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DEPARTMENT OF HEALTH

DOH STANDARD FOR EMERGENCY DEPARTMENTS AND URGENT CARE CENTERS

June 2021

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Applies to	DOH Licensed Healthcare Providers in the Emirate of Abu Dhabi		
This Standard should be read in conjunction with related UAE laws, DOH standards, policies, and circulars (general and related to Emergency Disaster Management & Preparedness), CBRNE, NCEMA Standards, Policies, DOH Manuals, licensing regulations and reporting requirements.			

1. Purpose

The purpose of this Standard is to:

1.1. Define the types and levels of Emergency care recognized in Abu Dhabi;

1.2. Define the licensing requirements and minimum service specifications and requirements for Emergency and Urgent Care Departments in the Emirate of Abu Dhabi that healthcare providers are required to comply with to be able to provide high quality emergency care; and

1.3. List specific duties that healthcare providers, insurers and TPAs that provide emergency care must comply with.

2. Scope

This Standard applies to all healthcare providers, public and private, licensed by DOH in the Emirate of Abu Dhabi that wish to provide and operate emergency department and urgent care services.

3. Definitions

3.1. **ACLS**: Advanced Cardiac Life Support.

3.2. **ATLS**: Advanced Trauma Life Support.

3.3. **CASMEET:** is a mnemonic acronym used by emergency medical services to communicate the important details of a patient over to an emergency control center, receiving hospital, or other definitive care provider.

- **C**all – sign of the vehicle/unit responding.
- **A**ge – patient's age.
- **S**ex – whether the patient is male or female.
- **M**echanism/Mode – the mechanism of injury or the mode of illness.
- **E**xamination – the clinical findings from the initial assessment of the patient.
- **E**TA – estimated time of arrival.
- **T**reatment – any treatment that has already been provided.

3.4. **City Definition:** city is regarded as an urban area with population of more than 75,000. (1,2)

3.5. **CBRNE**: Chemical, Biological, Radiological, Nuclear, Explosive.

3.6. **Emergency Department**: Facilities in a hospital devoted to providing emergency medical care for all.

3.7. **Emergency Medical Care:** Patient care for a medical or surgical emergency condition.

3.8. **Emergency Condition:** An emergency medical condition is defined as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs." (3).

3.9. **Emergency Medicine:**

As per the American College of Emergency Physicians definition used in this Standard, "Emergency medicine is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury. It encompasses a unique body of knowledge. The practice of emergency medicine includes the initial evaluation, diagnosis, treatment, coordination of care among multiple providers, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care". (4)

3.10. **Maternity Emergency Department:** Facilities in a hospital devoted to providing emergency maternity care.

3.11. **Medical or Surgical Emergency:** Injury or illness that occurs suddenly or unexpectedly and poses an immediate risk /threat to a person's life, limb, body function or long-term health.

3.12. **Medical Screening Examination:** The medical screening examination aim to determine if the patient condition needs urgent attention or patient is stable and safe to seek treatment in another facility of their choice where they are covered and is to be performed by licensed medical practitioner or equivalent. Medical screening examination may include some testing to reach the conclusion of medical stability. (5).

3.13. **NCEMA**: National Emergency, Crises and Disasters Management Authority.

3.14. **NRP:** Neonatal Resuscitation Program

3.15. **PALS**: Pediatric Advanced Life Support.
3.16. **PAT**: Pediatric Assessment Triangle (PAT)
3.17. **Pediatric Emergency Department:** Facilities situated in a hospital devoted to providing pediatric emergency medical care for children up to the age of 16.
3.18. **Planned Care:** Care that is scheduled in advance.
3.19. **Remote Emergency Department:** An Emergency Department that is more than 100 km distance away from city with population more than 15,000 and annual emergency department visits more than 10,000 patients. (2)
3.20. **TPAs:** Third Party Administrators.
3.21. **T1, T2, …T5:** Triage categories based on 5 level Triage system where T1 is critically ill and needs immediate attention by healthcare provider and T5 is non-acutely ill and can wait to be seen when health care provider is available.
3.22. **The Emergency Severity Index (ESI):** is a five-level emergency department (ED) triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. (Agency for Health Research and Quality).
3.23. **Urgent Care Centers**: Facilities in a hospital that provide initial evaluation, stabilization, diagnostic capabilities to treat the least minor injuries and illnesses and transfer to a higher level of care if needed.

