GAHAR AMBULATORY ACCREDITATION STANDARDS

2026

Ambulatory 2026 Draft

Section 1: Accreditation Prerequisites and Conditions

Section Intent:

Transparent and ethical relationships

APC.01 The AHC provides GAHAR with accurate and complete information through all steps of the accreditation process.

Effectiveness

Keywords:
Accurate and complete information

Intent:
During the accreditation process, there are many points at which GAHAR requires data and information. Once the AHC is accredited, it lies under GAHAR's scope to be informed of any changes in the AHC and any reports from external evaluators.

The AHC may provide information to GAHAR verbally, through direct observation, an interview, application, or any other type of communication with GAHAR employees. Relevant accreditation policies and procedures inform the AHC of what data and/or information are required and the period for submission. The AHC is expected to provide timely, accurate, and complete information to GAHAR regarding its structure, AHC scope of work, building, governance, licenses, and evaluation reports by external evaluators. GAHAR requires each AHC to be engaged in the accreditation process with honesty, integrity, and transparency.

Survey process guide:

- GAHAR surveyor may review reports of other accreditation, licensure, inspection, audits, legal affairs, reportable sentinel events, and reportable measures.

Evidence of compliance:

1. The AHC reports accurate and complete information to GAHAR during the accreditation process.
2. The AHC reports accurate and complete information to GAHAR in between accreditation visits.
3. The AHC reports within 30 days any structural changes in the AHC 's scope of work, such as the addition or deletion of more than 20% of medical services (e.g., beds, specialties, staff), building expansions, or demolitions.
4. The AHC provides GAHAR access to evaluation results and reports of any evaluating organization.

Related standards:

IMT.01 Information Management Processes, OGM.01 Governing body structure and responsibilities, OGM.04 AHC Director, QPI.11 Sentinel events

APC.02 The AHC maintains professional standards during the survey.

Effectiveness

Keywords:

Professional standards during surveys

Intent:

A surveyor's aim is to perform their duties and responsibilities and attain the highest levels of performance by implementing the ethical framework that is required to meet the public interest and maintain the reputation of GAHAR. To achieve these objectives, the survey process has to establish creditability, professionalism, quality of service, and confidence. The AHC is expected to maintain professional standards in dealing with surveyors. The AHC is expected to report to GAHAR if there is a conflict of interest between a surveyor and the home care that could affect any of the following values:

a) Integrity
b) Objectivity
c) Professional competence
d) Confidentiality
e) Respect

Survey process guide:

- GAHAR surveyor may observe to ensure that all aspects of the safety, security, confidentiality, privacy, respect, integrity, objectivity, professional competence values, and proper ethical management implementation.

Evidence of compliance:

1. The AHC maintains the values mentioned from a) to e) in the intent during the survey process.
2. Before the survey, the AHC reports any conflict of interest to GAHAR with evidence.
3. During surveys, the AHC ensures that the environment does not pose any safety or security risks to surveyors.
4. During the survey, the AHC avoids media or social media releases without GAHAR's approval.
5. The accredited AHC can use the GAHAR accreditation seal according to GAHAR's rules.

Related standards:

OGM.08 AHC leaders, OGM.15 Ethical Management, CAI.07 AHC advertisement.

Sustaining compliance with accreditation standards

APC.03 The GAHAR accredited AHC ensures continuous compliance with the standards.

Effectiveness

Keywords:

Sustaining compliance with accreditation standards

Intent:

Accreditation requirements are considered the optimum quality, safety, and compliance level for any AHC aiming to unroll in the Universal Health Insurance system. When a AHC is accredited, either conditioned or fully, it is expected that it sustains or improves the same quality score during all subsequent accreditation visits. This standard is not applicable during the first accreditation visit.

Surveyor process guide:

- The GAHAR surveyors may review the AHC's process of frequent assessment of compliance with the safety and regulatory requirements and may review the related corrective action plans.
- GAHAR surveyor may review and observe to check evidence of the AHCs' corrective actions taken in response to GAHAR feedback reports during accreditation period.

Evidence of compliance:

1. The AHC establishes a process for periodic assessment of compliance with accreditation standards.
2. The AHC acts on all feedback and reports received from GAHAR during the accreditation period.
3. The AHC reacts to all GAHAR requirements and reports in a timely manner.
4. The AHC demonstrates (using monitoring tools) compliance with GAHAR Safety Requirements and acts on identified gaps.

Related standards:

QPI.02 Quality improvement Plan, QPI.05 Performance Measures, QPI.12 Sustaining Improvement

Patient-Centeredness Culture

Planning and protecting the patient-centeredness culture

PCC.01 Patient-centered culture is developed and supported by the Multidisciplinary collaboration.

Patient-centeredness

Keywords:

Multidis

ciplinary patient-centeredness

Intent:

Patient-centered culture development and maintenance require careful planning, agile implementation, and close monitoring.

Patient-centeredness culture sustainability requires informing and engaging staff on how to be patient-centered. An assigned personnel shall oversee and support the implementation and maintenance of a patient-centered culture. Participation of patients and their family members should be encouraged to ensure their perspectives are represented, integrated and addressed all aspects of patient-centered care, including patient experiences, satisfaction, complaints, suggestions, and the related procedures and practices. Developing a patient-centered culture requires a collaborative teamwork from multiple disciplines. The ambulatory healthcare centers leadership can develop patient-centered initiatives, but it requires staff adoption and implementation. The team may also go for quick wins till the culture change matures up and becomes an integrated part of daily processes. The ambulatory healthcare centers shall have a plan to guide patient-centered activities practices. The plan addresses at least the following:

a) Create a vision of establishing a patient-centered culture with the required approaches to achieve it.
b) Communicate this vision to multiple stakeholders and staff members.
c) Education and training of the staff to ensure that they understand and can implement patient-centered care practices including empowerment of patients to make an informed choice/decision.
d) Involving the patients in the patient centered activities and initiatives planning.
e) Identify potential obstacles and resistance.
f) Work to remove these obstacles and ease down resistance.

Survey process guide:

- GAHAR surveyor may interview ambulatory healthcare centers leaders to inquire about the strategies and measures in place to plan, assist, and maintain patient-centered practices.
- GAHAR surveyor may interview staff members to ask about patient-centered initiatives.
- GAHAR surveyor may review the terms of references, meeting minutes, and meeting notes of the AHC patient-centered culture committee.

Evidence of compliance:

1. The ambulatory healthcare center has an approved plan fulfilling the detailed practices for patient-centered activities includes elements mentioned in intent from a) to f).

2. Ambulatory healthcare center leadership assign an individual(s) with defined responsibilities and authorities to oversight patient centeredness plan.
3. Responsible staff are aware on a patient-centeredness culture.
4. Ambulatory healthcare center leadership takes action to encourage staff participation in patient-centeredness initiatives.
5. Patient-centered care initiatives are evaluated, and lessons are learned to improve patient-centered care delivery.

PCC.02 Patient and family rights are protected and informed to patients and families.

Patient-centeredness

Keywords:

Patient and family rights

Intent:

Seeking and receiving care and treatment at the ambulatory healthcare center can be overwhelming for patients, making it difficult for them to act upon their rights and understand their responsibilities in the care process. Patients should be able to understand their rights and know how to use them. If for any reason, a patient does not understand his/her right, the ambulatory healthcare center is committed to help the patient to gain knowledge about his/her rights. The ambulatory healthcare center empowered staff members, patients, and families are able to report violations of any patient's or family's rights.

The ambulatory healthcare center provides direction to staff regarding their role in protecting the rights of patients and families. Patients' cultural context, emotional, religious, spiritual needs and other preferences shall be addressed and recognized. Whenever appropriate, provide separate facilities and services for women and men according to their cultural needs. Patient and family rights shall be defined by laws and regulations, and the ethical code of healthcare professionals' syndicates.

The ambulatory healthcare center shall develop a policy and procedures to ensure that all staff members are aware of, respect, and respond to patient and family rights issues when they interact with and care for patients throughout the ambulatory healthcare center. The policy addresses at least the following:

a) Patient and family right to access care if provided by the ambulatory healthcare center.
b) Patient and family right to know the name of the treating, supervising, and/or responsible medical staff member.
c) Patient and family right to receive care that respects the patient's personal values, beliefs, choices and personal preferences including cultural and spiritual.
d) Patient and family rights to be informed and participate in making decisions related to their care.
e) Patient and family right to refuse care and discontinue treatment.
f) Patient and family right to have security, personal safety, privacy, confidentiality, and dignity.
g) Patient and family right to have pain assessed and treated.

h) Patient and family right to make a complaint or suggestion without fear of retribution.
i) Patient and family right to know the price of services and procedures.
j) Patient and family right to seek a second opinion either internally or externally.
k) Patient and family right to have protection from any violations or abuse.

Survey process guide:

- GAHAR surveyor may review patient rights policy and interview staff members to check their awareness.
- GAHAR surveyor may observe patient rights statements availability in the ambulatory healthcare center may also observe how patients receive information about their rights and may check conditions under which patient rights are protected.
- GAHAR surveyor may interview staff to check their awareness on how to manage violations or predict violation as one of the patient and family rights.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that describe the process of defining patient and family rights, as mentioned in the intent from (a) through (k).
2. All staff members are aware of patient and family rights.
3. Patients' rights are posted in all public areas in a way that makes it visible to patients, families, and staff.
4. Patient and family rights are protected in all areas and at all times.
5. Information about patient rights is provided in writing or in another manner in which the patients and their families understand.
6. Violations against patients' rights are reported and analyzed, and corrective action is taken.

Related standards:

PCC.03 Patient and family responsibilities, PCC.04 Patient and family education process, PCC.07 Patient and family feedback, PCC.08 Complaints and suggestions EFS.08 Security Plan, PCC.05 informed consent, OGM.08 billing system

PCC.03 Patients and families are empowered to assume their responsibilities.

Equity

Keywords:

Patient and family responsibilities

Intent:

Patients and their families should be able to identify responsibilities related to the care process. If, for any reason, a patient/family does not understand his/her responsibilities, the ambulatory healthcare center is committed to help him to gain relevant knowledge. The inability to identify these responsibilities might affect the care or the management processes of the patients themselves, their families, and other patients or staff members. The ambulatory healthcare center is responsible for making the patients' responsibilities visible to patients and staff members at all times. The ambulatory healthcare center shall empower staff members, patients, and families to report violations of any patient's or family's responsibilities.

The ambulatory healthcare center shall develop and implement a policy and procedures to ensure that patients are aware of their responsibilities. The policy shall address at least the following:

a) Patients and their families have the responsibility to provide clear and accurate information on the disease/condition including the current and past medical history.
b) Patients and their families have the responsibility to comply with the policies and procedures of the ambulatory healthcare center.
c) Patients and their families have the responsibility to comply with financial obligations according to laws and regulations and ambulatory healthcare center policy.
d) Patients and their families have the responsibility to show respect to other patients and healthcare professionals.
e) Patients and their families have the responsibility to follow the recommended treatment plan.

Survey process guide:

- GAHAR surveyor may review patient responsibilities policy and procedure, corrective action taken when violation against patients' responsibilities is reported.
- GAHAR surveyor may interview staff members to check their awareness of patient and family responsibilities.
- GAHAR surveyor may observe patient responsibility statements availability in the ambulatory healthcare center. The surveyor may also observe how patients receive information about their responsibilities.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that describe the process of defining patient and family responsibilities as mentioned in the intent from (a) through (e).
2. All staff members are aware of patients and families' responsibilities.
3. Patients' responsibilities are posted in all public areas in a way that makes it visible to patients, families, and staff.
4. Information about patient responsibilities is provided in writing or in another manner that the patient understands.
5. Violations against patients' responsibilities are reported and analyzed, and corrective action is taken.

Related standards:

PCC.02 Patient and family rights, PCC.04 Patient and family education process,

PCC.08 Complaints and suggestions, PCC.05 informed consent, ICD.08 plan of care.

Empowerment and involvement of patients and their families

PCC.04 Patients and families' education is provided.

Patient-centeredness

Keywords:

Patient and family education process

Intent:

Patient and family education helps to understand the care process and empower patients and families taking informed decisions. Multiple disciplines contribute to the process of educating patients and families during the course of care processes. The ambulatory healthcare center shall develop and implement a policy and procedures to define the process of patient and family education. All Patient education activities required shall recorded in the patient's medical record. The policy shall address at least the following:

a) Identifying patient and family educational needs that may vary from one patient to another. However, at least the following needs are to be addressed for all patients:
   i. Diagnosis and current condition explanation.
   ii. Plan of care, expected outcome of care, and alternative to the planning of care.
   iii. Discharge instructions.
b) Multidisciplinary responsibility to educate patients and families.
c) Method for education provided, according to patient and family values and level of learning, and in a language and format that they understand.
d) Process of recording patient's educational activities including patient education needs, responsibility of providing education, and method used.

Survey process guide:

- GAHAR surveyor may review a policy describing the patient and family education process.
- GAHAR surveyor may interview staff members to check their awareness of patient and family education process
- GAHAR surveyor may check patient and family education records to assess completion.
- GAHAR surveyor may check the availability of patient education materials.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy guiding the process of patient and family education and includes at least item mentioned in the intent from a) to d).
2. ~~All~~ staff members are aware of patients and families' education process.
3. Patients receive education relevant to their condition.
4. Patient education activities such as patient education needs, the responsibility of providing education, and the method used are recorded in the patient's medical record.
5. Appropriate patient education materials are available as per center's policy.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, PCC.05 Informed consent, PCC.08 Complaints and suggestions, ICD.08 plan of care.

PCC.05 Health education materials are available.

Effectiveness

Keywords:
Health education materials.

Intent:
The ambulatory healthcare center shall provide educational materials for patients and families on certain health topics based on the served community's needs and /or patient condition.

The educational materials may take the form of videos, social media posts, brochures, pamphlets, text messages, or other forms. It is important for the ambulatory healthcare center to make sure that these materials are available when needed, especially during health campaigns, and to ensure that these educational materials are understandable by the target patients, with different languages or pictorial illustrations if needed. Health educational materials shall contain relevant and evidence-based information matching with the individualized patient plan of care.

Education materials should be appropriate for the ambulatory center 's scope of services and the patient's health needs, level of education, language, and culture to support, maintain, and improve their own health and well-being. Education materials may include smoking cessation programs, stress management advice, diet and exercise guidance and substance abuse management.

The ambulatory healthcare center shall develop a clear process, which includes at least the following:

a) Educational materials need to cover each patient's and family's clinical and educational needs.
b) Applying suitable education methods to match with patient and family values, education level, and language.
c) Identify the places for distributing health education materials.

Survey process guide:

- GAHAR surveyor may review the process of describing health educational needs, and may interview staff members to ensure their full awareness.
- GAHAR surveyor may observe health education materials availability for patients in the places and locations identified by the center.

Evidence of compliance:

1. The health educational materials are readily available in the places and locations identified by the ambulatory center.
2. Staff are aware of how to provide the educational material and how to enable the patient to use it.
3. Health education materials contain relevant and evidence-based information.
4. Health education materials are appropriate for readers of varying literacy levels and translated in different languages for foreigner patient groups.

PCC.06 The ambulatory healthcare center has a defined process to obtain informed consent for certain medical processes according to laws and regulations.

Patient-centeredness

Keywords:

Informed consent

Intent:

One of the main pillars to ensure patients' involvement in their care decisions is by obtaining informed consent. To give consent, a patient should be informed about many factors related to the planned care. These factors are required to make an informed decision. Informed consent is a process of getting permission before performing a healthcare intervention on a person, or for disclosing personal information.

The ambulatory healthcare center shall develop and implement a policy and procedures to describe how and where informed consent is used and documented as required by applicable laws and regulations. The policy shall include at least the following:

a) The list of medical processes when informed consent is needed, this list includes:
   i. Anesthesia, moderate and deep sedation.
   ii. Use of blood and donation of blood.
   iii. Surgery and invasive procedures.
   iv. High-risk procedures or treatments including but not limited to (electroconvulsive treatment, radiation, therapy, and chemotherapy… Renal dialysis) and others.
   v. Research, if applicable.
   vi. Photographic and promotional activities, for in which the consent could be for specific time or purpose
b) The likelihood of success and the risk of not doing the procedure or intervention, benefits, and alternatives for performing that particular medical process.
c) Specific informed refusal consent used to document the refusal process in case of refusing or discontinuing a step or steps in the medical care process.
d) Certain situations when consent can be given by someone other than the patient, and mechanisms for obtaining and recording it according to applicable laws and regulations and approved ambulatory healthcare center policies.
e) Required staff training on obtaining informed consent.
f) Consent forms availability in all applicable, relevant locations.
g) The validity requirements for informed consent.
h) Informed consent is available is all relevant areas.

Survey process guide:

- GAHAR surveyor may review a policy describing the patient informed consent process.
- GAHAR surveyor may review a sample of patients' records to check informed consent completion.
- GAHAR surveyor may check the distribution and availability of consent forms in areas where they are mostly needed, such as operating room, dental clinic, endoscopy unit, and others.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy guiding the process of informed consent that includes all elements mentioned in the intent from (a) through (h).
2. All relevant staff members are aware of the consent process.
3. Informed consent given by someone other than the patient complies with laws and regulations.
4. Informed consent is obtained in a manner and language that the patient understands.
5. Informed consent is recorded and kept in the patient's medical record.
6. The most responsible physician obtaining the informed consent signs the form with the patient.

Related standards:

PCC.02 Patient and family rights, PCC.04 Patient and family education process, ACT.07 Patient's care responsibility

PCC.07 Patient-centered waiting spaces are available for various services.

Patient-centeredness

Keywords:
Waiting spaces.

Intent:
Waiting spaces and waiting times are the most critical points in the patient experience. Emotions such as anxiety, fear, confusion, frustration, and annoyance are high when a patient is waiting for a healthcare service for a long time. It is even more frustrating to be combined with uncomfortable seating, a lack of basic human needs, and overcrowding. Therefore, to avoid putting patients under any additional stress, the physical therapy center shall provide comfortable, safe, clean, and well-ventilated waiting spaces, equipped with toilets and potable water, and adequate for the expected number of patients waiting.

Survey process guide:

- GAHAR surveyor may observe waiting space cleanliness, ventilation, lighting, distancing, and safety.
- GAHAR surveyor may check toilets and potable water availability through the waiting areas.

Evidence of compliance:

1. Waiting spaces are lit, ventilated, clean, and safe.
2. Waiting spaces are adequate for the expected number of patients.
3. Waiting spaces are supported by basic human needs such as toilets and potable water.
4. Patients receive information on how long they may wait after their registration.

Related standards:
PCC.02 Patients and family rights, EFS.01 environment and facility safety.

Responding to patient needs

PCC.08 The patient's dignity, preferences, privacy, and confidentiality are protected during all care processes, such as assessments and care.

Patient-centeredness

Keywords:
Dignity, preferences, privacy, and confidentiality.

Intent:
One of the most important human needs is the desire for respect and dignity. The patient has the right to receive care that is respectful and considerate at all times, in all circumstances. Ambulatory healthcare centers must provide care that respects patients' emotional, religious, spiritual, and personal preferences. Healthcare providers should receive training in cultural competence with a focus on sensitivity to religious and spiritual beliefs to promote respectful and effective interactions with patients from diverse backgrounds. Patient privacy, particularly during assessments, care, and transport, is important. Patients may desire privacy from other staff, from other patients, or even from accompanying family members. The Ambulatory healthcare center shall deal with the patient's information as confidential and shall implement processes to protect such information from leakage, loss, or misuse.

Survey process guide:

- GAHAR surveyor may observe locations for patient care to assess if privacy and confidentiality are maintained.
- GAHAR surveyor may interview patients to assess how they are satisfied and involved in the decision of allowing persons who can attend the patient assessment process.
- GAHAR surveyor may interview staff or patients to inquire about emotional, religious, and spiritual needs and how some routine functions may be adjusted based on these needs.

Evidence of compliance:

1. Places of providing care ensure that the care is respectful and considerable for the patient's dignity and self-worth.
2. Patient privacy is respected for all physical therapy assessments, care, and transport.
3. Patients' emotional, religious, and spiritual needs are identified and documented in patient medical records.
4. Confidentiality of patient information is maintained according to laws and regulations.
5. Patients are allowed to decide who can attend their assessment or care processes.

Related standards:
PCC.02 Patients and family rights, ICD.04 Individualized plan of care, IMT.02 Confidentiality and security

PCC.09 The ambulatory healthcare center's responsibility towards the patient's belongings is defined.

Patient-centeredness

Keywords:
Patient's belongings

Intent:

Patient's belongings may include clothing, dentures, hearing aids, eyeglasses or contact lenses, or valuables such as jewelry, electronic devices, cash, and credit/debit cards. The ambulatory healthcare center shall develop and implement a policy and procedures to accept custody of patients' belongings or not. Ambulatory healthcare centers shall accept custody of patient's belongings for the patient's best interests; and especially if the patient is not capable of being responsible for the belongings and family is unavailable to take custody for their belongings. Ambulatory healthcare center policy address at least the following:

a) Determine the facility's level of responsibility for patient belongings.
b) How patients and families are informed about the Ambulatory healthcare center's responsibility for belongings.
c) Clarify the accountability of staff who have the responsibility for managing patient's property.
d) Ensure that there are safe and appropriate procedures in place to manage patient's property.
e) Define lost and found process, lost and found items shall be recorded, protected, and returned when possible; the ambulatory healthcare center shall define a clear process to follow when items are not returned within a defined timeframe.

Survey process guide:

- GAHAR surveyor may review the policy that guides ambulatory healthcare center responsibilities for patient's belongings.
- GAHAR surveyor may interview staff members to check their awareness of the ambulatory healthcare center policy.
- GAHAR surveyor may observe posters, brochures, or other means of communication that inform patients about ambulatory healthcare center responsibility.
- GAHAR surveyor may review security records and cabinets where patient belongings are kept and recorded.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy guiding ambulatory healthcare center responsibilities for patient's belongings as mentioned in the intent from a) through e).
2. Responsible staff members are aware of the ambulatory healthcare center's policy.
3. Information about the ambulatory healthcare center's responsibility for belongings is given to the patient or family, as applicable.
4. Records of patient's property management are available and matching the cabinet's contents.
5. Lost and found items are recorded, protected, and returned when possible.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, EFS.08 Security Plan

Responsiveness to patients' and families' voices

PCC.10 The ambulatory health care center improves its provided services based on measured patient and family feedback.

Patient-Centeredness

Keywords:

Patient and family feedback.

Intent:

Patient and family feedback could include concerns, compliments and formal complaint through surveys that may help ambulatory healthcare center to identify ways of improving clinical and non-clinical performance. Ambulatory healthcare center can solicit feedback from patients in a variety of ways: phone surveys, written surveys, focus groups, or personal interviews. Many ambulatory healthcare centers shall use written surveys, which tend to be the most cost-effective and reliable approach. The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of managing patient feedback.

The ambulatory healthcare center shall define if the process addresses the measurement of patient experience or patient satisfaction.

For patient experience, the ambulatory healthcare center shall assess whether something that should happen in a healthcare setting (such as clear communication with a healthcare professional) actually happened or for how long it happened. While for patient satisfaction, the ambulatory healthcare center shall measure whether a patient's expectations about a health encounter were met. Measuring alone is not enough. Ambulatory healthcare centers need to analyze and interpret information obtained from measured feedback and identify potential improvement projects or plan for new services.

Survey process guide:

- GAHAR surveyor may review the policy of patient and family feedback.
- GAHAR surveyor may observe the process of using patient and family feedback for performance improvement

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy guiding the process of patient and family feedback measurement.
2. Feedback from patients and families is received, analyzed and interpreted in a timely manner.

3. The interpreted feedbacks have been communicated with the concerned staff members.
4. The ambulatory healthcare center monitors the reported data on patients' and families' feedback and takes actions to control, improve the process or plan for new services as appropriate.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, PCC.08 Complaints and suggestions, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan

PCC.11 Patients and families are able to make oral, written complaints or suggestions through a defined process.

Patient-Centeredness

Keywords:

Complaints and suggestions.

Intent:

While Ambulatory health care center shall be able to proactively measure and use patient's feedback, patients and families may also want to give oral or written anonymous complaints or suggestions about their care and to have those complaints or suggestions reviewed and acted upon. The Ambulatory health care center shall develop and implement a policy and procedures to create a uniform system for dealing with different complaints and suggestions from patients and/or their families to make it easy to follow up, monitor, and learn from practices. Ambulatory health care center policy shall address at least the following:

a) Mechanisms to inform patients and families of communication channels to voice their complaints and suggestions.
b) Tracking processes for patient and family complaints and suggestions.
c) Responsibility for responding to patient complaints and suggestions.
d) Timeframe for giving feedback to patients and families about voiced complaints or suggestions and advising the patient of progress and outcome.
e) Monitor the reported data on patient' complaints and take actions to control or improve the process.

