MIO-MOD/2025/81

قرار وزاري رقم (82) لسنة 2025

بشأن اعتماد المعايير الوطنية لمراكز جراحة اليوم الواحد

وزير الصحة ووقاية المجتمع:

بعد الاطلاع:

- على القانون الاتحادي رقم (1) لسنة 1972 م بشأن اختصاصات الوزارات وصلاحيات الوزراء وتعديلاته،
- وعلى القانون الاتحادي رقم (4) لسنة 2015 م في شأن المنشآت الصحية الخاصة وتعديلاته ولائحته التنفيذية،
- وعلى القانون الاتحادي رقم (5) لسنة 2019 م في شأن تنظيم مزاولة مهنة الطب البشري ولائحته التنفيذية،
- وعلى القانون الاتحادي رقم (6) لسنة 2023 م بشأن مزاولة غير الأطباء والصيادلة لبعض المهن الصحية،
- وعلى المرسوم بقانون اتحادي رقم (4) لسنة 2016 م بشأن المسؤولية الطبية، وتعديلاته ولائحته التنفيذية،
- وعلى قرار مجلس الوزراء رقم (20) لسنة 2017 م باعتماد المعايير الموحدة لترخيص مزاولي المهن الصحية على مستوى الدولة وتعديلاته،
- وعلى قرار مجلس الوزراء رقم (11) لسنة 2021 م في شأن الهيكل التنظيمي لوزارة الصحة ووقاية المجتمع.

وبناء على مقتضيات المصلحة العامة،،،

قـــرّر ما يلي:

المادة (1): تعتمد المعايير الوطنية لمراكز جراحة اليوم الواحد المرفقة بهذا القرار.

المادة (2): ينشر هذا القرار في الجريدة الرسمية ويعمل به اعتباراً من اليوم التالي لتاريخ نشره.

عبدالرحمن بن محمد العويس

وزير الصحة ووقاية المجتمع

صدر بتاريخ: 28 / 04 / 2025

UNITED ARAB EMIRATES
MINISTRY OF HEALTH & PREVENTION
OFFICE OF THE MINISTER

الإمارات العربية المتحدة
وزارة الصحة ووقاية المجتمع
مكتب الوزير

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مرفق القرار الوزاري رقم (82) لسنة 2025 م

بشأن اعتماد المعايير الوطنية لمراكز جراحة اليوم الواحد

National Standard of Standalone Day Surgery Centers

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PURPOSE

This standard defines the specifications of Standalone Day Surgery Centers licensed by Concerned Health Authorities, aiming to ensure the highest levels of safety and quality care for patients in the United Arab Emirates.

SCOPE

This standard applies to all licensed Standalone Day Surgery Centers in the UAE approved under licensure to provide Day Surgical Services according to the specifications of this standard.

ABBREVIATIONS

ACLS	:	Advanced Cardiovascular Life Support
ASA-PS	:	American Society of Anesthesiologists Physical Status
ATLS	:	Advanced Trauma Life Support
BLS	:	Basic Life Support
BMI	:	Body Mass Index
CAD	:	Coronary Artery Disease
CCTV	:	Closed-Circuit Television
COPD	:	Chronic Obstructive Pulmonary Disease
CSF	:	Cerebrospinal Fluid
DAMA	:	Discharge Against Medical Advice

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DM	:	Diabetes Mellitus
DSC	:	Day Surgery Centre
ESRD	:	End-Stage Renal Disease
Etco2	:	End-tidal carbon dioxide
FANR	:	Federal Authority for Nuclear Regulation
HTN	:	Hypertension
IPPV	:	Invasive Positive Pressure Ventilation
IV	:	Intravenous
MOHAP	:	Ministry of Health and Prevention
MSDS	:	Material Safety Data Sheets
OR	:	Operating Room
PALS	:	Pediatrics Advanced Life Support
PSA	:	Procedural Sedation and Analgesia
RN	:	Registered Nurse
SIMV	:	Synchronized Intermittent Mandatory Ventilation
TIA	:	Transient Ischemic Attack
VTE	:	Venous Thromboembolism

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DEFINITIONS

Analgesia: means the reduction or elimination of pain. It is usually induced by drugs that act locally (by interfering with nerve conduction) or generally (by depressing pain perception in the central nervous system).

CCTV (Closed-Circuit Television) is a TV system in which signals are not publicly distributed but are monitored, primarily for surveillance and security purposes.

Clinical Audit: is a systematic examination to review and determine whether actual activities and results comply with standards of care.

Specialized Led Service: is a service where a consultant or specialist physician or dentist retains overall clinical responsibility for the service, care professional team or treatment. The consultant or specialist takes clinical responsibility for the overall patient care and is the lead for the surgical procedure.

Day Surgery Center (standalone): A Standalone Day Surgical Centre (DSC) is a free standing ambulatory surgery center mainly providing surgical procedures and services for patients who do not require hospitalization or overnight stay. An outpatient surgical center may provide outpatient services for other medical specialties including diagnostics. It shall be classified according to the American Association for Accreditation of Ambulatory Surgery Center as Class A, Class B, Class CM or Class C Day Surgery Centers.

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Dissociative Anesthetics: Are different type of anesthetics characterized by Catalepsy, amnesia and marked analgesia and elicit feelings of detachment/dissociation from the environment and self, e.g. Ketamine.

Healthcare professional: Any individual who hold a current and valid license issued by the Concerned Health Authority within the emirate and is qualified by education, training, certification, and licensure to provide clinical services as per the U.A.E's Unified Healthcare Professional Qualification Requirements (PQR).

Hybrid Operating Room: is an operating room that has permanently installed equipment to enable diagnostic imaging before, during, and after surgical procedures (use of mobile imaging technology does not make an OR a hybrid operating room).

Informed Consent: refers to an agreement and permission accompanied by full information on the nature, risks and alternatives of a surgical or interventional procedure.

Local Anesthesia: It's the application or injection of a drug or a combination of drugs to stop or prevent a painful sensation to a circumscribed area of the body where a painful procedure is to be performed.

Operating Room: is defined as a room in the surgical suite that meets the requirements of a restricted area and is designated and equipped for performing surgical operations or other invasive procedures that require an aseptic field.

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Patient: Any individual who receives medical attention, care, treatment or therapy by a licensed healthcare professional in a licensed health facility.

Pediatric: Every human being born alive and who is under eighteen (18) years old.

Procedural Sedation and Analgesia (PSA): is a continuum of depressed level of state of consciousness ranging from minimal sedation to general anesthesia as per the permitted levels of sedation per DSC facility type.

Procedure Room: is a room for the performance of medical procedures that do not require an aseptic field but may require the use of sterile instruments or supplies.

Procedures: are surgical interventions, which require Informed Consent from the patients or next of kin/ legal guardian, as per UAE Federal Laws.

Recovery Area: means a room/area dedicated to providing medical services to patients recovering from Surgery or Sedation/Anesthesia.

Restricted Area: A surgical suite designated space that can only be accessed through a semi-restricted area to achieve a high level of asepsis control. Traffic in the restricted area is limited to authorized personnel and patients.

Safety: the state of being shielded from physical, psychological, or other potential harm, including failures, errors, or undesirable outcomes. It involves protection from events or exposures that could lead to health issues, such as the use of a drug, undergoing a procedure, or risks in the care environment.

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Sedation: The administration of a sedative agent or drug to induce a state of calm, restfulness, or drowsiness. The sedative agent or drug depresses the central nervous system's activity, reduces anxiety, and induces sleep.

Semi-restricted Area: comprises the peripheral support areas surrounding the restricted area of a surgical suite. These support areas include storage areas for clean and sterile supplies, sterile processing rooms, work areas for storage and processing of instruments, scrub sink areas, corridors leading to the restricted area, and pump rooms.

Spinal Anesthesia: is a single injection with a thin needle that puts the local anesthetic close to the nerves within the Cerebrospinal Fluid (CSF) surrounding the spinal cord.

Topical Anesthesia: means the application of an anesthetic agent (spray, gel, cream or eye drops) directly to the skin or mucous membranes, intended to produce a transient and reversible loss of sensation to a circumscribed area.

Venous Thromboembolism (VTE) risk assessment: is the process of evaluating the risk of VTE, a condition where blood clots form in the veins. VTE assessment should be done for all patients admitted to the health facility and prior to surgical procedures in the DSC.

1. REGISTRATION REQUIREMENTS

1.1. All Day Surgery Centers (DSC) must adhere to the United Arab Emirates (UAE) laws and regulations.

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1.2. Health facilities intending to provide Day Surgery Services must comply with the licensure and administrative procedures of the Concerned Health Authorities.

1.3. All Day Surgery Centers (DSC) must apply for a license and meet the requirements set by the Concerned Health Authorities.

1.3.1. Any modification to a licensed facility or its services must obtain a prior approval from the regulatory authority.

1.4. A summary of Day Surgery Centers (DSC) classifications and minimum requirements can be found in Appendix 1.

1.5. Day Surgery Centers shall be granted a license based on their classification and permitted levels, as outlined in Appendix 2-4.

1.6. All Day Surgery Centers (DSC) are mandated to be accredited within two (2) years of licensure, and meet the requirements set out by each health authority.

1.6.1. Accreditation shall include entities approved by the International Society for Quality in Healthcare (ISQua), such as, but not limited to:

- Accreditation Canada International (ACI)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- Australian Council of Healthcare Standards International (ACHSI)
- Joint Commission International (JCI) Ambulatory Care
- Emirates International Accreditation Center (EIAC)
- American Accreditation Commission International (AACI)

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2. HEALTH FACILITY REQUIREMENTS

2.1. The Health Facility shall comply with the Health Facility Guidelines related to each health authority.

2.2. DSC operational requirements include the following:

2.2.1. DSCs shall not operate or open between 12:00 AM and 6:00 AM.

2.2.2. Surgeries in DSC Class CM and Class C, requiring general anesthesia, shall not start after 5:00 PM.

2.2.3. Surgeries in DSC CM under deep sedation shall not exceed two (2) hours.

2.2.4. Surgeries in DSC C under deep sedation and or general anesthesia shall not exceed three (3) hours.

2.2.5. Multiple surgeries in different sites that exceed three (3) hours are not permitted.

2.3. Day Surgical Services shall be led by a licensed surgeon with training and expertise in the relevant services provided.

