gowns, masks, eye protection, and N95 respirators.

11.12. LTCFs shall ensure all healthcare professionals are trained in proper PPE use and disposal, following Standard and Transmission-Based Precautions.

11.13. LTCFs shall adhere to DHA immunisation protocols for healthcare professionals to ensure staff and residents' safety.

11.13.1. Refer to the DHA Policy for Health Screening and Immunization of Healthcare Professionals.

11.14. LTCFs shall enforce hand hygiene practices per DHA Health Facility Guidelines (Part D – Infection Control, Chapter 2 - Hand Hygiene).

11.15. LTCFs shall communicate infection control requirements to all external service providers and visitors.

11.16. LTCFs shall conduct routine surveillance to ensure a clean and safe environment across the premises. This includes regular maintenance of the following:

11.16.1. Air-conditioning systems

11.16.2. Water-cooling towers

11.16.3. Sanitation and disinfection equipment

11.17. LTCFs shall ensure that the Environmental Health and Safety Department maintains Safety Data Sheets (SDS) for all chemicals used in cleaning and disinfection.

11.17.1. These sheets shall detail a chemical's safe and proper use and emergency protocol.

11.17.2. Safety Data Sheets shall be used to train staff on the safe use of each chemical.

11.17.3. All domestic area requirements for equipment and items are to be maintained.

11.18. For further information, please refer to the DHA Communicable Disease notification policy.

12. STANDARD EIGHT: MEDICATION MANAGEMENT REQUIREMENTS

12.1. LTCFs shall organise medication management to meet the therapeutic needs of residents while ensuring compliance with UAE local and federal regulations.

12.2. LTCFs shall store medications securely, including:

12.2.1. A secured, lockable steel cabinet(s) for controlled and semi-controlled drugs.

12.2.2. Access to storage areas is limited to authorised healthcare professionals (HPs).

12.2.3. All medications shall be stored in accordance with the manufacturer's requirements.

12.3. LTCFs shall manage risks related to medications by:

12.3.1. Identifying and segregating look-alike, sound-alike (LASA) medications.

12.3.2. Labelling multi-use medications with the open and expiration dates.

12.3.3. Promptly remove expired medications and dispose of them in accordance with DHA's Medication Disposal and Waste Management Policy.

12.3.4. Reporting controlled/semi-controlled drug issues to the DHA Drug Control.

12.4. LTCFs shall provide residents with adequate medication information, including therapeutic effects, potential side effects, and safety precautions.

12.5. LTCFs shall ensure all medications are clearly labelled with the resident's name, drug name, dosage, administration instructions, and expiration date.

12.6. LTCFs shall check all medications regularly to ensure integrity and expiry compliance.

12.7. LTCFs shall document medication administration in the resident's health record at each instance.

12.8. Only qualified physician shall be authorised to prescribe, dispense, and administer medications.

12.9. LTCFs shall report medication errors and drug incidents to HRS through the email Drugcontrol@dha.gov.ae by filling out the Drug Incident Report form within forty-eight (48) hours. The form is available in Appendix 5 of the DHA Pharmacy Guidelines.

12.10. LTCFs shall develop and implement an antibiotic stewardship program that includes participation from infection prevention and control professionals, physicians, nurses and pharmacists.

12.11. LTCFs shall include in the program clear guidelines for the appropriate use of antibiotics, including treatment of infections and the proper use of prophylactic antibiotic therapy.

12.12. For further information, refer to Medications Disposal and Waste Management and DHA policy for emergency medications.

13. STANDARD NINE: MEDICAL EQUIPMENT MANAGEMENT

13.1. LTCFs shall ensure that all medical equipment used in the facility is registered with MOHAP in the UAE.

13.2. LTCFs shall use equipment approved by at least one of the following international authorities:

13.2.1. Food and Drug Administration (FDA)

13.2.2. Health Canada

13.2.3. Conformité Européenne (CE)

13.2.4. Australian Register of Therapeutic Goods (ARTG)

13.3. LTCFs shall establish a comprehensive plan for the maintenance and management of medical equipment that include but are not limited to:

13.3.1. Equipment acquisition and selection.

13.3.2. Equipment tagging and inventory management.

13.3.3. Breakdown reporting and preventive maintenance.

13.3.4. Safety testing and performance evaluation.

13.3.5. Medical device recalls procedures.

13.3.6. Handling of compressed gases.

13.4. LTCFs shall ensure all equipment is safety tested before use, with documented inspection dates and next testing due dates.