Survey process guide:

- GAHAR surveyor may review the policy of managing patient complaints and suggestions.
- GAHAR surveyor may interview staff to check their proper awareness.
- GAHAR surveyor may review the reported data on patients' complaints and suggestions to assess the process of managing patient suggestions and complaints.

Evidence of compliance:

1. The ambulatory health care center has an approved policy guiding the process of managing patients' complaints and suggestions as mentioned in the intent from (a) through (e).
2. Staff is aware of complaints and suggestion process.
3. The ambulatory health care center allows the complaining process to be publicly available.

4. Complaints and suggestions are investigated, analyzed by the ambulatory health care center, and resolved in a defined timeframe.
5. Patients and families receive feedback about their complaints or suggestions within approved timeframes and according to the level of urgency of the complaint.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, PCC.07 Patient and family feedback, QPI.02 Performance Measures, QPI.08 Performance improvement and patient safety plan.

Access, Continuity, and Transition of Care

Effective and safe patient flow-in the ambulatory healthcare center

ACT.01 The ambulatory healthcare center advertisements are clear and comply with applicable laws, regulations, and ethical codes of the healthcare professionals' syndicates.

Patient-centeredness

Keywords:
Ambulatory healthcare center advertisement

Intent:

Usually, ambulatory healthcare centers use advertisements as an important tool to improve the utilization of services. Good advertisement aims to help the community having a better understanding of the available health services. Ambulatory healthcare centers might use newspapers, TV advertisements, banners, brochures, pamphlets, websites, social media pages, call centers, SMS messaging, mass emailing, or other media to advertise provided services.

According to Egyptian laws and regulations, an advertisement for healthcare services should be done honestly. Medical syndicate, nursing syndicate, pharmacists syndicate, and others addressed honesty and transparency as high values in their codes of ethics. The ambulatory healthcare center can start complying with this standard by exploring the relevant laws, regulations, and ethical codes and finding out how they apply to the ambulatory healthcare center advertisement/communication plan. Information must be accurate, updated, and clearly communicated about types of services, healthcare professionals, cost of services (when relevant), and working hours.

Survey process guide:

GAHAR surveyor may check ambulatory healthcare center website, social media, or other forms of advertisement at any time from the receiving of application and assigning of surveyors until sending the survey report. Advertisements may be matched with the application information and with survey visit observations.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy guiding the process of providing clear, updated, and accurate advertisements of services.
2. Advertisements are done in compliance with applicable laws, regulations, and ethical codes of healthcare professionals' syndicates.
3. Patients and their families receive clear, updated, and accurate information about the ambulatory healthcare center's services, healthcare professionals, cost of each service (when relevant), and working hours.
4. Violations of advertisements or providing false information to the community are subjected to actions according to the ambulatory healthcare center's code of ethics.

Related standards:

PCC.02 Patient and family rights, OGM.12 Ethical Management, OGM.04 Scope of services, ACT.01 granting access.

ACT.02 The ambulatory healthcare center grants patients access to its services according to pre-set eligibility criteria.

Patient-centeredness

Keywords:

Granting access.

Intent:

Services available shall be relevant and effective for the served population to gain access to satisfactory health outcomes. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs, and material and cultural settings of diverse groups in society, such as not hindering women by offering female healthcare professionals when and where it is relevant. Pre-set criteria need to be available for those responsible for granting access to patients. In order to improve accessibility to the ambulatory healthcare center services, patients and families should be well informed about the available services, as patients with the same needs may vary in terms of age, abilities, language, and cultural context, or they may present other barriers that make the process of accessing and receiving care difficult.

The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of patient granting access. The policy addresses at least the following:

a) The process of general, non-specific screening of patients that aims to determine that the ambulatory healthcare center scope of services can meet their healthcare needs.
b) How to inform patients of the accessibility methods.
c) Actions to be taken if the patient needs do not match the ambulatory healthcare center scope of service

Survey process guide:

- GAHAR surveyor may review the policy describing the patient granting access process.
- GAHAR surveyor may observe the process for informing patients about criteria of granting access at the point of the first contact in the ambulatory healthcare center (such as service desks, receptions, call centers, emergency rooms, and outpatient areas).
- GAHAR surveyor may interview patients to assess their awareness of the information given about concerning services that are suitable for their needs.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy for granting access to patients that addresses all elements mentioned in the intent from a) through c).
2. Staff is aware of the granting access policy.
3. The ambulatory healthcare center has a defined process for informing patients and families about services that are suitable for their needs.
4. When a patient's healthcare needs do not match the ambulatory healthcare center scope of service, the patient is referred and/or transferred to another healthcare organization or given assistance in locating the service.

Related standards:

PCC.02 Patient and family rights, ACT.03 Physical access and comfort, ACT.05 Patient's flow and uniform access, ACT.06 Coordination and continuity of care, ACT.10 Patient's transfer, referral and discharge, ICD.04 screening of healthcare needs, PCC.01 ambulatory healthcare center advertising.

ACT.03 The ambulatory healthcare center ensures comfortable and easy physical access.

Patient-centered

Keywords:
Physical access and comfort

Intent:

Community members often encounter barriers to healthcare that limit their ability to obtain the care they need. In order to have sufficient access, necessary and appropriate healthcare services should be available and obtainable in a defined timeframe manner. Even when an adequate supply of healthcare services exists in the community, there are other factors to consider in terms of healthcare access. For instance, to have good healthcare access, a patient should also have the means to reach and use services, such as transportation to services that may be located at a distance. Ambulatory healthcare centers shall provide infrastructure that accommodates patients with special needs, including features such as designated handicapped parking, wheelchair-accessible entrances, toilets designed for disabled patients, and walking rails. These measures ensure that healthcare services are physically accessible to patients with various types of disabilities.

Survey process guide:

- GAHAR surveyor may observe the ambulatory healthcare center access, identifying potential blockages of access such as the absence of nearby public transportation, presence of a physical barrier like a canal or even absence of clear signs to direct patients in.
- GAHAR surveyor may observe the availability of ramps, wheelchairs, and trollies to ensure accessibility for patients with disabilities.

Evidence of compliance:

1. The ambulatory healthcare center has a defined process that guides safe physical access through multiple means of transportation, either private, public, or both.
2. The ambulatory healthcare center's services are accessible for patients with disabilities.
3. Measures as ramps, wheelchairs and trollies are available for served patients.
4. Barriers to access the ambulatory healthcare center services are identified and proper corrective actions are taken.

Related standards:

PCC.02 Patient and family rights, ACT.01 granting access,

ACT.05 Patient's flow, EFS.01 Ambulatory healthcare center environment and facility safety structure.

Effective and safe patients flow within the ambulatory healthcare center.

ACT.04 Appropriate and clear wayfinding signage are used to help patients and families to easily reach their destination inside the ambulatory healthcare center.

Safety

Keywords:
Wayfinding signage

Intent:

Wayfinding systems aim to help ambulatory healthcare center to reduce their patients' stress by providing easy-to-follow signage and legible directions to their destinations. Wayfinding signage is important for the prospective patients as they need to find their way and its design should be suitable for all types of patients, good lighting is very important. Signage needs to be readable in different lighting conditions and in different weathers (if the signage is used outdoors). In some settings, reliance on text-based signs is minimized, and systems rely heavily on non-text signs such as colors and symbols.

Survey process guide:

GAHAR surveyor may observe wayfinding signs readability, clarity, and acceptability. Wayfinding signs may include all those signs encountered by patients during their journey in the ambulatory healthcare center.

Evidence of compliance:

1. All ambulatory healthcare center areas are identified with signs.
2. Staff is fully aware of wayfinding signage used.
3. Clear, readable, illuminated wayfinding signs are used in all relevant places and areas during working hours to reduce patient and family confusion.
4. When color-coded signage is used, clear instructions on what each color means should be available.

Related standards:

PCC.02 Patient and family rights, ACT.05 Patient's flow and uniform access, EFS.01 Ambulatory healthcare center environment and facility safety structure.

ACT.05 The ambulatory healthcare center has a process in place guiding patient registration and flow pathways.

Patient-centeredness

Keywords:

Registration process

Intent:

Patient registration is a starting point for community members to benefit from the healthcare system services. it involves collecting of patient demographic information such as personal and contact information, collection of patient health history, and checking of health payer coverage. If not managed well, it may discourage patients from pursuing care.

The ambulatory healthcare center shall develop and implement policies and procedures to guide the registration process and flow pathways. The policy includes at least the following:

a) Criteria for reception/registration staff to make consistent decisions, including patients who may need immediate assistance and when medical staff should be notified.
b) Minimum information required to register the patient.
c) Coordinating patient flow between necessary services.
d) Minimum information required for the registration process and flow of patients are visible to patients and families at the point of the first contact and in public areas in a manner and language that the patient understands.

When there is a delay in care or treatment, or there are known long waiting periods for diagnostic and/or treatment services that require the patient to be placed on a waiting list, the patient is informed of the reasons for the delay or wait and informed of available alternatives.

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center policy and related documents guiding the registration process.
- GAHAR surveyor may interview staff to ask about their awareness and how to inform patients for reasons of the delay or wait.
- GAHAR surveyor may observe patient registration areas in the ambulatory healthcare center, such as receptions, call centers, or registration offices to assess compliance with the policy.
- GAHAR surveyor may observe the availability of information related to the registration process and patient flow in registration areas, either in the form of brochures, posters, digital or verbal messages, or any other means.
- GAHAR surveyor may also trace different patients to ensure that their registration processes are uniform.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy guiding registration process and flow pathways that addresses all elements mentioned in the intent from a) through d).
2. All staff members involved in patient registration and flow pathways are aware of the policy.
3. The registration process and patient flow information are available and visible to patients and families at the point of the first contact and in public areas in a manner and language that the patient understands.
4. There is a standardized process in place for registering patients based on the scope of services provided.
5. The registration process is managed to give priority to patients with urgent needs.
6. Patients are informed of the reasons for delays and provided with available alternatives based on clinical needs.

Related standards:

PCC.02 Patient and family rights, ACT.04 Wayfinding signage, ACT.03 Physical access and comfort, ACT.06 Coordination and continuity of care, ACT.09 Safe patient transportation, EFS.01 Ambulatory healthcare center environment and facility safety structure

ACT.06 NSR.01 Accurate patient identification through at least two unique identifiers to identify the patient and all elements associated with his/her plan of care.

Safety

Keywords:

Patient identification.

Intent:

Providing care or performing interventions on the wrong patient are significant errors, which may have grave consequences. Using two identifiers for each patient is the key driver in minimizing such preventable errors, which is especially important with the administration of high alert medications or performing high risk or invasive procedures.

The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of patient identification. The policy addresses at least the following:

a) Two unique identifiers (personal).
b) Occasions when verification of patient identification is required.
c) Elements associated with care such as medications, clinical specimens, blood and blood products and others.
d) Methods to document identifiers such as wristbands, ID cards, and others.
e) The exclusion criteria for the patient identification such as the patient's bed number, patient's room number and others.
f) Special situations when patient identification may not follow the same process, such as for unidentified patients, disasters and others.

Survey process guide:

- GAHAR surveyor may review patient identification policy.
- GAHAR surveyor may review a sample of medical records and check correct patient identification in each sheet as per center's policy.

GAHAR surveyor may interview the healthcare professionals, to check their awareness of the ambulatory healthcare center policy and ensure their usage of at least two unique patient identifiers before procedures such as blood sampling, medications administration…etc.

- GAHAR surveyor may observe patient identification wristbands for the two identifiers and to observe the patient identification process before any planned procedures or care.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy and procedure for patient identification that addresses all elements mentioned in the intent from a) through f).
2. All healthcare professionals are aware of ambulatory healthcare center policy.
3. Patient identification is conducted before performing diagnostic procedures, providing treatments, and performing any procedures.
4. The patient's identifiers are recorded in each sheet of the patient's medical record.
5. The ambulatory healthcare center monitors the reported data on patients' identification and takes actions to control or improve the process as appropriate.

Related standards:

DAS.04 Medical imaging pre-examination process, DAS.11 Laboratory pre-examination process, Minimum retesting, DAS.12 Specimen reception, tracking and storage, DAS.16 Laboratory -post examination process, Laboratory- turn-around time, STAT, DAS.24 Distribution and transfusion of blood and blood components, SAS.13 Time-out, MMS.05 Safe medication prescription_ Medication reconciliation, IMT.05 Patient's medical record management

ACT.07 The ambulatory healthcare center designs and carries out processes to ensure continuity of patient care services.

Patient-centeredness

Keywords:

Coordination and continuity of care.

Intent:

Throughout all phases of access to care and continuity of care, patient needs are matched with the required resources within the ambulatory center or outside when necessary. Continuity is enhanced when the healthcare professionals get the required information from patients about the current situation and past history that will help in patient diagnosis and decision-making. For patient care to appear seamless, the ambulatory center needs to design and to implement processes for continuity and coordination of care, prioritize of patient clinical needs, setting criteria for patient end of care or transfer/referral process.
The responsible staff work together to design and to implement the processes of care coordination and continuity. These processes may be supported with the use of tools such as guidelines, clinical pathways, care plans, referral forms and checklists.
Ambulatory healthcare centers shall offer care to patients whose needs can be met within the capabilities of the centers' staff and scope of services. Appropriateness of care shall be based upon patient assessments, re-assessments, and desired outcomes. Provided care shall be uniformed for all ages regardless of national or ethnic origin, economic status, lifestyle, or beliefs.

The ambulatory healthcare centers shall develop a policy that addresses all the above-mentioned components of continuity of care, including patients' referral when their needs do not match the center's scope of services.

Survey process guide:

- GAHAR surveyor may review coordination and continuity of care policy that describes the components of continuity of care, including patients' referral when their needs do not match the center's scope of services.
- GAHAR surveyor may interview healthcare professionals to check their awareness of the approved policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all components of coordination and continuity of care.

2. Responsible staff is aware of the coordination and continuity of care policy.
3. Continuity and coordination of care are evidenced and documented throughout all phases of patient care.
4. The patient's medical record(s) is available and categorized to involve and document all phases of patient care.

Related standards:

PCC.02 Patient and family rights. ACT.01 granting access, ACT.05 Patient's flow and uniform access, ACT.07 Patient's care responsibility, ACT.08 Handover communication, ACT.10 Patient's transfer, referral and discharge, ICD.01 Uniform care provision, ICD.09 Consultation process

ACT.08 The ambulatory healthcare center ensures safe, effective and clear responsibilities for patient care.

Safety

Keywords:

Patient's care responsibility.

Intent:

Patients often require concurrent care from more than one healthcare professional in ambulatory healthcare centers. Patients of large clinics or other healthcare facilities may also be cared for by more than one physician.

The term *most responsible physician* (MRP) generally refers to the physician who has overall responsibility for directing and coordinating the care and management of an individual patient at a specific point in time. Misunderstandings about who among the healthcare team is responsible for a patient's care may compromise that care and may result in an adverse event and increased medicolegal risk.

The ambulatory healthcare center shall identify the most responsible physician who shall properly manage handovers of care to reduce the possible medico-legal risks that arise and prevent potential breakdowns in the chain of communication between both patient and healthcare providers.

The identity of who will act as MRP for a patient should be determined early and based on the particular circumstances of each case. It should be clear in the patient's medical record, which the physician is designated as the MRP. While typically the attending or admitting physician will be the MRP, this may not always be the case.

The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of assigning patient care responsibility. The policy addresses at least the following:

a) Each patient is assigned to one Most Responsible Physician (MRP) as relevant to a patient's clinical condition.

b) Conditions to request and grant transfer of care responsibility.
c) How information about assessment and care plan, including pending steps, can be transferred from the first most responsible physician to the next one. (handover)
d) The process to ensure clear identification of responsibility between transfer of responsibility parties.

Survey process guide:

- GAHAR surveyor may review the policy for assigning patient care responsibility.
- GAHAR surveyor may interview medical staff members to ensure their awareness of the ambulatory healthcare center's policy.
- GAHAR surveyor may review a sample of patients' medical records to identify who is the most responsible physician for checked patients. Identified gaps may be assessed by interviewing other healthcare professionals to check the consistency.
- GAHAR surveyor may observe the process of transfer of care responsibility.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy and procedure for assigning patient care responsibility that address all elements mentioned in the intent from a) through d).
2. The medical staff is aware of the contents of the policy.
3. The patient's medical record identifies the physician responsible for care.
4. In cases of transfer of care responsibility, clear handover is signed by the most responsible physician and documented in patient medical record.

Related standards:

PCC.02 Patient and family rights, ACT.06 Coordination and continuity of care, ACT.08 Handover communication, ACT.10 Patient's transfer, referral and discharge, WFM.03 Job Description

ACT.09 GSR.06 The ambulatory healthcare center ensures standardized accurate and complete handover communication process.

Safety

Keywords:

Handover communication

Intent:

The primary objective of a 'handover' is the direct transmission of accurate patient care information among staff members to ensure the continuity of care. Moreover, it provides a chance for clarifications, which subsequently decreases medical errors.
The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of handover communication. The policy addresses at least the following:

a) Use of standardized methods, forms, or tools to facilitate consistent and complete handovers of patient care; such as SBAR, ISOBAR, I PASS the BATON, and others.
b) Situations that require implementing handover process and tools between healthcare professionals.
c) Assign staff responsibilities.
d) Recording of the process, such as handover logbook, endorsement form, electronic handover tool, and/or other methods as evidence of implementation.

Handover forms or tools are not required to be part of the medical record, and the detailed information communicated during the handover is not required to be documented.

Survey process guide:

- GAHAR surveyor may review the policy of handover communication and check the process implementation.
- GAHAR surveyor may review medical records, handover logbooks, endorsement form, electronic handover tool, and/or other methods as evidence of implementation.
- GAHAR surveyor may interview staff to check their awareness of handover policy and procedures.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all elements mentioned in the intent from a) through d).
2. All healthcare providers are aware of how to apply the policy.
3. Handover communications records are available as per center's policy.
4. The ambulatory healthcare center acts on the findings and results identified in the handover communication process.
5. The ambulatory healthcare center monitors the reported data on handover communication and takes actions to control or improve the process as appropriate.

Related standards:

ACT.06 Coordination and continuity of care, ICD.01 Uniform care provision, ICD.10 verbal and telephone orders, ICD.11 critical results

ACT.10 The ambulatory health care center coordinates and provides patient transportation to meet patients' needs.

Safety

Keywords:

Safe patient transportation.

Intent:

Transportation in this standard refers to the act of lifting, maneuvering, positioning, and moving patients from one point to another point under the custody of ambulatory healthcare center staff members.

Evidence-based research has shown that safe patient handling interventions can significantly reduce overexertion injuries by replacing manual patient handling with safer methods. The ambulatory healthcare center should coordinate patient transportation between different departments and services. The ambulatory healthcare center should be able to meet patient needs within an approved timeframe, especially in critical conditions. Patient transportation should be facilitated and coordinated within the available services and resources. The ambulatory healthcare center shall develop and implement a policy and procedures for managing patient transportation. The policy addresses at least the following:

a) Safe patient handling to and from examination bed, trolley, wheelchair, and other transportation means.
b) Staff safety while lifting and handling patients.
c) A Coordination mechanism to ensure safe transportation within the approved timeframe, especially in critical conditions.
d) Competence of responsible staff members for transportation of patients depending on the type of the patient being transferred.
e) Defined criteria to determine the appropriateness of transportation needs.

Survey process guide:

- The GAHAR surveyor may review the policy for patient transportation.
- GAHAR surveyor may also interview healthcare providers to check their awareness of the policy.
- GAHAR surveyor may review a sample of medical records to assess the process implementation and ensure compliance with the policy.
- GAHAR surveyor may observe the mechanisms of lifting, handling, and/or transporting patients during the survey.
- GAHAR surveyor may observe equipment used for lifting, handling, and/or transporting patients during ambulatory healthcare center tracers and tours.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. All staff members involved in the transportation of patients are aware of the ambulatory healthcare center's policy.
3. Competent staff members are allowed to lift, handle, and transport patients.

4. Transportation of patients occurs in a safe, appropriate manner and within an approved timeframe.
5. Requirements for transporting patients in critical conditions are identified, used, and timely recorded in the patient's medical record.

Related standards:

ACT.05 Patient's flow and uniform access, EFS.01 Ambulatory healthcare center environment and facility safety structure, ACT.10 Patient's transfer, referral and discharge.

Effective and safe patients flow-out of the ambulatory healthcare center

ACT.11 Processes of patient transfer outside the ambulatory healthcare center, referral and discharge of patients are defined.

Safety

Keywords:

Patient's transfer, referral and discharge.

Intent:

Discharge from the ambulatory healthcare center is the point at which the patient leaves the ambulatory healthcare center and returns home.

A referral is when the patient leaves the ambulatory healthcare center to seek additional medical care temporarily in another organization. A transfer is when the patient leaves the ambulatory healthcare center to another organization, such as a tertiary care organization, to a rehabilitation organization. Discharge, referral, and transfer involve the medical instructions that the patient will need to fully recover.

For ambulatory healthcare centers, an effective patient referral system is an integral way of ensuring that patients receive optimal care at the right time and at the appropriate level, as well as cementing professional relationships throughout the healthcare community. Recording and responding to referral feedback ensures continuity of care and completes the cycle of referral. The ambulatory healthcare center shall develop and implement a policy and procedures to guarantee the patient referral within an approved timeframe, which is based on the identified patient's needs that are guided by clinical guidelines/protocols.

Discharge summery is a communication tool that helps clinicians outside the center understand what happened to the patient during his patient care journey.

An essential part of this process is the documentation of a discharge summary as it is considered a legal document, and it has the potential to jeopardize the patient's care if errors are made. A copy of the discharge summery shall be kept in the patient medical record.

The ambulatory health care center shall identify conditions that require obtaining a discharge summery. The components of discharge summery shall be determined in the ambulatory health care center policy.

The discharge, referral, and/or transfer policy addresses at least the following:

a) Planning for discharge, referral, and/or transfer out begins once diagnosis or assessment is settled and, when appropriate, includes the patient and family.
b) The discharge, referral/transfer process documentation requirements include at least the following:
    i. Reason for admission/referral/transfer.
    ii. Collected information through assessments and care.
    iii. Medications and provided treatments.
    iv. Transportation means and required monitoring.
    v. Condition on discharge or referral/transfer.
    vi. Destination on discharge or referral/transfer.
    vii. Any special discharge instructions for the patient including diet, medications, etc.
    viii. Patient details, discharge or referral/transfer' date and time.
    ix. Name and signature of the medical staff member who decided the patient discharge or referral/transfer.
c) A qualified individual is responsible for ordering and executing the discharge, referral, and/or transfer out of patients.
d) Defined criteria determine the appropriateness of referrals and transfers-out are based on the approved scope of service and patient's needs for continuing care.
e) Coordination with transfer/ referral agencies, if applicable, other levels of health service and other organizations.

Survey process guide:

- GAHAR surveyor may review a policy that describes the ambulatory healthcare center processes for referrals, transfers, and discharges.
- GAHAR surveyor may interview staff especially the healthcare providers to check their awareness of the policy.
- GAHAR surveyors may observe patient wards to assess the process.
- GAHAR surveyors may review a sample of closed patient's medical records for patients who were transferred, referred, or discharged to ensure completeness.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all elements mentioned in the intent from a) through e).
2. All staff members involved in discharge, referral, or transfer of patients are aware of how to apply the policy.
3. The discharge, referral, and/or transfer out is recorded in the patient's medical record using all the required elements from i) through ix).
4. The referral and/or transfer feedback is reviewed, signed, and recorded in the patient's medical record.

Related standards:

PCC.02 Patient and family rights, ACT.01 granting access, ACT.06 Coordination and continuity of care, ACT.07 Patient's care responsibility, ACT.09 Safe patient transportation.

ACT.12 The ambulatory healthcare center defines the access and scope of clinical telemedicine services delivered and the associated technological modalities used for various types of patient encounters.

Effectiveness

Keywords

Telemedicine

Intent

Telemedicine refers to the remote diagnosis and treatment of patients using telecommunications technology. It allows healthcare professionals to evaluate, diagnose, and treat patients at a distance, typically through video conferencing, phone calls, secure messaging platforms, or other virtual communication tools. Telemedicine enables patients to receive medical care without physically visiting a healthcare facility, which can be especially beneficial for individuals with limited mobility, those living in remote areas, or those seeking more convenient access to healthcare services.

In addition to direct patient care, telemedicine platforms can be utilized for consultations between specialists and general practitioners, mentorship programs where experienced physicians provide guidance to less experienced colleagues, and case discussions among interdisciplinary teams. This standard is applicable only when the ambulatory healthcare center scope of services includes telemedicine service.

Teleradiology is one of the telemedicine modalities that facilitates the transmission and interpretation of medical images remotely. It enhances the diagnostic capabilities of the healthcare center through secure imaging protocols, specialized software applications, and qualified radiologist interpretation, contributing to timely and accurate clinical decision-making.