2.3.1. The lead surgeon shall have a minimum of five (5) years of experience in the surgical service provided at the center.

2.4. The DSC may specialize in one or more of the following surgical specialties but not limited to:

2.4.1. General Surgery (pediatric and/or adult)

2.4.2. Dentistry

2.4.3. Ophthalmology

2.4.4. Vascular

2.4.5. Orthopedic

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2.4.6. Obstetrics and Gynecology

2.4.7. Gastroenterology

2.4.8. Plastic Surgery

2.5. DSC should have a **contract** with the following types of healthcare facilities:

2.5.1. **A nearby hospital:** for referral of urgent and emergency cases, ward and ICU Admissions (if required), Assessment and follow up with professionals, specialties and services not available or not within the scope of the DSC.

2.5.2. **External Laboratory service** (Applicable to DSC class A, B, and any DSC that provides solely vascular or ophthalmology services).

2.5.3. **External Diagnostic imaging services** (Applicable to DSC class A, B and any DSC that provides solely vascular or ophthalmology services).

2.5.4. **Pharmacy, rehabilitation, Home healthcare, and Telehealth services** (if required).

2.6. DSC healthcare professionals (physicians, nurses, and allied health) shall be trained to operate the medical equipment assigned to them.

2.6.1. Training shall be documented and kept up to date.

2.7. The surgical setup shall be capable of providing the required level of sedation/anesthesia and emergency response.

2.8. The Health Facility shall put in place annual simulation scenarios with all surgical teams to manage patient recovery and transfer.

2.8.1. Simulation outcome and improvement plans shall be documented.

2.9. All DSC facilities are required to have an Operating Theatre (OT) equipped to manage permitted surgeries.

2.9.1. For OT specifications and equipment requirements, see Appendix 2.

2.10. Class B Day Surgical Centers should have sufficient medical equipment to manage permitted endoscopic procedures:

2.10.1. Procedural sedation shall be performed in designated areas where the patient can be resuscitated if sedation is deeper than intended.

2.10.2. Each procedure requiring sedation must be attended by a practitioner certified in ACLS and trained in resuscitation skills to manage deeper-than-expected sedation.

2.11. Class A and B (without endoscopy) do not require a ventilator and should have the required medical equipment to manage permitted surgeries:

- Emergency Medical Service (EMS) call system;
- Pulse oximeter
- Automated External Defibrillator (AED)
- A surgical sterilizing area available in the clinic or outsourced.
- Emergency crash cart that includes all emergency supplies and medications.

2.12. Class B (with endoscopy), CM and C Day Surgical Centers should have the required medical equipment to manage permitted surgeries:

- Emergency Medical Service (EMS) call system;
- One portable ventilator is required for (1) one to (4) four OTs (backup); and
- One ventilator is required for two beds in the recovery bay
- Pulse oximeter, and hemodynamic monitoring equipment shall include but not limited to the following:
  - ECG

- Heart rate
- Blood pressure
- Central venous pressure
- Temperature, peripheral venous oxygen saturation
- ABG

2.13. A malignant hyperthermia kit shall be available in Class C to manage emergencies related to malignant hyperthermia.

2.14. All DSC shall have access to laboratory and diagnostic services as per patient needs determined by the services provided and the medical team.

2.14.1. Refer to the Standards of Clinical Laboratory Services and the Standards of Diagnostic Services as outlined by each Concerned Health Authority.

2.15. DSC shall assure the safe and appropriate practice system for sample collection, storage, blood transportation and other samples.

2.16. As a minimum, the DSC must ensure the provision of the services mentioned in Appendix 6.

- Any other radiology and lab services may be contracted with accredited and licensed external providers as per patient needs.

2.17. Inhouse radiology services is optional for DSC class CM and C providing solely Vascular services.

2.18. All DSC must have a Business Continuity Plan to ensure core functions of the center are met.

2.19. **External Services**

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2.19.1. DSCs may use external contractor for operational services essential to their functions, e.g. nutrition, laundry, cleaning, maintenance, transport, and security.

2.19.2. Clinical services (e.g., radiology, lab, pathology) may also be provided by external contractors.

2.19.3. External service providers must be effectively managed to ensure safe, high-quality care.

3. POLICIES AND PROCEDURES

3.1. The DSC shall adhere to the Sentinel Events Notification and Management Policy of each Concerned Health Authority.

3.2. DSCs are not required to have an in-house mortuary but must have a documented mortuary management policy.

3.3. The DSC shall have in place internal policies and procedures including but not limited to:

3.3.1. Service Description and Scope of Services.

3.3.2. Prrocess map for OT Emergency response.

3.3.3. List of accepted diagnosis, patient eligibility criteria, patient referral criteria.

3.3.4. Lab and diagnostic services, including reporting timeframes for non-critical and critical results.

3.3.5. Patient assessment, admission, follow up, and discharge criteria.

3.3.6. Patient education, communication, and informed consent.

- Informed consent must include provisions for higher sedation, whether within the same facility or through transfer to a higher level facility.

3.3.7. Staffing plan, staff management, and clinical and privileging.

3.3.8. Clinical Audit.

3.3.9. Patient health records, confidentiality, and privacy, as per Health Information Assets Management Policy of the Concerned Health Authority.

3.3.10. Infection control

3.3.11. Patient safety policy

3.3.12. Incident reporting.

3.3.13. Fall management policy

3.3.14. Lost and found policy

3.3.15. Quality, Performance Management and Learning Systems.

3.3.16. Emergency (internal & external) disaster policy

3.3.17. Medication management and pharmacy services.

3.3.18. Reprocessing of reusable equipment and safe handling of chemicals for cleaning and disinfecting.

3.3.19. Medical and hazardous waste management:

3.3.19.1. The medical waste storage and collection area must be well-ventilated, secure from public and patient access, and clearly labeled with appropriate hazard signs.

3.3.19.2. Labels should include warnings in appropriate languages to prevent unauthorized access.

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3.3.20. Monitoring and maintenance of medical, electrical, and mechanical equipment, including visual inspections for defects and valid testing certificates from competent entities.

3.3.21. Laundry and housekeeping services.

3.3.22. Management of patient belongings.

3.3.23. Zero Tolerance to violence against staff

3.3.24. Narcotic Handling Policy, covering all processes from ordering to discarding to prevent misuse.

3.3.25. Procedural Sedation Policy to guide practitioners and ensure high-quality care and patient safety.

3.4. The health facility shall maintain documented evidence of treatment protocols and care pathway for surgical procedures to include, but not be limited to the following:

3.4.1. Referral criteria.

3.4.2. Consultation processes.

3.4.3. Clinical laboratory services and diagnostics.

3.4.4. Pre-op assessment and patient acuity classification.

3.4.5. Staffing requirements.

3.4.6. Informed Consent.

3.4.7. Surgical Safety Checklist for Surgical Procedures.

3.4.8. Patient Monitoring, Recovery and Discharge.

3.4.9. Follow-up after patient discharge.

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3.4.10. Patient complaints management.

3.5. All DSCs must have a written agreement for patient referral and emergency transfer to a nearby hospital. This agreement must outline the transfer protocol and comply with the emergency transfer timeframes specified by the Concerned Health Authority's policy.

3.6. The DSC may provide allied health services based on patient needs and the facility's type of services.

3.6.1. Such services may be provided on-site or through formal agreements with external providers.

4. HEALTHCARE PROFESSIONALS' REQUIREMENTS

4.1. All healthcare professionals should have an up to date medical malpractice insurance according to article 25 and 26 of the UAE Federal Law number 4/2016 concerning Medical Liability.

4.2. Healthcare professionals are mandated to be aware of their professional liabilities and the Code of Professional Conduct, which they are required to sign.

4.3. All employed healthcare professionals should hold an active professional license issued by the relevant local health authority and work within their scope of practice and granted privileges.

4.4. The privileging committee and/or medical director of the health facility shall grant privileges to physicians based on their education, training, experience and

competencies. The privileges shall be reviewed and revised at regular intervals in accordance with the Clinical Privileging Policy set out by each health authority.

4.5. The standalone DSC shall comply with the following minimum requirements:

4.5.1. There must be one full-time licensed physician designated as the Medical Director.

4.5.2. At least one full time licensed specialist or consultant surgeon present in the DSC.

- The specialist or consultant surgeon is responsible to ensure the availability of the surgical team before, during and after the procedure.

4.5.3. The specialist or consultant surgeon and anesthesiologist must always be present until the patient is discharged or transferred to a higher level healthcare setting.

4.5.4. At least one anesthetist is required in Class B (with endoscopy) where permitted narcotics, and dissociative anesthetics are being administered for endoscopic procedures (Appendix 4).

4.5.5. At least one full-time anesthetist must be present in DSC Class CM and C.

4.5.6. An anesthetist must be present for each surgical procedure where deep sedation or general anesthesia is administered.

4.5.7. The anesthetist may be supported by a licensed technician/anesthetist privileged nurse.

4.6. Pediatric cases should be managed and treated only by professionals within the pediatric specialty (e.g.: pediatric surgery) or by a healthcare professional who is privileged to conduct the procedure, has documented training in managing pediatric cases, and is PALS certified.

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4.7. The treating surgeon shall be available at the DSC facility until the patient is discharged safely.

4.8. Healthcare professionals engaged in surgery shall maintain up to date hands-on certification in:

4.8.1. Basic Life Support (BLS), applicable to all healthcare professionals.

4.8.2. Advanced Cardiac Life Support (ACLS), applicable to all healthcare professionals working within the scope of medicine.

