



وزارة الصحة
Ministry of Health

Urgent Care Center Standard Policy

N.B. Staff should be discouraged from printing this document.
This is to avoid the risk of out-of-date printed versions of the document.
The Intranet should be referred to for the current version of the document.

Policy Title	Policy Version & Number	Policy Issuer	Replacement of Policy Number
Urgent Care Center Standard Policy	AST.HS-EMDP-001-IPP	EMDP	
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1. Purpose

1.1 The aim of this document is to:

- 1.1.1 To standardize the Urgent Care Centers (UCCs) practice in the Kingdom of Saudi Arabia.
- 1.1.2 To provide practical recommendations on preparing and operating UCCs.
- 1.1.3 To provide clear UCC pathways, structures, policies, guidelines, essential checklists, and mandatory competencies for all staff who work in the UCCs.
- 1.1.4 To define quality control measures for evaluating the performance of UCCs.
- 1.1.5 To emphasize that the ideal standard of UCCs is a stand-alone model, either level 1 or 2, based on MOH regulation.

2. Terms and Definitions

- 2.1 **Board Certified Physicians:** Doctors who have completed the necessary education and training in a specific medical specialty and have successfully passed the examination conducted by a recognized specialty board, according to the Saudi Commission for Health Specialties (SCFHS).
- 2.2 **Classification of Urgent Care Centers:** Classification is a 'categorization' of an Urgent Care facility to provide better clarity for patients seeking treatment. The classification consists of four levels;
- 2.2.1 Level 1:** Essentially equivalent of FSED (Freestanding Emergency Departments) - (Stand-alone).
- 2.2.1.1 Staffed by board-certified emergency medicine physicians and other specialties when needed.
 - 2.2.1.2 Physicians must be certified in ATLS (Advanced Trauma Life Support), ACLS (Advanced Cardiovascular Life Support), and PALS (Pediatric Advanced Life Support).
 - 2.2.1.3 CT scan on-site, X-ray, Ultrasound on-site and clinical laboratory.
- 2.2.2 Level 2:** It is the standard of UCC in Saudi Arabia (Stand-alone)
- 2.2.2.1 Staffed by board-certified emergency medicine physicians and other specialties when needed.
 - 2.2.2.2 Physicians must be certified in ACLS (Advanced Cardiovascular Life Support) and PALS (Pediatric Advanced Life Support).
 - 2.2.2.3 X-ray and Ultrasound on-site and clinical laboratory.

2.2.3 Level 3:

2.2.3.1 Staffed by a General Practitioner with experience in Emergency and Family Medicine.

2.2.3.2 Providers must be certified in BLS (Basic Life Support), ACLS (Advanced Cardiovascular Life Support), and PALS (Pediatric Advanced Life Support).

2.2.4 Level 4:

2.2.4.1. Staffed by General Practitioner.

2.2.4.2. Providers must be certified in BLS (Basic Life Support).

- 2.3 **Emergency Department (ED):** a medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment, either by their own means or by an ambulance.
- 2.4 **Health Cluster:** Health clusters will focus on holistic, preventive care rather than solely on curative approaches. Each health cluster is an integrated network of healthcare providers under one administrative structure serving approximately one million people. A cluster will consist of primary care centers, general hospitals, and specialized services so that beneficiaries who receive care in the cluster may avail themselves of all the required services through an integrated administrative system.
- 2.5 **Health Information System (HIS):** is a system designed to manage healthcare data, which includes the collection, storage, management, and transmission of patients' electronic medical records, hospital administration functions, and healthcare policy decisions.
- 2.6 **Ministry of Health (MOH):** provides health care, public health promotion, and disease prevention. It also formulates rules and regulations governing the public and private health sector and monitors its performance, with an interest in research, academic training, and health investment areas.
- 2.7 **Patient Experience:** is the sum of all interactions and perceptions shaped by a healthcare organization's culture, affecting patients' views and feelings across the entire continuum of care. This includes every touchpoint from scheduling and reception to treatment, discharge, and follow-up, encompassing factors like the quality of care, communication, wait times, environment comfort, and overall satisfaction with the healthcare services received.
- 2.8 **Patient Flow:** The movement of patients through the UCC, from arrival to discharge, including all clinical interactions.
- 2.9 **Primary Healthcare Center (PHC):** is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment.
- 2.10 **Resource Control Center (RCC):** is simply a capability that combines information, planning, coordination (if necessary "command and control") communication to manage often urgent, time critical, always complex activities that require the use of finite resources.