To ensure consistency, quality, and efficiency in the delivery of telemedicine services, the facility shall develop a program that is overseen by a qualified director and experienced clinical director The program addresses at least the following:

a) Define the scope of services and the technological modalities used.
b) The appropriate telemedicine platforms, mobile or internet–based applications, and other peripheral devices to be used in accordance with recommended industry guidelines.
c) The resources required to sustain the planned telemedicine clinical services based on program goals.
d) The training required for employees, participating providers, and other technical personals specific to telemedicine services.
e) The process of overseeing outsourced telemedicine services or functions.
f) A clear method for the patient to initiate an encounter for telemedicine services.
g) The process to verify and document patient/provider identities and physical locations for each telemedicine encounter.
h) Adherence to generally accepted evidence-based guidelines relevant to the clinical services used for patient encounters.

i) The process for referring patients to direct patient care, if indicated, based on objective and physiologically based criteria.
j) The process of ensuring the privacy and cybersecurity of protected health information (PHI) in accordance with applicable laws and regulations.
k) Periodical evaluation of telemedicine services based on quality indicators, including access, effectiveness, and satisfaction.
l) The inclusion of teleradiology services (if available), addresses the following:

i. Initiation from imaging requests
ii. Use of standardized imaging protocols and relevant clinical history
iii. Integration of 3D and image-processing software
iv. Compliance with screen resolution and pixel quality standards.
v. Secure data transfer, protection, and archiving
vi. Qualifications and credentials of interpreting radiologists
vii. Structured reporting for documented findings

Survey process guide:

- If applicable According to the scope of ambulatory healthcare center, GAHAR surveyor may review the ambulatory healthcare center program guiding telemedicine.
- GAHAR surveyor may interview and review the staff file of the telemedicine or teleradiology services clinical director to check his qualifications.
- GAHAR surveyor may interview involved staff members to ensure their awareness of the ambulatory healthcare center program.
- GAHAR surveyor may observe the availability of the resources required to sustain the planned telemedicine clinical services.

Evidence of compliance

1. The ambulatory healthcare center has a program for telemedicine addresses items in the intent from a) through l).
2. All involved staff are aware of the program and received the required training.
3. The ambulatory healthcare center has the resources required to sustain the planned telemedicine or teleradiology clinical services based on program goals.
4. The delivery of telemedicine or teleradiology services is overseen by a trained medical staff.
5. The telemedicine or teleradiology services are periodically evaluated.

Related standards:

IMT. 01 Information Management Processes, IMT. 07 Patient's Medical record Management, ACT.01 Granting access (before patient's registration), PCC.07 Patient's dignity and privacy, EFS.10 Medical Equipment Plan.

Integrated Care Delivery

Sustaining uniform care

Sustaining uniform care

ICD.01 The ambulatory healthcare center has a uniform process for care provision and treatment.

Equity

Keywords:

Uniform care.

Intent:

Ambulatory healthcare centers treat similar patients in a similar way regardless of their different backgrounds (such as religion, economic class, literacy level, race, language, etc.) and regardless of the location or the time, the patients receive their care. Ambulatory healthcare centers are expected not to discriminate between patients and provide them a uniform medical care per their clinical requirement.

Ambulatory policies, procedures, and professional practice guidelines guide the provision of the same level of care throughout the Ambulatory healthcare centers e.g., patient assessment, care plans, pain management, sedation, and anesthesia. Ambulatory policies and procedures are implemented uniformly throughout the Ambulatory healthcare centers as per patient needs.

Ambulatory healthcare centers are able to demonstrate a similar level of compliance across all departments and services. To carry out the principle of uniform care requires that the center's leaders plan and coordinate the provision of care and standardize care processes. To ensure this, ambulatory healthcare centers shall develop a policy that specifies what constitutes the uniform care and what practices can be followed to ensure that patients are not discriminated based on their background or category of their accommodation. Describing clear process for addressing and reporting the discrimination and\or harassment, if any.

Survey process guide:

- GAHAR surveyor may review the policy for uniform care provision.
- GAHAR surveyor may interview staff to check their awareness of the policy.
- GAHAR surveyor may review sample of pre-selected medical records.

Evidence of compliance:

1. Ambulatory healthcare center has a policy to guid the commitment to providing uniform care to all patients when a similar service is needed.
2. All staff members involved in patient care are aware of the ambulatory healthcare center policy.

3. Patients, based on the acuity of their condition, equally receive the same level of care regardless of any barriers, such as patient background, location, or the timing of care.
4. The uniformity of care all over the Center is provided according to clinical guidelines .
5. There is a clear process that explains options for addressing discrimination and\or harassment and describes methods of investigations and reporting, if any.

ICD.02 The process of adopting and adapting clinical practice guidelines is defined.

Effectiveness

Keywords:

Clinical practice guidelines adaptation and adoption

Intent:

Clinical practice guidelines (CPGs) serve as a framework for clinical decisions and supporting best practices. Clinical practice guidelines are also statements that include recommendations intended to optimize patient care.

Adopting and adapting clinical practice guidelines involves systematically integrating evidence-based practices into the AHC's unique context. Customizing guidelines to the specific AHC can enhance acceptance and adherence. Actively involving end-users in this process significantly improves practice changes.

The AHC shall develop and implement a policy and procedure for clinical guidelines adoption and adaptation that addresses at least the following:

a) Selection criteria of clinical practice guidelines.
b) How clinical practice guidelines/protocols implementation are monitored and evaluated
c) Staff training required to apply the selected guidelines, pathways, or protocols
d) Periodic update of clinical practice guidelines based on changes in the evidence and evaluation of processes and outcomes.

Survey process guide:

- The GAHAR surveyor may review the ambulatory healthcare center policy followed by interviewing staff members to check their awareness of the policy.
- The GAHAR surveyor may review medical records to check implementation of clinical practice guidelines.
- The GAHAR surveyor may review a sample of staff file to check for the training records.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that guides all the elements mentioned in the intent from a) through d).
2. All medical and nursing leaders are aware of the Ambulatory Healthcare center policy.
3. At least three clinical guidelines, for the most common/high risk three diagnoses managed in the Ambulatory Healthcare center, are adopted/adapted in the Ambulatory Healthcare center annually.

4. Training programs are implemented to communicate and train staff members on the approved clinical guidelines.
5. Clinical practice guidelines are implemented uniformly for all patients with the same condition.

ICD.03 The ambulatory healthcare center develops Clinical pathways according to guidelines and protocols .

Effectiveness

Keywords:
Clinical pathways
Intent:
Clinical pathways (CPs) are "structured, multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem. They are evidence-based tools designed to translate clinical guidelines into local practice by outlining the timing, sequence, and responsibilities of care. In ambulatory healthcare centers (AHCs), pathways must reflect needs such as same-day diagnostics, timely interventions, referral criteria, and follow-up, while being customized to the center's scope of services and resources.

To ensure effectiveness and sustainability, the ambulatory healthcare center shall develop and implement a policy and procedure for clinical pathways development that addresses at least the following:

a) The related annually approved clinical guidelines.
b) Formation of a multidisciplinary team that collaborates in developing and maintaining clinical pathways.
c) Comprehensive training programs covering all healthcare providers involved in pathway implementation to ensure consistent understanding and practice.
d) Deviation management as any deviation from the pathway must be clinically justified, documented, and discussed with the concerned medical leaders.
e) Regular monitoring of compliance with pathways, with results linked to staff appraisal and performance evaluation.
f) Variance analysis (documenting reasons for deviations) with feedback loops for Continuous improvement.
g) Clinical pathways must be reviewed at least every 2 years or according to any changes or updates in the related guidelines.

Survey process guide:

- GAHAR surveyor may review the AHC's policy on clinical pathways and confirm it includes selection, development, monitoring, and review processes.
- GAHAR surveyor may interview clinical staff to verify knowledge and use of implemented pathways.
- GAHAR surveyor may review patient medical records to ensure care provided aligns with approved pathways and that variances are documented.
- GAHAR surveyor may review quality improvement and monitoring reports showing pathway adherence, outcomes, and corrective actions.

- GAHAR surveyor may verify training records of staff on pathway implementation and updates.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy and procedure that covers all required elements for the development of clinical pathways from a) to g).
2. All relevant staff are Trained on the use of clinical pathways, its adoption and their roles in implementation.
3. A multidisciplinary team is actively involved in the development of clinical pathways, based on recognized clinical guidelines and protocols.
4. Patient medical records demonstrate consistent adherence to the clinical pathways.
5. The AHC has a process to manage the deviations (if any) from the clinical pathways. with the concerned medical leaders.
6. The AHC monitors the reported data of compliance with clinical pathways and takes actions to control or improve the process as appropriate.

Effective screening, assessment, and care for ambulatory healthcare patients

ICD.04 Initial medical assessment and reassessments are performed.

Effectiveness

Keywords:

Medical patient assessments

Intent:

The initial medical assessment is considered the basis of all medical care decisions; it aids in the determination of the severity of a condition, and it helps in prioritizing initial clinical interventions. Initial medical assessment should be standardized, comprehensive, detailed, and completed within a specific time span to achieve high-quality care that fulfills patient needs. The Most Responsible Physician, or his/her designee, usually performs it. The frequency of assessment and reassessments may vary according to the patient's condition, the specialty of treatment, level of care, or diagnosis.

The AHC shall develop and implement a policy and procedures to define the minimum acceptable contents and frequency of clinical assessment and reassessments.

The initial assessment includes at least the following:

a) Chief complaint.
b) Details of the present illness.
c) Past medical and surgical history.
d) Allergies and adverse drug reactions.
e) Medications history.
f) Social, emotional, and behavioral history.
g) Family history.
h) The required elements of the comprehensive physical examination.
i) Specialized assessment is performed per specialty or patient category.
j) Provisional diagnosis.

k) Reassessment frequency and content.

The specific assessments are performed when the initial screening labels the patient "at risk" for the screening elements. Identification of special-needs patient populations that visit the ambulatory healthcare center shall include at least the following:

i. Adolescents
ii. Elderly
iii. Disabled
iv. Immunocompromised.
v. Patients with communicable diseases .
vi. Patients with chronic pain .
vii. Victims of abuse and neglect

The AHC should ensure continuous monitoring of the patient's clinical status by defining who is permitted to perform clinical reassessments and the minimum frequency and content of these reassessments. The AHC also defines the timeframe for completing the initial assessment, which is guided by clinical guidelines. The AHC also defines whenever history and physical examination completed prior to hospitalization may be used and whether AHC medical staff members verify and/or accept the results of patient assessments performed outside the AHC.

Survey process guide:

- GAHAR surveyor may review The AHC policy guiding initial medical assessment.
- GAHAR surveyor may interview healthcare professionals to check their awareness of The AHC policy.
- GAHAR surveyor may observe to ensure compliance with The AHC policy.
- GAHAR surveyor may review a sample of patients' medical records to check initial medical assessment and re-assessment records in compliance with The AHC policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved assessment and re-assessment policy including The initial assessment with items addressed from (a) to (j) in the intent
2. All staff, who is responsible of patient assessment process, is aware of the components of the policy.
3. Only qualified individuals conduct the patient' medical assessments and reassessment.
4. Patient medical assessment is timely documented in the patient medical record according to the center's policy
5. The assessment process for special patient groups and populations is modified to reflect their needs including items from i) to v) in the intent.
6. Patient re-assessments are performed and timely documented in the patient's medical record according to the center's policy.

ICD.05 Initial nursing assessments and reassessments are performed.

Effectiveness

Keywords:

Nursing patient assessments and reassessments

Intent:

Nursing assessment is gathering information about a patient's physiological, psychological, sociological, and spiritual status by a licensed nurse. Nursing assessment is the first step in the nursing process. A section of the nursing assessment may be delegated to a certified nurse aide. Nursing reassessments may vary according to the patient's condition, the specialty of treatment, level of care, or diagnosis.

The AHC shall develop and implement a process to define the minimum acceptable contents and frequency of nursing clinical assessments and reassessments.

Initial nursing assessment record includes at least the following:

a) Vital signs and additional measurements such as height and weight.
b) Fall assessment.
c) Required screening, e.g., for pain, bedsores, functional, nutritional, psychosocial, etc., as per The AHC policies.
d) Airway, breathing, circulation, disability, skin, and hydration.
e) Outputs (as relevant).
f) A detailed nursing assessment of a specific body system(s) relating to the presenting problem or other current concern(s) required.
g) Reassessment frequency and content.

The AHC shall ensure the continuous monitoring of patients' clinical status by defining the minimum frequency and content of these reassessments.

Survey process guide:

GAHAR surveyor may review The AHC policy guiding nursing initial assessment.
GAHAR surveyor may interview nurses to check their awareness of The AHC policy.
GAHAR surveyor may observe the compliance with The AHC policy.
GAHAR surveyor may review a sample of patient's medical records to check nursing initial assessment and re-assessment records in compliance with The AHC policy.

Evidence of compliance:

1. The AHC has an approved policy to guide nursing initial assessment and to define its timeframe and minimum content as per the elements from a) through f) in the intent.
2. Nurses are qualified and aware of the elements of nursing assessment.
3. Initial nursing assessments are performed upon admission within the timeframe identified in the policy, as per patient needs.
4. Nursing reassessments are performed at the frequency identified in the AHC policy and according to patient needs.
5. Nurses' assessment and reassessment are timely recorded in the medical records.

ICD.06 Patient's needs are identified based on defined screening processes.

Effectiveness

Keywords:

Screening for further healthcare needs.

Intent:

Screening is a set of standardized rules or tests applied to patient groups on which to base a preliminary judgment that further evaluation or interventions are warranted, such as the need for a nutritional evaluation based on nutritional screening. Initial medical and/or nursing screening shall help to determine the need of further in-depth assessment or not and help to identify those patients in need of further nutritional, functional and special needs assessment. Qualified individual shall perform the screenings, and when the need for additional specialized assessments identified, patients shall be referred within the ambulatory care organization or to outside services in the community with a referral feedback for appropriate follow up. In addition, psychosocial screening may help to identify any behavioral issues and social determinants of health. Signs of abuse and neglect shall be included in the screening process, the ambulatory healthcare center shall develop a policy to guide the screening process; the policy addresses at least the following:

a) Define screening criteria for assessing the patients' needs and determine who is responsible to perform the screenings and the related further assessments, when needed.
b) Timeframe to complete and document the screening.
c) Screening includes at least the following:
    i. Nutritional status
    ii. Functional status
    iii. Psychosocial status
    iv. Victims of abuse and neglect and other special needs population.

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center policy that guide the screening process.
- GAHAR surveyor may review a patient's medical record to evaluate documents of screening.
- GAHAR surveyor may interview staff members to check their awareness of the screening policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy including elements in the intent from a) through c) to guide screening for patient's healthcare needs to define its content and timeframe based on center's policy.
2. All staff who perform the screening process are qualified and aware of how to apply it.
3. All screenings are completed and recorded within an approved timeframe as per center's policy.

4. The AHC has a defined process for managing patients who need further specialized assessments.

ICD.07 NSR.05 Patient's risk of falling is screened, assessed, and managed.

Safety

Keywords:

Fall screening, assessment, and prevention.

Intent:

All patients are liable to fall; however, some are more prone to. Identifying the more prone is usually done through a screening process in order to offer tailored preventative measures against falling.

Screening tools are commonly used and include questions or items that are used to identify fall risk patients. For example, the questions may require a simple yes/no answer, or the tool may involve assigning a score to each item based on the patient's responses. When fall risk identified from the screening process, fall risk assessment shall be implemented to reduce fall risk for those patients identified to be at risk, effective preventive measures to minimize falling are those that are tailored to each patient and directed towards the risks being identified from risk assessment.

The ambulatory healthcare center shall develop and implement a policy and procedures to guide the fall risk screening assessment and prevention process. The policy addresses at least the following:

a) Patient risk screening at first point of care.
b) Timeframe to complete the fall screening.
c) The need and frequency of fall re-assessment.
d) General measures required to reduce risk of falling such as call systems, lighting, corridor bars, bathroom bars, bedside rails, wheelchairs, and trolleys with locks.

Survey process guide:

- The GAHAR surveyor may review the policy describing screening and prevention of patient fall.
- The GAHAR surveyor may review a sample of medical records to check the completeness of the patient fall screening/ assessment forms.
- The GAHAR surveyor may interview healthcare providers, to assess their knowledge about patient fall screening/ assessment process.
- The GAHAR surveyor may observe patient fall prevention' general measures.

Evidence of compliance:

1. The ambulatory care center has an approved policy and procedures for fall screening assessment, reassessment and prevention that addresses items a) and d) of the intent.
2. Healthcare professionals are aware of the elements of approved policy.
3. General fall prevention measures and tailored care plans are implemented.
4. Patients at high risk of fall and their families are identified and educated on fall prevention measures.
5. All fall risk screenings, fall prevention measures and tailored care plans are recorded in the patient's medical record
6. The ambulatory healthcare center monitors the reported data of the fall risk management and takes actions to control or improve the process as appropriate.

Patient-tailored screening, assessment, and care processes

ICD.08 patients are screened for pain, assessed , whenever pain is present, and managed accordingly.

Patient-Centeredness

Keywords:

Pain screening, assessment, reassessment and management.

Intent:

Each patient has the right to a pain-free life. Pain, when managed properly, leads to patient comfort, proper role function, and satisfaction. The ambulatory healthcare center shall develop and implement a policy and procedures for screening, assessment reassessment, and management of pain processes. The policy addresses at least the following:

a) Pain screening, assessment tool suitable for different patient populations as per the AHC scope, i.e., tools for adults, pediatrics, neonates, and cognitively impaired patients.

b) Complete pain assessment elements that include nature, site, and severity.
c) The need and frequency of pain re-assessments.
d) Pain management protocols.
e) Assign responsibility for managing the pain.
f) Process of recording pain management plan in the patient's medical record.

Survey process guide:

- GAHAR surveyor may review the policy for screening, assessment and management of pain, followed by interviewing relevant staff members to check their awareness of the policy.
- GAHAR surveyor may review a patient's medical record to check for evidence of pain assessment, re-assessment and management.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide pain screening, assessment and management processes that addresses all elements mentioned in the intent from a) through f).
2. Relevant staff members are aware of how to apply the policy.
3. All patients are screened and assessed (when indicated) for pain using a valid, approved tool, that suits the patient population,
4. Pain screening, assessment, pain management plan, and reassessment are documented in the patient records.

ICD.09 An individualized plan of care is developed for every patient.

Patient-centeredness

Keywords:

Plan of Care.

Intent:

A plan of care provides direction on the type of healthcare the patient may need. The focus of a plan is to facilitate standardized, evidence-based, and holistic care. Recording a plan of care ensures medical staff members, nurses, and other healthcare professionals integrate their findings and work together with a common understanding of the best approach towards the patient's condition. The plan of care is:

a) Developed by all relevant disciplines providing care under the supervision of the most responsible physician (MRP).
b) Based on assessments of the patient performed by the various healthcare disciplines and healthcare professionals, including the result of diagnostic tests where relevant. .
c) Developed with the involvement of the patient and/or family through shared decision making, with discussion of benefits and risks that may involve decision aids.
d) Updated according to guidelines, re-assessment, patient needs, , and preferences.
e) Includes identified needs, interventions, and desired outcomes with timeframes.
f) The progress of patient/service user in achieving the goals or desired results of treatment, care or service is monitored.
g) The progress of the patient in achieving the desired outcomes of care is monitored.

Survey process guide:

- The GAHAR surveyor may review a patient's medical record to review the recorded plan of care.
- The GAHAR surveyor may interview healthcare professionals to check their awareness of the process.

Evidence of compliance:

1. Patient' plan of care is developed and implemented by all relevant disciplines based on their assessments and addresses all the elements mentioned in the intent from (a) through (g).
2. Healthcare professionals are aware of the plan of care components.

3. Plan of care is revised/updated based on a re-assessment finding or any change of patient condition.
4. Individualized plan of care is recorded in each patient's medical file.

ICD.10 The consultation process is available, safe and effective.

Safety

Keywords:

Consultation process.

Intent:

Consultation is the process of seeking an assessment by a medical staff member of a different discipline to suggest a diagnostic or treatment plan. Often, consultation leads to professional communication where clinicians share their opinions and knowledge with the aim of improving their ability to provide the best care to their patients. Such dialogue may be part of a clinician's overall efforts to maintain current scientific and professional knowledge or may arise in response to the needs of a particular patient. Although consultation usually is requested in an efficient manner that expedites patient care. The ambulatory healthcare center shall develop and implement a policy for safe and appropriate consultation process. The policy addresses at least the following:

a. Defined criteria for patient consultation.

b. Type and urgency of consultation.
c. A clear process of communicating consultation requests to concerned medical staff member.
d. Timeframe to respond to consultation requests.
e. Consultation feedback' documentation process to ensure safe and appropriate care planning especially in case of urgency.

Survey process guide:

- GAHAR surveyor may review the policy for the consultation.
- GAHAR surveyor may also interview medical staff members to check their awareness of the policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy of consultation that addresses all elements mentioned in the intent from a) through e).
2. Medical staff members who are involved in the consultation process are aware of how to apply the policy.
3. Consultations are performed and timely documented in the patient's medical record according to the center's policy.

ICD.11 NSR.02 Verbal or telephone orders are communicated and documented according to the defined process.

Safety

Keywords:

Verbal and telephone orders.

Intent:

Miscommunication is the commonest root cause for adverse events. Writing down and reading back the complete order, by the person receiving the information, minimizes miscommunication and reduces errors from unambiguous speech, unfamiliar terminologies, or unclear pronunciation. This also provides an opportunity for verification.

The AHC shall develop and implement a policy and procedures for receiving verbal and telephone communication.

The policy addresses the process of reporting:

a) When verbal and telephone orders may be used.
b) Verbal orders and telephone orders are documented by the receiver.
c) Verbal orders and telephone orders are read back by the receiver.
d) Confirmed by the ordering physician.
e) Documentation and authentication requirements.

Survey process guide:

- The GAHAR surveyor may review the policy of verbal or telephone orders to check whether it clearly describes the process of recording, read-back by the recipient and confirmation by individual giving the order.
- The GAHAR surveyor may review documents of recording as dedicated registers and patient's medical record.
- The GAHAR surveyor may interview healthcare professionals to check
- their awareness of the policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide verbal communications and to define its content that addresses at least all elements mentioned in the intent from a) through e).
2. Healthcare professionals are aware of the elements of the policy.
3. All verbal and telephone orders are documented, then read back by the receiver, and confirmed by the ordering physician.
4. All verbal and telephone orders are recorded in the patient's medical record within a predefined timeframe.
5. The ambulatory healthcare center monitors the reported data of verbal and telephone orders and takes actions to control or improve the process as appropriate.

Safe critical and special diagnostic and care procedures

ICD.12 NSR.07 Critical results are communicated in time and documented according to the defined process.

Safety

Keywords:

Critical results.

Intent:

Patient safety and quality of care can be compromised when there are delays in completion of critical tests or in communicating the critical tests or critical results to the requestor. Miscommunication is the most common root cause for adverse events. Writing down and reading back the results, by the person receiving the information, minimizes miscommunication and reduces errors resulting from ambiguous speech, unfamiliar terminologies, or unclear pronunciation. This also provides an opportunity for verification. The process includes instructions for immediate notification of the authorized individual responsible for the patient with results that exceed the critical intervals. Any difficulties encountered in notifications shall be reported in the incident reporting system. The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of identifying and reporting critical results. The policy addresses at least the following:

a) Lists of critical results and values.
b) Critical test results reporting process including timeframe and read-back by the recipient.
c) Process of recording shall include:
    i. Date and time of notification.
    ii. Identification of the notifying responsible staff member.
    iii. identification of the notified person.
    iv. Description of the sequence of conveying the result.
    v. Examination results conveyed.
    vi. Any difficulties encountered in notifications.
d) Measures to be taken in case of critical results.

Survey process guide:

- The GAHAR surveyor may review the policy of critical results to check whether it clearly describes the process of recording, read-back by the recipient
- The GAHAR surveyor may review the recording in the dedicated registers and patient's medical record.
- The GAHAR surveyor may interview healthcare professionals to check their awareness of the policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide critical results communications and to define its content that addresses at least all elements mentioned in the intent from a) through d).
2. Healthcare professionals are aware of the elements of the policy
3. All critical results are recorded in the patient's medical record within a pre-defined timeframe, including all elements in the intent from i) through vi) ,
4. The AHC monitors the reported data on critical results and takes actions to control or improve the process as appropriate.

ICD.13 NSR.04 Systems are implemented to prevent catheter and tubing misconnections.