4.8.3. Pediatric Advanced Life Support (PALS), applicable to all healthcare professionals working within the scope of pediatrics or managing pediatric cases.

4.8.4. Advanced Trauma Life Support (ATLS), recommended for healthcare professionals working within the scope of surgery to enhance their ability to manage trauma cases effectively.

4.9. For DSC that provide full radiology/diagnostic services must have:

4.9.1. One full time consultant/specialist radiologist shall be available to supervise and manage radiology services in the DSC.

4.9.2. At least one radiography technician shall be available in each shift and shall only be responsible for essential radiography services.

4.9.3. The health facility shall employ a biomedical engineer or maintain a service contract with a certified maintenance company to ensure safety, reliability, validity and efficiency of medical devices and mechanical equipment.

4.10. For DSC that provide full laboratory services must have:

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4.10.1. One full time licensed pathologist shall be available to supervise and manage the clinical laboratory services in the DSC.

4.10.2. At least one laboratory technician shall be available in each shift and shall only be responsible for essential laboratory services.

4.11. Infection control and antimicrobial stewardship should be led by a licensed infectious disease professional or a healthcare professional with formal training in infection control and antimicrobial stewardship.

4.12. Additional staff must be in place as per specialization, service descriptions, scope and patient volume.

5. FACILITY DESIGN REQUIREMENTS

5.1. **The facility must have in place:**

5.1.1. Entrance and reception area

5.1.2. Patients and visitor's waiting area

5.1.3. Consultation/Examination Room

5.1.4. Treatment Room

5.1.5. Operating Theater and procedure room

- The facility shall include one or more operating rooms (or procedure rooms), depends on the facility's capacity and scope of procedures.

5.1.6. Recovery Area

5.1.7. Patient care and support areas

5.1.8. Clinical Laboratory Services

5.1.9. Radiology Services

5.1.10. Central Sterile Supply Department

5.1.11. Pharmacy services

5.1.12. Linen Services

5.1.13. Catering Services

5.1.14. Engineering Services

5.1.15. Clean Utility

5.1.16. Dirty Utility

5.1.17. Storeroom

5.1.18. Housekeeping room

5.1.19. Medical waste room

6. MEDICAL EQUIPMENT

6.1. The health facility shall install and operate equipment required for the provision of proposed services in accordance with the manufacturer's specifications.

6.2. The health facility shall always have the appropriate equipment and trained healthcare professionals to perform necessary diagnostics, patient assessments, surgery, resuscitation, stabilization and transfer of critical and emergency cases to a nearby hospital.

6.3. The DSC shall maintain a copy of operator and safety manuals of all medical equipment and inventory list with equipment location.

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6.4. All Medical Equipment should be registered and documented properly in the inventory which will be updated every time a new equipment arrives prior to use.

6.5. The inventory shall include only medical equipment currently in use. Equipment that is not operational or maintained should be stored in the facility.

6.5.1. The medical equipment Inventory should include the following:

- Device name
- Description of the device
- The name of the factory
- The supplying company (agent)
- Year of purchase
- Section (location)
- Serial number
- Duration of preventive maintenance work (PM)
- Last date maintenance & the next
- Periodic maintenance reports (qualitative and quantitative tests)

7. PRE-OPERATIVE EVALUATION AND INFORMED CONSENT

7.1. All Day Surgical Centers must have in place a written Surgical Care Pathway.

7.2. Day Surgical Centre shall only provide surgical and diagnostic procedures for ASA-PS Classification I, II and III patients (adults and pediatrics) as outlined in Appendix 3-4.

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7.3. Patients classified as ASA-PS III must undergo a medical consultation, assessment, and clearance for day surgical procedures involving deep sedation or general anesthesia.

7.4. Refer to Appendix 5 for the list of permitted procedures by Day Surgical Centre Classification.

7.5. Refer to Appendix 9 for patient eligibility criteria in dentistry under general anesthesia.

7.6. The following exclusions must be considered during patient consultations and pre-op assessments:

- Emergency cases.
- Inpatients.
- Unprepared/ Uncooperative patients.
- Patients with sleep apnea, airway difficulties, or severe allergies.
- Patients with a history of drug or alcohol abuse.
- Patients at risk of excessive bleeding or requiring transfusion.
- Patients requiring cardiac catheterization or Interventional Cardiology
- Patients with metabolic disorders (ASA IV and above).
- High-risk patients classified as ASA-PS IV-VI
- Patients requiring surgical procedure, intra or immediate post-operative care from specialized services or professionals unavailable at the DSC.

7.7. Prior to patient referral for surgery, patients with ASA Classification III should have:

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7.7.1. A complete consultation, including laboratory tests, by the treating physician within or outside the DSC prior to the surgery.

7.7.2. Documentation of the assessment and feedback e.g.: referral letter, medical report or other communication evidence between the healthcare team and a follow-up appointment with the physician to discuss surgical and non-surgical options.

7.8. If the surgical procedure requires higher-level sedation, which does not align with the existing day surgical category, then the provider is required to refer the patient to a higher facility category.

7.8.1. Surgical procedures are limited to those where there is only a small risk of surgical and anesthetic complications and hospitalization.

7.9. A comprehensive pre-op patient assessment process and testing shall be conducted with the support of a multi-disciplinary team (as applicable) and based on each patient's clinical and priority needs.

7.9.1. **For DSC Class A and B:**

- blood pressure
- blood glucose
- BMI
- Exclusions noted in 7.6.

7.9.2. **For CM and C:**

- CBC
- Blood Pressure
- Blood Glucose

- Coagulation Profile
- BMI
- General anesthesia consult
- Venous Thromboembolism (VTE) risk assessment
- Exclusions noted in 7.6

7.9.3. Pre-op assessments shall be conducted in the same health facility where the surgery will be provided.

7.9.4. Patients undergoing elective surgery shall provide their consent at pre-op assessment.

7.9.4.1. Patients or their legal guardian must receive written instructions on the surgery and preparation, with adequate time to make an informed decision.

7.9.4.2. The consent form should elaborate risks, benefits and alternatives and be available in both English and Arabic.

7.9.4.3. Pre-op assessment and consent shall be conducted within 4-weeks of surgery; Patients exceeding the 4-week window should be re-assessed.

7.9.4.4. The physician shall be available to answer any further questions in a non-technical way.

7.10. Prior to the procedure, the surgical team must confirm the correct patient, procedure, and potential risks following the pre-op assessment.

7.10.1. A Physician, Anesthetists (if applicable) and RN must document, complete and verify the Surgical Safety Checklist.

7.10.2. All surgeries under Day Surgical Centre **category B** must always be overseen by:

- A licensed surgeon and nurse.
- An anesthetist must be present if narcotic drugs are being used for permitted endoscopic procedures (Appendix 5) .

7.10.3. All surgeries under Day Surgical Centre **category CM and C** must always be overseen by a licensed surgeon, anesthetist and nurse.

- The surgical team shall be competent to stabilize critically ill patients and transfer them to a higher level of care if the health facility cannot manage the patient onsite.

7.11. Minimally invasive procedures shall follow Procedural Sedation and Analgesia (PSA), as per the permitted levels of sedation per DSC facility type.

7.12. A different form of anesthesia may be administered in an OR as long as appropriate anesthesia gas administration devices and exhaust systems are provided.

7.13. Procedure rooms are considered open areas. Local anesthesia and minimal and moderate sedation may be administered in a procedure room, but anesthetic agents used in procedure rooms should not require special ventilation or scavenging equipment.

7.14. All surgical personnel are required to wear surgical attire and cover their head and facial hair. Masks are required when opening sterile supplies or when scrubbed personnel are present.

8. PATIENT SAFETY, MONITORING, AND DISCHARGE

Patient Safety Documentation

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8.1. The following should be considered and documented in the patient record:

8.1.1. Patient identity and medical history including family history.

8.1.2. Evidence of consultation, physical examinations and confirmatory lab or diagnostics (patient selection).

8.1.3. Treatment plan and outcomes.

8.1.4. Procedure to be undertaken and location with clear markings.

8.1.5. Confirmation that no new issues have emerged since the last pre-operative assessment.

8.1.6. Informed Consent for the procedure.

8.1.7. Verification of Nothing by Mouth Status.

8.1.8. Mitigating circumstances/exclusions that would prevent performing the surgery

8.1.9. Adequate staff levels for the procedure.

8.1.10. Pre-anesthesia assessment and patient acuity (Class I or II).

8.1.11. Sedation/anesthesia and recovery plan.

8.1.12. Document adherence to the completed Surgical Safety Checklist for all surgeries.

8.1.13. Control of concentrated electrolyte solutions.

8.1.14. Assuring medication accuracy and safe dosing.

8.1.15. Avoiding catheter and tubing misconnections.

8.1.16. Prophylaxis.

8.1.17. Infection control.

8.1.18. Single-use of injection devices and insert of the IV line.

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Pre-Procedural Safety Measures

8.2. Patient safety measures must be regularly documented in facility logbook such as and not limited to:

8.2.1. Confirmation of functioning equipment and a back-up plan.

8.2.2. Medical devices should be labelled to ensure they are fully functional.

8.2.3. A list of look-alike, sound-alike medication.

Monitoring During Procedures

8.3. All patient diagnostic procedures shall be continuously monitored in accordance with the surgical procedure, patient safety and risk factors.

8.3.1. Monitoring should be performed and evidenced:

8.3.1.1. Before the procedure

8.3.1.2. After administrating sedatives

8.3.1.3. At regular intervals during the procedure

8.3.1.4. During the initial recovery phase

8.3.1.5. Just before discharge

8.4. Minor procedures performed under topical or local anesthesia, not involving drug-induced alteration of consciousness other than minimal preoperative anti-anxiety medications (e.g. mole removals or incision and drainage of superficial abscesses) may be performed by a licensed physician or dentist within their scope of practice and privileges.