- 2.11 **Sentinel Event:** A patient safety issue that is not primarily related to the natural course of the patient's illness or underlying condition of a patient that reached the patient and resulted in death, permanent or severe temporary harm.
- 2.12 **Service Line Lead:** is a professional responsible for overseeing a specific area of medical services or treatment, managing both the operational and strategic aspects to ensure efficient, high-quality patient care within that service line.
- 2.13 **ST Elevation Myocardial Infarction (STEMI):** is a severe type of heart attack during which one of the heart's major arteries is blocked. It is a medical emergency that requires immediate attention.
- 2.14 **Stroke:** an acute neurological impairment following an interruption in blood supply to a specific brain area.
- 2.15 **The Canadian Triage and Acuity Scale (CTAS):** is a tool used both nationally and internationally to allow healthcare centers and their staff to prioritize patient care requirements. CTAS has five acuity levels that extend from life-threatening conditions (CTAS 1) that require immediate attention to conditions that are non-urgent (CTAS 5) or that may be part of a chronic problem.
- 2.15.1. CTAS 1 – Resuscitation:**
- 2.15.1.1. Patient requires immediate life-saving intervention such as cardiac arrest, severe trauma, major burns, active seizures.
- 2.15.2. CTAS 2 - Emergent:**
- 2.15.2.1. Patient requires rapid medical intervention within minutes such as severe respiratory distress, chest pain suggestive of heart attack, uncontrolled bleeding.
- 2.15.3. CTAS 3 – Urgent:**
- 2.15.3.1. Patient requires prompt attention, but the condition is not immediately life-threatening such as moderate dehydration, uncomplicated fractures, acute abdominal pain without alarming symptoms.
- 2.15.4. CTAS 4 - Less Urgent:**
- 2.15.4.1 Patient's condition is potentially urgent, but the severity is not high such as minor injuries, mild respiratory distress, minor infections.
- 2.15.5. CTAS 5 - Non-urgent:**
- 2.15.5.1. Patient's condition is non-urgent and may be part of a chronic problem such as minor illnesses (e.g., mild cold, minor rash), prescription refills, routine follow-up appointments.
- 2.16 **Triage:** The process of sorting patients to prioritize care based on illness/injury, severity, prognosis, and resource availability. Triage aims to identify patients needing immediate care and how long they can wait safely and to initiate diagnostic/therapeutic measures as appropriate.
- 2.17 **Urgent Care Centers:** are walk-in centers focused on delivering medical care for illnesses and injuries in an ambulatory medical facility outside a traditional hospital in a separate building stand-alone model.
- 2.18 **Visual nurse:** a nurse whose role involves visually assessing patients upon arrival to determine the urgency of their medical needs quickly. This concept is fundamental in emergency care settings, where



rapid evaluation can be crucial for prioritizing treatment based on the severity of each Patient's condition.

3. Policies

- 3.1** All age group patients seeking emergency medical help must be triaged according to acuity level. Critically ill patients must be stabilized according to the UCC-level capabilities and transferred to the nearest emergency department. Patients meeting the criteria for CTAS 5,4 and CTAS 3 without advanced care may receive appropriate medical assessment and treatment at UCCs.
- 3.2** The design of an UCCs should prioritize efficient patient flow, accessibility, and the integration of necessary medical facilities and technologies to provide rapid, effective treatment in a safe and patient-friendly environment in a model of stand-alone UCCs according to MOH regulation.
- 3.3** The Urgent Care Service Line Lead (Emergency Service Lead in the MOH Cluster) oversees the delivery and quality of medical services, coordinates patient care, and ensures operational efficiency and compliance with healthcare standards within their designated service line.
- 3.4** All UCCs must have a visual nurse who visually assesses the severity of a patient's illness as they arrive.
- 3.5** All patients presenting to the UCCs shall be assessed by a triage nurse regardless of eligibility using the CTAS, which prioritizes patient care based on the severity of their condition. It helps healthcare professionals determine the urgency of a patient's need for medical treatment (Appendix 1).
- 3.6** UCCs offer a scope of service and provide immediate medical and surgical attention and unscheduled episodic care to patients who need prompt care, which is internationally classified under categories level 1, 2, 3, 4 and 5 (Appendix 1).
- 3.7** Walk-in cases within the scope of the Emergency Department, such as CTAS 1, 2, and CTAS 3 (need more advanced care and investigation), and significant trauma cases shall be referred to the nearest ED after providing essential care.
- 3.8** UCCs can vary in their capabilities, but generally, they can be categorized based on the level of care they provide. UCCs level 1, 2, and 3 shall be appropriate infrastructure maintained as mentioned in (Appendix 2).
- 3.9** Appropriate equipment and medical supplies shall be maintained as mentioned in (Appendix 3).
- 3.10** Minimum staff required to operate a UCC (Independently assigned to Urgent Care Service) are the following:
 - 3.10.1 Urgent Care Center manager
 - 3.10.2 Medical manager for each shift
 - 3.10.3 Receptionist
 - 3.10.4 Physician
 - 3.10.5 Head nurse
 - 3.10.6 Nurse
 - 3.10.7 Emergency medical services technician/specialist
 - 3.10.8 Pharmacist
 - 3.10.9 Lab technician