4. DOH Classification of Emergency Care Provision

4.1. Emergency Department (See **Appendix 1** for full licensing requirements).
4.2. Pediatric Emergency Department (See **Appendix 2** for full licensing requirements).
4.3. Maternity Emergency Department (See **Appendix 3** for full licensing requirements).
4.4. Remote Emergency Department (See **Appendix 4** for full licensing requirements).
4.5. Urgent Care Centers (See **Appendix 5**: for full licensing Requirements)

5. Emergency Departments and Urgent Care Centers Service Specifications and Requirements

Healthcare Providers that wish to operate Emergency Departments and Urgent Care services must:

5.1. Comply, with all service requirements found in Comply with all the service requirements found in Appendix 1, Appendix 2, Appendix 3, Appendix and Appendix 5.
5.2. Comply with the specific duties found in Section 6 of this Standard.

6. General Duties for Healthcare Providers/Payers/Third Party Administrators (TPAs)

6.1. All Emergency Departments must:
6.1.1. Liaise with DOH AD Emergency/Operation Center on emergency capacity.
6.1.2. Register, clinically triage and treat all patients with a medical emergency to avoid loss of life or occurrence of damage to limb, body function or long-term health regardless of insurance and residency status, nationality or ability to pay. This includes:

6.1.2.1. Provide medical screening examination and/or stabilizing treatment to all T1 and T2 patients without delay in order to inquire about payment status and ensure that assessment is documented on the patient's medical records.

6.1.2.2. Provide T3, T4 and T5 patients' medical screening examination beyond initial triage. Triage is not equivalent to a Medical Screening Examination. Triage merely determines the "order" in which patients will be seen, not the presence or absence of an emergency medical condition. The medical screening examination is to be performed by licensed medical practitioner or equivalent with the aim to determine if the patient condition needs urgent attention or patient is stable and safe to seek treatment in another facility of their choice where they are covered. Medical screening examination may include some testing to reach the conclusion of medical stability.

6.1.2.3. If a patient's insurance does not cover ongoing treatment at the receiving hospital but the patient requires further urgent medical or surgical intervention and is stable and safe to transfer to another hospital, the receiving hospital should seek advice and guidance from the patient's insurance company to identify an appropriate transfer location. If an alternative, appropriate location is not identified or available the insurance company must reimburse the receiving hospital until the transfer is complete. If the patient refuses the transfer then the patient shall commit to cover all treatment cost and seek insurance refund afterwards.

6.1.2.4. For those patients not deemed as a medical emergency, in line with the definition in Section 3.7, the Emergency Department may, following medical screening exam and where clinically documented as safe to do so, discharge the patient and advise the patient where they might get the appropriate non-emergency medical treatment.

6.1.2.5. For patients who do not have health insurance the hospital should recover the medical expenses direct from the patient, his sponsor, or include it under activity-based mandates as per the rules and regulations without jeopardising the delivery of 6.1.2.

6.1.2.6. For patients who refuse medical screening and decide to leave the facility:

- Provide an explanation of the risk of their actions.
- If they insist on leaving, they must sign a "Leaving against medical advice" form. In case of refusal, the healthcare provider shall document that clearly.

6.1.3. When unable to treat or when not designated by DOH regulation to treat,[1] the healthcare facility must provide an appropriate transfer of an unstable individual to another medical facility after obtaining the consent of the receiving hospital to accept the transfer.

6.2. All insurers and TPAs must:

[1] For transfers of Burns, Pediatric, STEMI and Stroke time critical emergencies please refer to DOH triage protocols.

6.2.1. Reimburse the emergency treatment provided regardless of whether the hospital is in its insurance network.

7. Enforcement and Sanctions

7.1. Healthcare service providers must comply with the terms and requirements of this Standard, the DOH Standard Provider Contract and the DOH Data Standards and Procedures. DOH may impose sanctions in relation to any breach of requirements under this Standard in accordance with the Complaints, Investigations, Regulatory Action and Sanctions in the Health Regulator Manual.

8. Appendix 1: Licensing Requirements and Minimum Service Specifications for Emergency Departments

	Emergency Departments
1. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services. • Mandatory services and infrastructures: ➢ Emergency Medicine ➢ Internal Medicine ➢ General Surgery ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation ➢ Blood Bank ➢ Clinical Pathology services ➢ Anesthesiology ➢ Operating Theatres ➢ Critical Care ➢ Psychiatric assessment area ➢ Decontamination facilities (if designated by DOH) ➢ Designated area for the assessment and management of pediatric patients • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care.
2. Assessment, Stabilization & Care	• Capability to resuscitate patients with life-threatening condition or injury. • Capability to assess and early treatment of patients with acute condition or severe/ life threatening injuries. • Use of 5 Level Triage • Capability to manage patients requiring a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions.