8.4.1. Procedures requiring light or moderate sedation/analgesia must include intraoperative and post-operative monitoring. This often involves intravenous (IV)

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administration of anxiolytic, hypnotic, analgesic, or amnesic drugs, either alone or as a supplement to a local or regional anesthesia.

8.5. When moderate sedation is targeted, a healthcare professional is assigned the responsibility for patient monitoring and may perform brief interruptible tasks.

8.5.1. Monitoring must include tools such as a nerve stimulator, RASS score, electronic devices for blood pressure, respiratory rate, heart rate, and pulse oximetry. Additionally, visual monitoring of the patient's level of consciousness and discomfort is required.

8.6. Procedures that require the use of deep sedation/analgesia, general anesthesia, or major conduction blockade (e.g. liposuction) may be serious or life-threatening (Appendix 3-4).

8.6.1. Major regional blocks include but are not limited to the spinal, epidural or caudal injection of any drug, which has analgesic, anesthetic or sedative effects.

8.6.2. When deep sedation or general anesthesia is used, the anesthetist must be solely responsible for patient monitoring and be prepared to take immediate action to ensure patient safety during the procedure.

8.7. The DSC shall put in place procedures to rescue patients who are sedated deeper than intended.

Post-Procedural Monitoring

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8.8. Documentation of the clinical assessments and monitoring data during sedation and recovery and discharge is required to include:

8.8.1. Time, date, physician name, patient condition and action taken.

8.8.2. Food consumption appropriate for the patient and consistent with the patient's condition, and clinical care shall be provided.

8.8.3. Ability to pass urine following surgery.

8.8.4. Assessment of the patient's consciousness level and ability to dress independently.

Discharge Planning and Process

8.9. A discharge plan shall start from patient admission and include various staff, information and resources.

8.10. Considerations for discharge preparation shall include but not be limited to:

8.10.1. Risk assessment and process for discharge.

8.10.2. Medication needed from the pharmacy.

8.10.3. Physician written authorization for discharge.

8.10.4. Documentation of the procedure for the patient and treating physician.

8.10.5. The pickup person and aftercare support within the first 24-hours.

8.10.6. No driving policy.

8.10.7. Environmental factors such as accessibility, including stairs, toilet and bedroom access, and other home conditions that may affect recovery.

8.11. The carer's/authorized persons contact details and their awareness of possible issues and requirements following discharge.

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8.11.1. Provide contact numbers for post-discharge support, including the doctor or emergency contact. Follow-up actions should include:

- A follow up phone call to check on the patient's condition.
- Scheduling follow-up appointments as necessary.

Discharge Against Medical Advice (DAMA)

8.11.2. The treating physician shall respect patients' choices if they decide to Discharge Against Medical Advice (DAMA), in alignment with Federal Law No. 4/2016 regarding Medical Liability.

8.11.3. For DAMA cases, patients must sign a discharge form witnessed by both the treating physician and a nurse before leaving the facility.

9. MEDICATION MANAGEMENT AND PHARMACY

9.1. Medications shall be managed to ensure safe and effective practice. The DSC shall maintain a policy and procedures on medication management, medication storage and monitoring of medication inventory and expiration dates consistent with applicable legislation and regulations.

9.1.1. Adhere to the requirements of Emergency Medication policy as well as the Pharmacy Guidelines.

9.2. DSC Class A and B shall ensure that the full time surgeon is responsible for managing medications, ensuring that patients receive appropriate pharmacological treatments, and maintaining record-keeping in accordance with facilities policies and procedures (Appendix 4).

9.3. DSC Class B (with endoscopy), CM and C shall ensure that the anesthetist is responsible for managing anesthesia, narcotic and controlled medications, emergency medications, other medications, and maintaining record-keeping in accordance with facilities policies and procedures (Appendix 4).

9.4. DSC with pharmacy services , shall ensure the pharmacist is responsible for managing anesthesia, narcotic and controlled medications, emergency medicine, any other medication and record-keeping in the DSC (Appendix 4).

9.5. DSC that provide ambulatory care pharmacy services must employ a full time pharmacist.

9.5.1. The pharmacy service should include storage of medication, medication preparation, dispensing and safe disposal.

9.6. Refer to Appendix 7 for the list of Minimum Emergency Medications (Class A, B, and CM).

9.7. Refer to Appendix 8 for the list of Minimum Emergency Medications (Class C).

10. CRITICAL CARE SERVICES AND EMERGENCY MANAGEMENT

10.1. DSC shall have written policies and procedures that must be established and implemented. They should define and describe the scope of critical care services that ensure safe and competent delivery of the patients' services.

10.2. The DSC shall ensure there is one competent Registered Nurse (RN) during surgery with suitable training and experience in critical care on duty to provide the critical care services if required.

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10.2.1. Evidence of the competency and training shall include the following:

- Recognizing arrhythmias.
- Assisting the physician in placing central lines or arterial lines.
- Obtaining blood gases ABG's.
- Central Venous Pressure (CVP) line.
- Infection control principles.
- Glasgow Coma Scale (GSC).
- Point of Care Testing Assessment.
- Training in using defibrillator and care of patients on ventilators.

10.3. The DSC shall ensure periodic training and education for staff in the use of equipment for emergency management.

10.3.1. Training and assessment of competency shall be documented as per the requirements of the training provider.

10.4. DSC Class B that uses anesthetics only for permitted endoscopic procedures shall have a room for post-operative recovery.

10.5. DSC Class B (with endoscopy), CM and C must have a room for post-operative recovery or for patients that require extended recovery or for critical patients awaiting emergency transfer.

10.5.1. The ratio of recovery rooms should consider the number of surgical theatres, hours of operation, procedures being performed and patient scheduling.

10.5.2. Critical care services equipment and supplies must be immediately available in the DSC for the immediate and safe provision of care and treatment required.

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10.5.3. Pharmaceutical agents, oxygen, oral suction, laryngoscope, Ambu-bag shall be readily available in the health facility.

10.5.4. Emergency equipment shall include portable ventilators (with different ventilation mode (IPPV, SIMV, spontaneous, PS), tracheostomy set, defibrillator machine, pulse oximetry and vital signs monitor (ECG), Infusion pumps, blood gas analyzer with capability for electrolytes measuring and emergency crash cart that includes all emergency supplies and medications.

10.6. At a minimum, DSC shall have a clear protocol and provision for essential emergency management for illness and/or injection injuries that occurred for the patient, healthcare professionals, employees or visitors, which needs immediate emergency care and assistance before transport to another health facility.

10.7. Emergency services must be provided by qualified and licensed physician(s) who are authorized by their scope of practice to provide emergency services and received privileges from the facility to perform specific emergency procedures.

10.8. Emergency devices, equipment and supplies must be available for immediate use for treating life-threatening conditions shall include but not limited to the following:

10.8.1. Defibrillator (except for DSC class A and class B without endoscopy)

10.8.2. Emergency cart with emergency medicines.

10.8.3. Resuscitation kit, cardiac board and oral airways.

10.8.4. Laryngoscope with blades.

10.8.5. Diagnostic set.

10.8.6. Patient trolley with an IV stand.

10.8.7. Nebulizer.

10.8.8. Refrigerator for medication.

10.8.9. Floor Lamp (Operating light mobile).

10.8.10. Sets of instruments shall include suturing set, dressing set, foreign body removal set or minor set and cut down set.

10.8.11. Disposable surgical supplies and wound care supplies must be listed or checked regularly.

10.8.12. Fluids (e.g. D5W, D10W, Lactated Ringers, Normosol R, Normosol M, Haemaccel) and Glucometer.

10.8.13. Sufficient electrical outlets to satisfy monitoring equipment requirements, including clearly labelled outlets connected to an emergency power supply.

10.8.14. A reliable source of oxygen.

10.8.15. Portable vital signs monitor (ECG, Pulse-Oximetry, Temperature, NIBP, EtCO2).

10.8.16. Suction apparatus.

10.8.17. One portable ventilator is required for (1) one to (4) four OTs (backup)

Note: EtCo2, ventilators and defibrillator are not required in **DSC class A and B (without endoscopy).**

10.9. Policy for maintaining personal items and food in the emergency area shall be established and maintained by the health facility.

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10.10. Storage areas for general medical/surgical emergency supplies, medications and equipment shall be under staff control and out of the path of normal traffic.

10.11. A record must be kept for each patient receiving emergency services and integrated into the patient's health records.

10.11.1. The record shall include patient name, date, time and method of arrival, physical findings, care, procedure, medication, and treatment, Name of treating physician and discharging/transferring time.

10.12. Well-equipped ambulance services shall be ready and nearby with licensed, trained and qualified Emergency Medical Technicians (EMT) for patient transportation if required.

10.12.1. Ambulance services can be outsourced through a written contract with a licensed emergency services provider.

10.12.2. Ambulance services shall meet the emergency transfer timeframes.

10.13. The facility shall have Uninterrupted Power Supply (UPS) or Power Generator.

11. MEDICAL RECORD AND HEALTH INFORMATION MANAGEMENT

11.1. DSC shall ensure all patients have a medical file that is protected, secured, accurate and up to date. As a minimum, the file shall entail the following:

11.1.1. Patients full contact details.

11.1.2. Emergency contact person (next of kin).

11.1.3. Patient health status.

11.1.4. Treating physician.

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11.1.5. Any drug allergies or contract indications.