13.5. LTCFs shall train staff to operate new equipment and devices used in resident care safely.

13.6. LTCFs shall perform regular equipment safety checks and performance evaluations.

13.7. LTCFs shall maintain a full inventory of emergency medical equipment, including:

13.7.1. Emergency Medical Service (EMS) Call System: for immediate alerting of emergency responders.

13.7.2. Automated External Defibrillator (AED): Accessible and maintained according to manufacturer guidelines, with clear instructions for use during cardiac emergencies.

13.7.3. Emergency Crash Cart: Equipped with essential emergency supplies, medications, and tools for immediate use in critical situation, as per DHA Standards for the Management of Crash Carts in Hospitals.

13.7.4. Backup Power Supply: A functional backup power system to sustain essential equipment operation during power failures.

13.7.5. Respiratory Support: Availability of the following equipment for emergency airway management and safe resident transfer during critical incidents: ventilators, portable ventilators, suction machines, oxygen cylinders or concentrators with masks/cannula, and a tracheostomy emergency kit.

13.7.6. Pulse Oximetry and Vital Signs Monitor: Devices for continuously monitoring oxygen saturation, heart rate, and blood pressure in emergencies.

13.7.7. Transfusion Pumps: for emergency fluid or blood product delivery.

13.7.8. Mobility and Evacuation Aids: Includes evacuation chairs and sledges specifically designed for non-ambulatory residents with limited mobility.

13.8. For more information, refer to the DHA standards for Medical Equipment Management.

14. STANDARD TEN: TELEHEALTH SERVICES

14.1. Long-term care facilities (LTCFs) implement telehealth services to complement in-person care, enhancing access and continuity of care across all LTC settings while ensuring residents' safety and quality. This includes, but is not limited to:

14.1.1. Remote physician consultations and virtual rounds enable off-site physicians or specialists to assess and monitor resident's health in coordination with onsite staff.

14.1.2. Remote residents monitor residents' health parameters using approved devices to track health status in real time and alert care staff to significant changes.

14.1.3. Multidisciplinary team coordination via secure video conferencing, facilitating case discussions and care planning with physicians, nurses, therapists, and other specialists.

14.1.4. Tele-mental health services (remote counselling or psychiatric consultations) to support residents' psychological well-being.

14.1.5. Virtual family engagement via video calls to support residents' social and emotional well-being and keep family members informed.

14.2. LTCFs utilising telehealth shall ensure the following:

14.2.1. All virtual services comply with the DHA Standards for Telehealth Services, particularly in data protection, privacy, residents' identification, and consent.

14.2.2. Use DHA-approved telehealth platforms and devices that meet minimum data security and confidentiality requirements.

14.2.3. Informed consent is obtained and documented before the initiation of any telehealth service.

14.2.4. Staff are trained and competent in operating telehealth equipment, managing virtual consultations, and supporting residents during digital interactions.

14.2.5. Access to private, quiet spaces equipped for teleconsultations to maintain confidentiality and resident dignity.

14.2.6. All telehealth interactions are documented in the resident's electronic medical record, including date, time, provider identity, summary of consultation, and follow-up plan.

14.3. For more information, refer to the DHA Standards for Telehealth Services.

15. STANDARD ELEVEN: EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT

15.1. LTCFs shall develop and maintain a comprehensive Emergency Preparedness Plan (EPP) to protect the lives and well-being of residents, staff, and visitors in the event of internal or external emergencies.

15.2. LTCFs shall ensure that the EPP complies with UAE Civil Defence laws, Dubai Municipality guidelines, and international emergency planning standards.