3. Clinical Staffing	• The ED shall be led by an Emergency Medicine Consultant. All the staff working in the ED inclusive of physicians, nursing and non-clinical support staff shall report to the ED lead. • At least one Consultant/Specialist in Emergency Medicine per shift. • All physicians working in the ED with General Practitioner license, specialist license in Internal medicine or General surgery, need to maintain active certification in adult, pediatric and trauma resuscitation (ACLS, PALS, ATLS). Physicians with Emergency Medicine License are exempted from having active certification. • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care. • Pediatric Emergency area can be staffed by trained pediatrics emergency physician (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians with experience in emergency medicine of no less than 5 years.
4. Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover.
5. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. • Undertake regular clinical audits and review
6. Reporting	• Participating in local emergency registry as defined by DOH Trauma registry including related functions of coordination of trauma communication and trauma case management and follow up, and trauma data analysis, monitoring and reporting.

7. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process
8. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DOH website on this link https://www.doh.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

9. Appendix 2: Licensing Requirements and Minimum Service Specifications for Pediatric Emergency Departments

	Pediatric Emergency Departments
1. Access	Open 24hours a day, seven days a week with access to comprehensive pediatric emergency services. • Mandatory services and infrastructures: ➢ General Pediatrician (consultant and/or specialist) ➢ Pediatric critical care Department ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation ➢ Clinical pathology services ➢ Blood bank ➢ Anesthesiology ➢ Pediatric Surgery Service • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports pediatric patients, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care. • There is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department. The HLS should conform to Civil Aviation Authority standards.
2. Assessment, Stabilization & Care	• Capability to resuscitate pediatric patients with life-threatening illness or injury. • Capability to assess and early treatment of pediatric patients with sudden serious illness or injury. • Use of 5 Level Triage. Triage score PAT can be used in addition to 5 level triage too. • Capability to manage pediatric patients requiring a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions.
3. Clinical Staffing	• The Pediatric ED shall be led by: ➢ A Pediatric Emergency Medicine Consultant; or ➢ Emergency Medicine Consultant, or ➢ A Pediatric consultant with 5 years Emergency experience if no Pediatric Emergency Medicine consultant can be found.

	All the staff working in the ED inclusive of physicians, nursing and non-clinical support staff shall report to the ED Head of Department; • Pediatric Emergency Departments can be staffed by trained pediatrics emergency physician (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians with experience in emergency medicine of no less than 5 years. • At least one Consultant/Specialist as identified above per shift. • All physicians with General Practitioner license, specialist license in Internal medicine or General surgery, need to maintain active certification in adult, pediatric and trauma resuscitation (PALS, ATLS, NRP). Physicians with Emergency Medicine License are exempted from having active certification. • Availability of appropriate mix of multidisciplinary pediatric emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to pediatric patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe pediatric emergency care.
4. Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET format; and providing medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover.
5. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. • Undertake regular clinical audits and review
6. Reporting	• Participating in local emergency registry as defined by DOH Trauma registry including related functions of coordination of trauma communication and trauma case management and follow up, and trauma data analysis, monitoring and reporting.
7. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process
8. Signage & Patient	Emergency Department Signage Patient information is appropriate to the facilities scope

information	of services. All Emergency Departments are expected to display the correct signage which is published on DOH website on this link https://www.doh.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

10. Appendix 3: Licensing Requirements and Minimum Service Specifications for Maternity Emergency Departments

	Maternity Emergency Department
1. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services. • Mandatory services and infrastructures: ➢ Obstetrics: emergency obstetric care, early pregnancy complications and postnatal emergency care ➢ Neonatal intensive care for level 3 and above ➢ Internal Medicine ➢ Radiology/ Diagnostic imaging including plain radiography, ultrasound, access to CT and timely access to radiologist consultation and image interpretation ➢ Blood Bank ➢ Clinical Pathology services ➢ Anesthesiology ➢ Operating Theatres ➢ Critical Care or agreement to transfer patient who need ICU to another facility with critical care facility: If the facility has no onsite ICU (critical care level 3), the facility must have onsite critical care level 2 as a minimum (this is also known as HDU care) as well as access to another facility with ICU • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all maternity and neonatal patients, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care.
2. Assessment, Stabilization & Care	• Capability to resuscitate maternity and neonatal patients with life-threatening illness or injury. • Capability to assess and early treatment of maternity patients with sudden serious illness or injury. • Use of 5 Level Triage • Capability to manage patients requiring a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions.