11.1.6. Prescriptions.

11.1.7. Lab and diagnostic information.

11.1.8. Date of last assessment.

11.1.9. Information on consent form.

11.1.10. Date, time and observations for all consultations.

11.2. Up to date operating theatre records shall be maintained, including but not be limited to:

11.2.1. Name, date of birth and identification number of the patient.

11.2.2. Date, inclusive of time of the surgical procedure.

11.2.3. Surgical procedure(s) performed, time in and time out.

11.2.4. Name(s) of Physicians, Nurses and Technicians.

11.2.5. Name of nursing personnel (scrub and circulating).

11.2.6. Type of anesthesia administered, dose, time, date and professional.

11.2.7. Name and title of the person managing anesthesia.

11.2.8. Requirements for testing and disposal of surgical specimens.

11.2.9. Circumstances that require the presence of an assistant during surgery.

11.2.10. Procedures for handling infectious cases.

11.3. Maintain post-op quality data to inform quality management and patient safety, including but not be limited to:

11.3.1. Recovery timeframe.

11.3.2. Wound healing time.

11.3.3. Complication rate.

11.3.4. Incidence of pain, nausea and vomiting.

11.3.5. Incidence of treatment-related side effects.

11.3.6. Incidence of changes to patient mobility arising directly from the procedure.

11.3.7. Patient satisfaction rate.

12. PATIENT RIGHTS AND RESPONSIBILITIES

12.1. DSC must have in place a written policy that adheres to the requirements for patient rights and responsibilities in accordance with Ministerial Decision No. (14) of 2021 on the Patient's Rights and Responsibilities Charter.

12.1.1. Information on patients' rights and responsibilities shall be communicated and displayed in at least two languages (Arabic and English) at the entrance, reception, waiting area(s) of the premises, and on the website.

13. FACILITY MANAGEMENT

13.1. **Medical Equipment and Supplies**

13.1.1. Medical equipment shall be installed and operated in accordance with manufacturer specifications.

13.1.2. The DSC shall maintain effective Preventive Maintenance (PM) as per the manufacturer recommendations (all medical equipment shall receive PM). The PM shall include the following:

13.1.2.1. Electrical safety testing for patient-related equipment.

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13.1.2.2. Each piece of equipment has a checklist for its maintenance schedule, failure incidence and repairs date.

13.1.2.3. Make use and maintain Statistical data of Preventative Maintenance (PM) for upgrading/replacing equipment.

13.1.2.4. The DSC shall maintain a copy of operator and safety manuals of all medical equipment and inventory list with equipment location.

13.1.2.4.1. DSC healthcare professionals (physicians, nurses, and allied health) shall be trained to operate the medical equipment assigned to them.

13.1.2.4.2. Training shall be documented and kept up to date.

13.1.2.5. Maintain written policy for medical tagging equipment which should include:

13.1.2.5.1. PM with the testing and due date.

13.1.2.5.2. Inventory number.

13.1.2.5.3. Safety checks.

13.1.2.5.4. Installation.

13.1.2.5.5. Removal.

13.1.2.5.6. Reporting incidents, hazards and corrective actions.

13.2. **Safety and Quality Management System**

13.2.1. The safety management system shall be supported by a policy and shall comply with the related UAE laws and regulations. The safety officer shall undertake appropriate training relevant to jurisdictional requirements.

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13.2.2. DSC management shall ensure compliance with Federal Authority for Nuclear Regulation (FANR) rules and regulations regarding the use of ionizing radiation and radioactive materials in DSC.

13.2.3. DSC shall ensure that the healthcare environment is safe, functional, supportive and effective for patients, family and staff members.

13.2.4. The DSC shall designate a safety officer person(s) with skills and experience responsible for the safety program's operation and implementation.

13.2.5. The safety management system shall include fire safety, hazardous waste, emergencies, and security.

13.2.5.1. Staff shall be educated and provided with information on waste management, fire safety, hazardous substances and their responsibilities.

13.3. **Fire Safety**

13.3.1. Fire is a potential risk for all healthcare organizations and is critical where immobile patients are in locations that are difficult to evacuate. To respond to fire risk, the DSC shall:

- Establish a fire safety plan for early detection, confining, extinguishment, Rescue and alerting the Civil Defense.
- Establish a No Smoking policy.
- Assess the fire risks to the facility.
- Understand and manage risks associated with the facility's location and physical structures.
- Maintain and test fire protection and emergency communication systems

- Train staff to respond to a fire event in the building.
- Monitor whether adequate numbers of suitably trained staff are posted across all shifts to respond appropriately to a fire event.
- Rehearse emergency scenarios to assess preparedness.

13.4. **Hazardous Substances and Dangerous materials.**

13.4.1. The DSC shall have policies and procedures on the procurement, management and disposal of dangerous materials and hazardous substances and shall comply with local regulations.

13.4.2. There should be adequate space and ventilation for the safe handling of dangerous materials and hazardous substances.

13.4.3. Each DSC shall have a current list of hazardous substances and dangerous materials used in their area, the list covers:

- Purpose of use.
- The responsible person.
- Permitted Quantity.

13.4.4. All substances should be clearly labelled; this includes corrosives, acids, toxic material, hazardous gases and anesthetic gases.

13.4.5. Hazardous substances shall be appropriately labelled and maintained on a register of all hazardous substances in the workplace. Labels should never be altered, and substances should be stored in their original containers.

13.4.6. Employees dealing with hazardous substances shall have protective clothing or equipment as required.

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13.4.7. Material Safety Data Sheets (MSDS) shall be available for employees at the point of use in case of an emergency.

13.5. **Waste and Environmental Management**

13.5.1. Waste and environmental management shall support safe practice and a safe environment. The DSC shall develop and implement a waste and environmental management policy. The policy shall include the segregation and disposal of DSC clinical waste responsibly in accordance with UAE laws and regulations.

13.5.2. The waste management policy shall cover handling, storing, transporting, and disposing of all kinds of waste. All waste shall be labelled as:

- Anatomical, e.g. blood and organs (yellow).
- Clinical/infectious waste (yellow).
- Clinical/highly infectious, pathological waste and sharps (yellow).
- Medicine unused drugs (yellow).
- Cytotoxic, Cytostatic, Chemotherapeutic, Chemotherapy medicines waste (yellow).
- Dental (yellow).
- Chemical or pharmaceutical (yellow).
- Offensive but not hazardous (yellow).
- Radioactive waste (lead box).
- Domestic waste (black).

13.5.3. Proper storage and containers for disposing of waste material shall be maintained.

13.5.4. Contracting with a specialized company to transport and destroy medical waste materials.

13.5.5. Disposing medical liquids, drugs, solutions and dangerous chemical materials into usual sewage disposal are prohibited.

13.5.6. Cleanliness throughout the DSC shall be maintained by trained staff.

13.6. **Emergency and Disaster Management**

13.6.1. The DSC shall develop a plan and policies for dealing with and managing emergencies and disasters, which shall include:

- Duties and responsibilities of healthcare professionals and employees in the DSC.
- Identifying the responsible person who announces the emergency state and calls local authority.
- The triage areas, their locations, and triage action cards.
- Names of all staff called, including their contact details.

13.6.2. The DSC shall conduct Emergency practice/drill exercises, including fire and evacuation, to test the following:

- The timely response of staff to the emergency call.
- The efficiency of the communication system, e.g. bleeps, mobile phone and overhead paging system.
- If all staff can perform their expected roles.
- The time taken to evacuate patients and beds.

13.6.3. Evacuation maps posted in the DSC indicating locations of:

- You are here.
- Fire extinguishers.
- Fire hose reel/cabinets.
- Escape routes.
- Assembly points.
- Fire exits.
- Call points break glass/pull station.

13.6.4. External service providers shall comply with the DSC requirements for the prevention of emergencies.

13.6.5. Staff are educated and trained at orientation and annually in fire and evacuation.

13.7. **Security Management**

13.7.1. The facility management may assign specific personnel to take care of security in the DSC or ensure security by installing a CCTV camera or other surveillance means.

13.7.2. Security personnel (if available) shall be educated and provided with information in relation to security risks and responsibilities and oriented on their scope of work, fire safety and emergency codes.

13.7.3. Major security risks shall be identified in the DSC.

13.7.4. Restricting access to sensitive areas by Security Personnel/Security System such as operating area, no filming in operating theatre.

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14. KEY PERFORMANCE INDICATORS (KPIS)

14.1. DSC management must capture KPIs by the 2nd week of each quarter and report them to concerned health authority in accordance with the Guidelines for Reporting Standalone Day Surgery Centre Key Performance Indicators.

14.2. The submission must reflect the outcomes achieved in the previous quarter. Reported data includes, but is not limited to, indicators related to:

- Access
- Quality
- Notification of diseases and conditions required by the national surveillance system, according to Federal law No. 14/2014 concerning the control of communicable diseases.

14.3. A comprehensive record of KPIs must be maintained. This includes tracking the following metrics:

- Number of patients discharged against medical advice out of total number of One Day Surgery Admissions
- Number of One Day surgery transfers to Acute Care Hospitals
- Extended length of stay during Day Case admissions
- Total cosmetic procedures among all day case surgical procedures
- Complications resulting from Anesthesia for Day Surgery Procedures
- Percentage of Surgical Site Infection (SSI)
- Re-operation within 15 days from Day case procedure
- Percentage of surgeries in which a surgical safety checklist was performed

APPENDICES

APPENDIX 1: SUMMARY OF DAY SURGICAL CENTRE CLASSIFICATIONS AND MINIMUM REQUIREMENTS

Requirements	Class A	Class B	Class CM	Class C
Led by Consultant OR specialist surgeon	✓	✓	✓	✓
Anesthetist	-	1 part time (for endoscopy)	1 full time	1 full time
Minimum surgical team	Surgeon and Nurse	Surgeon and Nurse	Surgeon, anesthetist and Nurse	Surgeon, anesthetist and Nurse
Patient Category*	ASA I, II, III [1]	ASA I, II, III [1]	ASA I, II, III [1]	ASA I, II, III [1]
Medication management responsibility	Surgeon	Surgeon	Anesthetist or pharmacist [2]	Anesthetist or pharmacist [2]
Ventilator	-	✓ [3] (for endoscopy)	✓ [3]	✓ [3]
Operating theatre	✓	✓	✓	✓
Surgery duration	-	-	Not exceed 2 hours	Not exceed 3 hours
Point of Care Testing	✓	✓	✓ [5]	✓ [5]
Onsite laboratory [6]	-	-	-	-
Onsite radiology [7]	-	-	✓	✓
Emergency Medications & Equipment	✓ [8]	✓ [8]	✓	✓
Onsite Sterilizing area	✓ [9]	✓ [9]	✓	✓

O_33 Accreditation within 2 years of license	✓	✓	✓	✓

*ASA-American Society of Anesthesiologists

[1] Patients categorized as ASA PS III will need to be cleared for operation as per the medical assessment.