15.3. All staff shall receive emergency preparedness training upon hire and at least annually.

15.4. LTCFs shall conduct an annual all-hazards risk assessment to identify potential threats, including:

15.4.1. Natural disasters (e.g., flooding, sandstorms)

15.4.2. Utility failures (e.g., power or water outage)

15.4.3. Infectious disease outbreaks or pandemics

15.4.4. Structural fires and hazardous material exposure

15.4.5. Internal incidents (e.g., violence, technical failure, mass casualty)

15.5. LTCFs shall provide emergency preparedness training to all staff, including:

15.5.1. Orientation during onboarding

15.5.2. Refresher training at least once per year

15.6. LTCFs shall conduct and document regular emergency drills, including:

15.6.1. Fire drills: at least once per quarter, including a nightshift scenario.

15.6.2. Annual evacuation or tabletop exercises simulating non-fire emergencies.

15.6.3. Medical emergency response drills, such as for cardiac arrest

15.6.4. Full-scale disaster simulations, when feasible

15.7. LTCFs shall educate residents about emergency alarms and evacuation procedures using age-appropriate and accessible communication methods.

15.8. LTCFs shall maintain updated emergency contact information for residents' families or legal representatives.

15.9. LTCFs shall ensure uninterrupted access to emergency medical equipment and supplies, as STANDARD NINE outlines.

15.10. LTCFs shall assign specific roles and responsibilities to staff during emergencies and ensure designated teams are trained to coordinate the evacuation and relocation of residents with mobility, cognitive, or medical dependencies.

15.11. LTCFs shall establish a communication protocol for consulting with emergency responders, hospitals, and regulatory bodies during crisis events.

16. STANDARD TWELVE: CONVALESCENCE FACILITIES

16.1. Convalescence Facilities (CFs) shall admit residents based on a formal referral from a licenced physician or upon discharge from a hospital or other inpatient care setting.

16.2. CFs shall ensure that admitted residents are medically stable and do not require intensive monitoring or emergency medical interventions.

16.3. CFs shall provide 24-hour nursing coverage at all times.

16.4. CFs shall ensure that each shift is staffed by at least one Registered Nurse (RN), or by Assistant Nurses (ANs) working under the supervision of an RN who is available onsite or on-call, to oversee resident care.

16.5. CFs shall employ a full-time or part-time licenced physician responsible for conducting daily rounds (at least five days per week) and being available on-call 24/7.

16.6. CFs shall employ adequate numbers of allied health professionals, including but not limited to:

16.6.1. Physiotherapist

16.6.2. Clinical Dietitian

16.6.3. Occupational Therapist

16.6.4. Speech Therapist/Speech & Language Pathologist

16.6.5. Clinical Psychologist

16.6.6. Social Worker

16.7. Convalescence facilities shall not perform invasive procedures or emergency medical interventions unless expressly authorised by the Dubai Health Authority and supported by relevant licensure, equipment, and staff training.

16.8. Convalescence Facilities Clinical Services

16.8.1. 24-Hour Nursing Services:

a. Monitoring of vital signs, pain, and recovery progress.

b. Assistance with mobility, personal hygiene, toileting, and oral intake.

c. Managing catheters, stomas, and tracheostomies within the facility's capabilities

d. Administration of prescribed medications.

e. Coordinating chronic disease care with physicians

16.8.2. Physiotherapy and Functional Rehabilitation

a. Post-surgical physiotherapy for orthopaedic, cardiac, or neurological recovery.

b. Ambulation and mobility training.

c. Pain-relieving modalities (e.g., Transcutaneous Electrical Nerve Stimulation (TENS), cold therapy).

d. Strengthening, balance, and endurance exercises.

16.8.3. Non-complex wound and Post-Surgical Site Management

a. Daily wound assessments and sterile dressing application.

b. Pressure injury prevention and management.

c. Monitoring for signs of infection.

d. Documentation of healing progress.

16.8.4. Nutrition Support and Dietetic Monitoring

a. Tailored meal plans based on medical conditions.

b. Provision of therapeutic diets (e.g., diabetic, renal, post-surgical diets)

c. Monitoring of dietary intake and weight trends.

d. Consultations with clinical dietitians as needed.

16.8.5. Psychosocial and Emotional Support

a. Initial psychosocial assessment and periodic follow-up.

b. Short-term psychological support or referral for counselling.

c. Family education and involvement in discharge planning.

d. Stress and anxiety management tools.

16.9. CFs shall initiate discharge planning upon resident admission, including:

16.9.1. Development of a structured transition plan to home or other care settings.

16.9.2. Coordination with the resident's primary physician, home care services, or rehab centres.

16.9.3. CFs shall provide education to residents and caregivers on medication, wound care, and rehabilitation continuation.