Safety

Keywords:

Catheter and tube misconnections

Intent:

Tubing and catheters are important steps of daily healthcare provision for the delivery of medications and fluids to patients. Patients, especially within critical and specialized care areas, are connected to many tubes and catheters, each with a special function (monitoring, access, drainage). During care, these tubes and catheters may be misconnected leading to the administration of wrong material via the wrong route resulting in grave consequences. The ambulatory healthcare center shall develop and implement a policy and procedures for catheter and tubing misconnections. The policy addresses at least the following:

a) Responsibility of connection and disconnection of tubes should not be left to nonmedical staff members, families, or visitors.
b) Labeling of high-risk catheters (e.g. arterial, epidural, intrathecal).
c) Avoidance of use of catheters with injection ports for these applications.
d) Tracing of all lines from their origin to the connection port to verify attachments before making any connections or re-connections, or administering medications, solutions, or other products.
e) Standardized line reconciliation, re-checking process, and catheter maps as part of handover communications.
f) Acceptance testing and risk assessment (failure mode and effects analysis, etc.) to identify the potential for misconnections when purchasing new catheters and tubing.

Survey process guide:

- GAHAR surveyor may review the policy for catheter and tubing misconnections and may interview responsible staff to check their awareness.
- GAHAR surveyor may review patient' medical record to check recording of the used catheters and tubes.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy of catheter and tubing misconnections that addresses all the elements mentioned in the intent from a) through f).
2. All staff members using tubes and catheters are competent and aware of the ambulatory healthcare center policy.
3. Documents of tubes and catheters used as catheter map are recorded in the patient's medical record.

ICD.14 Response to cardio-pulmonary arrest in the AHC is managed for both adult and pediatric patients.

Safety

Keywords:

Cardiopulmonary resuscitation

Intent:

Any patient receiving care within an AHC is liable to suffer from a medical emergency requiring a rapid and efficient response. Time and skills are essential elements for an emergency service to ensure satisfactory outcomes. Therefore, staff members trained on at least basic life support should be available during working hours and ready to respond to any emerging situation. The AHC shall develop and implement a policy and procedures to ensure the safe management of cardio-pulmonary arrests. The policy shall address at least the following:

a) Defined criteria for recognition of cardio-pulmonary arrest, including adults and pediatrics.
b) Training of staff members on the defined criteria.
c) Identification of the involved staff members to respond.
d) Mechanisms to call staff members to respond, including the code(s) that may be used for calling emergency.
e) The time frame of response.
f) The response is uniform at all working hours.
g) Recording of response and management.
h) Management of emergency equipment and supplies, including:
    i. Identification of required emergency equipment and supplies list according to laws, regulations, and standards of practice that include at least automatic external defibrillator, sphygmomanometer, stethoscope, and bag valve masks in different sizes.
    ii. Emergency equipment and supplies are age-appropriate.
    iii. Emergency equipment and supplies are replaced immediately after use, or when they expire or are damaged.
    iv. Emergency equipment and supplies are available throughout the PTC and checked daily for readiness.

Survey process guide:

- GAHAR surveyor may review the policy for medical emergencies and cardio-pulmonary arrest and may interview healthcare professionals to check their awareness of the policy.
- GAHAR surveyor may check evidence of staff training on recognition and communication of medical emergencies or cardio-pulmonary arrest.
- GAHAR surveyor may observe the compliance with policies for medical emergencies and cardio-pulmonary arrest.

Evidence of compliance:

1. The AHC has an approved policy that addresses all the elements mentioned in the intent from a) through h).
2. Responsible staff members are aware of the AHC policy.
3. Trained individuals are responsible for the management of cardio-pulmonary arrests with evidence of training on basic life support.
4. Age-appropriate emergency equipment and supplies are available throughout the AHC.
5. Emergency equipment and supplies are checked daily and replaced after use.
6. Management of cardio-pulmonary arrests is recorded in the patient's medical record

ICD.15 The ambulatory healthcare center ensures a safe use of laser therapy

Safety

Keywords:

Laser therapy

Intent:

Laser therapy has become an essential modality in ambulatory centers because it allows minimally invasive treatment with reduced bleeding, faster healing, and shorter recovery times compared to conventional techniques. In ophthalmology, lasers such as argon or femtosecond systems enable precise retinal photocoagulation or corneal reshaping without the need for hospitalization. In dentistry, diode and CO_2 lasers provide effective soft-tissue surgery, periodontal treatment, and cavity sterilization with minimal discomfort. However, to ensure safe delivery of laser therapy in such settings, services must be provided in accordance with applicable laws, regulations, and professional practice guidelines. The ambulatory healthcare center shall develop and implement a program for laser therapy that include at least the following:

a) Procedure-specific guidelines (ophthalmology, dermatology, dentistry, etc.)
b) Standardized protocols based on the type of laser (e.g., CO_2, Nd:YAG, femtosecond).
c) Indications and contraindications.
d) Required pre-procedural testing according to manufacturer's recommendations.
e) Required qualifications, privilege and roles of involved staff.
f) Required training for staff involved in laser use.
g) Monitoring patient response throughout the session.
h) Infection control and cleaning procedures.
i) Equipment safety checks and maintenance.
j) Emergency protocols in case of laser-related incidents
k) Accurate documentation and follow-up.
l) Laser safety measures:
    I. Laser safety PPEs
    II. Installation of non-reflective surfaces in procedure rooms where laser equipment is used.
    III. clearly visible laser warning signs outside laser-operating rooms.

Survey process guide:

- GAHAR surveyors may review the ambulatory healthcare center policy guiding laser therapy.
- GAHAR surveyors may interview involved staff members to check their awareness of the policy.
- GAHAR surveyor may review a sample of the involved staff members' files to check their training and qualifications.
- GAHAR surveyor may review a sample of the patients' medical records to check documentation and evidence of education.

Evidence of compliance:

1. The ambulatory healthcare center has an approved program guiding laser therapy which addresses the elements mentioned in the intent from a) through l).
2. Only a qualified staff can provide laser therapy services.
3. The ambulatory healthcare center provides laser therapy according to the center program, laws, regulations, and professional practice guidelines.
4. Each laser therapy session is accurately documented in the patient's medical record.
5. The patient and/or family are educated on the purpose, expected outcome, and safety precautions of laser therapy.

ICD.16 Chemotherapy service is provided according to laws, regulations, and clinical guidelines/protocols.

Effectiveness

Keywords:

Chemotherapy

Intent:

Chemotherapy, defined as the systemic administration of cytotoxic drugs to destroy or inhibit the growth of malignant cells, remains a cornerstone in cancer treatment. The use of chemotherapy in ambulatory centers has grown significantly due to advances in supportive care, safer drug formulations, and improved monitoring techniques.

The AHC shall develop and implement a program to ensure the safe and effective use of chemotherapy that addresses at least the following:

a) The treatment plan is based on a comprehensive evaluation of the patient's medical history, imaging studies, pathology reports, and staging information.
b) Chemotherapy administration following established protocols and guidelines.
c) Procedures for safe preparation and handling of chemotherapy drugs.
d) Pre-treatment evaluation prior to each chemotherapy session to assess their overall health and suitability for treatment.
e) Patient education about the chemotherapy regimen, including precautions to take during and after treatment.
f) Proactive management of chemotherapy-related symptoms to minimize their impact and improve patient comfort.
g) Monitoring and follow-up throughout the treatment course.

Survey process guide:

- GAHAR surveyor may review The ambulatory healthcare program for chemotherapy service and interview involved healthcare professionals to ensure their awareness.
- GAHAR surveyor may observe the chemotherapy preparation area design and equipment used and assess appropriate ventilation and compliance with aseptic techniques.

- GAHAR surveyor may review a sample of patients' medical records to check assessment, plan of care, monitoring of progress, and discharge instructions documentation.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment and privileges.
- GAHAR surveyor may interview patients and/or their families to ensure their education on the treatment plan.

Evidence of compliance:

1. The AHC has a program for chemotherapy service that addresses all the elements mentioned in the intent from a) through g).
2. The healthcare professionals involved in chemotherapy service are competent in handling the program.
3. The chemotherapy preparation area is designed and equipped to meet the professional guidelines of safe compounding of high-risk medications, including appropriate ventilation and adherence to aseptic techniques.
4. Patients and/or their families are educated on the treatment plan.
5. Assessment, plan of care, monitoring of progress, and discharge instructions are documented in the patient's medical record.

ICD.16 The ambulatory healthcare center develops a program for radiotherapy according to laws, regulations, and clinical guidelines/protocols.

Effectiveness

Keywords:

Radiotherapy program

Intent:

Radiotherapy, also known as radiation therapy, is a vital treatment modality in the field of oncology used to combat cancer and certain non-cancerous conditions. It involves the controlled delivery of high-energy radiation to target specific areas of the body affected by disease. By precisely directing radiation beams to the affected regions, radiotherapy aims to destroy cancer cells, inhibit their growth, or alleviate symptoms caused by non-cancerous conditions.

The ambulatory healthcare center shall develop and implement a program to ensure the safe and effective use of radiotherapy that addresses at least the following:

a) Treatment planning based on a comprehensive evaluation of the patient's medical history, imaging studies (such as CT scans or MRI), and pathology reports.
b) Simulation and imaging prior to treatment to accurately map the treatment area.
c) Radiation treatment delivery, including external and internal radiation therapy.
d) Verification of treatment plans, radiation doses, and delivery in accordance with safety protocols.
e) Accurate patient positioning and immobilization techniques to ensure precise radiation delivery; immobilization devices (e.g., molds, masks, customized cradles) may be used to minimize movement.
f) Measures to optimize therapeutic effect using the effective radiation dose to the targeted organ while minimizing radiation hazards.
g) Management of side effects to minimize impact and maximize patient comfort.
h) Patient and/or family education and support.
i) Regular monitoring and assessment to evaluate treatment response and adjust the treatment plan as required.

Survey process guide:

- GAHAR surveyor may review the ambulatory center’s program for safe and effective use of radiotherapy.
- GAHAR surveyor may interview involved healthcare professionals to ensure their awareness.
- GAHAR surveyor may review a sample of involved staff members' files to check their competency assessment.
- GAHAR surveyor may observe the radiotherapy area design and used equipment and check to ensure safe radiotherapy services.
- GAHAR surveyor may review a sample of patients' medical records to check assessment, plan of care, and monitoring of progress documentation.

Evidence of compliance:

1. The ambulatory healthcare center has a radiotherapy program that addresses all the elements mentioned in the intent from a) through i).
2. Involved staff is aware of the program.
3. Involved staff is competent in handling the program.

4. The radiotherapy area is designed and equipped to fulfill the safety requirements for the use of radiotherapy.
5. Assessment, plan of care, and monitoring of progress are documented in the patient's medical record.

Related standards:

ICD.06 Medical patient assessments; ICD.16 Clinical practice guidelines adaptation and adoption; ICD.15 Plan of Care; DAS.09 Radiation Safety Program.

ICD.17 The ambulatory healthcare center establishes optimization measures to achieve the required therapeutic effect using the effective radiation dose to the targeted organ with minimal radiation hazards.

Safety

Key Word:

Effective therapeutic radiation dose

Intent:

Radiation therapy uses high doses of radiation, most commonly X-rays, but may also use electrons, protons, or other energy forms, to destroy cancer cells and shrink tumors.

For each patient, the radiation oncologist, in cooperation with the medical physicist and the radiographer, ensures that the prescribed dose is delivered to the planning target volume (PTV) within the required tolerance limits, while minimizing exposure to surrounding tissues and critical organs in accordance with the ALARA (As Low As Reasonably Achievable) principle.

There are three basic principles of radiation protection: justification (involves an appreciation for the benefits and risks of using radiation for procedures or treatments), optimization (Achieving the therapeutic objective with the lowest reasonable exposure), and dose limitation (Ensuring doses to non-target tissues remain within safe thresholds).

Optimization measures shall be documented and readily used to achieve the required therapeutic effect using the effective radiation dose.

Any amount of radiation exposure will increase the risk of stochastic effects, namely the chances of developing malignancy following radiation exposure. Therefore, the ambulatory healthcare center shall implement the protection practices consistently with the ALARA principle.

The Dose-volume histogram (DVH) is a histogram relating radiation dose to tissue volume in radiation therapy planning. DVHs are most commonly used as a plan evaluation tool in radiation therapy.

Survey process guide:

- GAHAR surveyor may review the patient medical record.
- GAHAR surveyor may review records of the planning, the dose-volume histogram (DVH) of the planning quality control (QC) records in high/advanced technology procedures, and patient therapeutic radiation doses
- GAHAR surveyor may interview relevant staff about the therapeutic radiation dose planning process

Evidence of Compliance:

1. All clinical data are documented in the patient medical record.
2. Relevant staff is aware of the therapeutic radiation dose planning process.
3. The ambulatory healthcare center has records for both therapeutic radiological planning and for the dose-volume histogram (DVH) of the planning.
4. The ambulatory healthcare center has records for the calculation of the therapeutic radiation dose.
5. Quality control records are available for high/advanced technology procedures.

Diagnostic And ancillary Services

Medical Imaging

Efficient planning and management of radiological services

DAS.01 Medical Imaging services are planned, operated, and provided according to applicable laws and regulations.

Effectiveness

Keywords:

Planning and provision the medical imaging services.

Intent:

Medical Imaging is a cornerstone for any ambulatory healthcare center. An efficient, high quality, medical imaging service increases patient satisfaction because of its ability to improve patient care. Over time, the service adds significant patient's volumes to the ambulatory healthcare center.

The location of medical imaging is important for easy access by emergency patients, ambulant patients and inpatients, different functional areas need to be identified.

Special attention shall be given to the design of a medical imaging unit such as structural support for equipment, equipment positioning and safe patient movement, provision for cable support trays, ducts or conduits may be made in floors, walls, and ceilings, Equipment ventilation, required space and required special human expertise.

The ambulatory healthcare center should plan and design a system for providing medical imaging services required by its patient population, clinical services offered, and healthcare practitioner needs.

The ambulatory healthcare center can provide some or all of the services on-site or can refer to/ contract with other healthcare professionals for some or all of the services, to be performed according to quality expectations and professional standards.

When a medical imaging service is provided outside the designated radiology service area, it should follow the same protocols, guidelines, and safety procedures as the ambulatory healthcare center' main radiology service area.

The medical imaging services should meet national laws, regulations, and applicable guidelines/ protocols.

Survey process guide:

- GAHAR surveyor may review the provision of medical imaging services, licenses and permits.
- GAHAR surveyors may observe the provided medical imaging services to check uniformity and standardization
- GAHAR surveyor may review contractual agreements and related reports.

Evidence of compliance:

1. Medical Imaging services ~~are~~ provided, either onsite or through outside source, meet laws, regulations, and applicable guidelines/protocols.
2. All related licenses, permits and guidelines are available.
3. List of medical Imaging services meets the scope of clinical services of the ambulatory healthcare center.
4. The ambulatory healthcare center ensures the quality and safety of outsourced medical imaging services.
5. Evidence of annual evaluation of the medical imaging services is provided in a report discussed by the ambulatory healthcare center leaders and presented to the governing body.

Related standards:

APC.01 national regulation, licensures requirements, DAS.02 Medical imaging services healthcare professionals, DAS.03 Technical medical imaging standards (Practice Parameters), EFS.01 Ambulatory healthcare center environment and facility safety structure

DAS.02 Medical imaging services are performed by competent healthcare professionals according to applicable laws and regulations.

Efficiency

Keywords:

Medical imaging services healthcare professionals.

Intent:

Medical imaging professionals are vital members in a multidisciplinary team that forms a core of highly trained healthcare professionals.

They also play a critical role in the delivery of health services as new modalities emerge and the need for medical imaging procedures increases within the laws and regulations. Medical imaging professionals integrates scientific knowledge, technical competence, and patient interaction skills to provide safe and accurate procedures with the highest regard to all aspects of patient care.

Medical imaging professionals are sensitive to the needs of the patient through good communication, patient assessment, patient monitoring and patient care skills.

As members of the healthcare team, medical imaging professionals participate in quality improvement processes and continually assess their professional performance. When Medical Imaging services are provided on-site at the ambulatory healthcare center they are managed by a healthcare professional who is qualified by education and training consistent with applicable laws and regulations.

The ambulatory healthcare center shall develop and implement a policy and procedures describing the performance and documentation of staff members' competency assessment that addresses at least the following:

a) Direct observation of routine work processes and procedures, including all applicable safety practices.
b) Direct observation of equipment maintenance, function checks, and monitoring recording and reporting of examination results.
c) Review of imaging professionals' human resources records;
d) Training on special modalities, equipment, and studies.

Competence of medical imaging services staff can be assessed annually using any combinations, all of the approaches mentioned in the policy or following the guidelines according to the assigned job.

Privileges for performing each medical imaging service function is determined based on documented evidence of competency (experience- qualifications – certifications-skills) that is reviewed and renewed as needed. There is a mechanism to grant privileges temporarily in emergencies.

Survey process guide:

- GAHAR surveyor may review the competency assessment policy during document review session.
- GAHAR surveyor may interview medical imaging services staff members to inquire about competence assessment methods, frequency and granting privileges.
- GAHAR surveyor may review medical imaging services staff members to verify competence assessment process.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all the elements mentioned in the intent from a) through d).
2. Licensed healthcare professionals are providing medical image services.
3. Privileges are granted for performing each medical imaging service function based on assessed competencies.
4. Competency assessment is performed annually and recorded in the staff file.
5. There is a mechanism to grant privileges temporarily in emergencies.

Related standards:

DAS.01 Planning and provision the medical imaging services, WFM.01 Workforce Laws and regulations, WFM.03 Job Description, WFM.04 Verifying credentials, WFM.10 Clinical Privileges, WFM.07Staff Performance Evaluation.

DAS.03 Performance of medical imaging studies and procedures is standardized and effective.

Effectiveness

Keywords:

Technical medical imaging standards.

Intent:

Medical imaging service encompasses different techniques, modalities, processes to analyse services, and therefore plays an important role in initiatives to improve public health for all population groups.

Furthermore, Medical imaging service is frequently justified in the follow-up of a disease already diagnosed and/or treated.

A procedure manual provides a foundation for the medical imaging service's quality assurance' program; its purpose is to ensure consistency while striving for quality.

The procedure manual may be used to document how studies are performed; train new staff members; remind staff members of how to perform infrequently ordered studies; troubleshoot technical problem; and measure acceptable performance when evaluating staff. The medical imaging service develops technical procedures for all modalities.

The technical medical imaging procedures should be available in a language commonly understood by the working staff and available in an appropriate location, it could be in a paper-based, electronic, or web-based format.

The ambulatory healthcare center shall develop and implement procedures for medical imaging to ensure safety and usability of modalities. For each modality, procedure manuals address at least the following:

a) Scope and general overview
b) Equipment description
c) Maintenance procedures
d) Quality control
e) Safety procedures
f) Critical findings

Survey process guide:

- GAHAR surveyor may review a sample of medical imaging procedure manuals and check for their availability.
- GAHAR surveyors may interview staff to check their awareness about the procedure manual.

Evidence of compliance:

1. The medical imaging service has adopted/ adapted guidelines/protocols for each modality.
2. Procedure manuals are readily available. Each procedure manual includes all the required elements mentioned in the intent from a) through f).
3. Staff is trained on the contents of procedure manuals.

4. Review the procedures manual are performed and reviewed on predefined intervals by authorized staff members.

Related standards:

DAS.01 Planning and provision the medical imaging services, DAS.02 Medical imaging services healthcare professionals.

Effective operational processes of medical imaging

DAS.04 Ambulatory healthcare center develops a process for medical imaging services' pre-examination.

Effectiveness

Keywords:

Medical imaging pre-examination process.

Intent:

Pre-examination processes in the path of workflow for medical imaging include all activities from the time the medical imaging services are ordered to the time that the patient be present in the medical imaging service area.

Medical imaging service should provide referrers and patients with information regarding the merits of the various diagnostic imaging techniques, so that referrers can make informed decisions about the diagnostic information and relative value of the range of studies provided as information about patient preparation requirements is important to ensure effectiveness.

The ambulatory healthcare center shall develop and implement a pre-examination policy that can be in the form of medical imaging service manual and communicate it with all service users.

The policy includes at least the following:

a) Proper completion of request form to include:
   i. Patient information (Full patient name, date of birth, gender, and patient contact).
   ii. Name of the ordering physician.
   iii. Studies requested.
   iv. Date of request.
   v. Clinical information.
   vi. Special marking for urgent tests request.

b) Patient preparations including specific risks.
c) Pre-study review of requests to ensure that the requested examination is appropriate to the needs of the referrer and the patient.
d) Actions to be taken when a request is incomplete, illegible, or not clinically relevant, or when the patient is not prepared.
e) Patients and referrers are informed when an additional or substituted examination is called for.

Survey process guide:

- GAHAR surveyor may review medical imaging pre-examination policy.
- GAHAR surveyor may trace a patient receiving a medical imaging service and review service request, patient preparation and service manual.
- GAHAR surveyor may interview responsible staff to check their awareness on preparation requirements.

- GAHAR surveyors may observe the implementation of medical imaging pre-examination process

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide the medical imaging pre-examination process that includes elements mentioned in the intent from a) to e).
2. Medical imaging service provides referrers and patients with information regarding the merits of the various diagnostic imaging techniques.
3. Medical imaging service' staff members review the patient requests and verify patient identity.
4. Medical imaging service' staff member ensures that the patient has complied with any preparation requirements (e.g. fasting) for the procedure that is being performed.
5. Actions are taken when a request is incomplete, illegible, or not clinically relevant, or when the patient is not prepared, to ensure patient safety.
6. When an additional or substituted examination is called for, medical imaging service staff member informs patients and referrers and records in the patient's medical record.

Related standards:

ACT.02 Patient identification, ICD.05 Patient assessment process.

DAS.05 A medical imaging quality control program is developed.

Effectiveness

Keywords:

Medical imaging quality control program.

Intent:

Management of the routine quality control (QC) of medical imaging equipment is a major responsibility of the medical imaging professionals.

Quality control measures are performed to monitor and ensure the reliability of study results produced by the medical imaging service.

Quality controls can identify performance problems not identified by quality control systems and help the medical imaging service to determine accuracy of images. Management of routine quality control includes developing the QC protocols, implementation of the program, oversight of the program, and responsibility for determining the need for corrective action.
Quality control data is reviewed at regular intervals and recorded.

Outliers or trends in examination performance, that may indicate problems in the examination system, are analyzed and followed up, then preventive actions are taken and recorded before major problems arise.

The ambulatory health center shall develop and implement a procedure for quality control that include at least the following:

a) Elements of the internal quality control performed according to guidelines and the manufacturer instructions.
b) The frequency for quality control testing is determined by the ambulatory healthcare center according to the guidelines and the manufacturer instructions whichever is more stringent.
c) Quality control methods to be used. It can be handled and tested in the same manner and by the same medical imaging staff member.
d) Quality control performance expectations and acceptable results should be defined and readily available to staff so that they will recognize unacceptable results in order to respond appropriately.
e) The quality control program is approved by the designee prior to implementation.
f) Responsible authorized staff member reviews Quality Control data at a regular interval (at least monthly).
g) Remedial actions taken for deficiencies are identified through quality control measures and corrective actions are taken accordingly.

Survey process guide:

- GAHAR surveyor may observe areas where medical imaging services provided to check the quality control procedures and records.
- GAHAR surveyor may interview medical imaging service' staff members and other healthcare professionals to check their awareness on quality control performance.

Evidence of compliance:

1. The ambulatory healthcare center has an approved procedure describing the quality control process of all medical imaging tests addressing all elements in the intent from a) through g).
2. Medical imaging service staff members involved in quality control are competent in quality control performance.
3. All quality control processes are performed according to quality control procedure.
4. All quality control processes are recorded.
5. Responsible authorized staff member reviews quality control process and function and check data at least monthly.
6. Corrective action is taken whenever targets are unmet.

Related standards:

EFS.09 Medical Equipment management plan, QPI.02 Performance Measures

DAS.06 Medical Imaging investigations are reported within approved timeframe.

Timeliness

Keywords:

Medical imaging reports.

Intent:

Reporting medical imaging investigations within the planned and targeted time frame is crucial for proper decision making and an essential function of the service, whenever emergency conditions occur.

Turnaround time (TAT) is the time interval from the time of submission of a process to the time of the completion of the process.

The process is initiated when a request is made. A medical imaging service' staff member identify the patient and performs the study. Next stage is to record the study result and write a report for it and finally the result sent back to the referring medical staff member.

The ambulatory healthcare center shall develop and implement a policy and procedures to guide the process of reporting medical imaging investigations that addresses at least the following:

a) Timeframes for reporting various types of images to healthcare professional and to patients.
b) Emergency and routine reports.
c) Accountabilities on the medical Imaging services across the ambulatory healthcare center.
d) Qualified licensed medical staff member is responsible for interpretation and reporting.

The written medical Imaging report is the most important means of communication between the radiologist and the referring medical staff member. It is part of the patient's medical record, and interprets the investigation in the clinical context.

Appropriate construction, clarity, and clinical focus of a radiological report are essential to high quality patient care that addresses at least the following:

i. The ambulatory healthcare center name.
ii. Patient identifiers on each page.
iii. Type of the investigation.
iv. Results of the investigations.
v. Time of reporting.
vi. Name and signature of the reporting radiologists.