3.10.10 Radiology technician

3.10.11 Security

3.10.12 Cleaner

- 3.11** UCCs must be equipped and maintain an up-to-date and comprehensive list of medications and therapeutic agents, adhering to regulatory standards and tailored to the medical conditions commonly treated in urgent care settings. The minimum required list is mentioned in (Appendix 4), and it can be modified according to the scope and needs of the center.
- 3.12** All staff at UCCs must complete comprehensive, ongoing training and education to ensure the highest standards of patient care and up-to-date medical practices—the list of mandatory courses in (Appendix 5).
- 3.13** UCCs require comprehensive policies encompassing patient care protocols, infection control, staff training and competency, emergency response, medication management, privacy compliance, and facility maintenance to ensure efficient, safe, and high-quality healthcare services (Appendix 6).
- 3.14** UCCs require the implementation of Key Performance Indicators (KPIs) as part of their Quality Assessment and Performance Improvement program to systematically monitor and enhance the efficiency, effectiveness, and quality of patient care services (Appendix 7).
- 3.15** UCCs require well-defined clinical protocols and patient care pathways to ensure standardized, efficient, and high-quality treatment for a wide range of urgent medical conditions (Appendix 8).
- 3.16** For high-acuity cases such as stroke, trauma, or STEMI, the UCCs must have a well-defined and rapid transfer protocol in place involving immediate identification, stabilization, and coordinated communication with the Emergency Department to ensure swift and seamless patient transition for specialized care by cooperation with each service line lead.
- 3.17** Upon recognizing signs of an ST-Elevation Myocardial Infarction (STEMI) in a patient, an UCCs should immediately activate the STEMI protocol in the cluster or where service is provided.
- 3.18** Upon recognizing signs of a stroke in a patient, an UCC should immediately activate the stroke protocol in the cluster or where service is provided.
- 3.19** Upon the arrival of a trauma patient at an UCC, the protocol is activated by immediately triaging the patient to assess the severity of their injuries and swiftly mobilizing the necessary medical staff and resources for urgent treatment in a backup hospital in the cluster or where service is provided.
- 3.20** The RCC must establish a clear and efficient pathway for transferring patients from UCCs to Emergency Departments, ensuring seamless communication, timely patient transport, and proper exchange of medical information between facilities.
- 3.21** Patients who need further clinical care or care out of UCC's scope of service are referred to a higher care system, e.g., ED, through a defined patient-centered referral system either physically or virtually.
- 3.22** The number of health centres that provide urgent care services will be determined according to the needs of health clusters/region catchment areas while considering the proximity to hospitals, emergence demand, and distance.
- 3.23** Eligibility criteria for services at UCCs will be determined and applied by the regulations set by the Ministry of

Health.

- 3.24** Daily statistics shall be collected and reviewed by the UCCs lead and Quality Officer to evaluate the quality and performance of care.
- 3.25** All near misses and adverse incidents shall be reported through the incident reporting system in compliance with MOH regulations.
- 3.26** Patient experience in an UCCs should focus on providing compassionate, efficient, and high-quality care, ensuring patient comfort and satisfaction throughout their visit, from reception to discharge. It should be monitored continuously through systematic collection and analysis of patient feedback, satisfaction surveys, and healthcare outcome data, enabling ongoing improvements in service delivery, staff training, and care quality to meet and exceed patient expectations.
- 3.27** Accurate documentation should be recorded in patients' charts for monitoring and quality improvements.
- 3.28** The policy will undergo regular review and modification to ensure it remains up to date, reflects the latest best practices, and continually meets the evolving needs of our service and stakeholders.

4. PROCEDURES

4.1 Patient Arrival/Visual Nurse:

- 4.1.1 Upon arrival, the visual nurse will initially assess all patients entering the center.
- 4.1.2 The visual nurse is responsible for visually assessing patients as patient arrive, to quickly assess the severity of their conditions. This informal, immediate assessment helps prioritize patients for further evaluation and treatment, particularly in busy settings where triage efficiency is crucial.
- 4.1.3 If the visual nurse detects any concerning cases such as patient with chest pain, shortness of breath, directly send the patient to the critical care area, connect the patient to the cardiac monitor, measure vital signs, obtain the ECG if indicated and inform the physician without delay.

4.2 Desktop/Reception:

- 4.2.1 After the visual nursing process, the patient will be directed to the reception for registration.
- 4.2.2 All patients treated in the UCCs must provide valid identification/Iqama or other approved identification.