16.10. CFs shall issue written discharge instructions and ensure follow-up appointments are scheduled.

16.11. Convalescence facilities shall maintain a memorandum of understanding (MOU) or collaboration with a hospital to ensure immediate 24/7 access to emergency services, including admissions and radiology, per resident's care requirements.

16.12. Convalescence facilities shall establish protocols for the timely and efficient transfer of residents to hospitals for necessary investigations, coordinated through formal agreements with healthcare providers.

17. STANDARD THIRTEEN: NURSING HOMES FACILITIES

17.1. Nursing Home Facilities (NHFs) shall admit residents following a formal assessment by a licenced physician, preferably a geriatrician or internal medicine specialist.

17.2. NHFs shall ensure that admission assessments document the resident's chronic medical conditions, functional impairments, or cognitive decline.

17.3. NHFs shall operate 24/7 with continuous nursing and medical supervision, including at least one registered nurse (RN) to oversee resident's care.

17.4. NHFs shall employ a licenced physician on a full-time or part-time basis to conduct daily rounds or consultations and remain available on-call 24/7 to address emergencies.

17.5. NCHs shall employ adequate numbers of allied health professionals, including but not limited to:

17.5.1. Physiotherapist

17.5.2. Occupational therapist

17.5.3. Speech-language pathologist

17.5.4. Clinical dietitian

17.5.5. Clinical psychologist

17.5.6. Respiratory Therapist

17.6. NHFs shall provide comprehensive clinical Services, including:

17.6.1. Basic Nursing Care Services

a. Monitoring vital signs and clinical status.

b. Administering prescribed medications.

c. Performing wound care and pressure injury prevention.

d. Coordinating care plans and ensuring adherence to medical protocols

17.6.2. Physiotherapy Services

a. Physical assessments for residents with mobility issues.

b. Personalised exercise regimens.

c. Strengthening and balancing training

17.6.3. Occupational Therapy Services

a. Functional assessments for ADLs.

b. Training in adaptive techniques and assistive device use.

c. Environmental modifications to enhance safety and independence.

17.6.4. Speech-Language Pathology Services

a. Assessment and treatment for speech, language, swallowing, or cognitive disorders.

b. Therapy sessions focus on communication and safe feeding strategies.

17.6.5. Dietary and Nutrition Services

a. Nutritional assessments and meal planning.

b. Management of therapeutic diets.

c. Monitoring of nutritional intake and status

17.6.6. Psychological and Social Services

a. Psychological counselling by licenced clinical psychologists.

b. Social work support for resident needs, family liaison, and resource navigation.

17.6.7. Medical Management and Coordination Services

a. NHFs shall coordinate medical care with residents' primary care physicians and specialists as needed.

b. Medical management shall include regular health assessments, medication management, and coordination of diagnostic tests and treatments.

17.7. Nursing home facilities shall maintain a memorandum of understanding (MOU) or collaboration with a hospital to ensure immediate 24/7 access to emergency services, including admissions and radiology, per resident's care requirements.

17.8. NCHs shall establish protocols for the timely and efficient transfer of residents to hospitals for necessary investigations, coordinated through formal agreements with healthcare providers.

18. STANDARD FOURTEEN: PALLIATIVE AND HOSPICE FACILITIES

18.1. Palliative and Hospice Facilities (PHFs) shall operate only under DHA-approved healthcare facility types, which include:

18.1.1. Hospitals with specialised palliative care units.

18.1.2. Long-term care facilities integrating palliative/hospice units.

18.1.3. Standalone dedicated PHFs

18.1.4. Home healthcare providers as home-based palliative services.

18.2. Outpatient facilities like specialist clinics may offer palliative care consultations if appropriately licenced. For instance, an oncology clinic may provide outpatient palliative consultations.

18.3. PHFs not falling into an approved category for palliative services are not permitted to deliver palliative care beyond basic symptomatic treatment and shall refer residents to licenced providers as needed.

18.4. PHFs shall be designed to ensure accessibility for residents with disabilities and to create a calm, private, and dignified care environment.

18.5. PHFs shall provide single-occupancy rooms with private sanitary facilities and adequate space to accommodate family presence and overnight stays.