Survey process guide:

- GAHAR surveyor may review policy of medical imaging reports during document review session.
- GAHAR surveyor may trace a patient receiving a medical imaging service and review service request, patient access to the service, study time and reporting time.
- GAHAR surveyor may perform patient's medical record review and assess completion of medical imaging service reports.
- GAHAR surveyor may interview responsible staff members to inquire about their experience regarding medical imaging service reporting time and report completion requirements.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all elements mentioned in the intent from a) through d).
2. Staff members involved in interpreting and reporting results are competent to do so.
3. Results are reported within approved timeframe.
4. Complete medical imaging reports include elements from i) to vi) are recorded in the patient's medical record.
5. When reports are not complete, there is a process to inform reporting radiologists.
6. The ambulatory healthcare center monitors the reported data on reporting time for medical imaging services and takes actions to control or improve the process as appropriate.

Related standards:

QPI.02 Performance Measures, WFM.03 Job Description, WFM.07Staff Performance Evaluation, IMT.05 patients medical record management, QPI.08 Performance improvement and patient safety plan.

Safe medical imaging studies

DAS.07 GSR.20 Radiation safety program is developed and implemented.

Safety

Keywords:

Radiation Safety Program.

Intent:

Radiation safety program provides information and training on the theory, hazards, biological effects, protective measures, monitoring and disposal of radioactive materials and radiological equipment; develops policies by which radiological equipment are used safely; ensures compliance with regulations; and provides emergency response assistance.

When Medical Imaging services are provided on-site, the ambulatory healthcare center monitors staff health by performing regular biannual CBC analysis and collecting their thermos-luminescent dosimeter (TLD) and/or badge film reports. When CBC results exceed the borderline further investigations are ordered. The ambulatory healthcare center shall develop and implement a program to guide the process of radiation safety to ensure the ambulatory healthcare center environment, staff, patients, families, and vendors are safe from radiation hazards. It should be properly communicated to all staff, implemented, reviewed, and updated annually. The program shall address at least the following:

a) Compliance to laws, regulations and guidelines.
b) All ionizing and non- ionizing radiation equipment are maintained and calibrated.
c) Protocols to identify dose of radiation for each type of examinations.
d) Staff self-monitoring tools.
e) Appropriate and safe waste disposal for radioactive materials.
f) Staff suitable personal protective equipment.
g) Patients' radiation safety precautions.
h) MRI safety program, which includes:
    i. Pre-exposure screening for metals.
    ii. Metallic implants, devices.
    iii. Use of MRI compatible devices.

Survey process guide:

- GAHAR surveyor may review the radiation safety program to check compliance with laws and regulations, lead shielding methods, PPEs and safety requirements for both staff members and patients.
- GAHAR surveyor may review thermos-luminescent dosimeter (TLD) and/or badge films of the staff results, CBC results, and lead aprons inspection.
- GAHAR surveyor may interview staff to check their awareness.
- GAHAR surveyor may observe medical imaging services inside medical imaging area or outside it to check compliance with radiation safety precautions.

Evidence of compliance:

1. The ambulatory healthcare center has a written, updated, and approved radiation safety program for patients and staff that addresses all elements mentioned in the intent from a) through h).

2. Staff members involved in medical imaging are aware of radiation safety precautions and receive on-going training for new procedures and equipment.
3. Radiation doses for patients in ionized radiology areas are recorded.
4. Identified radiation safety risks are mitigated through processes, safety protective equipment, and devices for both staff and patients.
5. The ambulatory healthcare center monitors the reported data on the radiation safety program, and it takes actions to control or improve the process as appropriate, at least quarterly.

Related standards:

ICD.02 Clinical practice guidelines, EFS.01 Ambulatory healthcare center environment and facility safety structure, EFS.06 Safety Management Plan, EFS.09 Medical Equipment Plan

Clinical Laboratory

Appropriate planning and management

DAS.08 Laboratory services are planned, provided, and operated according to applicable laws, regulations, and applicable guidelines.

Effectiveness

Keywords:

Laboratory services planning and management

Intent:

Planned laboratory services are critical to ensuring that communities receive good clinical care. Despite recent major efforts to improve laboratory services, many laboratory systems are inadequate to meet priority needs.

There is a major need to develop effective laboratory plans, provision and operation to strengthen clinical care systems, as an integral part of strengthening overall ambulatory healthcare center systems.

The ambulatory healthcare center shall develop and implement a management and technical system for providing laboratory services required by its patient population, offered clinical services, and healthcare professional needs as well as ambulatory healthcare center mission.

Laboratory scope of services is required to be enlisted and available for patients, ambulatory healthcare center staff, and healthcare professionals.

The designated area should fullfil the following:

a) Is physically separate from other activities in the ambulatory healthcare center.
b) Accommodate all laboratory activities.
c) According to the governance's requirements.
d) Dedicated area for sample collection.

Survey process guide:

- GAHAR surveyor may visit the laboratory area(s) as part of a patient tracer or ambulatory healthcare center tour. During this visit, the surveyor may check laboratory scope of services and match it with related laws and regulations.

Evidence of compliance:

1. Laboratory services meet applicable national guidelines, standards of practice, laws and regulations.
2. Laboratory services are available to meet the needs related to the ambulatory healthcare center mission and patient population.
3. Scope of services is defined and documented in the ambulatory healthcare center Laboratory.
4. The scope of services is annually reviewed and modified as the requirements for services evolve and change.
5. The designated laboratory area is available and separate from any other activities
6. Dedicated area for sample collection is available.

Related standards:

DAS.09 Laboratory Staff, referral EFS.01 Ambulatory healthcare center environment and facility safety structure

DAS.09 Licensed, competent healthcare professionals are assigned to operate laboratory services and duties.

Effectiveness

Keywords:

Laboratory Staff

Intent:

Laboratory competent staff have an influential role in the creation of a safe, healthy, productive working environment.

Staff competency assessment is an ongoing process for managers to evaluate an employee's work performance, identify strengths and weaknesses, offer feedback, and set goals for future performance.

The laboratory shall develop and implement a policy and procedures describing the performance and documentation of personnel competency assessment that includes at least the following:

a) Direct observation of routine work processes and procedures, including all applicable safety practices.
b) Direct observation of equipment maintenance, function checks; and monitoring recording and reporting of examination results.
c) Review of work records.
d) Assessment of problem-solving skills.
e) Examination of specially provided samples, such as previously examined samples, inter-laboratory comparison materials, or split samples.

Competence of laboratory staff can be assessed annually using any combinations, all of the approaches mentioned above or following the guidelines according to the assigned job.
Privileges for performing each laboratory function is determined based on documented evidence of competency (experience - qualifications - certifications - skills) that is reviewed and renewed as needed.

Survey process guide:

- GAHAR surveyor may review the policy that describing the performance and documentation of personnel competency assessment.
- GAHAR surveyor may interview laboratory services staff members to inquire about competence assessment methods, frequency and granting privileges.
- GAHAR surveyor may review laboratory services staff files members to verify competence assessment process.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy and procedure that address all the elements mentioned in the intent from a) through e).
2. Responsible staff is aware of ambulatory center policy.
3. Competency assessment is performed annually and recorded in laboratory staff file.
4. Privileges are granted for performing each laboratory function based on assessed competencies.

Related standards:

DAS.08 Laboratory services planning and management, EFS.01 Ambulatory healthcare center environment and facility safety structure, WFM.01 Workforce Laws and regulations

WFM.02 Staffing Plan, WFM.03 Job Description, WFM.04 Verifying credentials
WFM.07 Staff Performance Evaluation

DAS.10 The ambulatory healthcare center has a process for selecting and monitoring referral laboratory services

Effectiveness

Keywords:

Referral Laboratory services.

Intent:

A clinical Laboratory often requires the assistance of an outside laboratory or laboratories to perform unique or unusual services, as a backup service, or for routine services that the referring (primary) laboratory does not perform, as a result, primary laboratories refer selected tests as to be sent to referral laboratories.

Laboratory remains responsible for the quality of testing even when it refers samples for testing to other laboratories (referral laboratories), so the performance of the referral laboratories should be monitored. The ambulatory healthcare center shall have dedicated

area for sample collection.The ambulatory healthcare center shall develop a policy describing the quality of performance. The referral laboratory services control shall include:

a) Selection

Selection should be based primarily on quality of performance.

Whenever possible, referral specimens are sent to a national or international accredited laboratory.

b) Evaluation:

The laboratory should implement an evaluation process either before starting contracting, during the contract, or upon renewal of the contract for the referral laboratory through monitoring the quality of performance, turnaround time, and result reporting.

c) Requirements:

A signed document specifying the expectations of the two parties involved should be readily available for quick referral. The document includes at least the following:

i. Scope of Service
ii. Agreement conditions (including accreditation status).
iii. Sample requirements
iv. Sample transportation responsibility
v. Turnaround Time (TAT)
vi. Result reporting
vii. Release of information to the third party
viii. Mean of solving disputes
ix. The validity of the agreement and review schedule.

Survey process guide:

- GAHAR surveyor may review ambulatory healthcare center policy.
- GAHAR surveyor may review send-out test records in the laboratory.
- GAHAR surveyor may review the evaluation of the referral laboratory.
- GAHAR surveyor may review the evidence of referral laboratory accreditation status.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all elements mentioned in the intent from a) to c).
2. There is a written agreement between the two laboratories describing the expectations of the two parties fulfilling items in the intent from i) to ix).
3. Referral laboratory meets the selection criteria.
4. Referral laboratory is evaluated based on a predefined criteria and timeframe.
5. Records of send-out tests support compliance.

Related standards:

DAS.09 Laboratory Staff, OGM.09 Contracted services management.

Effective operational processes in the laboratory

DAS.11 The ambulatory healthcare center has a process for laboratory pre-examination.

Effectiveness

Keywords:

Laboratory pre-examination process.

Intent:

Pre-examination processes are the path of workflow for clinical laboratory including all activities from the time the laboratory tests are ordered through the time that the specimens are processed and delivered to the laboratory testing location. Informing the patient of what the laboratory provides is paramount to the quality of laboratory services.
Understanding pre-analytical variation and reducing errors in the pre-examination phase of the testing process are important for improved safety and quality of laboratory services delivered to patients.
The laboratory shall develop and implement a pre-examination policy that include all needed information for the patient and laboratory staff including at least the following:

a) Proper completion of request form to include:
    i. Patient information (Full patient name, date of birth, gender, and patient contact).
    ii. Name of the ordering physician.
    iii. Tests requested.
    iv. Date and time of specimen collection.
    v. Identification of the person who collected the specimen.
    vi. Clinical information.
    vii. Type of specimen (source of specimens).
    viii. Special marking for urgent tests request.
b) Patient preparations including instructions for dietary requirements (e.g., fasting and special diets).
c) Description of specimen type collection techniques.
d) Proper specimen labeling.
e) Criteria for safe disposal of materials used in the collection.
f) Proper handling and transportation of specimens.
g) Minimal Retesting Interval (defined as the minimum time before a test should be repeated, based on the properties of the test and the clinical situation in which it is used).

Informing the patient of what the laboratory provides is paramount to the quality of laboratory services. Laboratory service manual (LSM) provides an overview for the laboratory service, containing information about the laboratory to the patients and explains all information they need regarding the pre-examination phase.

The laboratory service manual should be communicated to all service users to provide valuable information about the service offered by the laboratory for best patient care.

Survey process guide:

- GAHAR surveyor may review laboratory pre-examination policy.
- GAHAR surveyor may trace a patient receiving a laboratory service and review service request, patient preparation and service manual.
- GAHAR surveyor may interview responsible staff to check their awareness on preparation requirements.
- GAHAR surveyor may observe the laboratory services area to check request review, patient identification process and communication with requestors and patients, specimen labelling, handling and transportation of specimens.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide the pre-examination process that includes elements mentioned in the intent from a) to g).
2. Involved staff is aware of pre-examination policy.
3. There is a laboratory service manual distributed to all users and available in all technical areas.
4. Preparation of specimen collection and labeling requirements are implemented.
5. Specimens are handled and transported according to the center's policy.

Related standards:

ACT.02 Patient identification, ICD.05 Patient assessment process, DAS.12 Specimen reception, tracking and storage

DAS.12 The ambulatory healthcare center has a process for specimen reception, tracking, and storage.

Effectiveness

Keywords:

Specimen reception, tracking and storage

Intent:

Specimen tracking is a process starting with specimen registration, collection, and labeling to specimen reception, analysis, and storage to significantly allow workers to identify the specimen location, history, and status.

The ambulatory healthcare center shall develop and implement a policy and procedures to describe securing patient samples and avoiding deterioration, loss, or damage during pre-examination activities and during handling, preparation, and storage.

The policy shall include at least the following:

a) Setting criteria for acceptance or rejection of specimens.

b) Evaluation of received specimens by authorized staff member to ensure that they meet the acceptance criteria relevant for the requested examination(s).
   i. Acceptable specimen: Specimen recording process in an accession book, worksheet, computer, or another comparable system, Recording includes the date and time of specimen's reception/registration and the identity of the person receiving the specimen.
   ii. Unacceptable specimen: Records of rejection are maintained, including the cause of rejection, time and date, name of rejecting person, and name of the notified individual.
   iii. Indications of acceptance of suboptimal specimen, taken measures, and recording that includes the date and time of specimen's reception/registration and the identity of the receiving person.
c) Traceability of all portions of the primary specimen to the original primary sample.
d) Process of recording all specimens referred to other laboratories for testing.
e) Instructions for proper sample storage in the pre-examination phase.

Survey process guide:

- GAHAR surveyor may review ambulatory healthcare center policy followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may visit the laboratory to review records of received specimens and match reasons for rejection with approved criteria.
- GAHAR surveyor may also review laboratory specimen identification and traceability process and storage.
- GAHAR surveyor may review records of specimens referred to other laboratories.

Evidence of compliance:

1. The laboratory has an approved policy that addresses all elements in the intent from a) through e).
2. All staff involved in receiving specimens are aware of the policy requirements.
3. All accepted and rejected specimens are recorded including all data mentioned in the intent.
4. All specimens referred to other laboratories are recorded.
5. Evidence of traceability of all portions of the primary sample to the original primary sample.
6. Samples are stored in appropriate conditions during all examination activities.

Related standards:

ACT.02 Patient identification, DAS.11 Laboratory pre-examination process, Minimum retesting.

DAS.13 Verified/validated analytical test methods are selected and performed.

Effectiveness

Keywords:

Verified / Validated test methods

Intent:

Analytical laboratory techniques and testing provide the data required to make critical decisions during clinical care, drive test improvement or meet regulatory compliance requirements.

In depth, knowledge of analytical laboratory technologies and how to apply them to a specific sample is critical to drive understanding about a test during analysis.

These technologies are often highly specialized analytical instruments, which can only be operated by competent professionals.

In order to ensure accurate and relevant test results, the laboratory uses accurate and reproducible analytical methods. This can be confirmed when the specified requirements for each examination procedure relate to the intended use of that examination.

The ambulatory healthcare center shall assign competent staff member for different activities of the selected methods.

The validated examination procedures, used without modification shall be subject to verification by the laboratory before being in routine use.

The laboratory shall develop a policy for verification of examination procedure following reliable guidelines.

Once the manufacturer claim is confirmed, the laboratory documents the procedures used for verification, records the results obtained and the staff with the appropriate authority.

Verification of performance characteristics of the process shall include at least the following:

a) Measurement of trueness.
b) Measurement of precision.
c) Measurement of linearity (detection and quantification limits).

The laboratory shall validate the examination procedures when:

i. Using a non-standard method.
ii. The standard method used outside its intended scope.
iii. The validated method with modification.

The laboratory shall follow verification/validation methods endorsed by reliable guidelines. When changes are made to a verified/ validated examination procedure, a new verification/validation shall be carried out and documented.

Survey process guide:

- GAHAR surveyor may review ambulatory healthcare center policy check the followed by interviewing staff members to check their awareness of the policy, their competence and knowledge of the introduced or changed tests.
- GAHAR surveyor may review verification/validation records for each test method.

Evidence of compliance:

1. The laboratory has an approved policy that describe the process for verification/validation of examination methods for all laboratory tests.
2. The authorized staff is aware about the verification/validation process.
3. The laboratory follows verification/validation methods endorsed by reliable guidelines.
4. Records of verification and /or validation results fulfilling acceptable criteria based on predetermined guidelines.

Related standards:

DAS.14 Laboratory examination procedures instructions, DAS.15 Laboratory Internal quality control -External quality control- proficiency test

DAS.14 Instructions for performing test methods and procedures are followed.

Effectiveness

Keywords:

Laboratory examination procedures.

Intent:

Laboratory service encompasses different techniques, processes to analyze services, and therefore plays an important role in initiatives to improve public health for all population groups.

Furthermore, laboratory service is frequently justified in the follow-up of a disease already diagnosed and/or treated.

A procedure manual provides a foundation for the laboratory's quality assurance program. The laboratory shall provide carefully documented instructions—in the form of procedures—for all activities that support the performance of analytic testing. These instructions provide essential information for both new and experienced employees on how to perform all examination procedures. Its purpose is to ensure consistency while striving for quality.

The laboratory shall develop technical procedures for all analytical test methods. The technical laboratory procedures should be written in a language commonly understood by the working staff and available in an appropriate location. It could be in a paper-based, electronic, or web-based format.

The Laboratory technical procedures are consistently followed and regularly reviewed.

They include at least the following:

a) Principle and clinical significance of the test.
b) Requirements for patient preparation and specimen type, collection, and storage.
c) Criteria for acceptability and rejection of the sample.
d) Reagents and equipment used.
e) Verifiction/validation of examination procedures.
f) The test procedure, including test calculations and interpretation of results.

g) Calibration and control procedures and corrective actions to take when calibration or control results fail to meet the laboratory's criteria for acceptability.
h) Biological reference intervals/clinical decision values.
i) Critical test results.
j) Analytical measurement range and instructions for determining results when it is not within the measurement interval.
k) Limitations in methodologies including interfering substances.
l) References.

Survey process guide:

- GAHAR surveyor may review laboratory procedures.
- GAHAR surveyor may trace and observe a patient undergoing a laboratory service and review preparation processes.
- GAHAR surveyor may interview laboratory staff members to check their awareness on analytic procedures.
- GAHAR surveyor may visit laboratory service areas to observe medical calibration, reagent use, ranges and results.

Evidence of compliance:

1. The laboratory has a written procedure for each analytical test method.
2. Responsible staff are trained on the contents of procedure manuals.
3. The technical laboratory procedures are readily available when needed.
4. Each procedure includes all the required elements mentioned in the intent from a) through l).
5. The procedures are consistently followed.
6. Authorized staff member reviews the technical laboratory procedures at least annually.

Related standards:

DAS.13 Verified / Validated test methods, DAS.15 Laboratory Internal quality control External quality control- proficiency test .

DAS.15 Quality control programs are developed and implemented for all tests.

Effectiveness

Keywords:

Laboratory Internal quality control - External quality control - proficiency test.

Intent:

Quality control programs include the internal and external quality control or its alternatives. Internal quality control testing is performed within a laboratory to monitor and ensure the reliability of test results produced by the laboratory. Control materials are used to monitor the test system and verify that quality patient test results have been attained.

A control is a stabilized sample with a predetermined range of result values that simulates a patient sample.

Quality control data shall be reviewed at regular intervals (at least monthly) and shall be recorded.

Outliers or trends in examination performance, that may indicate problems in the examination system, shall be analyzed, followed up and preventive actions shall be taken and recorded before major problems arise.

The laboratory shall develop and implement an approved procedure for internal quality control which shall include at least the following:

a) The frequency for quality control testing is determined by the ambulatory healthcare center according to guidelines and manufacturer instructions whichever is more stringent.
b) Quality control materials to be used. They shall be handled and tested in the same manner and by the same laboratory staff member testing patient samples.
c) Quality control performance expectations and acceptable ranges should be defined and readily available to staff so that they will recognize unacceptable results and trends in order to respond appropriately.
d) Acceptance-rejection rules for internal quality control results.
e) Quality Control data is reviewed at a regular interval (at least monthly) by responsible authorized staff member.
f) Remedial actions taken for deficiencies identified through quality control measures and corrective actions taken accordingly.

External quality control program is a system designed to objectively assess the quality of results obtained by laboratories, by means of an external body.

The laboratory shall participate in an external quality assessment program that covers the maximum number and complexity of tests performed by the laboratory.

The laboratory shall subscribe to proficiency testing according to the laboratory scope. When there is no proficiency testing available, the laboratory performs inter-laboratory comparison or proficiency test alternatives according to guidelines. This system is used, and its results are recorded at least semiannually.

Survey process guide:

- GAHAR surveyor may visit laboratory to check internal and external quality control procedures and records.
- GAHAR surveyor may interview laboratory staff members to check their awareness on internal and external quality control performance.

Evidence of compliance:

1. The laboratory has an approved procedure describing the internal quality control process of all laboratory tests addressing all elements in the intent from a) through f).
2. Laboratory staff members involved in internal quality control are competent and responsible authorized staff member reviews quality control data at least monthly.

3. All internal quality control processes are performed and recorded according to the internal quality control procedure and the Corrective actions are taken when indicated.
4. The laboratory subscribes to an external proficiency-testing program that covers the whole number of analysts performed by the laboratory and available from the provider, as well as the complexity of the testing processes used by the laboratory.
5. Records of all processes of external quality control including testing, reporting, review, conclusions, and actions, are present and retained for at least one cycle.
6. Evidence of proficiency testing alternative procedures used according to guidelines whenever no proficiency testing is available.

Related standards:

DAS.13 Verified / Validated test methods, DAS.14 Laboratory examination procedures instructions.

DAS.16 Laboratory post-examination process is developed and implemented to ensure accurate, timely reporting and release of verified laboratory tests.

Effectiveness

Keywords:

Laboratory - post examination process, Laboratory- turn-around time, STAT

Intent:

Laboratory post-examination key processes in the path of workflow include activities related to reporting results and archiving results and specimen material.

The overall purpose of all post-examination activities is to ensure that the results of examinations are presented accurately, timely and clearly.

Turnaround time (TAT) is a period of time required for completing a particular process. TAT is commonly measured in the clinical analyses in the lab, but nowadays, TAT includes all the phases from request of the samples until the reporting of test results.
STAT testing is defined as laboratory testing urgently needed for diagnosis or treatment of a patient when any delay can be life threatening. The laboratory shall develop a policy defining the total turnaround time for each laboratory test. The laboratory shall define the tests that can be ordered on a STAT basis and the interval of time between sample collection, reception, and reporting results.

The ambulatory healthcare center shall develop and implement a policy and procedures for post examination process that includes at least the following:

a) Final report data fulfillment including at least:
    i. Identity of the laboratory.
    ii. Patient identification.
    iii. Tests performed.
    iv. Ordering clinician.
    v. Date and time of specimen collection and the source of specimen.
    vi. Reporting date and time.
    vii. Test results and reference interval.
    viii. Identification of the verifying individual (Approved).
    ix. Interpretation of results, appropriate, advisory, or explanatory comment when needed.
b) Reviewing, verifying, and reporting of results by authorized staff member
c) All laboratory test (TAT) shall be defined by the laboratory.
d) The laboratory shall define the tests that can be ordered on STAT base.
e) Criteria for specimen storage.
f) The defined retention time of laboratory results
g) The defined retention time of patient samples

h) The safe disposal of clinical specimens.

Survey process guide:

- GAHAR surveyor may review the policy for post examination process during document review session.
- GAHAR surveyor may interview laboratory healthcare professionals to check their awareness of the post examination policy and laboratory retention time.
- GAHAR surveyor may visit laboratory area to check specimen storage, ~~and~~ retention times and disposal.
- GAHAR surveyor may perform patient's medical record review and assess laboratory result' report time and authorization.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide the post examination process that include all elements mentioned in the intent from a) through h).
2. The laboratory defines the authorized staff member who review and release the patient's results.
3. The laboratory has a STAT List of tests, acceptable STAT reporting time for each laboratory test is defined.
4. Delays in turnaround time are notified to requestors, investigated and proper actions are taken accordingly.
5. The retention process of a final laboratory report is implemented with easy retrieval.
6. The procedure of specimen storage, retention, and disposal is implemented, and required specimens are easily retrieved.

Related standards:

ACT.02 Patient identification, ICD.11 Critical results

Safe laboratory services

DAS.17 GSR.21 A comprehensive laboratory safety program is implemented.

Safety

Keywords:

Laboratory Safety Program

Intent:

The laboratory environment can be a hazardous place to work.

Laboratory staff member is exposed to numerous potential hazards including chemical, biological, physical and radioactive hazards, as well as musculoskeletal stresses. Laboratory safety is governed by numerous regulations and best practices. Over the years, multiple guides published to make laboratories increasingly safe for staff members.

Laboratory management should design a safety program that maintains a safe environment for all laboratory staff, patients, and families.

The laboratory should have a documented program that describes the safety measures for laboratory facilities according to the national requirements.