4.3 Triage:

- 4.3.1 After calling the patient, the triage nurse is responsible for the initial assessment and prioritization of patients based on the severity of their symptoms and medical needs upon arrival at a healthcare facility.
- 4.3.2 Triage nurses require solid clinical skills, the ability to make quick decisions, excellent communication abilities, and the capacity to work effectively under pressure. Their role is integral to the smooth operation of emergency and urgent care services, ensuring patients receive the right level of care promptly.
- 4.3.3 All patient's objective and subjective complaints to be documented, including;
- 4.3.3.1 Personal information.
- 4.3.3.2 Date and Time of Arrival.
- 4.3.3.3 Arrival Mode.
- 4.3.3.4 Vital Signs.
- 4.3.3.5 Chief Complaint.



4.3.3.6 CTAS Category upon nursing judgment.

4.3.4 The nurse will inform the patient about the expected waiting time based on his/her category (Appendix 1)

4.3.5 Any concerning cases under category 1 or 2 or other categories must be allocated directly to the critical care area, the patient must be connected to a cardiac monitor, and the doctor must be informed.

4.3.6 Retriage in the center involves reassessing patients waiting for treatment to ensure their condition hasn't changed or worsened, thus maintaining prioritization accuracy for timely and appropriate care. It is usually conducted every 30 to 60 minutes, or the patient's condition is needed while in the waiting area to maintain patient safety in the center.

4.3.7 All nursing documentation requirements should be completed at the appropriate time.

4.5 Waiting Area:

4.5.1 Waiting areas aim to provide a safe, comfortable, and efficient environment for patients awaiting medical care, accommodating the varying needs and urgencies in an emergency department.

4.5.2 The characteristics of an urgent care waiting room are designed to cater to the specific needs of a diverse patient population under various levels of distress and urgency. Here are some key characteristics:

4.5.2.1 Space and Layout:

4.5.2.1.1 **Spacious and Accessible:** Adequate space to accommodate patients, their families, and emergency equipment.

4.5.2.1.2 **Wheelchair Accessibility:** Ensuring easy access for patients with mobility issues.

4.5.2.1.3 **Waiting Area Visibility:** The waiting needs to be visible for the triage nurse for safety purposes.

4.5.2.2 Seating and Comfort:

4.5.2.2.1 **Ample Seating:** Comfortable and sufficient seating for patients and accompanying persons.

4.5.2.2.2 **Specialized Seating:** Areas for patients who may need extra space or privacy, such as those with infectious diseases.

4.5.2.3 Safety and Cleanliness:

4.5.2.3.1 **Regular Sanitization:** To prevent the spread of infections.

4.5.2.3.2 **Secure Environment:** Surveillance and security measures to ensure patient and staff safety.

4.5.2.4 Information and Communication:

4.5.2.4.1 **Display Boards:** Showing wait times, patient status updates, and general information.

4.5.2.5 Child-Friendly Zone:

4.5.2.5.1 **Dedicated Area for Children:** To keep them occupied and reduce anxiety.

4.5.2.6 Amenities:

4.5.2.6.1 **Restrooms:** Clean and accessible facilities

4.5.2.6.2 **Vending Machines.**

4.6 Urgent Care Physician Role:

4.6.1 The physician will review the initial nursing triaging and evaluating the patient clinically.

4.6.2 The triage score might be upgraded based on the physician's clinical judgment and diagnostic test.

4.6.3 If the cases fall under categories 4 and 5 and stable, the patient will be treated, prescribed medication, and



discharged.

4.6.4 If the patient's condition is not under the scope of the UCCs. However, the integration between the urgent care physician and emergency physician should be evident through the hotline for further consultation and a pathway to be written.

4.6.5 The emergency transfer among cluster components should be conducted electronically.

4.6.6 If the case is unstable, the transfer will be through the RCC for patient safety.

4.7 Patient Transfer:

4.7.1 If the case must be transferred to a hospital setting after the ED physician advised the transfer, the RCC is activated to transfer the patient safely.

4.7.2 An RCC in patient transport or emergency services typically has a structured and efficient system for receiving calls.

4.7.3 An RCC in the context of patient transport or emergency services typically has a structured and efficient system for receiving calls.

4.7.4 Dedicated Phone Lines: The RCC should use dedicated phone lines or communication channels.

4.7.5 During transferring, the crew must be able to manage cardiac arrest adequately and should have valid ACLS certification. The ambulance must have a functioning defibrillator monitor and emergency drug kit.

4.8 Data Collection:

4.8.1 The UCCs should collect data for continuous quality improvement measures.

4.8.2 The UCCs quality unit should meet on a regular basis to discuss their KPIs and quality improvement measures.

4.9 Urgent Care Facility Design:

4.9.1 The design of an Urgent Care Facility is strategically planned to optimize patient flow, ensure accessibility, and provide the necessary medical infrastructure for rapid, effective treatment of acute health conditions.