18.6. PHFs shall establish and maintain a fully integrated Interdisciplinary Team (IDT) to address the full spectrum of resident needs—physical, psychological, social, spiritual, and existential.

18.7. PHFs shall include the following IDT members, but not limited to:

18.7.1. Physicians: licenced Palliative Medicine Specialist (part-time or full-time)

18.7.2. Registered Nurses: Nursing staff with certification or documented competency in palliative and end-of-life nursing care.

18.7.3. Clinical Pharmacists: A licenced clinical pharmacist with training in palliative pharmacology.

18.7.4. Clinical psychologists: A licenced clinical psychologist shall be accessible to conduct comprehensive psychological assessments, provide grief counselling, and support residents and families in coping with emotional and cognitive challenges related to terminal illness.

18.8. PHFs shall convene IDT meetings at least weekly to review care plans, assess progress, and address complex or ethical care issues.

18.9. PHFs shall appoint a designated IDT Coordinator (senior nurse, physician, or qualified administrator) to oversee team communication and care integration.

18.10. PHFs shall ensure the availability of one physician (part-time/full-time) per 10 inpatients onsite five days per week, with 24/7 on-call access.

18.11. PHFs shall ensure that at least one palliative-trained nurse is always present.

18.12. PHFs shall provide annual training for all healthcare professionals, covering:

18.12.1. Pain and symptom management

18.12.2. Ethics in end-of-life care

18.12.3. Cultural and religious competency

18.12.4. Therapeutic communication skills

18.13. resident's Admission and Evaluation

18.13.1. PHFs shall document clear clinical indicators for admission, focusing on residents with life-limiting illnesses.

18.13.2. PHFs shall complete a comprehensive medical, psychological, and social assessment within 24 hours of admission.

18.14. Care Planning and Clinical Interventions

18.14.1. PHFs shall develop personalised care plans within 48 hours of admission, incorporating resident preferences and family input.

18.14.2. PHFs shall reassess residents at least every 8 hours or following major clinical interventions, using validated symptom scales.

18.14.3. PHFs shall ensure access to the following clinical services:

a. Pain and Symptom Management

i. Assessment and control of physical symptoms such as pain, dyspnoea, nausea, fatigue, constipation, anorexia, and delirium.

ii. Individualised pharmacologic and non-pharmacologic treatment plans.

b. Medication Management

i. Comprehensive review and reconciliation of medications.

ii. Safe prescribing, dispensing, and administration of controlled substances (e.g., opioids, adjuvants).

iii. Monitoring for side effects, polypharmacy, and appropriate deprescribing.

c. Psychosocial and Emotional Support

i. Psychological assessment and counselling for residents and families.

ii. Management of anxiety, depression, grief, fear, and emotional distress.

d. Minor Palliative Procedures

i. Performance or coordination of minor procedures for symptom relief (e.g., ascitic drainage, wound care, paracentesis).

ii. Non-invasive interventions for distressing symptoms (e.g., oxygen therapy for dyspnoea, antiemetic therapy). Nutrition and Hydration Planning.

iii. Nutritional assessment and tailored care plans.

iv. Counselling on feeding alternatives (e.g., oral comfort feeding vs. artificial nutrition).

e. Rehabilitation Therapies

i. Physical therapy, occupational therapy, and speech-language therapy as indicated to maintain function and comfort.

ii. Use of assistive devices and environmental modifications to enhance resident's mobility and safety.

f. Social Services and Family Support

i. Psychosocial assessments, caregiver support, and discharge planning.

ii. Assistance with social needs and home care coordination.

iii. Advocacy for vulnerable residents and family education.

g. Paediatric Palliative Subspecialties

i. Neonatal palliative care for life-limiting congenital anomalies.

ii. Support for rare paediatric genetic and metabolic disorders.

iii. Paediatric-specific pain assessment tools (e.g., FLACC, Wong-Baker)

h. Advance Care Planning (ACP) and Goals of Care Discussions

i. Facilitate discussions regarding treatment preferences, prognosis, and goals of care.

ii. Documentation and review of Advance Care Plans (ACPs) and Do-Not-Resuscitate (DNR) directives in accordance with Do-Not-Resuscitate policy and the UAE law.

iii. Shared decision-making involves residents, families, and the interdisciplinary team.

i. End-of-Life Care

i. Provision of clinical care during the active dying phase.

ii. Implementation of comfort-focused treatment protocols.

iii. Emotional and spiritual support for residents and families in the final hours of life

18.15. The assessment shall include:

18.15.1. Pain location, type (nociceptive/neuropathic), intensity, duration, frequency, and response to prior interventions.