This program should be properly implemented and communicated to all staff. The program shall include at least the following:

a) Safety measures for healthcare professionals.
b) Safety measures for the specimen.
c) Safety measures for the environment and equipment.
d) List of laboratory chemicals and hazardous materials.
e) Incidents handling and corrective action are taken when needed.
f) Proper Disposal of Laboratory Waste.
g) Safety Data Sheets (SDS) Requirements.
h) Handling Chemical Spills/Spill Clean Up.
i) Instructions for the use of personal protective equipment.
j) Risk management process.

Survey process guide:

- GAHAR surveyor may review laboratory safety program that should include at least: list of chemicals and hazardous materials, dealing with spills, safety requirements, suitable PPE, Laboratory risk assessment, Safety Data Sheets (SDS) requirements, maintenance and calibration of medical equipment, and staff orientation, and proper waste disposal.
- GAHAR surveyor may review laboratory safety reports, lab equipment safety, storage of chemicals, labeling and waste disposal process.
- GAHAR surveyor may interview laboratory staff to inquire about their experience regarding laboratory Safety Program.

Evidence of compliance:

1. A written, updated and approved program that describes safety measures for laboratory services and facilities is documented and includes the items in the intent from a) to j).
2. Laboratory staff are trained on the safety program.
3. Laboratory risk assessment is performed and safety reports are issued at least semiannually to the ambulatory healthcare center environment and facility safety committee.
4. Spill kits, safety showers and eye washes are available, functioning and tested.
5. Safety precautions are implemented.
6. The ambulatory healthcare center monitors the reported data on laboratory safety program and takes actions to control or improve the process as appropriate.

Related standards:

EFS.01 Ambulatory healthcare center environment and facility safety structure, EFS.05 Hazardous materials safety, EFS.06 Safety Management Plan EFS.09 Medical Equipment management plan, IPC.04 infection risk and assessment

Effective Point of care testing

DAS.18 Point-of-care testing is monitored for providing accurate and reliable results.

Effectiveness

Keywords:

Point of care testing.

Intent:

Point-of-care testing (POCT) is defined by the College of American Pathologists as “tests designed to be used at or near the site where the patient is located, that do not require permanent, dedicated space, and that are performed outside the physical facilities of the clinical laboratories.”

The laboratory shall assign a responsible staff member to ensure the quality of these devices and that the reagents and other laboratory supplies are consistently available for it. The laboratory shall have a clearly defined approach to POCT to ensure that it is performed safely and correctly and that the results generated are accurate and reliable. The ambulatory healthcare center shall identify all POCT sites and the testing performed, prepare an audit form, perform inspection to determine if any deficiencies currently exist, implement corrective actions for any deficiencies identified in the inspection.

Survey process guide:

- GAHAR surveyor may review procedure manual in each point of care testing area, patient results and reporting process, quality control, maintenance, and function checks, evidence of testing staff member training and competency records.

Evidence of compliance:

1. The laboratory assigns a competent responsible staff member for supervising the point of care testing services.
2. Staff members who are responsible for performing point of care testing are competent to do so.
3. The ambulatory healthcare center identifies all POCT sites, and the testing performed.
4. There is a defined process for performing and reporting point of care testing (POCT).
5. Quality control procedures for POCT are recorded and implemented.

Related standards:

DAS.11 Laboratory pre-examination process, Minimum retesting, DAS.15 Laboratory Internal quality control -External quality control- proficiency test, DAS.16 Laboratory -post examination process, Laboratory- turn-around time, STAT , WFM.07 Staff Performance Evaluation

Blood Transfusion Services

Efficient planning and management of blood bank

DAS.19 Blood transfusion services are planned, operated and provided according to applicable laws, regulations and clinical guideline /protocol.

Efficiency

Keywords:

Blood Transfusion services and planning.

Intent:

With the growing population and the advancement in medical science, the demand for blood has increased. Lack of communication between the blood donors and the blood recipients lead to a situation where most of the patients in need of blood do not get blood on time.

Improper management of blood may lead to wastage of the available blood inventory.

These problems can be dealt with by developing a robust management system for blood transfusion services to bridge the gap between the donors and the recipients and to ensure safety and efficiency.

The blood bank should function under the direction of a certified physician who is trained and experienced on blood bank activities

Blood bank should have its own policies and procedures manual. The manual addresses at least the following:

a) Organization and Management.
b) Resources, Equipment and Supplies
c) Customer needs
d) Process control
e) Documents and records
f) Deviations, nonconformance and complications
g) Donor Assessments
h) Blood screening
i) Process improvements
j) Facilities and safety

Suitable and safe space, environment and equipment should be available

All blood bags, tubes, connections, reagents and supplies used for storage, preservation or testing of blood and blood components should meet professional requirements

Survey process guide:

- GAHAR surveyor may review the blood bank manual.
- GAHAR surveyor may observe areas where blood banking and transfusion occur and observe the space, design, environment, equipment, and supplies to ensure safe blood transfusion process.

- GAHAR surveyor may interview blood transfusion services staff members to inquire about competence assessment methods, frequency and granting privileges for requestors
- GAHAR surveyor may review blood transfusion services staff members' files to verify competence assessment process.

Evidence of compliance:

1. There is an approved manual that addresses all elements mentioned in the intent from a) through j).
2. All blood bank staff members are aware of the content of the manual.
3. Blood transfusion services have suitable space, environment, equipment and supplies.
4. Blood transfusion services are monitored by a licensed medical staff member.

Related standards:

DAS.20 Safe blood donation, EFS.01 Ambulatory healthcare center environment and facility safety structure, WFM.03 Job Description, WFM.04 Verifying credentials

Effective operational processes of blood transfusion service

DAS.20 Blood donation is accepted only from voluntary, non-remunerated, low risk, safe and healthy donors.

Safety

Keywords:

Safe blood donation

Intent:

Millions of people need blood transfusions each year. Some may need blood during surgery. Others depend on it after an accident or because they have a disease that requires blood components. Blood donation makes all of this possible.
There is no substance yet that can act as a 100% substitute for human blood functions. Blood donation remains the main source of human blood
The ambulatory healthcare center shall develop and implement a policy and procedures for donors' selection. The policy shall include at least the following:

a) Screening based on:
   i. Donor's history of surgeries, vaccination, receiving blood and donation interval.
   ii. Donor's physical examination including general appearance, height and weight and vital signs.
   iii. Blood bag laboratory testing, including specified communicable diseases, Blood grouping and RH typing

b) Mechanisms to ensure voluntary non-remunerated blood donation.
c) Pre-donation counselling by trained staff that include risk behaviors and self-exclusion for patient safety, tests carried out on donated blood and potential side effects. (Questionnaires may be used)
d) Donor safety and privacy

Survey process guide:

- GAHAR surveyor may review blood donation selection policy.
- GAHAR surveyor may interview staff to check their awareness of the policy.
- GAHAR surveyor may interview a person donating blood unit to inquire about assessment and counseling.
- GAHAR surveyor may review blood donation records.
- GAHAR surveyor may observe areas where blood donation occurs to check compliance with requirements.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that describes all elements mentioned in the intent from a) through d).
2. Blood bank staff is aware of the ambulatory healthcare center policy.
3. Blood donors are selected according to the policy.
4. Blood donors receive pre-donation counselling.
5. Blood donor selection and counselling is recorded.

Related standards:

DAS.19 Uniform Blood Transfusion services and planning, DAS.21 Blood Procurement and storage.

DAS.21 Processes of collection, handling, testing, labelling and storage of blood, and blood components are performed according to regulations and national requirements.
Or rephrased to be " Blood and blood components are collected, handled, tested, labelled, and stored according to regulations and national requirements.

Safety

Keywords:

Blood Procurement and storage

Intent:

Each step in the process of blood procurement (collection, handling and testing) affects the specimen quality, thus it is important for preventing specimen laboratory error, subsequent patient injury or even death.

The ambulatory healthcare center shall develop and implement a policy for management of blood and blood components. The policy addresses at least the following:

a) Collection:
   i. Donation of blood: Donor area cleanliness and convenience, Donor Reaction and Outdoor blood donation campaigns.
   ii. Infection control precautions.
b) Handling:
   i. Identification of blood/blood components bags and tubes.
   ii. Temperature controls.
   iii. Transportation of blood.

c) Testing:
   i. Determination of ABO group
   ii. Determination of Rh(d) type previous records
   iii. Laboratory tests for infectious diseases
   iv. Quarantine storage
d) Preparation:
   i. Sterility
   ii. Seal
   iii. Blood components preparation instructions and protocols

e) Labelling :
A numeric or alphanumeric system should be used, that will track any unit of blood or component from source to final destination and to recheck records applying to the specific unit. Labels should include at least the following:

i. Traceable number
ii. Name of blood bank
iii. Product type and volume
iv. Blood group and Rh group
v. Sero-negative
vi. Used anticoagulant, when applicable
vii. Required storage conditions
viii. Date of collection
ix. Date of expiry

f) Storage :

i. Storage conditions should limit deterioration and prevent damage to materials in process and final products. Storage should be access-controlled.
ii. Refrigerators, freezers and platelets incubators in which blood and blood components are stored should be used for storage of blood, blood components and blood samples only and not for any other items and should have monitored temperature as per approved guidelines and recorded regularly.
iii. Expiry dates should be monitored, recorded, and actions are taken for expired blood or blood components as per approved guidelines
iv. Blood bank should have physical separation between screened and unscreened blood bags
v. Method of disposal of blood bags should comply with requirements of waste management rules, regulations, and approved ambulatory healthcare center process.

Survey process guide:

- GAHAR surveyor may review blood transfusion services policy.
- GAHAR surveyor may perform a tracer session on a person donating blood or on the donation process to review assessment, collection, handling, testing and preparation steps
- ~~GAHAR surveyor may interview blood transfusion services healthcare professionals to check their awareness of requirements.~~
- GAHAR surveyor may observe at the blood storage and preparation areas to assess storage conditions and labeling.
- GAHAR surveyor may observe areas such as perioperative and procedural settings to check handling conditions of blood bags before their use.
- GAHAR surveyor may inspect alarm systems and backup power supply in blood storage areas to ensure their availability and functional.

- GAHAR surveyor may review records and processes for managing expired blood and blood components to ensure its disposal according to established procedures.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that describes all elements mentioned in the intent from a) through f) and based on national guidelines.
2. Blood and/or blood components are collected and handled as elements from a) through
   b) and based on national guidelines
3. Blood and/or blood components are tested and prepared as elements from c) through d) and based on national guidelines
4. Blood and /or blood components are labelled and stored as elements from e) through f) and based on national guideline
5. An alarm system and a provision for alternate power supply is available.
6. Expired blood or blood components are managed according to guidelines.

Related standards:

DAS.19 Uniform Blood Transfusion services and planning, DAS.20 Safe blood donation

DAS.22 obtaining blood from a blood bank outside the ambulatory healthcare center has a safe and effective process.
Or rephrased to be" The ambulatory healthcare center has a process for obtaining blood from outsourced blood bank.

Safety

Keywords:

Contracted blood banks

Intent:

Due to regulations organizing blood transfusion services and the pressure to provide quality services while operating cost-effectively, providing all required blood and blood components types in-house becomes unfeasible.

As a result, ambulatory healthcare center blood bank may obtain blood units from an outside blood bank. Blood bank should take all necessary measures to ensure quality of blood or blood components; this means that the performance of the outside blood bank should be evaluated to assure the quality of performance. The ambulatory healthcare center shall develop a policy and procedure for proper control of outside blood bank services, the policy includes the following:

a) Selection
   Selection should be based primarily on quality of performance.

   Whenever possible, blood and blood components are obtained from an accredited blood bank.

b) Evaluation:

The blood bank should implement an evaluation process before starting relationship by assessing blood bank accreditation status, inspection reports, performing an onsite visit to the blood bank, or by other means of evaluation.

The blood bank should implement an evaluation process during the relationship with the outside blood bank by monitoring and evaluating certain quality measures.

c) Requirements:
A signed document specifying the expectations of the two parties involved should be readily available for quick referral. The document includes at least the following:

i. Scope of Service.
ii. Agreement conditions (including accreditation status and availability of blood during emergencies).
iii. Agreement on safe storage and transportation conditions.
iv. Role of the involved parties in look back and transfusion transmitted diseases investigation.
v. Predefined acceptance criteria for each blood component received.
vi. Release of blood, blood components or information to the third party.
vii. Mean of solving disputes.
viii. Validity of the agreement and review schedule.

d) Inspection:
I) Checking for meeting predefined acceptance criteria for each blood component received.
II) Evaluation and verification of units' identification information including unit numbers, ABO/Rh-D and Expiration dates.
III) Conformation of ABO/Rh-D for RBC components.
IV) Actions taken for unsatisfactory blood or blood component units.
V) Evaluation and verification of the transportation condition of each blood component.

Survey process guide:

- GAHAR surveyor may review ambulatory healthcare center policy and review contracted blood bank agreement and results.
- GAHAR surveyor may review records in the blood bank or observe the receiving process.
- GAHAR surveyor may review records of the evaluation process and check compliance with the predefined criteria
- GAHAR surveyor may interview blood bank staff to check their awareness of the predefined acceptance criteria for receiving blood or blood components.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all elements mentioned in the intent from a) to d).
2. There is a written agreement between the two blood banks describing the expectations of the two parties fulfilling items in the intent from i) to viii).
3. Contracted blood bank meets the selection criteria.
4. Contracted blood bank is evaluated based on predefined criteria.

5. Blood bank staff members involved in receiving blood or blood components from contracted blood banks are aware of the predefined acceptance criteria.
6. Records of inspecting received blood and blood components support compliance.

Related standards:

DAS.21 Blood Procurement and storage, OGM.09 Contracted services management.

Safe transfusion services

DAS.23 Requesting blood and/or blood component services occurs in a safe and effective way.

Or rephrased to be" The ambulatory healthcare center has a process for requesting blood and/or blood components.

Safety

Keywords:

Ordering of blood and blood component.

Intent:

Access to sufficient supplies of safe blood and blood products provided within a blood transfusion service is a vital component in achieving equitable health outcomes. To ensure timely and equitable access to safe blood transfusion, the providers of blood for transfusion need to know how much blood is required for their patients and where and when it is needed so that blood is neither under- or over-supplied.

A realistic assessment of blood requirements is fundamental to effective planning for the rational, fair, and effective distribution of blood and blood components within a blood transfusion service.

Usually, a physician's order is required for blood components and products. In some case; such as elective surgeries, over ordering of blood is a common practice.

The ambulatory healthcare center shall develop and implement a policy and procedure to address safe blood transfusion service. The policy shall include at least the following:

a) Assessment of patient's clinical need for blood.
b) Education of patient and family about proposed transfusion and recording in the patient's medical record.
c) Selecting blood product and quantity required and completing the request form accurately and legibly.
d) Recording the reason for transfusion, so that the blood bank can check that the product ordered is suitable for diagnosis.
e) Clearly communicate whether the blood is urgently or routinely needed.
f) Sending the blood request form with blood sample to the blood bank.
g) When recipient's blood sample is received, a qualified member of the staff should confirm, if the information on the label and on the transfusion request form are identical. In case of any discrepancy or doubt, a new sample should be obtained.

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center policy followed by interviewing medical staff members, nurses and other healthcare professionals to check their awareness of the order process.
- GAHAR surveyor may observe patient's medical records to assess the completion, legibility and clarity of blood transfusion orders.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that describes all elements mentioned in the intent from a) through g).
2. Involved staff members are aware of the ambulatory healthcare center policy.
3. Indication for transfusion is recorded in the patient's medical record.
4. Blood bank staff members receive information about indication of transfusion, clinical information of the patient and whether the request is needed on emergency or routine basis.
5. Blood sample label and blood transfusion request are completed with all required data and cross-checked before issuing blood or blood components.

Related standards:

ICD.02 Clinical practice guidelines, ICD.05 Patient assessment process , DAS.24 Distribution and transfusion of blood and blood components

DAS.24 Blood and/or blood components are distributed from the blood bank and transfused according to professional practice guidelines.

Safety

Keywords:

Distribution and transfusion of blood and blood components

Intent:

Distribution of blood and/or blood components is a big line of defense to prevent tragic mistakes that could cost a patient his/her life.

By following the steps of safe distribution process and using a few good techniques to reduce the risk of error. The ambulatory healthcare center shall develop and implement a policy and procedures for safe distribution of blood and blood components The policy addresses at least the following:

a) Blood compatibility testing of all whole blood and red cells transfused.
b) The cross-matching report form should have patient's first name with surname, age, sex, identification number, ABO and Rh (D) type.
c) The form should have donor' unit identification number, segment number, ABO and Rh (D) type and expiry date of the blood.
d) Interpretation of cross matching report and the name of the person performing the test and issuing the blood should be recorded.

e) Each unit of blood should visually inspected before distribution. It should not be distributed if there is any evidence of leakage, hemolysis or suspicion of microbial contamination such as unusual turbidity, or change of color.

In addition, the policy shall include special situations such as;

f) Conditions for reissuance of blood: when blood and/or blood components are returned to blood bank to be reused/reordered.
g) Urgent requirement of blood.
h) Actions to taken when required blood type is not available.

Errors in transfusion of blood and/or blood components lead to significant risks for patients. Wrong blood administration incidents are mainly due to human error leading to misidentification of the patient and can lead to life-threatening hemolytic transfusion reactions and other significant morbidities.

The ambulatory healthcare center shall develop and implement a policy and procedures for transfusion of blood and/or blood components The policy addresses at least the following:

i. Visually checking the bag for integrity.
ii. Blood transfusion in emergencies
iii. Conditions when the bag shall be discarded.
iv. The rate for blood transfusion.
v. Recording the transfusion.
vi. Monitoring and reporting any adverse event.
vii. Special considerations for use of blood components.
viii. Management of transfusion complications.

Survey process guide:

- GAHAR surveyor may review the policy and procedures of safe distribution of blood and blood components and policy guiding transfusion of blood and/or blood components.
- GAHAR surveyor may interview responsible staff to check their awareness of the policy.
- GAHAR surveyor may observe the process of blood distribution and transfusion and check compliance with the requirements.
- GAHAR surveyor may review patient's medical record to check records of blood transfusion.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy regarding distribution that describes all elements mentioned in the intent from a) through h).
2. The ambulatory healthcare center has an approved policy regarding blood transfusion that describes all elements mentioned in the intent from i) through viii).
3. ~~Blood bank~~ Involved staff members are aware of the ambulatory healthcare center policy.
4. Cross matching reports show recipient and donor data.
5. Blood or blood component bags are checked before transfusion.
6. Monitoring of patient condition during transfusion is recorded in patient's medical record.

Related standards:

ACT.02 Patient identification, DAS.23 Ordering of blood and blood component.

Sedation , Anesthesia and Surgery

Regulatory Compliance in Sedation, Anesthesia service.

SAS.01 Anesthesia, and sedation services are provided according to applicable laws and regulations and professional practice guideline/protocol.

Safety

Keywords:

Provision of anesthesia, Sedation services.

Intent:

The provision of anesthesia and sedation is a complex process and problem-prone service; Laws, regulations, and guidelines sets governing framework to control these services.

Sedation and anesthesia require complete patient assessment, continued patient monitoring, and identified recovery criteria. The ambulatory healthcare center shall define sedation and anesthesia services required to provide according to its patient population, clinical services offered, and health care practitioners' needs.

For the safe provision of anesthesia and sedation, a minimum setup shall be available, which includes equipment, medications, medical supplies, and medical gases.

Anesthesia and sedation services are provided based on the applicable professional practice standards for providing anesthesia and sedation care and meet all applicable national laws and regulations.

Survey process guide:

- GAHAR surveyor may review clinical guidelines and protocols for anesthesia.
- GAHAR surveyor may interview staff to check their awareness of the standardized techniques for anesthesia.
- GAHAR surveyor may observe the structure of the place, available equipment, medications, and medical supplies followed by observing the process.

Evidence of compliance:

1. The provision of sedation and anesthesia service meets the applicable professional practice guidelines, national laws and regulations.
2. Sedation and anesthesia services are available to meet patient needs.
3. The ambulatory healthcare center has the needed equipment, medications, medical supplies, and medical gases for the provision of sedation and anesthesia service.
4. Sedation and anesthesia services are standardized and uniformly implemented throughout the ambulatory healthcare center.

Related standards:

ICD.02 Clinical practice guidelines, SAS.02 Qualified Anesthesiologist. APC.01 National regulations and licensure requirements.

SAS.02 Anesthesia and sedation services are provided under the direction of a qualified anesthesiologist.

Effectiveness

Keywords:
Qualified Anesthesiologist.

Intent:

Safe provision of anesthesia and sedation services requires appointment of experienced and qualified individual(s) (anesthesiologist) to perform and supervise the services provided. The job description shall clearly determine his responsibility that include at least the following:

a. Determines the resources required including staffing, equipment, medications and medical supplies.
b. Develop all required policies, procedures, applicable guidelines and protocols
c. Supervise all activities related to anesthesia and sedation services
d. Evaluates the outcome of anesthesia and sedation services
e. Perform anesthesia staff ongoing performance evaluation.

The ambulatory healthcare center shall determine the required qualifications, training, expertise, and experience of anesthesiologist that all are consistent with the applicable laws and regulations.

Survey process guide:

- GAHAR surveyor may review the staff file for the anesthesia and sedation leader to check the availability of all requirements in his job description.
- GAHAR surveyor may interview the anesthesia leader to check his awareness of the assigned responsibilities.

Evidence of compliance:

1. Clear, specific job description for the anesthesia and sedation leader is available in the leader's staff file, that include items from a) to e) in the intent.
2. Sedation and anesthesia services are under the direction of one or more qualified individuals.
3. The qualified individual (anesthesiologist) is fully understand and aware of his responsibilities mentioned in the job description.

Related standards:

SAS.01 Provision of anesthesia, Sedation services, WFM.03 Job Description WFM.04 Verifying credentials, WFM.10 Clinical Privileges, WFM.07Staff Performance Evaluation

Safe and patient-centered sedation services

SAS.03 Procedural sedation techniques and management of related complications are guided by clinical protocols.

Effectiveness

Keywords:

Sedation administration and monitoring_ Sedation complications.

Intent:

Procedural sedation, which includes moderate and deep sedation, involves any sedation administered intravenously for a procedure. Procedural sedation may also include the use of oral medications (for example, the use of chloral hydrate in children). To ensure uniformity of sedation services, sedation techniques shall be based on approved clinical protocols. Sedation techniques are provided according to the scope of service of the ambulatory healthcare center and type of surgeries and invasive procedures. The qualifications of the physician, dentist, or other individual responsible for the patient receiving procedural sedation are important. All individuals privileged to perform sedation are trained for at least on the following items:

a. Proper use and administration of sedation techniques and methods.
b. Management of complications that could occur by providing sedation and the process followed, if any.
c. Monitoring requirements

Procedural sedation provided by a qualified individual trained in advanced life support (appropriate for the age of patient), use of emergency medical equipment and supplies. Uninterrupted monitoring of the patient's physiological parameters and assistance in supportive or resuscitation measures shall be documented in patients' medical records. Patients continue to require monitoring until they have reached near their baseline level of consciousness and hemodynamic parameters. Identified criteria help identify patients who are recovered and/or ready for discharge. All required training records shall be documented in the staff personnel file.

Survey process guide:

- GAHAR surveyor may review the standardized sedation records, relevant staff file for the required training records.
- GAHAR surveyor may review the list of individuals privileged to perform sedation.
- GAHAR surveyor may observe process of discharging sedated patients after surgery or invasive procedures.

Evidence of compliance:

1. The administration of procedural sedation is standardized throughout the ambulatory care center.
2. Procedural sedation is performed by a qualified individual with advanced life support training (appropriate for the age of the patient).
3. All individuals privileged to perform sedation are trained for items from a) to c) in the intent.
4. The ambulatory healthcare center has a defined process for the management of sedation complications. (If any).

5. A competent, trained healthcare provider is responsible of patient post- procedural sedation care.
6. Established criteria are identified and documented for patient recovery and discharge from procedural sedation.

Related standards:

ICD.02 Clinical practice guidelines, ICD.13 Cardiopulmonary resuscitation and medical emergencies, SAS.08 Pre- sedation assessment, WFM.10 Clinical Privileges, EFS.09 Medical Equipment management plan.

SAS.04 The pre-sedation assessment is performed by a qualified individual.

Safety

Keywords:

Pre- sedation assessment.

Intent:

Sedation services start with performing a pre-sedation assessment. The pre- sedation assessment determines patient's condition, risk scoring for receiving sedation, and required interventions/care before, during, and after receiving sedation.

Sedation services shall be performed by a qualified individual who is trained on providing sedation service and have advanced competency in resuscitative services.

The ambulatory healthcare center is required to perform pre- sedation assessment for all patients before transfer to perform the surgeries or procedures. A pre-sedation assessment of the patient shall include at least the following:

a) Identify any airway problems.
b) Evaluate at-risk patients
c) Plan the type of sedation and the level of sedation the patient will need based on the procedure being performed
d) Safely administer sedation
e) Interpret findings from patient monitoring during procedural sedation and recovery.
f) The outcome of the assessment includes the risk scoring of receiving sedation and the sedation plan.