4.9.2 Needs Assessment: Evaluate community healthcare needs and patient volume projections.

4.9.3 Site Selection: Choose a location that is accessible and visible.

4.9.4 Compliance with Regulations: Ensure the design adheres to health and safety regulations such as CBAHI and JCI.

4.9.5 Layout Planning: Design a layout that promotes efficient workflow, including separate areas for triage, examination, treatment, and waiting. The layout may be expanded based on the UCC level and need and often include:

4.9.5.1 Waiting Area

4.9.5.2 Visual Triage

4.9.5.3 Reception

4.9.5.4 Triage Room

4.9.5.5 EMS Service

4.9.5.6 Critical Care Area

4.9.5.7 Acute Care Area

4.9.5.8 Respiratory Illnesses Area (Negative Pressure Room)

4.9.5.9 Producer Room

4.9.5.10 Radiology Area



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- 4.9.5.11 Lab Service
- 4.9.5.12 Waste Room
- 4.9.5.13 Security Room
- 4.9.5.14 Administration Offices
- 4.9.5.15 Storage Room
- 4.9.5.16 Pharmacy Room
- 4.9.5.17 Examination Rooms

4.9.6 **Future Flexibility:** Allow for adaptable spaces to meet future healthcare demands.

5. REFERENCES

- 5.1 Canadian Triage and Acuity Scale. (n.d.). Retrieved December 22, 2023, from <https://ctas-phctas.ca/>
- 5.2 Ministry of Health, Saudi Arabia. (2009). Guide to Excellence in Primary Health Care Centers. Retrieved from <https://www.moh.gov.sa/Documents/MOH-Guide-to-Excellence-English.pdf>
- 5.3 National Hospital Standards, The Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI)
- 5.4 Joint Commission International Accreditation Standards for Hospitals
- 5.5 The American College of Emergency Physicians (ACEP)
- 5.6 The National Urgent Care Center Accreditation

6. APPENDIX

- 6.1 Appendix 1: Canadian Triage and Acuity Scale
- 6.2 Appendix 2: Infrastructure/Services
- 6.3 Appendix 3: Equipment/Medical Supplies
- 6.4 Appendix 4: Therapeutic Agent / Medications (Essential)
- 6.5 Appendix 5: Training Requirements
- 6.5 Appendix 6: General Policies
- 6.7 Appendix 7: Quality Assessment and Performance Improvement indicator (KPI)
- 6.8 Appendix 8: Clinical Protocols and pathway (example and not limited)



Appendix 1 Canadian Triage and Acuity Scale

Patients should have an INITIAL TRIAGE ASSESSMENT WITHIN 10 MINUTES* of arrival

TRIASGE LEVEL I - RESUSCITATION

Time to NURSE Assessment
IMMEDIATE*

Time to PHYSICIAN Assessment
IMMEDIATE*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Code / Arrest	Traumatic Shock
Major Trauma	Trauma, Multiple Sites, Multiple Rib Fracture
Shock States	Facial Burns with Airway Compromise
Near Death Asthma	Severe Burns > 30% TBS
Severe Respiratory Distress	Overdose with Hypotension / Unconscious
Altered Mental State (unconscious, delirious)	AAA
Seizures	AMI with Complications / CHF / Low BP
	Status Asthmaticus
	Head Injury - Major / Unconscious
	Status Epilepticus

TRIASGE LEVEL II - EMERGENT

Time to NURSE Assessment
IMMEDIATE*

Time to PHYSICIAN Assessment
15 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury (Risk Features ± Altered Mental State)	Head Injury
Severe Trauma	Trauma, Multiple Sites, Multiple Rib Fracture, Neck Injury / Spinal Cord
Altered Mental State (lethargic, drowsy, agitated)	
Chemical Exposure - Eyes	Alkaline / Caustic Ocular Burns
Allergic Reaction (Severe)	Anaphylaxis
Chest Pain - Visceral, Non-Traumatic	AMI, Unstable Angina, CHF, Chest Pain NOS, Gastroesophageal Reflux
± Associated Symptoms	Unspecified Drug / Medicinal Overdose, "d.t.s"
Overdose (conscious), Drug Withdrawal	AAA, Appendicitis, Cholecystitis
ABD Pain (Age >50) with Visceral Symptoms	
Back Pain (Non Trauma, Not MSK)	
GI Bleed with Abnormal Vital Signs	Gastrointestinal Bleed, Hypotension
CVA with Major Deficit	CVA
Asthma Severe (PEFR <40%)	Severe Asthma
Moderate / Severe Dyspnea / Difficulty Breathing	COPD, Croup
Vaginal Bleeding - Acute, Pain scale >5	Spontaneous Abortion
± Abnormal Vital Signs	Ectopic Pregnancy / Rupture
Vomiting and/or diarrhea (with suspicion of dehydration)	
Signs of serious infection (purpuric rash, toxic)	
Chemotherapy or immunocompromised	
Fever (age ≤ 3 months) Temp ≥ 38.0 (rectal)	Epiglottitis, Meningitis, Sepsis
Acute Psychotic Episode / Extreme Agitation	Acute Psychotic Episode / Agitation
Diabetes: Hypoglycemia, Hyperglycemia	Hypoglycemia, Diabetic Ketoacidosis, Hyperglycemia
Headache (Pain Scale 8 - 10/10)	Migraine
Pain Scale 8-10 (CVA, Back, Eye)	Renal Colic, LBP / Strain (Disc), Keratitis, Iritis
Sexual Assault	
Neonate (≤ 7 days old)	