18.15.2. Associated symptoms such as dyspnoea, delirium, insomnia, itching, depression, and anxiety.

18.15.3. Impact on functional status and quality of life.

18.15.4. Resident's and family's goals and values concerning symptom relief.

18.16. PHFs shall stock all required emergency and palliative medications at all times, including but not limited to:

18.16.1. Opioid analgesics (e.g. morphine, fentanyl, oxycodone, and methadone) for severe pain and dyspnoea relief (with an opioid antagonist such as naloxone readily available for overdose reversal).

18.16.2. Antispasmodics/anticholinergics (e.g. hyoscine compounds) for bowel colic and respiratory secretion control in terminal care.

18.16.3. Antiemetics (e.g. metoclopramide, ondansetron, or haloperidol in low doses) to manage nausea and vomiting.

18.16.4. Anxiolytics (e.g. benzodiazepines such as lorazepam or midazolam) for acute anxiety, agitation, or refractory dyspnoea (also useful as anticonvulsants for seizures).

18.16.5. Corticosteroids (e.g. dexamethasone) for pain due to oedema, appetite stimulation, or other palliative indications.

18.16.6. Antipsychotics (e.g. haloperidol or quetiapine) for delirium, severe agitation, or terminal restlessness.

18.17. PHFs shall prohibit euthanasia or physician-assisted suicide in alignment with UAE Federal Law.

18.18. Palliative care and hospice facilities shall maintain a memorandum of understanding (MOU) or collaboration with a hospital to ensure immediate 24/7 access to emergency services, including admissions and radiology, per resident's care requirements.

18.19. Palliative care and hospice facilities shall establish protocols for the timely and efficient transfer of residents to hospitals for necessary investigations, coordinated through formal agreements with healthcare providers.

19. STANDARD FIFTEEN: ADDICTION TREATMENT AND REHABILITATION FACILITIES

19.1. For information, refer to the DHA Standards For Addiction Treatment And Rehabilitation Services Version 1.0

20. STANDARD SIXTEEN: KEY PERFORMANCE INDICATORS (KPIs)

20.1. To effectively monitor and enhance the performance of long-term care services, LTCFs shall have internal quality monitoring and improvement procedures that cover clinical outcomes, operational efficiency, and resident satisfaction, serving as measurable benchmarks for success and progress.

20.2. LTCFs medical director and quality team shall assure continuous review of service performance and implementation of improvement plans.

20.3. LTCFs shall monitor internally performance measures including but not limited to:

20.3.1. Emergency Attendance Rate: Number of unplanned emergency department visits per 1,000 long term resident days.

20.3.2. Deep Vein Thrombosis (DVT) Rate: Number of newly diagnosed deep vein thrombosis cases per 1,000 long term resident days among adult residents.

20.3.3. Ventilator-Associated Event (VAE) Rate: Number of ventilator-associated complications per 1,000 long term resident days (among residents requiring ventilatory support).

20.3.4. Catheter-Associated Symptomatic Urinary Tract Infection (CA-SUTI) Rate: Number of CA-SUTI events per 1,000 long term resident days among residents with indwelling catheters.

20.3.5. Non-Catheter Associated Symptomatic Urinary Tract Infection (SUTI) Rate: Number of SUTI events per 1,000 long term resident days in residents without catheters.

20.3.6. Gastroenteritis Rate: Number of gastroenteritis cases per 1,000 long term resident days.

20.3.7. Resident Satisfaction Score: Average score from resident and family satisfaction surveys.

20.3.8. Medication Error Rate: Number of medication errors per 1,000 medication administrations.

20.3.9. Incidence of Sepsis: Number of new sepsis episodes per 1,000 long term resident days.

20.3.10. Clostridioides difficile Infection Rate: The frequency of C. difficile infections per 1,000 long term resident days.