[2] DSC that provide ambulatory care pharmacy services must employ a full time pharmacist who will be responsible for medication management.

[3] One (1) portable ventilator is required for one (1) to four (4) OTs (backup) AND One (1) ventilator is required for two (2) beds in recovery bay.

[4] Only procedures requiring GA shall not start after 5:00pm.

[5] With additional Arterial Blood Gas Testing.

[6] DSC Class A and B that provides solely vascular or Ophthalmology Services may have contracted with external laboratory services if required.

[7] Class A and B may have contract with external radiology if required. Onsite or contracted radiology services is optional for DSC Class CM and C providing solely Ophthalmology or Vascular services.

[8] Ventilator is optional for DSC Class A and Class B without endoscopy but should have Automated External Defibrillator (AED) available.

[9] Sterilizing area can be outsourced in DSC Class A and B.

APPENDIX 2: OPERATING THEATRE (OT) SPECIFICATION MATRIX

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Class	OT	Recovery Room	Equipment
DSC Class A & B (without endoscopy)	• Min. 1 OT • Size: 20-30m2	Recommended	• **OT table:** Required • **Anesthesia Machine:** Not required • **Ventilator in Recovery:** Optional (1 ventilator for every 2 beds in the recovery bay) • **Mobile x-ray:** Optional • **Crash Cart Trolley:** Required. • **ABG machine:** Optional
DSC Class B (with endoscopy)	• Min. 1 endoscopy room • Size 25-30m2	Mandatory	• **OT table:** Required • **Anesthesia Machine:** Not required • **Ventilator in Recovery:** Optional (1 ventilator for every 2 beds in the recovery bay) • **Portable Ventilator:** Required (1 portable ventilator for 1-4 OTs (backup). • **Mobile x-ray:** Optional • **Crash Cart Trolley:** Required. • **Endoscope set with Cabinet:** Required. • **Scopes storage cabinets (HEPA):** optional • **ABG machine:** Optional
Class C- M	• Min. 2 OTs • Size 30m2 each	Mandatory	• **OT table:** Required • **Anesthesia Machine:** Required • **Ventilator in Recovery:** Required (1 ventilator for every 2 beds in the recovery bay) • **Portable Ventilator:** Required (1 portable ventilator for 1-4 OTs (backup). • **Mobile x-ray:** Required • **Crash Cart Trolley:** Required. • **ABG machine:** Required
Class C	• Minimum 2 OTs • Size: 36m2 each	Mandatory	• **OT table:** Required • **Anesthesia Machine:** Required • **Ventilator in Recovery:** Required (1 ventilator for every 2 beds in the recovery bay) • **Portable Ventilator:** Required (1 portable ventilator for 1-4 OTs (backup). • **Mobile x-ray:** Required • **Crash Cart Trolley:** Required. • **ABG machine:** Required

APPENDIX 3: DSC CLASSIFICATION (ANESTHESIA, SEDATION AND PATIENT SAFETY I AND II)

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Health Facility CLASS A	**Minimal Sedation (Anxiolysis)** is a drug-induced state to reduce patient anxiety during which the patient usually responds to verbal commands (technically awake). In this stage, the following should be present: • Normal respirations. • Normal eye movements. • Intact protective reflexes. • Amnesia may or may not be present. ○ Topical anesthesia, oral sedative and Local Anesthesia
Health Facility CLASS B	**Moderate Sedation/Analgesia (Conscious Sedation)** is a drug-induced depression of consciousness. The patient tolerates unpleasant therapeutic or diagnostic procedures and responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation, while maintaining cardiorespiratory function. Commonly involves the intravenous administration of drugs with anxiolytic, hypnotic, analgesic, and amnesic properties either alone or as a supplement to a local or regional anesthetic. Moderate sedation is a medically controlled state of drug induced depressed consciousness that: ○ Allows protective reflexes to be maintained ○ Retains the patient's ability to maintain a patent airway independently and continuously; ○ Permits appropriate response by the patient to physical stimulation or verbal command, for example, "open your eyes." ○ The drugs, doses, and techniques used are not intended to produce a loss of consciousness. ○ Topical anesthesia, Local Anesthesia and sedatives (oral or injection).

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	○ Regional Anesthesia. ○ Narcotic Analgesics. ○ Dissociative Anesthetics. **Note 1:** Regional Anesthesia involves the injection of the local anesthetic in the vicinity of major nerve bundles supplying body areas, such as the thigh, ankle, forearm, hand or shoulder, so the patient cannot feel pain in that area **Note 2:** Propofol, Spinal Anesthesia, Epidural Anesthesia, Endotracheal Intubation Anesthesia, Laryngeal Mask Airway Anesthesia, is prohibited in a Class B Centre. **Note 3:** Exceptions for permitted endoscopic (**see Appendix 5**)
Health Facility CLASS CM	**Deep Sedation/Analgesia** is a drug-induced depression of consciousness or unconsciousness during which patients cannot be easily aroused and respond purposefully following repeated or painful stimulation or verbal command. The ability to independently maintain ventilatory function may be impaired; thus, patients may require assistance in maintaining a patent airway and spontaneous ventilation. Cardiovascular function is usually maintained. ○ Topical anesthesia, Local Anesthesia and Sedatives (oral or injection). ○ Regional Anesthesia. ○ Narcotic Analgesics. ○ Dissociative Anesthetics. ○ Spinal Anesthesia. ○ Epidural Anesthesia. **Note 1:** The use of Endotracheal Intubation Anesthesia, Laryngeal Mask Airway Anesthesia, and/or Inhalation General Anesthesia (including Nitrous Oxide) is prohibited in a Class CM Centre.

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	Note 2: Epidural Catheter is a fine plastic tube (an epidural catheter) threaded through a needle, and the tube is left in the epidural space in the back. A local anesthetic is injection down the tube to cause numbness, which varies according to the amount of local anesthetic injection.
Health Facility CLASS C	**General Anesthesia** is a controlled state of drug-induced unconsciousness state accompanied by a loss of protective reflexes, including losing the ability to maintain a patent airway independently or to respond purposefully to physical stimulation or verbal command. Cardiovascular function may be impaired, and Positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. ○ Topical anesthesia, oral sedative and Local Anesthesia. ○ Regional Anesthesia. ○ Dissociative Anesthetics ○ Epidural Anesthesia. ○ Spinal Anesthesia. ○ General Anesthesia (with or without Endotracheal Intubation or Laryngeal Mask Airway Anesthesia). **Note 1:** Major regional blocks including, but not limited to, spinal, epidural or caudal injection of any drug, which has analgesic, anesthetic or sedative effects are in the same category as general anesthesia.

ASA PS Classification	Definition	Examples including but not limited to

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ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

Note 1: The American Society of Anesthetists' Physical Class System was designed to describe the patient's current health status. As such, it is one of the most important factors used to assess the overall perioperative risk.

Note 2: Level IV-VI patients are not permitted in a DSC setting

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APPENDIX 4: DSC CLASSIFICATION AND PERMITTED MEDICATIONS

No.	Day Surgical Classification (A, B, CM or C)	Method of Delivery*	Medications
1.	A	Topical Anesthesia	Benzocaine, lidocaine, lignocaine, prilocaine
	A	Oral sedative	Alprazolam Clonazepam Diazepam Midazolam needs reversible agent Lorazepam Chlordiazepoxide Chloral Hydrate
	A	Local Anesthesia	Lidocaine Prilocaine benzocaine Mepivacaine Bupivacaine Ropivacaine Levobupivacaine Other local anesthesia may be provided if licensed by MOHAP
2.	B	Topical Anesthesia	See Health Facility Class A
	B	Oral Sedative	See Health Facility Class A
	B	Local Anesthesia	See Health Facility Class A
	B	Intravenous Sedative	Midazolam with reversible agents
	B	Intravenous Analgesics	Pethidine Hydrochloride Fentanyl (only for permitted endoscopic procedures)
	B	Regional Anesthesia	Lidocaine Mepivacaine Levobupivacaine Bupivacaine Ropivacaine
	B	Dissociative Anesthetics	Ketamine (only for permitted endoscopic procedures)
3.	CM	Topical Anesthesia	See Health Facility Class A and B

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	CM	Oral Sedative	See Health Facility Class A and B
	CM	Local Anesthesia	See Health Facility Class A and B
	CM	Intravenous Sedative	See Health Facility Class B (plus propofol)
	CM	Intravenous Analgesics	See Health Facility Class B Fentanyl
	CM	Regional Anesthesia	See Health Facility Class B
	CM	Dissociative Anesthetics	Ketamine
	CM	Spinal Anesthesia	Bupivacaine Ropivacaine Lidocaine Levobupivacaine
	CM	Epidural Anesthesia	Bupivacaine Ropivacaine Levobupivacaine Lidocaine Fentanyl Pethidine Morphine
4.	C	Topical Anesthesia	See Health Facility Class A , B and CM
	C	Oral Sedative	See Health Facility Class A , B and CM
	C	Local Anesthesia	See Health Facility Class A , B and CM
	C	Intravenous Sedative	See Health Facility Class A , B and CM
	C	Intravenous Analgesics	See Health Facility Class A , B and CM
	C	Regional Anesthesia	See Health Facility Class A , B and CM
	C	Dissociative Anesthetics	See Health Facility Class B and CM
	C	Spinal Anesthesia	See Health Facility Class CM
	C	Epidural Anesthesia	See Health Facility Class CM
	C	General Anesthesia	Propofol Thiopental Injection Midazolam Injection Diazepam Sevoflurane, Isoflurane Halothane

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			Ketamine Dexmedetomidine Morphine Sulfate Injection Pethidine Hydrochloride Fentanyl Remifentanil

*Other topical and local anesthesia may be provided if licensed by MOHAP

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APPENDIX 5: LIST OF PERMITTED PROCEDURES BY DAY SURGICAL CENTRE CLASSIFICATION

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Assisted Reproductive Techniques (ART)		
1.	Intra Uterine Insemination (IUI)	C
2.	In-vitro Fertilization (IVF)	C
3.	Intracytoplasmic Sperm Injection (ICSI)	C
4.	Gamete Intra-fallopian Transfer (GIFT)	C
5.	Zygote Intra-fallopian Transfer (ZIFT)	C

Note: The above procedures can only be performed in a licensed fertility center.