TRIASGE LEVEL III - URGENT

Time to NURSE Assessment
30 MINUTES*

Time to PHYSICIAN Assessment
30 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, Vomiting	Head Injury
Moderate Trauma	Anterior Dislocated Shoulder, Tibia / Fibula Fracture, Bimalleolar, Trimalleolar Ankle Fracture
Abuse / Neglect / Assault	
Vomiting and/or diarrhea (≤ 2 years)	
Dialysis problems	
Signs of infection	Pyelonephritis
Mild / Moderate Asthma (PEFR > 40%)	Asthma without Status / COPD
Mild / Moderate Dyspnea	Bronchiolitis / Croup, Pneumonia
Chest Pain - No Visceral Symptoms (Sharp/MSK) - No Previous Heart Disease	Chest Pain NOS (MSK, GI, Resp)
GI Bleed with Normal Vital Signs	GI Bleed, No complications
Vaginal Bleeding Acute, Normal Vital Signs	Spontaneous Abortion
Seizure, Alert on Arrival	Seizure
Acute Psychosis ± Suicidal Ideation	Acute Psychosis ± Suicidal Ideation
Pain Scale 8 - 10 / 10 with minor injuries	
Pain Scale 4 - 7 / 10 (Headache, CVA, Back)	Migraine, Renal Colic, LBP / Strain (Disc)

TRIASGE LEVEL IV - LESS URGENT

Time to NURSE Assessment
60 MINUTES*

Time to PHYSICIAN Assessment
60 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, No Vomiting	Head Injury, Alert, No Vomiting
Minor Trauma	Colles Fracture, Ankle Sprain
ABD Pain (Acute)	Appendicitis, Cholecystitis
Earache	Otitis Media / Otitis Externa
Chest Pain, Minor Trauma or MSK, No Distress	Chest Pain NOS (MSK, GI, Resp), Gastroesophageal Reflux
Vomiting and diarrhea (>2 years/no dehydration)	
Suicidal Ideation / Depression	Suicidal Ideation / Depression
Allergic Reaction (Minor)	Urticaria
Corneal Foreign Body	Corneal Foreign Body
Back Pain (Chronic)	LBP / Strain
URI Symptoms	URI
Pain Scale 4 - 7	
Headache (Non Migraine / Not Sudden)	

TRIASGE LEVEL V - NON URGENT

Time to NURSE Assessment
120 MINUTES*

Time to PHYSICIAN Assessment
120 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Minor Trauma, Not Necessarily Acute	LBP / Strain
Sore Throat, No Resp Symptoms	URI
Diarrhea alone (no dehydration)	Gastroenteritis
Vomiting alone normal mental status (no dehydration)	Vomiting
Menses	Disorders of Menstruation
Minor Symptoms	Dressing Changes
ABD Pain (Chronic)	Cast Changes
Psychiatric complaints	Constipation
Pain Scale < 4	Symptoms / Neurotic, Personality and Nonpsychotic Mental Disorders
	Unspecified Superficial Laceration(s)

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Appendix 2: Infrastructure/Services

- Special Needs Accessibility
- Dressing Rooms
- Resuscitation Room
- Electronic Patient Records and Patient Information Systems
- Laboratory
- Imaging Technology (X-Ray Room – CT scan) – Based on UCC Level
- Pharmacy
- Isolation Room
- Triage Room
- Waiting Rooms
- Examination Room (Clinics)
- Observation Beds
- Procedure Room
- Sterilization Room
- Supply Room
- Medical Waste Room
- Reception Area
- Emergency Exits
- Waiting Area
- Reception and Administrative Area
- Online Check-in and Wait Time Monitoring
- Security Room
- Amenities: Restrooms/Toilets
- Signage and Wayfinding: For directions, instructions, and information
- Clear signage visible from the road
- Emergency Vehicle Access: Designated areas for ambulances and emergency vehicles
- Break Rooms
- Parking Facility: Ample parking space for patients and staff, including handicap-accessible spots.
- Handicap Accessibility: Wheelchair-accessible entrances, restrooms, and examination rooms.
- Controlled Access: To restricted areas for authorized personnel only.
- Facilities for Education: Used for staff training, community health education, and meetings.
- Safety and Emergency Equipment: Fire extinguishers, emergency lights, and safety signage, AED (Automated External Defibrillator) and emergency medical kits.
- Storage Space: Secure storage for medical supplies and equipment.
- Filtration systems for maintaining air quality.
- Community Accessibility: Easy access for the local community, including public transportation options.