20.3.11. Rate of Multidrug-Resistant Organisms (MRSA): Number of MRSA colonisation or infection events per 1,000 long term resident days.

20.4. LTCFs shall monitor and report to DHA a set of performance measures as outlined Below.

20.4.1. Reporting Shall Be on an Annual Basis To Monitoringkpis@Dha.Gov.Ae

20.4.2. Data shall capture indicator definitions as outlined in (appendix 1 KPI cards) for:

a. Rate Of Unplanned Hospital Admission

b. Rate Of Newly Acquired or Worsening Pressure Injury (Stage II and Above)

c. Rate Of Falls Resulting in Injury

d. Percentage Of New/ Worsened Mental Health Symptoms

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APPENDIX

APPENDIX 1: KPI Cards

KPI 1: Rate of Unplanned Hospital Admission	
Main Domain:	Quality
Subdomain:	Effectiveness of Care.
Indicator Definition:	The number of emergency/ unplanned admissions of long-term care facility (LTCF) residents to a higher level of care (ICU, inpatient hospital ward) per 1000 LTCF residents' days
Calculation:	Numerator: Number of unplanned/ emergency admission to a higher level of care - Exclusions: planned transfers/ admissions Denominator: Total number of LTCF resident days.
Target:	NA.
Methodology:	Numerator/ denominator x1000.
Measuring Unit:	Rate per 1000 resident days.
Collection Frequency:	Annual.
Desired Direction:	Lower % is better.
Rationale:	Metric of effectiveness in managing LTCF resident needs.
KPI Source:	DHA, MOHAP, DoH, CMS

KPI 2: Rate of Newly Acquired or Worsening Pressure Injury (Stage II and above)	
Main Domain:	Quality
Subdomain:	Patient Safety
Indicator Definition:	The number of residents who developed new pressure injury/ pressure ulcer/ bed sores or whose existing pressure ulcers/injuries/ bed sores worsened during their stay at the long-term care facility (LTCF) per 1,000 LTCF resident days.
Calculation:	Numerator: Number of residents with new or worsening pressure injury (stage II or above) - Exclusions: residents with stable/ improved pressure injury Denominator: Total number of LTCF resident days.
Target:	NA.
Methodology:	Numerator/ denominator x1000.
Measuring Unit:	Rate per 1000 resident days.
Collection Frequency:	Annual.
Desired Direction:	Lower % is better.
Rationale:	Metric of effectiveness in managing LTCF resident safety.
KPI Source:	DHA, MOHAP, DoH, CMS

KPI 3: Rate of Falls Resulting in an Injury	
Main Domain:	Quality
Subdomain:	Patient Safety
Indicator Definition:	Total number of falls that residents of long-term care facility experienced and resulted in any injury (all levels of injury from minor to major and death) per 1,000 LTCF resident days.
Calculation:	Numerator: Number of falls that residents of long-term care facility experienced and resulted in any level of injury. - Exclusions: falls that resulted in no injury. Denominator: Total number of LTCF resident days.
Target:	NA.
Methodology:	Numerator/ denominator x1000.
Measuring Unit:	Rate per 1000 resident days.
Collection Frequency:	Annual.
Desired Direction:	Lower % is better.
Rationale:	Metric of effectiveness in managing LTCF resident safety.
KPI Source:	DHA, MOHAP, DoH, CMS

KPI 4: Percentage of New/ Worsened Mental Health Symptoms	
Main Domain:	Quality
Subdomain:	Outcome
Indicator Definition:	Total number of long-term care facility residents who show new signs of worsened mental health symptoms or whose symptoms worsen during the reported period. Worsened mental health symptoms include but are not limited to unexplained fatigue, loss of interest in normal activities, and poor appetite. This measure is especially important to LTCF serving geriatric population.
Calculation:	Numerator: Number of residents who show new/ worsened symptoms of mental health - Exclusions: residents admitted with mental health concerns and whose symptoms improved or stayed the same. Denominator: Total number of LTCF residents.
Target:	NA.
Methodology:	Numerator/ denominator x100.
Measuring Unit:	Percentage.
Collection Frequency:	Annual.
Desired Direction:	Lower % is better.
Rationale:	Metric of effectiveness in supporting LTCF residents.
KPI Source:	DHA, CMS, Canada