3. Clinical Staffing	• The Maternity Emergency Department shall be led by an Obstetric Consultant. All the staff working in the Maternity Emergency Department inclusive of physicians, nursing and non-clinical support staff shall report to the Maternity Emergency Department lead. • At least one Consultant/Specialist in Obstetrics per shift. • All obstetricians and neonatologists need to maintain active certification in adult and neonatal resuscitation (ACLS, NRP). • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care.
4. Admission & Handover	• The maternity Emergency Department must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient's condition ahead of arrival using CASMEET format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested. • Staff scheduling must be designed to ensure safe handover
5. Quality & Safety	• Maternity Emergency Department quality and safety committee to monitor, assess and improve performance and report on adverse incidents. • Undertake regular clinical audits and review
6. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process
7. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DOH website on this link https://www.doh.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

11. Appendix 4: Licensing Requirements and Minimum Service Specifications for Remote Emergency Departments

	Remote Emergency Departments
1. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services: • Mandatory services and infrastructures on site: ➢ Radiology/ Diagnostic imaging including plain radiography, CT and ultrasound and timely access to radiologist consultation and image interpretation. ➢ Basic Blood Bank services (ability to transfuse blood for unstable patients) ➢ Clinical Pathology services (either as conventional testing or point of care testing). ➢ Designated area for the assessment and management of pediatric patients ➢ Psychiatric assessment area. ➢ Decontamination facilities (if designated by DOH). ➢ Transfer agreements for surgical services not provided onsite. • Services that can be provided remotely via tele-consultation (patient to physician): ➢ Internal Medicine ➢ General Surgery • Services that can be provided through tele-counseling (physician to physician) to assist in the emergency management of complex patients and those requiring stabilization and transfer to a higher level of care: ➢ Internal Medicine ➢ General Surgery and Surgical Specialties ➢ Anesthesiology ➢ Critical Care Critical Care. • Provision of emergency care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access. • Availability of hospital wide escalation policy for when an ED is approaching full and the associated risks. Criteria for escalation should be determined locally. An escalation policy should involve all specialties with responsibilities for acute care.

2. Structure	• There is at least one room designated as the “Resuscitation” room. • There is a Helicopter Landing Site (HLS) readily accessible from the Emergency Department. The HLS should conform to Civil Aviation Authority standards.
3. Assessment, Stabilization & Care	• Capability to resuscitate patients with life-threatening illness or injury. • Capability to assess and early treatment of patients with sudden serious illness or injury. • Use of 5 Level Triage. • Capability to manage patients requiring a short period of programmed investigations and observation to ensure safe discharge of patients with symptoms that might suggest serious disease and avoid unnecessary hospital admissions.
4. Clinical Staffing	• The ED shall be led by an Emergency Medicine Consultant. All the staff working in the ED inclusive of physicians, nursing and non-clinical support staff shall report to the ED lead. • At least one Consultant/Specialist in Emergency Medicine per shift. • All physicians working in the Remote ED need to maintain active certification in adult, pediatric and trauma resuscitation (ACLS, PALS, NRP, ATLS). Physicians with Emergency Medicine License working in Remote area only and not covering shifts in tertiary or secondary hospitals are included. • Availability of appropriate mix of multidisciplinary emergency care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing emergency care to patients of varied acuity levels, and that staff receive appropriate and up to date training to support quality and safe emergency care. • Pediatric Emergency area can be staffed by trained pediatrics emergency physician (consultant or specialist), trained emergency medicine physicians (consultant or specialist) or pediatricians with experience in emergency medicine of no less than 5 years.
5. Admission & Handover	• The ED must have processes and policies in place to ensure proper coordination with incoming ambulances including receiving patient’s condition ahead of arrival using CASMEET format; and provide medical advice if requested by the ambulance. • Policies and procedures to ensure that all in-patient services listed under "Access" are available, including consultations and therapies to reduce time to definitive treatment, as soon as hospital admission is requested.