Survey process guide:

- GAHAR surveyor may observe the process of pre-sedation assessment
- GAHAR surveyor may review sample of patients' medical records to check for presedation assessment, sedation care plan' documentation.

Evidence of compliance:

1. There is a pre- procedural sedation assessment performed and documented that includes at least a) through f) in the intent.
2. Pre- procedural sedation assessment is performed and documented by a qualified individual.
3. Procedural sedation care plan is performed based on the outcome of pre-sedation assessment.
4. All sedation records are kept in the patient's medical record.

Related standards:

SAS.07 Sedation administration and monitoring_ Sedation complications., SAS.09 Post sedation care unit, IMT.05 Patient's medical record management.

Safe and effective anesthesia care

SAS.05 A qualified anesthesiologist performs a pre-anesthesia assessment and preinduction assessment

Safety

Keywords:

Pre- anesthesia assessment_ Pre- induction assessment.

Intent:

Anesthesia services usually starts with a pre-anesthesia assessment that performed by a qualified anesthesiologist. Pre-anesthesia assessment determines patient's condition, risk scoring for receiving anesthesia, and required interventions/care before, during, and after receiving anesthesia. The ambulatory healthcare center shall develop a policy for preanesthesia and pre-induction assessment that clearly identify when and how those assessments are performed.

The pre-anesthesia assessment shall be completed prior to the surgical procedure or shortly before the surgical procedure.

The pre-induction assessment is separate from the pre-anesthesia assessment, as it determines the physiological stability and readiness of the patient for anesthesia and occurs immediately prior to the induction of anesthesia.

In case of emergency, the pre-anesthesia assessment and pre-induction assessment shall be performed immediately, simultaneously, but are documented independently.

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center policy for preanesthesia assessment.
- GAHAR surveyor may observe and tracing a patient who received anesthesia to evaluate the process of pre-anesthesia assessment.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy of pre-anesthesia and preinduction assessment according professional practice guideline that clearly identify when and how those assessments are performed.
2. Pre-anesthesia assessment is performed for each patient to evaluate risk scoring for receiving anesthesia.
3. Pre- induction assessment is performed for each patient immediately before induction of anesthesia.
4. The pre-anesthesia assessment and pre- induction assessment are recorded separately in the patient's medical record.
5. Relevant staff is trained and fully aware of how to apply the policy.

Related standards:

PCC.05 Informed consent, SAS.04 Anesthesia plan, IMT.05 Patient's medical record management, WFM.03 Job Description, WFM.04 Verifying credentials.

SAS.06 The ambulatory healthcare center ensures performing anesthesia plan for each patients.

Effectiveness

Keywords:
Anesthesia plan.

Intent:

Anesthesia care shall be planned and documented in the medical record. The plan includes at least the following:

a. Information from the complete patient assessments and identifies the appropriate anesthesia to be used,
b. The method of administration,
c. Other medications and fluids needed,
d. Monitoring procedures,
e. Anticipated post anesthesia outcome.
f. The anesthesia agent, and anesthetic technique
g. Signature and full name of participated anesthesia team shall be documented in medical record.

Survey process guide:

- GAHAR surveyor may review sample of patients' medical records to check for anesthesia care plan' complete documentation.
- GAHAR surveyor may interview the relevant staff to check their awareness of the anesthesia care plan.

Evidence of compliance:

1. Each patient' anesthesia care plan is performed and documented in the patient's medical record.
2. The anesthesia care plan includes all items from a) to g) in the intent.
3. The anesthesiologist, anesthesia assistants and all participated team are identified in the patient's medical record.

Related standards:

PCC.05 Informed consent, SAS.03 Pre- anesthesia assessment, pre-induction assessment, IMT.05 Patient's medical record management

SAS.07 A qualified anesthesiologist performs continuous monitoring of the patient's physiological status during anesthesia.

Safety

Keywords:

Continuous monitoring during anesthesia.

Intent:

Administering anesthesia and performing surgeries and invasive procedures are associated with changes in the patient physiologic status that could be very rapid. Accordingly, the patient physiologic status is required to be continuously monitored starting before receiving the anesthesia to determine the baseline of patient condition, which is used in determining the patient criteria of discharge from the post-anesthesia care unit. Continuous monitoring allows the anesthesiologist for on-time intervention for any changes in the patient's condition. The type and frequency of anesthesia monitoring is determined according to, at least the following:

a. Patient's condition and age,
b. Pre-anesthesia assessment
c. Anesthesia plan
d. Type of anesthesia,
e. Type and duration of surgery or invasive procedure performed
f. The applicable professional practice guidelines.

Management of anesthesia emergencies and complications is the most critical part of providing anesthesia care. Written protocols for management of complications ensures professional management of these conditions if occurred.

Survey process guide:

- GAHAR surveyor may observe a patient while receiving the anesthesia service to evaluate the process of patient monitoring and the staff involved in this process.
- GAHAR surveyor may review samples of patients' medical records to check for anesthesia monitoring documentation.

Evidence of compliance:

1. The frequency and type of monitoring during anesthesia and surgery is determined according to item a) through item f) from the intent.
2. Monitoring of the patient's physiological status is consistent with the ambulatory healthcare center professional practice guidelines.
3. The results of monitoring are documented in the patient's medical record.
4. A qualified anesthesiologist performs the anesthesia monitoring.
5. The ambulatory healthcare center has an approved protocol for the management of any anesthesia emergencies or complications.

Related standards:

SAS.02 Qualified Anesthesiologist, SAS.03 Pre- anesthesia assessment_ Pre- induction assessment, SAS.04 Anesthesia plan, IMT.05 Patient's medical record management, EFS.10 Critical alarms

SAS.08 Post anesthesia care, monitoring, and discharge is done by competent individual.

Safety

Keywords:

Post- anesthesia care.

Intent:

Post-anesthesia care includes monitoring of the patient physiologic status that allows anesthesiologist to do an on-time intervention for any changes in patient's condition and determine patient's criteria of discharge from the post-anesthesia care unit.

Administration of any medications, IV fluids, blood, or blood products ordered and administered should be recorded in the patient's medical record.

The ambulatory healthcare center is required to record any special or unusual events occurred inside the post-anesthesia care unit with the management provided, the time of receiving the patient, and the time of transfer from post-anesthesia unit. If the patient is transferred directly from the operating theatre to a receiving unit, monitoring and documentation are the same as would be required in the recovery room. The ambulatory healthcare center shall develop and implement a policy of post anesthesia care and monitoring that describe the process of post-anesthesia care, assign responsibility and describe the documentation requirements.

The patient is discharged, by a fully qualified anesthesiologist or other individual authorized by the individual(s) responsible for managing the anesthesia services. A qualified individual develops post-anesthesia care plan which includes at least the following:

a) The patient's physiologic status
b) Time of receiving the patient
c) Used type of anesthesia.
d) Administered medications with dose, route, and time of administration.
e) Fluid management includes intake and output.
f) Administered blood or blood products.
g) The occurrence of any unusual event.
h) The patient condition before leaving according to defined criteria
i) Patient disposition
j) Time of transfer from the post-anesthesia care unit.

k) Signature of the physician who order patient discharge or disposition.

Survey process guide:

- GAHAR surveyor may review the post- anesthesia care and monitoring policy.
- GAHAR surveyor may observe the process of post-anesthesia care and monitoring process
- GAHAR surveyor may review a sample of patients' medical records to check for postanesthesia care plan documentation
- GAHAR surveyor may interview the relevant staff to check their awareness of the policy and process.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy of post anesthesia care and monitoring that clearly describe the process of post-anesthesia care, and assign responsibilities.
2. Patients are monitored during the postanesthesia recovery period.
3. Post-anesthesia care plan is documented in the patient's medical record including items from a) to k) in the intent.
4. The ambulatory healthcare center has a clear process of monitoring, when the patient is transferred directly from the operating theatre to a receiving unit.

Related standards:
SAS.03 Pre- anesthesia assessment_ Pre- induction assessment, SAS.04 Anesthesia plan, IMT.05 Patient's medical record management

Safe and effective surgical and invasive procedures care

SAS.09 Provision of surgery and invasive procedure services is according to applicable laws and regulations and professional practice guidelines/protocols.

Safety

Keywords:

Provision of surgeries and invasive procedures.

Intent:

The ambulatory healthcare center is required to provide the surgery and invasive procedure services all over the ambulatory healthcare center safely by providing the required resources as obliged by the national laws and regulations. All units providing surgery and invasive procedure services have appropriate spacing, ventilation, infrastructure including medical gases, appropriate equipment, medical supplies, and medication.

Applying the process of booking in the ambulatory healthcare center decreases the waiting time for surgeries and invasive procedures and allowing the ambulatory healthcare center to plan efficiently in providing the surgery and invasive procedure services.

The ambulatory healthcare center shall develop and implement a policy and procedures for surgery and invasive procedures safe provision that addresses at least the following:

a) Scheduling process (booking process) for surgeries and invasive procedures.
b) Granting clinical privileges to staff to perform those types of surgeries and invasive procedures.
c) Recording of surgeries and invasive procedures, whether they are scheduled, performed, or canceled.
d) Patients' identification verification methods.
e) A clear and safe mechanism to call patients for surgeries or invasive procedures.
f) The recorded timing of all patient flow steps inside the unit and the analysis of this punctuality.
g) Analysis of the postponed and canceled surgeries and invasive procedures to support the ambulatory healthcare center with reliable data for better management.
h) Process to verify availability of all required resources.

Survey process guide:

- GAHAR surveyor may review the policy for surgery and invasive procedures safe provision
- GAHAR surveyor may review qualifications and privilege of staff who permitted to perform surgeries and invasive procedures.
- GAHAR surveyors may review evidence of postponed and canceled procedures analysis.

Evidence of compliance:

1. All units providing surgery and invasive procedure services have appropriate spacing, ventilation, infrastructure, equipment, medical supplies and medication.
2. The ambulatory healthcare center has an approved policy to guide the surgery and invasive procedures safe provision that addresses all elements mentioned in the intent from a) through h).
3. Analysis of postponed and canceled procedures is continuously monitored, reported and acted upon.
4. Punctuality of the procedural unit is maintained and recorded starting by patient call until room cleaning after the procedure.
5. Staff who permitted to perform surgery and invasive procedure services are qualified and privileged in the ambulatory healthcare center to perform those types of surgeries and invasive procedures.

Related standards:

ICD.02 Clinical practice guidelines, SAS.11 Assessment before surgery and invasive procedures, WFM.10 Clinical Privileges, QPI.04 incident reporting system, SAS.12 preoperative verification process

SAS.10 Patient assessment is performed by the responsible physician before surgery or invasive procedure.

Safety

Keywords:

Assessment before surgery and invasive procedures

Intent:

Complete patient assessment before surgery with requesting the needed investigations either for ensuring the diagnosis, revealing risk factors, assessing patient medical condition, or determining baseline patient condition followed by proper management of all identified diagnoses and risk factors. This assessment shall be done by the responsible physician, (preferred the patient's surgeon). Assessment of the patient's condition is needed for all surgeries to determine the precautions needed and informing the patient and family about the expected outcome of the surgery.

Patient assessment should be reviewed and repeated if a surgery/invasive procedure is postponed or canceled to maintain the validity of the patient assessment. The pre-surgical assessment and care plan for each patient is documented in the patient's medical record, including a preoperative diagnosis.

The ambulatory healthcare center shall perform a complete patient assessment before any elective surgery supported by the results of required investigations. The ambulatory healthcare center is required to document the patient assessment in the patient's medical

record for the medico legal issues and for proper communication between staff followed by developing the patient's plan of surgical care that includes at least the following:

a) Patient needs and condition.
b) Pre-operative diagnosis.
c) Plan for surgery (and invasive procedure).

Survey process guide:

- GAHAR surveyor may review sample of patients' medical records to check for documentation of Pre-surgical assessment, Pre-operative diagnosis, Plan for surgery and actions taken for the management of any risk factors.

Evidence of compliance:

1. A complete pre- surgical assessment is performed and documented for all patients planned for surgery or invasive procedure, with documentation of any identified risks for the patient's conditions.
2. Pre-operative diagnosis and actions taken for the management of any risk factors are documented in the patient medical record before surgery or invasive procedure.
3. Patient's plan of surgical care is performed and timely documented in the medical record.
4. In life-threatening emergencies, a brief assessment and surgical care planning is performed and timely documented in the patient's medical record.

Related standards:

PCC.05 Informed consent, SAS.10 Provision of surgeries and invasive procedures. SAS.12 Pre-Operative verification process, ICD.05 Patient assessment process.

SAS.11 GSR.10 The ambulatory healthcare center has a pre-operative verification process to ensure patient safety, availability and appropriateness of care before calling for the patient for surgery.

Safety

Keywords:

Pre-operative verification process.

Intent:

Ensuring the availability of all needed items as blood booking, results of the requested investigation or special prosthesis should be done as a pre-operative verification process to ensure patient safety and appropriateness of care.

Ensuring the availability and functioning of needed equipment minimizes the risk of errors by preventing the use of malfunctioning equipment or cancellation of surgery and

invasive procedure after the patient went to the operating rooms or invasive procedure unit. The ambulatory healthcare center is required to ensure the availability and functioning of equipment needed for the surgery and invasive procedure before calling for the patient. This equipment and tools could be differed according to the type of surgery and invasive procedure or the use of anesthesia and sedation.

In addition, the ambulatory healthcare center is required to develop a process for preoperative verification of the availability of all needed or requested documents and other items before the patient going for the surgery or invasive procedure.

Survey process guide:

- GAHAR surveyor may review the policy of pre-operative verification and check the availability of all needed documents and equipment.
- GAHAR surveyor may interview responsible staff to check their awareness of the pre-operative verification process.

Evidence of compliance:

1. The ambulatory healthcare center has a defined process for pre-operative verification including all needed documents and equipment.
2. Pre-operative verification of all needed documents and equipment is documented before each surgery and invasive procedure.
3. Responsible staff is aware of the pre-operative verification process.
4. The ambulatory healthcare center monitors the reported data on the preoperative verification process and takes actions to control or improve the process as appropriate.

Related standards:

ACT.02 Patient identification, SAS.11 Assessment before surgery and invasive procedures SAS.13 Time-out, SAS.14 Site marking and identification.

SAS.12 The ambulatory healthcare center uses a noticeable mark for surgical/invasive procedure site identification that is consistent throughout the center.

Safety

Keywords:

Site marking and identification.

Intent:

Visible and clear site marking is an error reduction strategy that should be performed by the responsible physician who will perform the surgery and invasive procedure (patient's surgeon) with the involvement of the patient if the patient is an adult and fully conscious or patient's family in other situations. The site marking in each organization should be unified, detectable, and placed on the nearest site to the surgical site.

When performing a surgery or invasive procedure, healthcare professionals should verify the right patient, the right type of surgery, right site, right side. The site is marked in all cases including laterality, multiple structures (fingers, toes). Alternative methods for dental site marking include using images of the patient's teeth or paper diagrams of teeth to mark the site.

Survey process guide:

- GAHAR surveyor may interview staff to check their awareness of the site marking procedure

Evidence of compliance:

1. Site marking is a unified mark throughout the AHC and is performed by the physician responsible for the surgery or invasive procedure.
2. The patient is actively involved in the site marking process with exception in some circumstances.
3. The mark is visible after the patient is prepped, draped, prepared for surgery or procedure.
4. The AHC monitors the reported data regarding the site marking process and takes actions to control or improve the process as appropriate.

Related standards:

SAS.12 Pre-Operative verification process, SAS.13 Time-out

SAS.13 GSR.11 Time-out is performed pre-operatively, just before starting a surgical or invasive procedure.

Safety

Keywords:

Time-out.

Intent:

Time out aims for verification of the correct patient, correct procedure, and correct site and side of surgery or invasive procedure. Time- out is a single process that has been proved to reduce wrong-site surgery. The time-out shall conducted in the location at which the procedure will be done and involves the active participation of the entire team. Patient participation is not obligatory. Completion of the time-out is documented and includes the date and time that the time-out was completed. The ambulatory healthcare center shall develop and implement a policy of time- out that describe the process.

If surgery is performed in settings other than the operating theatre, the ambulatory healthcare center shall implement a uniform processes (as in operating theatre) to ensure the correct site, correct procedure, and correct patient.

According to WHO, sign-out is a part of the safe surgery checklist in which the operating team shall review all the processes so far before leaving the operating location, including the procedure name, ensuring completion of the counting process, verifying the extracted specimen against its label as well as raising any other concerns and problems during the procedure.

Survey process guide:

- GAHAR surveyor may review the policy for time –out and interview the relevant staff to check their awareness of the policy.
- GAHAR surveyor may review the document used to record time-out process GAHAR surveyor may observe the time-out process.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy for time-out to ensure the correct patient, procedure, site and side.
2. When surgery or invasive procedure is performed outside the operating theatre, Timeout process implemented.
3. Time- out is implemented immediately before the start of surgery or invasive procedure.
4. The surgery or invasive procedure team is involved in the time out process
5. Sign-out is conducted at the end of all surgical and invasive procedures and before leaving the operating location.
6. Relevant staff is fully aware and trained for time-out and Sign-out processes.

Related standards:

ACT.02 Patient identification, SAS.12 Pre-Operative verification process SAS.14 Site marking and identification.

SAS.14 Details and information about surgery or procedures are recorded in the operative report immediately after the procedure.

Safety

Keywords:

Operative report.

Intent:

Immediate reporting of the procedure has a significant role in the continuity of care. Planning for postoperative care depends on findings and special events that occurred during the procedure, as failure to report these events markedly compromises patient

care. The ambulatory healthcare center is requested to immediately report the procedure details before the patient leaving the procedural unit.

Recording the names of all staff involved in the procedure has a medico legal aspect and communication aspect and any similarity or discrepancy in the patient diagnoses before and after the procedure should be documented and clarified. Details of the procedure should be clearly stated, including the incision site, if applicable, step by step of the surgical technique, and ended by how the skin closure or ending the procedure is done. Use of any prosthesis or implantable devices should be stated in the report, including any special precautions when dealing with or to remove it.

Occurrence of complications during the procedure should be recorded with the action taken to manage. Any specimen removed from the body should also be stated clearly in the procedure report. That addresses at least the following:

a) Time of start and time of the end of the procedure.
b) Name of all staff involved in the procedure, including anesthesia.
c) Pre-procedure and post-procedure diagnoses.
d) The procedure performed with details.
e) The details of any used implantable device or prosthesis including the batch number
f) The occurrence of complications or not.
g) Any removed specimen or not.
h) Estimated blood loss and/or transfused blood.
i) Signature of the performing physician.

Survey process guide:

- GAHAR surveyor may review sample of patients' medical records to check the completeness of all components needed in the operative/procedure report.

Evidence of compliance:

1. The operative/procedure report is readily available for all patients who underwent a procedure before leaving the procedural unit.
2. The operative/procedure report includes at least items from a) through h) in the intent.
3. The report is kept in the patient's medical record.

Related standards:

SAS.11 Assessment before surgery and invasive procedures, IMT.05 Patient's medical record management

SAS.15 GSR.12 Accurate counting of sponges, needles, and instruments pre and post-procedure is verified.

Safety

Keywords:

Pre and post procedure count verification process.

Intent:

Missing sponges, needles, towels, or instruments inside the patient body act as a foreign body and causes serious morbidity in the form of pain, organ injury and sepsis, which necessitate re-opening the patient and could reach up to mortality.

The ambulatory healthcare center is required to spend every effort by the surgical team to prevent missing any foreign body during surgery/invasive procedure by meticulous counting of any used item before, during the closure of each body space, and after the closure of the skin. Once a miscount is identified, the team shall conduct re- counting, check the missing item, make provisions using imaging studies, and report the miscount.

Survey process guide:

- GAHAR surveyor may review the record for the preoperative, intraoperative and postoperative count of sponges, needles, towels, or instruments.
- GAHAR surveyor may interview relevant staff to check their awareness of the process.

Evidence of compliance:

1. Counting of sponges, needles, towels, or instruments is done pre, intra and post-operative by two independent staff.
2. There is a record for the preoperative, intraoperative and postoperative count of sponges, needles, towels, or instruments.
3. The performing physician confirmed the process and signed the count sheet.
4. There is a process to manage and deal with miscount once identified.
5. The ambulatory healthcare center monitors the reported data on the counting process and takes actions to control or improve the process as appropriate.

Related standards:

SAS.12 Pre-Operative verification process

SAS.16 Surgically removed tissue is sent for pathological examination unless present in the list of exempted tissues from the pathological examination.

Effectiveness

Keywords:

Pathological examination of surgically removed tissue.

Intent:

Surgically removed tissue from the human body shall be sent for pathological, histopathological, or immune histochemical examination for continuity of care as it is essential to confirm or prove a diagnosis. Operative care also may depend on findings in the examination of the frozen section. For some surgically removed tissues, there is no need to have a pathological examination of these tissues.

The ambulatory healthcare center has to identify those tissues clearly to be exempted from pathological examination in routine cases unless requested by the physician.

The ambulatory healthcare center is required to design a pathway for tissues removed from the human body to the laboratory to obtain a sample for examination, then sent to the appropriate disposition according to the type of tissue.

Survey process guide:

- GAHAR surveyor may trace the pathway of a surgically removed body part until its disposition. This tracing includes staff interviews and document review in the operating room and laboratory.
- GAHAR surveyor may review sample of medical record to check the availability of pathology results with the time -frame of the results.

Evidence of compliance:

1. There is a clear process and pathway of any surgically removed tissue.
2. There is a list of exempted tissue from pathological examination.
3. Surgically removed tissues are labelled and sent for pathological examination, and the results of the examination are available in the patient's medical record within the defined time- frame.

Related standards:

ACT.02 Patient identification, DAS.12 Specimen reception, tracking and storage.

SAS.17 The ambulatory healthcare center has a system for managing implantable devices or lenses, including recall.

Safety

Keywords:
Implantable Devices

Intent:

The implantable device is a medical device that is permanently placed into the body to continuously assist, restore, or replace a function or structure of the body throughout the useful life of the device.

Examples include intra-ocular lens, Intra-uterine devices, dental implants and infusion pumps.

There are many considerations while using implantable devices, which include the special instructions for use, sterility, manufactural consideration, and malfunction.

The ambulatory healthcare center is required to track the implantable device from its primary source to discover any unstable, contaminated, defective, or imitation product. Every patient who has an implantable device should be easily identified, easily reachable within a defined time- frame to be ready for any device recall.

Survey process guide:

- GAHAR surveyor may review the list of implantable devices and may inquire about the process for the retrospective tracing of any implantable device.
- GAHAR surveyor may review a process for the recall of a patient who has an implantable device in a defined time- frame after receiving the notification of a recall.

Evidence of compliance:

1. There is a list of implantable devices used in the ambulatory healthcare center.
2. There is a process for the retrospective tracing of any implantable device.
3. There is a process for the recall of a patient who has an implantable device in a defined time- frame after receiving the notification of a recall.

Related standards:

ACT.02 Patient identification, SAS.11 Assessment before surgery and invasive procedures, SAS.12 Preoperative verification process, SAS.12 Time-out.

SAS.18 Post-operative care plan is performed and recorded before transfer of patient to the next level of care.

Effectiveness

Keywords:

Post-operative plan of care.

Intent:

Post-operative care is a main factor in determining procedure outcome. Creating the postoperative care plan should start immediately after the procedure and before the patient leaving the procedural room to prevent any delay, wrong, unnecessary, or missing care. Postoperative plan of care is developed by the physician who performed the procedure and the anesthesiologist (when applicable) and includes

a. Recent level of care,
b. Patient position,
c. Patient activity,
d. Required further monitoring,
e. Diet,
f. Medications, intravenous fluids,
g. Required investigations
h. Follow up instructions.

Survey process guide:

- GAHAR surveyor may review sample of medical records to check for the postoperative plan of care followed by observing the implementation of the physician orders related to the postoperative plan of care

Evidence of compliance:

1. There is a postoperative care plan for all patients performing the surgery/procedure that includes items from a) to h) in the intent.
2. The postoperative care plan is documented in the medical record before patient leaving the procedure room.
3. Postoperative plan of care is developed by the physician who performed the procedure and the anesthesiologist (when applicable)
4. The postoperative care plan is implemented.

Related standards:

SAS.11 Assessment before surgery and invasive procedures, SAS.15 Operative Report, IMT.05 Patient's medical record management, ICD.08 Plan of Care.

Medication Management and Safety

Chapter intent

Getting the most from medications for both patients and society is becoming increasingly important as more people are taking more medications. Medications are offered by health services throughout the world. Medications prevent, treat, or manage many illnesses or conditions and are the most common interventions in healthcare.