Appendix 3: Equipment/Medical Supplies and Consumables

- Ultrasound Machine
- Glucose Meters and Strips
- Vital Signs Machine
- ECG Machine with Electrodes and paper.
- Exam Beds
- Otoscope Set
- Fundoscope Set
- Lamp Torch
- Neuro Kit
- Emergency Trolley
- Dressing Trolley
- Oxygen Source
- Infection Control Set
- Water Source
- Crash Cart (Equipped with essential resuscitation tools, including an AED (Automated External Defibrillator), emergency medications, and intubation equipment.)
- Automated external defibrillator
- Defibrillator
- ISTAT Machine (POC)
- Wheelchair
- Stretcher
- Spirometers
- Nebulizers and Related Supplies: For administering inhaled medications.
- IV Stands and Supplies: For intravenous medications and hydration.
- Minor Surgical Instruments: For simple procedures like suturing wounds, draining abscesses, or removing foreign objects.
- Splinting Materials for immobilizing limbs or joints.
- Wound Care Supplies: Various sizes of bandages, gauze, medical tapes, antiseptic solutions, and wound closure strips.
- Suture Kits and Staplers: For wound closure.
- Oxygen Tanks and Delivery Systems
- Suction Devices
- Personal Protective Equipment (PPE)
- Sharps Disposal Containers
- Biohazard Waste Bins
- Urine Test Strips
- Syringes and Needles: Various sizes for injections and aspirations
- IV Catheters, Tubing, and Fluids: For intravenous therapies
- Disinfectants and Antiseptics: Like alcohol swabs, iodine solution, and hydrogen peroxide
- Dressings and Bandages: Various types including sterile and non-sterile options.
- Miscellaneous Supplies: Medical Examination Gloves, Tongue Depressors, Cotton Balls and Swabs, Medical Tapes, Ice Packs and Heating Pads
- Clean and Dirty Utility Rooms: For storing clean supplies and disposing of used materials.
- Height and weight scale for Adult, Pediatric and Infant
- Foley catheter (different size)
- Cervical Collar (semi rigid)



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Ministry of Health

- Pediatric Cervical Collar (semi rigid)
- Spinal Board (Plastic)
- Cast cutter.
- Portable OR lamp.
- Arm sling for pediatric.
- Arm sling for adult.
- Epistaxis instrument and supplies, including balloon posterior packs.
- Extremity splinting and stabilization devices.
- Intraosseous needles and placement equipment.
- Gauze Sterile
- Gauze non-sterile
- Alcohol swab
- IV Cannula (different size)
- Crepe bandage.
- Nasal Cannula
- Oxygen mask (non-rebreather)
- Nebulizers mask (different size)
- Oxygen mask (simple)
- Disposable otoscope specula
- Tongue depressor
- Syringe (different size)
- Needles (different size)
- IV set
- Sutures (different size and type)
- Endotracheal tubes, size 2.5 to 8.5 mm
- Oropharyngeal airway (Different size)
- Nasopharyngeal airway (Different size)
- Bougie airway

Appendix 4: Therapeutic Agent / Medications (Essential)

(The provided medication list is indicative and may be expanded or modified to align with the specific scope of services and emerging needs)

Analgesics and Anti-Inflammatories

- Acetaminophen (Tylenol): For pain and fever.
- Nonsteroidal anti-inflammatory drug (NSAID) for pain and inflammation.
- Naproxen (Aleve): Another NSAID option.
- Aspirin: For pain, inflammation, and as a blood thinner in cardiac cases.
- Opioid Analgesics: Such as morphine or hydrocodone, for severe pain (used under strict regulation).

Antibiotics

- Amoxicillin: Broad-spectrum antibiotic.
- Augmentin.
- Clindamycin.
- Azithromycin (Z-Pak): For respiratory and other infections.
- Ciprofloxacin: For urinary tract and certain other infections.
- Doxycycline: Broad-spectrum, often used for skin and respiratory infections.
- Topical Antibiotics: Like mupirocin for skin infections.

Antivirals

- Oseltamivir (Tamiflu): For early treatment of influenza.
- Acyclovir: For herpes and shingles.

Asthma and COPD Treatments

- Albuterol Inhaler: For acute asthma or COPD exacerbations.
- Ipratropium (Atrovent): As a bronchodilator.
- Oral Corticosteroids: Like prednisone for asthma or COPD flare-ups.

Allergy Medications

- Diphenhydramine (Benadryl): For allergic reactions.
- Epinephrine Auto-Injector (EpiPen): For severe allergic reactions, such as anaphylaxis.
- Steroid Nasal Sprays: Like fluticasone for allergic rhinitis.