	• Staff scheduling must be designed to ensure safe handover.
6. Quality & Safety	• ED quality and safety committee to monitor, assess and improve performance and report on adverse incidents. • Undertake regular clinical audits and review
7. Reporting	• Participating in local emergency registry as defined by DOH Trauma registry including related functions of coordination of trauma communication and trauma case management and follow up, and trauma data analysis, monitoring and reporting.
8. Patient Referral, Retrieval & Transfer	The facility will have in place a patient referral and transfer process.
9. Signage & Patient information	Emergency Department Signage Patient information is appropriate to the facilities scope of services. All Emergency Departments are expected to display the correct signage which is published on DOH website on this link https://www.doh.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

12. Appendix 5: Licensing Requirements and Minimum Service Specifications for Urgent Care Centers

	Urgent Care Centers
1. Access	Open 24hours a day, seven days a week with access to comprehensive emergency services. • Mandatory services and infrastructures: ➢ Radiology/ Diagnostic imaging including plain radiography, ➢ Clinical Pathology services • Provision of urgent care services to be in an appropriate location and in an environment that is safe and that supports all age groups, considering disability access. • Availability of hospital wide escalation policy for when an urgent care center is approaching full and the associated risks. Criteria for escalation should be determined locally.
2. Assessment, Stabilization & Care	• Capability to resuscitate patients with life-threatening illness or injury. • Capability to assess and early treatment of patients with sudden serious illness or injury. • Stabilize and transfer patients with an immediate risk /threat to life, limb, body function or long-term health to an Emergency Department by interfacility ambulance.
3. Clinical Staffing	• The Urgent Care Center shall be Consultant led. All the staff working in the Urgent Care Center inclusive of physicians, nursing and non-clinical support staff shall report to the Urgent Care Center lead. • At least one Consultant/Specialist or GP per shift. • All Urgent Care Center physicians need to maintain active certification in adult and pediatric resuscitation (ACLS, PALS). • Availability of appropriate mix of multidisciplinary Urgent Care team, its members possessing the requisite levels of knowledge and skills in accordance with their role in providing Urgent Care to patients and that staff receive appropriate and up to date training to support quality and safe urgent care.
4. Admission & Handover	• Staff scheduling must be designed to ensure safe handover

5. Quality & Safety	• Urgent Care Center quality and safety committee to monitor, assess and improve performance and report on adverse incidents. • Undertake regular clinical audits and review
6. Patient Referral, Retrieval & Transfer	The facility will have in place a patient transfer and retrieval agreement per the DOH Standard for Inter-facility patient transfer
7. Signage & Patient information	Urgent Care Department Signage Patient information is appropriate to the facilities scope of services. All Urgent Care Centers are expected to display the correct signage which is published on DOH website on this link https://www.doh.gov.ae/featured/new-standard-for-healthcare-facilities-emergency-departments-in-abu-dhabi.aspx

13. Appendix 6: Key Performance Indicators for Emergency Departments

The Indicators are reviewed and developed annually by the DOH Quality Division with support from local and international emergence care expertise.

All DOH waiting time guidance can be accessed on this link (JAWDA Quarterly Waiting Time Guidelines for Specialized and General Hospitals):
https://www.doh.gov.ae/resources/jawda-abu-dhabi-healthcare-quality-index

DOH may revise and update these metrics taking into consideration service needs, performance and population health challenges.

14. References

1. List of cities in UAE [Internet]. [cited 2020 Dec 22]. Available from: http://www.dubaifaqs.com/list-of-cities-uae.php

2. Australian College of Rural and Remote Medicine. Recommended Minimum Standards for small rural hospital emergency departments [Internet]. 2019 Dec. (Version 02/19 SM). Available from: https://www.acrrm.org.au/docs/default-source/all-files/college-standards-for-small-rural-hospital-emergency-departments.pdf?sfvrsn=7b50f7b_6

3. EMTALA Fact Sheet [Internet]. [cited 2020 Dec 22]. Available from: https://www.acep.org/life-as-a-physician/ethics—legal/emtala/emtala-fact-sheet/

4. Definition of Emergency Medicine [Internet]. [cited 2020 Dec 22]. Available from: https://www.acep.org/patient-care/policy-statements/definition-of-emergency-medicine/

5. Best Practices – Medical Screening Exam [Internet]. [cited 2020 Dec 22]. Available from: https://www.acep.org/how-we-serve/sections/freestanding-emergency-centers/news/june-2015/best-practices—medical-screening-exam/