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Endoscopic Procedures (Upper and Lower GI) (including polypectomy)		
1.	Colonoscopy	B*
2.	Gastroscopy	B*
3.	Esophagoscopy (Flexible)	B*
4.	Sigmoidoscopy	B*
5.	Endoscopic ultrasound	B*
6.	Capsule endoscopy	B*
7.	Endoscopic Retrograde Cholangiopancreatography	C
8.	Esophagogastroduodenoscopy (EGD)	CM

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Endoscopic Procedures (Respiratory)		
9.	Laryngoscopy (indirect)	CM
10.	Bronchoscopy (flexible)	CM
Nasal Endoscopy (ENT)		
11.	Sleep Endoscopy	C

*Patients that require GA should be escalated to C.

Note: Thoracoscopy and laparoscopy can only be performed in a licensed hospital setting.

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
General Surgery		
1.	Ganglions	A[1]
2.	Hair Transplant	A[1]
3.	In-grown toe-nail	A[1]
4.	Excision of skin and subcutaneous benign mass	A[1]
5.	Drainage of Superficial Abscesses	A[1]
6.	Circumcision < 3 months old	A
7.	Haemorrhoids treatments using laser under local anesthesia	A
8.	Percutaneous Laser Ablation	B
9.	Temporal artery biopsy	B
10.	Hyperhidrosis	B
11.	Circumcision > 3 months old	CM
12.	Port-a-catheter removal	CM

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13.	Anal procedures - dilatation/fissure/banding/ low anal fistula	CM
14.	Breast lump excision (benign)	CM
15.	Excision varicocele	CM
16.	Testicular fixation and Orchidopexy	CM
17.	Varicose vein surgery	CM
18.	Hernia repair – inguinal/epigastric/femoral/ incisional/umbilical	C
19.	Hemorrhoids (2nd 3rd Degree) and Incision and Excision of superficial Thrombosed Hemorrhoid	C
20.	Pilonidal Sinus	C

[1] These procedures can be performed in a polyclinic/speciality outpatient clinic using local anesthesia.

Note: Appendectomy, Abdominoplasty, Bariatric and Laparoscopic surgery can only be performed in a licensed hospital setting.

No.	**Speciality/Procedure Names**	**Minimum Health Facility Classification/Type (A, B, CM or C)**
Vascular Surgery		
1.	Endovenous laser Ablation	A
2.	Endovenous Laser Treatment- EVLT	A
3.	Radiofrequency ablation (RFA)	A
4.	Ultrasound guided foam sclerotherapy (UGFS).	A
5.	Temporal artery biopsy	B
6.	Varicose vein surgery	CM

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No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Neurosurgery/anesthesia/pain management		
1.	Epidural Steroid Injections/Block	B
2.	Selective Nerve Root injections	B

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Interventional Radiology		
1.	Diagnostic ultrasound	A
2.	Ultrasound guided soft tissue / joints injections	A
3.	Ultrasound guided varicose veins sclerotherapy /interventions	A

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Obstetrics/Gynecology		
1.	Bladder distension	A
2.	Colposcopic procedures	A^1
3.	Intrauterine Device insertion	A^1
4.	Vaginal foreign bodies (e.g. retained medical device, pessaries, tampons, menstrual caps)	A
5.	Urethral dilatation	B

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6.	Cervical biopsies	B
7.	Vaginoplasties, vulva repair and perineal repair	CM
8.	Endometrial Biopsy	CM
9.	Anterior and Posterior Colporrhaphy	C
10.	Cautery to cervix	C
11.	Dilatation and curettage	C
12.	Endometrial ablation	C
13.	Tension-free vaginal tape	C
14.	Excision urethral caruncle	C
15.	Fenton's procedure	C
16.	Labial procedures/Bartholin's	C
17.	Polypectomy	C
18.	Hysteroscopy	C
19.	Hysteroresectoscopy	C
20.	Laparoscopic- diathermy endometriosis/division adhesions/aspirations ovarian cyst/dye test	C
21.	Labial Augmentation	C
22.	Clitoral hood reduction	C

[1] These procedures can be performed in a polyclinic/speciality outpatient clinic, with appropriate setting, using local anesthesia.

Note: Hysterectomy, laparoscopic surgery and pelvic floor repair can only be performed in a licensed hospital setting.

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No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Oral Surgery		
1.	Apicoectomy	A
2.	Biopsy of oral lesions/swellings	A
3.	Gum surgery	A
4.	Excision of oral cysts	A
5.	Exposure and bonding of impacted incisors	A
6.	Exposure of impacted canines	A
7.	Removal of impacted canines	A
Dental procedures in adults and pediatrics		
8.	Dental procedures under LA	A[1]
9.	Dental procedures under sedation	B
10.	Dental procedures under GA	C

[1] These procedures can be performed in a polyclinic/speciality outpatient clinic, with appropriate setting, using local anesthesia.

Note: Maxillofacial procedures can only be performed in a licensed hospital setting.

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Orthopedic Surgery		
1.	Serial casting for limbs/spine deformities	B
2.	Implant Removal (Minor)	B

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3.	DeQuervain's release	B
4.	Trigger finger/thumb release	B
5.	Tenolysis of trigger Finger (One, Two)	B
6.	Dupuytren's Contracture	B
7.	Claw Toe Reconstruction (One toe, Two Toes)	CM
8.	Closed Reduction of Fracture/ Dislocation	CM
9.	Closed Reduction + Percutaneous Fixation	CM
10.	Amputation of digit	CM
11.	Carpal Tunnel decompression	CM
12.	Examination under anesthesia	CM
13.	Correction of Hallux Valgus (Soft Tissue)	CM
14.	Bunionectomy	CM
15.	Open Reduction of Fracture/Fixation (Small Bone)	CM
16.	Tendon repair (Minor)	C
17.	Arthrodesis of small joints	C
18.	Arthroscopic procedures (Meniscal of the knee, Meniscectomy, Chondroplasty of the knee, Plica excision, lateral release of the knee, patella MPFL reconstruction, medial plication, micro fracture of ankle or knee, anterior fat pad decompression, shoulder, subacromial decompression of the shoulder, decompression of calcified tendinitis, slap lesion debridement/repair,	C

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	debridement/loose body removal of the knee/shoulder/elbow/wrist and ankle.	

Note: Intramedullary nailing and plating of long bones can only be performed in a licensed hospital setting

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Otolaryngology (E.N.T.)		
1.	Biopsy mouth/tongue/ear	A
2.	Submucous diathermy	B
3.	Laryngoscopy (indirect)	B
4.	Pharyngoscopy/esophagoscopy (Flexible)	B
5.	Cautery/out fracture inferior turbinate	CM
6.	Division tongue-tie	CM
7.	Intranasal polypectomy	CM
8.	Excision lymph nodes	C
9.	Functional Endoscopic Sinus (FESS) Surgeries	C
10.	Uvuloplasty	C
11.	Myringotomy	C
12.	Grommet insertion, tympanoplasty and simple mastoidectomy	C
13.	Antrostomy	C
14.	Tympanoplasty	C
15.	Uvulectomy	C

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16.	Removal submandibular calculus	C

Note: Rhinoplasty and tonsillectomy can only be performed in a licensed hospital setting.

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Ophthalmology		
1.	Cataract extraction	A
2.	BCC Excision and skin graft	A
3.	Sling Procedure	A
4.	Blepharoplasty	A
5.	Chalazion excision	A
6.	Conjunctiva Biopsy	A
7.	Cryotherapy	A
8.	Ectropion and Entropion	A
9.	Electrolysis	A
10.	Enucleation	A
11.	Epilation of lashes	A
12.	Evisceration	A
13.	Gold Weight Insertion	A
14.	Hughes Flap and Release	A
15.	Intraocular lens implantation	A
16.	Intravitreal injection	A
17.	LASIK and LASEK	A

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18.	Lacrimal repair	A
19.	Lensectomy	A
20.	Peripheral Iridectomy	A
21.	Pterygium excision/grafting	A
22.	Ptosis	A
23.	Punctal Plug Insertion	A
24.	Second Stage Reconstructions	A
25.	Syringe and Probe (adult)	A
26.	Strabismus surgery	A
27.	Tarsorrhaphy	A
28.	Temporal Artery Biopsy	A
29.	Three Snip Procedure	A
30.	Trabeculectomy (glaucoma)	A
31.	Keratoconus	A
32.	Keratoplasty (corneal transplant)	C
33.	Vitrectomy	A
34.	Syringe and Probe (pediatric)	A
35.	Blended Vision	A
36.	Small incision lenticule extraction (SMILE)	A
37.	Corneal crosslinking	A
38.	Corneal topography	A
39.	Fundus photography	A
40.	Phacoemulsification	A

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41.	Squint	A

No.	Speciality/Procedure Names	Minimum Health Facility Classification/Type (A, B, CM or C)
Plastic Surgery		
1.	Excision of skin tag or local skin lesion	A[1]
2.	Minor Scalp Surgery (lipoma, cyst, cut wounds)	A[1]
3.	Face, neck and eyebrow lift	A
4.	Blepharoplasty	CM
5.	Belly button surgery (or umbilicoplasty/navel surgery) (This procedure cannot be combined with mini abdominoplasty)	C
6.	Breast implants and augmentation	C
7.	Breast reduction (Total 800g for both breasts)	C
8.	Breast asymmetry	C
9.	Breast lift (small and medium)	C
10.	Breast Tuberous	C
11.	Calf, Cheek and Chin Surgery/implants	C
12.	Ear surgery (otoplasty/pinnaplasty)	C
13.	Liposuction (or lipoplasty/liposculpture) and fat transfer	C
14.	Mini Abdominoplasty with no umbilicus transposition (mini tummy tuck)	C
15.	Arm lifting	C
16.	Mini Thigh lifting	C

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17.	Male Gynecomastia	C
18.	Non-surgical cosmetic procedures	A[1]

[1] These procedures can be performed in a polyclinic/ outpatient clinic, with appropriate setting.