Cardiac Agents

- Aspirin: For suspected myocardial infarction.
- Nitroglycerin: For chest pain related to angina.
- Beta-Blockers: Like metoprolol for hypertension and chest pain.

Gastrointestinal Agents

- Ondansetron (Zofran): For nausea and vomiting.
- Loperamide (Imodium): For diarrhea.
- Antacids: For heartburn and indigestion.
- Proton Pump Inhibitors: Like omeprazole for GERD.

Dermatological Preparations

- Hydrocortisone Cream: For skin irritations and rashes.
- Antifungal Creams: For fungal skin infections.
- Sunburn Relief Agents: Like aloe vera gel.

Sedatives and Anxiolytics

- Lorazepam (Ativan): For anxiety and seizures.
- Diazepam (Valium): For muscle spasms and anxiety disorders.

Resuscitation Medication

- Adenosine phosphate 6mg/2ml
- Atropine sulphate inj. 0.1 mg syringe 10ml vial
- Atropine sulphate inj. 0.6mg/ml ampoule
- Amiodarone injection 50mg/1ml ampoule
- Calcium chloride injection 1gm (100mg/ml)
- Dextrose injection 50% 50ml vial
- Adrenaline injection 1:1000 1ml Ampoule
- Isoproterenol HCL inj. 1:5000 2mg 10ml amp
- Lidocaine HCL inj.2% 100mg /5cc syringe
- Magnesium sulphate inj. 50%.2ml vial
- Naloxone injection 0.4mg/ml 1ml amp
- Procainamide hydrochloride inj. 100mg/ml 10ml
- Sodium bicarbonate 8.4% inj.
- Solution injection water 10 ml vial ster



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- Vasopressin injection 20 unit/ml 1ml ampoule
- Verapamil injection 5mg/ml ampoule
- Lasix amp. 20mg.
- Hydrocortisone vial 100mg.
- Isosorbide dinitrate Tab.
- Ketamine
- Etomidate
- Fentanyl
- Midazolam
- Propofol
- succinylcholine
- Rocuronium

Eye and Ear Preparations

- Antibiotic Eye Drops: For bacterial conjunctivitis.
- Steroid Eye Drops: For inflammation.
- Ear Wax Removal Agents.

Hormonal Agents

- Insulin: For diabetic patients with blood sugar issues.

Anticoagulants and Thrombolytics

- Heparin: For thrombosis prevention in high-risk patients.

Respiratory Agents

- Cough Suppressants: Like dextromethorphan.
- Decongestants: For nasal congestion relief.

Emergency Medications

- Glucagon: For severe hypoglycemia.
- Naloxone (Narcan): For opioid overdose.

Miscellaneous

- Saline and IV Fluids: For dehydration and IV medication administration.
- Topical Anesthetics: Like lidocaine for minor procedures.
- Scorpion and Snakes Antivenom.
- Tetanus Toxoid.

Appendix 5: Training Requirements

- Basic Life support Course (BLS) Providers
- Advanced Cardiovascular Life Support (ACLS) providers
- Advanced Pediatric Life Support (PALS) providers
- Airway Management
- Triage Provider Course
- Advance Trauma Life Support Course (ATLS) providers
- ECG Interpretation
- Communication Skills

Appendix 6: General Policies

- Triage Policy
- Eligibility Criteria Policy
- Critical Results Reporting Policy
- Infection Control Policy
- High Alert Medications Policy
- Consultation Policy
- Transfer Policy to Backup Hospital
- Care of Minors
- Patients who leave against medical advice
- Patients who leave without being seen
- Management of Suspected Patients of Abuse, Violence or Neglect
- Internal disaster & Evacuation policy
- Medication Administration
- Code Blue Response (Cardiac Arrest)
- Disaster Preparedness and Response
- Incident Reporting

Appendix 7: Quality Assessment and Performance Improvement indicator (KPI)

- Door to physician (median time)
- Door to ECG in patient with chest pain
- Door to physical departure (median time)
- Total number of UCC visit.
- Left without being seen (total LWBS/total arrival)
- Return visit in 72 hours.
- Number of Urgent care cases transferred to emergency department.
- % of patient's referral to the Hospital ED from each UCC (PHC) in the cluster
- % of CTAS 4, 5 patients' referral to UCC from hospitals ER in the cluster
- Patient Satisfaction
- Quarter report of reported incidents of common causes of risk/harm.

Appendix 8: Clinical Protocols and pathway adult and pediatric (example and not limited)

- Syncope
- Headache
- Gastroenteritis
- Minor injury
- Hyperglycemia
- Minor Head Injury
- Renal colic
- Hypertension
- Bronchial Asthma (Adult and pediatric)