Note: Lip implants, breast reduction/reconstruction and abdominoplasty can only be performed in a licensed hospital setting.

Note: Multiple procedures in one setting should be avoided to minimize complications.

No.	**Speciality/Procedure Names**	**Minimum Health Facility Classification/Type (A, B, CM or C)**
Urology		
1.	Biopsies	A
2.	Intravesical botox injection	A
3.	Circumcision < 3 months old	A
4.	Rezum	B
5.	Urethral dilatation	B
6.	Circumcision > 3 months old	CM
7.	Locate/remove JJ stent	CM
8.	Incision for ureterocele	C
9.	Hypospadias repair	C
10.	Congenital hernia repair	C
11.	Epididymal cyst excision	C
12.	Cysto-diathermy bladder	C
13.	Excision Urethral caruncle	C

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14.	Excision hydrocele	C
15.	Lithoclast	C
16.	Urethral Stricture	C
17.	Fulguration of posterior urethral valve	C
18.	Ureteric stone laser lithotripsy	C
19.	Bladder neck incision	C
20.	Prostate - Plasma kinetic vaporization/biopsy	C
21.	Orchidopexy, Testicular and penile prosthesis	C
22.	Varicocelectomy	C
23.	Orchiectomy	C
24.	Cystoscopy	C
25.	Vasectomy*	C

* Any surgery leading to permanent sterility is impermissible except in life-threatening or with proven medical necessity. Temporary vasectomy is only permitted; under certain restrictions and conditions where a legitimate need for it, spouses' discretion, medical consultation and there is no aggression in the procedure which may prevent future pregnancies.

Appendix 6: DSC CLASSIFICATION AND PROVIDED LABORATORY AND DIAGNOSTIC SERVICES

Category	Services provided
Class A DSC **Class CM and C providing solely Ophthalmology services**	• Point of Care Testing for glucose, Dipstick urinalysis and Pregnancy test.

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Class B DSC	• Point of Care Testing for glucose, Prothrombin time/international normalized ratio (PT/INR), Dipstick urinalysis and Pregnancy test.
Class CM and C DSC	• Point of Care Testing (glucose, Prothrombin time/international normalized ratio (PT/INR), Dipstick urinalysis and Pregnancy test. • Arterial Blood Gas (ABG) • Radiology (or mobile x-ray) should include plain x-rays and chest x-rays as per FANR requirements.

APPENDIX 7: MINIMUM EMERGENCY MEDICATION (CLASS A, B and CM)

No.	Description	Strength	Qty
Mandatory			
1	Adenosine Injection	6mg/2ml	3
2	Epinephrine (Adrenaline) 1:10,000 (0.1mg/ml) 10ml Prefilled Syringe **or** 1:1000 (1mg/ml) 1ml Ampoule if prefilled syringe not available	0.1mg/ml **or** 1mg/ml	5
3	Amiodarone Injection	150mg/3ml	2
4	Atropine 0.2mg/ml 5ml Pre-filled Syringe **or** 0.6mg/ml 1ml Ampoule if prefilled syringe not available	0.2mg/ml 5ml **or** 0.6mg/ml 1ml	5
5	Calcium Chloride 10% Injection	1gm/10ml	2
6	Calcium gluconate 10%- 10ml Injection	1gm/10ml	2
7	Diazepam Injection	10mg/2ml	1
8	Diazepam Rectal solution	5 mg	1

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9	Dextrose 50% Vial	50gm/100ml	2
10	Dopamine Injection	200mg/5ml	1
11	Flumazenil (Anexate) Injection	0.5mg/5ml	1
12	Furosemide Injection	20mg/2ml	2
13	Glucagon Injection	1mg	1
14	Midazolam Injection	15mg/3ml	1
15	Hydrocortisone Injection	100mg/2ml	2
16	Magnesium Sulphate 50% Injection	(0.5g/ml)	2
17	Salbutamol Aerosol Inhalation Nebules	1mg/ml	10
18	Salbutamol Inhaler	100mcg/Dose	1
19	Glyceryl Trinitrate sublingual Spray	400mcg/Dose	1
20	Epinephrine (Autoinjector/prefilled Pen) Pediatric	0.15mg (150mcg)	1
21	Epinephrine (Autoinjector/prefilled Pen) Adult	0.3mg (300mcg)	1
22	Ringer Lactate	500ml	2
23	Dextrose 5% (D5W)	500m	2
24	Sodium Chloride 0.9% (NS)	500ml	2
25	Sodium Chloride 0.9% (NS) Ampoules	10ml	10
26	Water For Injection	5 ml	5

APPENDIX 8: MINIMUM EMERGENCY MEDICATION (CLASS C)

No.	Description	Strength	Qty
Mandatory			
1	Adenosine Injection	6mg/2m	4
2	Epinephrine (Adrenaline) 1:10,000 (0.1mg/ml) 10ml Prefilled Syringe **or** 1:1000 (1mg/ml) 1ml Ampoule if prefilled syringe not available	0.1mg/ml **or** 1mg/ml	5
3	Amiodarone Injection	150mg/3ml	2

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4	Atropine 0.2mg/ml 5ml Pre-filled Syringe **or** 0.6mg/ml 1ml Ampoule if prefilled syringe not available	0.2mg/ml 5ml **or** 0.6mg/ml 1ml	5
5	Calcium Chloride 10% Injection	1gm/10ml	2
6	Calcium Gluconate 10% Injection	1gm/10ml	2
7	Cisatracurium Injection *	2mg/ml	3
8	Dextrose 50% Vial	50gm/100ml	1
9	Diazepam Injection	10mg/2ml	2
10	Diazepam Rectal solution	5 mg	2
11	Dopamine Injection	200mg/5ml	2
12	Dantrolene sodium for injection**	20mg	12
13	Epinephrine (Autoinjector/prefilled Pen) Pediatric	0.15mg (150mcg)	1
14	Epinephrine (Autoinjector/prefilled Pen) Adult	0.3mg (300mcg)	1
15	Flumazenil (Anexate) Injection	0.5mg/5ml	1
16	Furosemide Injection	20mg/2ml	2
17	Glucagon Injection	1mg	1
18	Glyceryl Trinitrate sublingual Spray	400mcg/Dose	1 pack
19	Hydrocortisone Injection	100mg/2ml	3
20	Lidocaine Hydrochloride 2% Injection	100mg/5ml	2
21	Labetalol HCL Injection	100mg /20 ml	2
22	Vasopressin Injection *	20 IU/ml	2
23	Magnesium Sulphate 50% Injection	(0.5g/ml)	2
24	Midazolam Injection	15mg/3ml	1
25	Naloxone Injection	0.4mg /ml	2
26	Phenobarbitone Injection	200mg/ml	2
27	Rocuronium bromide Injection*	10mg/ml	3
28	Suxamethonium chloride Injection*	50mg/ml	3
29	Sodium Bicarbonate 8.4% 50ml Prefilled Syringe	84mg/ml	2
30	Salbutamol Injection	500mcg/ml	1

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31	Salbutamol Aerosol Inhalation Nebules	1mg/ml	10
32	Ringer Lactate	500ml	2
33	Dextrose 5% (D5W)	500ml	2
34	Sodium Chloride 0.9% (NS)	500ml	2
35	Sodium Chloride 0.9% (NS) Ampoules	10ml	10
36	Water For Injection	5ml	5
* Keep in fridge ** Only for Operation Theatre			

APPENDIX 9: ELIGIBILITY CRITERIA FOR DENTISTRY UNDER GENERAL ANAESTHESIA IN DSC.

1. General anesthesia should only be considered for extremely uncooperative children, those lacking psychological maturity, or children with mental/medical disabilities. It is also indicated for significant surgical procedures requiring immediate or comprehensive dental care and cases where local anesthesia is ineffective.
2. If the surgery involves the first permanent molars, root canal therapy and/or extraction of permanent molars, a consultation and assessment by the oral surgeon, endodontist and orthodontist is required before proceeding with general anesthesia.
3. The pre-op assessment shall be conducted in the same health facility where the procedure will take place.
4. Consent for the elective procedure shall be provided by the parent and should not exceed 4 weeks prior to the day of the procedure. A second consent is mandatory on the day of the procedure and must elaborate risk, benefits and alternatives. This includes and not limited to metal crowns, extraction of permanent teeth or extraction of primary anterior teeth.
5. Class II restorations in primary molars should not be performed under general anesthesia.
6. The Day surgical Center shall meet the following required healthcare professionals:

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- The Anesthesiologist must have experience in pediatric anesthesia field.
- The Anesthesiologist, pediatrician, and dental surgeon should hold a valid Pediatric Advanced Life Support (PALS) certificate.
- A pediatrician must be informed in advance and available onsite during the procedure to assist in emergencies, if needed.
- The Dental surgeon must be a Specialist /Consultant in one of dental surgical specialties, not a General Dentist.

7. Adherence to all other requirements for category C listed in this document and the guidelines for complete oral rehabilitation under general anesthesia.