Medication refers to any substance administered to individuals for the purpose of diagnosing, treating, or preventing disease or abnormal conditions. This includes prescription drugs, including narcotics, over-the-counter (OTC) medications, herbal remedies, vitamins, and nutraceuticals, vaccines and biologics, diagnostic and contrast agents, radioactive medications, respiratory therapy treatments, parenteral nutrition, blood products, and products containing medications and intravenous solutions with electrolytes and/or medications. Excluded from this definition are enteral nutrition solutions (considered food products), oxygen, and other medical gases—unless specifically stated otherwise.

Medication management is one of the major responsibilities in any healthcare organization. It is a complex process that involves different phases, including planning, procurement, storage, prescribing, transcribing, ordering, dispensing, administration, monitoring of the medications, and evaluation of the program. Evidence suggests that, at each phase of the cycle, errors do occur, adversely influencing patients' safety, which is a priority in today's practice. However, with substantial and increasing medication use comes a growing risk of harm. This is compounded by the need to prescribe for a special population, including pediatrics, pregnancy, and the aging population with increasingly complex medical needs, and the introduction of many new medications. These issues are particularly relevant in ambulatory healthcare centers.

Additionally, medication errors are one of the most commonly occurring errors in healthcare organizations, and they can occur in any step along the pathway of medication management. It is further stated that morbidity from medication errors results in high financial costs for healthcare institutions and adversely affects the patient's quality of life. Preventing medication errors is a major priority in the health system, and many international organizations, such as the World Health Organization (WHO), have launched medication safety as part of their global patient safety initiatives.

Chapter purpose

1. To highlight the principles for medication management and use in ambulatory healthcare centers, promoting safe, quality use of medications, and medication management.
2. To provide a framework for an effective and safe medication management and use program.
3. To evaluate the continuity of medication management processes from planning to monitoring and evaluation, with a special focus on the identification of risk points to improve patients' outcomes and patient safety.

4. To advocate a partnership and systems approach to achieve safe and quality use of medications and medication management in ambulatory healthcare centers.

Implementation guiding documents:
(Any of the following mentioned references needs to be read in the context of its terms, conditions, substitutes, amendments, updates, and annexes)

The decision of the Minister of Health and Population number 496, the year 2012

- The decision of the Minister of Health and Population number 368, the year 2012, for developing a pharmacovigilance center.
- The decision of the Minister of Health and Population number 475, the year 2019
- Institute for Safe Medication Practices. ISMP Medication Safety Tools and Resources. Accessed Dec 6, 2017. https://www.ismp.org/tools/.
- Law No. 127/1955 on practicing the profession of pharmacy.
- Law No. 182/1960 on narcotics
- Law No. 151/2019 on the establishment of the Egyptian Drug Authority.
- Prime Minister's Decree 777/2020 about the EDA executive bylaws.
- Rational Drug Use Publication No: 4, Year 2017 of Antimicrobial Stewardship
- Rational Drug Use Publication No: 1, year 2019 of The Egyptian Crash cart and emergency drug list.
- The Egyptian Guidelines of Medication Management Standards, first edition (2018).
- The Egyptian Drug Authority Decree No. 271, year 2021, on the regulation of Drug storage requirements for pharmaceutical institutions.
- The Egyptian Drug Authority Decree No. 340, year 2021, on the re-regulation of handling of the pharmaceutical substances and products affecting the mental state
- The Minister of Finance Decree No. 89, year 1998, on the regulation of tenders and auctions law was promulgated, and its implementing regulations.
- The Minister of Health and Population decree number 104, year 2003, on the regulation of expiry drugs.
- The Minister of Finance Decree No. 182, year 2018, on the regulation of tenders and auctions law promulgated, and its implementing regulations
- The Minister of Health and Population Decree No. 380, year 2009, on the re-regulation of the health requirements for pharmaceutical institutions.
- The Minister of Health and Population Decree Number 172, year 2011, on the reregulation of handling of the pharmaceutical substances and products affecting the mental state.
- The Minister of Health and Population Decree No. 475, year 2019, on the reregulation of handling of the pharmaceutical substances and products affecting the mental state.

Medication Use, Selection, and Procurement

MMS.01 Medications available for use are selected, procured, listed, and managed based on approved criteria to ensure safe and effective use. use *Effectiveness*

Keywords

Medication management.

Intent

Medication management remains a primary concern in any healthcare setting, and is often an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. The unsafe use of medication is not the only safety problem in any healthcare system, but it is certainly one of the most significant issues. Ensuring a safer medication management program at an organizational level is a major challenge.

All medication management processes (selections, procurement, prescribing, preparation, administration, and monitoring) in ambulatory healthcare centers are conducted and implemented according to the Egyptian laws and regulations (The Egyptian

Drug Authority (EDA) and the Egyptian Ministry of Health (MOH)). The ambulatory healthcare center is equipped with updated and appropriate medication-related information source(s) in electronic or paper-based formats for staff members involved in medication use.

The ambulatory healthcare maintains a current **inventory list** of medications, selected from EDA-approved sources based on community needs. The list shall include (but not be limited to:

a) Medication name(s).

b) Strength(s)/concentration(s) of medication(s)
c) Dosage form(s)
d) Indication

The procurement system ensures the selection of cost-effective essential medications, verification of supplier licensure and quality, prevention of counterfeit, defective, or contaminated products, and notification and substitution protocols when products are unavailable.

The ambulatory healthcare center shall have a process to investigate if the medications are contaminated, defective, or counterfeit, and to trace them back to determine the cause of the problem, and to notify the manufacturer and/or distributor when something is discovered when checking the supply at the receiving step. In addition, the ambulatory healthcare center shall define a procedure to inform healthcare providers and physicians about unavailable medications and products and respective substitutes.

Overuse and misuse of antimicrobials contribute to antimicrobial resistance, a major threat to patient safety. To address this, Egypt's Ministry of Health mandated antimicrobial stewardship (AMS) in 2017 and launched a national action plan in 2018. AMS promotes the optimal use of antibiotics, prevents resistance, and educates healthcare providers and the public. Ambulatory healthcare centers are required to implement at least one AMS activity, such as clinical guidelines, restrictions on certain antibiotics, criteria for switching from parenteral to oral therapy, or monitoring drug interactions—selected based on resources and patient needs. Effectiveness must be evaluated using indicators like inappropriate use, adherence to policies, consumption, and cost.

Survey process guide

- GAHAR surveyors may review the medication management program and the credential(s) and job description(s) of the healthcare professional(s) responsible for the program.
- GAHAR surveyors may review the updated list of medications available in the center.
- GAHAR surveyors may interview staff about the accessibility to the drug information source(s).
- GAHAR surveyor may review evidence of the antimicrobial stewardship activities implementation and evaluation.

Evidence of Compliance

1. The ambulatory healthcare center maintains an approved and updated medication management program, clearly outlining all processes of medication use and supervised by qualified healthcare professional(s).
2. Updated and appropriate medication-related information sources are available in written and/or electronic formats and accessible to all staff involved in medication use.
3. The ambulatory healthcare center has approved policy and procedures addressing the criteria of appropriate selection and procurement of medications in accordance with the organization's mission, patient needs, and safety.
4. The ambulatory healthcare center has an approved and updated list of the medications, which covers at least items from a) to e) in the intent.
5. The ambulatory healthcare center implements and evaluates at least one AMS activity using organization-approved interdisciplinary protocols and evaluates the outcomes for continuous improvement..

Related standards

MMS.02 Medication storage and labelling,

IPC.17 Multi-Drug-Resistant Organisms,

WFM.07 Staff Performance Evaluation,

OGM.07 Supply Chain Management.

MMS.02 NSR.08 Medications are safely and securely stored in a manner to maintain their quality. *Safety*

Keywords

Medication storage and labelling.

Intent

Well-designed and appropriate storage of medications can reduce waste, incorrect medication dispensing, and handling. The ambulatory healthcare center maintains proper medication storage conditions (temperature, light, and humidity) in medication storage areas to protect their stability 24 hours a day, and 7 days a week, according to the manufacturer/marketing authorization requirements. The stability and effectiveness of the medications depend on storing them at the correct temperature, for example, those medications requiring refrigeration and multi-dose containers.

There should be clear evidence that the ambulatory healthcare center ensures the storage of medications in a manner to maintains its quality and integrity even during power outages. Also, the ambulatory healthcare center limits access to medication storage areas with the level of security required to protect them against loss or theft, depending on the types of medications stored, like the storage requirements for narcotics and psychotropic medications.

When patient emergencies occur, quick access to appropriate emergency medications is critical and may save saving. The ambulatory healthcare center shall develop a policy and procedures that ensure the availability and the location of emergency medications and the medications to be supplied in these locations. For example, agents to reverse anaesthesia are found in the operating theatres.

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions being removed from their original

containers and placed into unlabeled containers. This unsafe practice neglects the basic principles of safe medication management. The ambulatory healthcare center shall ensure that the labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications. The following data are clearly shown on the labels (If not apparent on the original packages or boxes):

a) The name,
b) concentration/strength,
c) expiration date,
d) batch number, and
e) applicable warnings.

Survey process guide

- GAHAR surveyor may review the policy of handling emergency medications.
- GAHAR surveyor may observe that all medications are stored according to manufacturer/marketing authorization requirements, and all are clearly labeled.
- GAHAR surveyor may observe narcotic and psychotropic medications storage conditions and their security.
- GAHAR surveyor may interview the staff to check their awareness of the action(s) taken when there is an electric outage.

Evidence of Compliance

1. Medications are stored safely and securely, and under the manufacturer/marketing authorization holder recommendations, in clean and organized areas.
2. Emergency medications (including reversal agents and antidotes) are accessible, clearly arranged, securely stored, and protected from loss/theft.
3. Narcotics and psychotropic medications are stored in accordance with the applicable laws and regulations.
4. The ambulatory healthcare center has a process for the handling of multi-dose medications to ensure their stability and safety.
5. The ambulatory healthcare center has a clearly implemented process in place to ensure medication integrity during power outages.
6. Medications, medication containers, and the components used in their preparation are clearly labeled (if not apparent on the original packages or boxes) with elements from a) to e) in the intent.

Related standards

MMS.01 Medication management.

MMS.03 High- alert medications, Look-alike Sound-alike medications,

EFS.11 Utilities Management plan.

MMS.03 NSR.09 High alert medications and look-alike sound-alike medications are managed in a way to minimize risk and ensure patient safety.

Safety

Keywords

High-alert medications, look-alike, sound-alike medications.

Intent:

High-alert medications are those that bear a heightened risk of causing significant patient harm when they are used in error. Examples of high-alert medications include (but are not limited to): anesthesia medications, inotropic agents, adrenergic agonists, concentrated electrolytes, and lookalike/sound-alike medications.

The ambulatory healthcare center needs to develop its own list of high alert medications based on its own data and both national and international recognized organizations (e.g., the Institute of Safe Medication Practice (ISMP) and the World Health Organization (WHO)). In addition, the ambulatory healthcare center has strategies in place to prevent the inadvertent use and administration of these medications.

Look-alike/sound-alike (LASA) medications are those visually similar in physical appearance or packaging and names of medications that have spelling similarities and/or similar phonetics. Any confusion between these medications may lead to harmful errors. The Institute for Safe Medication Practices (ISMP) maintains an ongoing list of LASA medication names to highlight medications that may require special safeguards or strategies to help prevent healthcare providers from accidentally mistaking one medication for another. Another strategy that the ISMP recommends for reducing LASA medication name errors is to include both the brand name and nonproprietary name, dosage form, strength, directions, and the indication for use, which can be helpful in differentiating LASA medication names. Other recommendations aimed at minimizing name confusion include conducting a periodic analysis of new product names; physically separating and segregating these medications in medication storage areas prevents confusion and promotes safety.

An ambulatory healthcare center needs to establish risk management strategies to minimize adverse events with LASA medications, enhance patient safety, and protect against inadvertent administration.

Survey process guide:

- GAHAR surveyor may review the updated lists of high alert medications and LASA medications.
- GAHAR surveyors may observe the different strategies implemented to ensure safe management of high alert medications and LASA medications.
- GAHAR surveyor may interview staff to check their awareness of management of high alert medications and LASA medications.

Evidence of Compliance:

1. The ambulatory healthcare center has an annually updated list(s) of high alert medications, and concentrated electrolytes (if available)
2. The ambulatory healthcare organization has an annually updated list of look-alike sound alike medications.
3. The ambulatory healthcare center has a uniform process for the safe storage and administration of high alert medications and concentrated electrolytes (if available), including separation and labeling.
4. The ambulatory healthcare center has a uniform process for the safe handling of look-alike, sound-alike medications, including separation, labeling, and administration.
5. Responsible staff members are aware of the strategies implemented when managing high alert medications, concentrated electrolytes (if available), and loo- alike sound sound-alike medications

Related standards

MMS.02 Medication storage and labelling. MMS.06 Medication preparation and administration.

MMS.04 The ambulatory healthcare center maintains an effective drug recall system.

Effectiveness

Keywords
Drug recall system.

Intent

A drug recall is required when medication safety or integrity is compromised. This includes expired, outdated, damaged, contaminated, or dispensed but not used medications.

Drug recalls can be extremely costly and can damage consumer confidence in the product or company, so naturally, all companies try the maximum to avoid such scenarios.

The ambulatory healthcare center shall have a system for timely identification, segregation, and retrieval of recalled medications as issued by the Egyptian Drug Authority (EDA), manufacturer/marketing authorization holder, or other recognized bodies. Recalled medications are clearly labeled and separated from regular stock pending return or safe

disposal. When applicable, patients are notified. Regular monitoring ensures expired or unwanted medications are not inadvertently used and helps detect potential diversion.

The recall system components include:

a) Retrieve recalled medications
b) Clear labelling
c) Physical separation from stock
d) Removal or safe disposal
e) Patient notification (when applicable)

The ambulatory healthcare center shall develop and implement a policy and procedures to ensure that medications meet the required standards for product integrity, and that expired medications cannot be inadvertently used or administered. Regular monitoring of the disposal of unused, unwanted, or expired medications assists in identifying the potential for, and actual unauthorized diversion of medications.

It is the responsibility of the ambulatory healthcare center to ensure that all staff members dealing with medications are aware of the drug recall system and the procedures for handling expired, damaged, outdated, or contaminated medications.

Survey process guide

- GAHAR surveyors may observe the drug recall system for retrieval, labelling, separation, and disposal.
- GAHAR surveyor may interview staff members to verify their awareness of the drug recall policy.
- GAHAR surveyor may trace a recalled medication from notice to final removal/disposal.

Evidence of compliance

1. The ambulatory healthcare center has a drug recall system that includes elements from a) to e) in its intent.
2. The ambulatory healthcare center has an approved policy and procedures for the removal and disposal of expired, damaged, or contaminated medications.
3. Recalled medications are clearly labeled and separated per manufacturer/marketing instructions.
4. Staff involved in the recall process demonstrate awareness of the recall system and the process of handling expired medications.

Related standards

MMS.01 Medication management.MMS.02 Medication storage and labelling

MMS.05 Medications are safely prescribed, and ordered following accurate medication reconciliation. *Safety*

Keywords

Safe medication prescription_ Medication reconciliation.

Intent

Treating a patient with medication(s) requires specific knowledge and experience. When prescribed and used effectively, medications have the potential to significantly improve the quality of life and improve patients' safety and outcomes. However, the challenges associated with prescribing the right medications and supporting patients to use them effectively should not be underestimated. Patients often receive new medications or have changes made to their existing medications at times of transitions in care (ambulatory healthcare center admission or discharge from the ambulatory healthcare center). As a result, the new medication regimen prescribed at the time of discharge may inadvertently omit needed medications, unnecessarily duplicate existing therapies, or contain incorrect dosages. These discrepancies place patients at risk for adverse drug events (ADEs).

The ambulatory healthcare center shall develop and implement a structured process to guide the medication reconciliation process addresses on admission to and discharge from the ambulatory healthcare center. The reconciliation process addresses at least the following:

i. Situations where medication reconciliation is required:
    I. On admission (matching the current medication orders with the best possible medication history (BPMH),
    II. On discharge (ensuring that medications ordered on the discharge prescription match those on the discharge plan and the medications list, and confirming that changes have been documented).
ii. Identify the responsibility to perform medication reconciliation.
iii. Patients and/or family involvement.

Steps of the medication reconciliation process, such as collecting the list of .iv
medications, vitamins, nutritional supplements, over-the-counter drugs, and vaccines used by patients, clarifying whether these medications and their dosages are appropriate, matching with the new list of medications, and recording changes.

Each organization is responsible for identifying those individuals by experience and who are permitted by licensure, certification, laws, or regulations to prescribe or to order medications.

The ambulatory healthcare center has policies and procedures to guide the processes of ordering, prescribing, and transcribing of medications, including narcotics and psychotropic agents. The policy defines the elements of complete prescription and the types of orders that are acceptable for use to minimize the potential for errors when orders are recorded. The complete prescription includes at least the following:

a) Patient's identifications
b) Patient's demographics
c) Medication name
d) Dosage form
e) Strength or concentration
f) Dosage, frequency, and duration of medication
g) Route of administration
h) Rates of administration (when intravenous infusions are ordered).
i) Indications for use and the maximum frequency and maximum daily dose (for PRN orders).
j) Date and time of the order
k) Prescriber identification/signature

Abbreviation avoidance prevents misunderstanding, miscommunications, and the administration of incorrect prescriptions. The ambulatory healthcare center shall ensure the standardized use of approved symbols and abbreviations across the organization and prohibit unsafe or non-standard abbreviations.

Survey Process Guide:

- GAHAR surveyor may review several patients' medical records to verify medication reconciliation upon admission/discharge and assess compliance with safe prescribing policies (completeness, legibility, clarity).

Evidence of Compliance:

1. The ambulatory healthcare center is responsible for identifying those individuals permitted by law and regulation, qualification, training, experience, and job description to order/prescribe medications.
2. The ambulatory healthcare center has an approved policy and procedure for the safe and complete medication ordering and prescribing, which covers items from a) to k) in intent.
3. Psychotropic and narcotic medications are safely prescribed in accordance with the applicable laws and regulations.
4. Prescribers compare the list of current medications with the list of new medications to be prescribed and make clinical decisions based on the comparison.
5. The ambulatory healthcare center has an implemented structured process to ensure that accurate medication reconciliation is performed for all patients on admission to and before discharge from the ambulatory healthcare center.

Related standards

MMS.01 Medication management.

MMS.06 Medication preparation and administration.

WFM.10 Clinical Privileges

MMS.06 All medications are safely and accurately prepared and administered.

Safety

Keywords

Medication preparation and administration.

Intent

All medication orders are reviewed by a qualified healthcare professional before administration to ensure completeness, accuracy, and appropriateness to the patient's condition. This review includes at least: suitability to the patient, therapeutic duplication, allergies, major interactions, and potential organ toxicity. Appropriateness review covers at least the following.

a) Suitability of the medication to the patient's characteristics and condition
b) Therapeutic duplication,
c) Real or potential allergies,
d) Major drug interactions, and
e) Potential organ toxicity.

Actions must be taken when orders are incomplete, illegible, unclear, on inappropriate for the patient.

Safe preparation requires qualified staff, a clean/organized environment, proper equipment, shelving, storage, and aseptic technique. Staff preparing hazardous or sterile medications must be trained and use laminar airflow hoods if indicated.

The ambulatory healthcare center identifies the standards of practice for a safe medication preparation and administration environment. Healthcare professionals who prepare medications are requested to use techniques to ensure accuracy (e.g., double-checking calculations) and avoid contamination, including using clean or aseptic technique as appropriate, maintaining clean and uncluttered areas for product preparation. In addition,

healthcare professionals preparing compounded sterile products or preparing medications using multi-dose vials or hazardous medications are trained on the principles of medication preparation and aseptic technique. Similarly, laminar airflow hoods are available and used when indicated by professional practices (e.g., preparation of cytotoxic medications).

All prepared medications not administered immediately for emergency cases are labeled with standardized information, including patient identifiers, medication name, strength/concentration, amount, expiration/beyond-use date, directions for use, special instructions, and date/time of preparation. For IV admixtures and parenteral solutions, include the diluent. At a minimum, labels (if not apparent from the container) must include the following:

f) Patient identifications (2 unique identifiers)
g) Medication name
h) Strength/concentration
i) Amount
j) Expiration date
k) Beyond use date
l) Directions for use
m) Any special/cautionary instructions
n) Date and time of preparation and the diluent for all compounded intravenous (IV) admixtures, and parenteral solutions (if available).

In addition, medication preparation and administration within the ambulatory healthcare center follow standardized processes to ensure appropriateness, effectiveness, and safety of medication based on the medication prescription or order. Medication preparation and administration to manage a patient requires specific knowledge and experience. The safe administration of medications includes ensuring the following:

o) Right patient
p) Right medication
q) Right time and frequency of administration
r) The right dosage amount and regimen
s) Right route of administration
t) Right reasons/indication of medication therapy.
u) Review if the patient is allergic to any medication in the prescription or order.
v) Provision of information about the medications that they are going to be given, and the patients are given the chance to ask questions.

In addition, there is a clear process for the preparation and administration of psychotropic and narcotic medications in accordance with the applicable laws and regulations.

The ambulatory healthcare center educates patients and/or their families about the safe and effective use of medication(s) prescribed and to be administered, including (if needed) any potential significant adverse reactions, or other concerns about administering a medication.

Survey Process Guide

- GAHAR surveyor may interview the responsible staff to check their awareness of the appropriateness process.
- GAHAR surveyor may observe the process of preparing/compounding medication order and the labeling of the prepared products.
- GAHAR surveyor may review the medication administration process, including the narcotics and psychotropic medications.

Evidence of Compliance

1. The ambulatory healthcare center identifies those individuals, by law and regulation, qualification, training, experience, and job description, authorized to prepare and/or administer medications and admixtures, with or without supervision.
2. Each prescription/order is reviewed by a trained healthcare professional for completion, accuracy, and appropriateness before administration and covers at least elements from a) to e) in the intent.
3. The ambulatory healthcare center has a process to guide the preparation and compounding of sterile and non-sterile preparations, including preparation of cytotoxic medications (if available).
4. All medications prepared in the ambulatory healthcare center are correctly labeled in a standardized manner with at least the elements from f) to n) in the intent.
5. The ambulatory healthcare center has a process that covers elements from o) to v) in the intent to ensure safe medication administration.
6. Psychotropic and narcotic medications are prepared and administered in accordance with the applicable laws and regulations.

Related standards

ACT.02 Patient identification

MMS.03 High-alert medications, Look-alike Sound-alike medications

MMS.05 Safe medication prescription_ Medication

IPC.06 Standard precautions measures

MMS.07 The ambulatory healthcare has a defined process for monitoring the effects of medications on patients. The center also has a process for detecting, acting on, and reporting adverse drug events, medication errors, and near misses."

Effectiveness

Keywords

Medication errors_ adverse drug events, and near misses.

Intent

Medications are monitored for clinical effectiveness and adverse effects. to ensure therapeutic benefit, safety, and appropriate dosing. Monitoring medication effects includes observing and documenting any adverse effects. This is done using a standardized format (The Egyptian National Forms). Reporting to the authorized institutions is done promptly as per national regulations.

Medication errors and near misses are particularly important given the large and growing global volume of medication use. This is especially critical in healthcare settings where a significant proportion of prescribing occurs.

It is important that the ambulatory healthcare center has a process to identify and report on medication errors and near misses. The process includes defining a medication error and a near miss, and educating staff on the process and the importance of reporting.

Survey Process Guide:

- GAHAR surveyor may interview the responsible staff to check their awareness of monitoring the effect of the medication process.
- GAHAR surveyor may review the process of detecting and reporting adverse drug reactions/events.
  GAHAR surveyor may review the process of defining, acting on, and reporting medication errors, near misses.

Evidence of Compliance

1. Effects (s) of medication(s), including actual or potential adverse effects on patients is/are monitored and documented in the patient's record, along with actions taken in response.
2. Adverse drug events (ADEs) are reported in a manner consistent with the national guidelines using a standardized national format.

3. The ambulatory healthcare center has clear definitions for medication error(s), and near miss(es), and implements a process for managing and reporting them consistent with the national guidelines.

Related standards

MMS.05 Safe medication prescription

MMS.06 Medication preparation and administration.

QPI.04 Incident Reporting System

QPI.07 Sentinel events

Environmental and Facility Safety

Effective leadership and planning of environment and facility safety

EFS.01 The ambulatory center facilities comply with laws, regulations, and civil defence requirements.

Safety

Keywords:

ambulatory center environment and facility safety

Intent:

The safe physical environment of ambulatory centeris Crucial to ensuring the well-being of both patients and healthcare providers.

The ambulatory center should comply with relevant laws, regulations, and civil defence requirements to ensure the safety of patients, staff, visitors, vendors, and the environment.

While ambulatory centers are meant to provide healing and comfort, they also include certain dangers. ambulatory center contain hazardous chemicals, wastes, and infectious matter, among other threatening items. There are also dangers from fire and smoke that can be threatening to ambulatory center patients, staff, visitors and vendors. Safe evacuation and traffic inside the facility are directly related to the design as exits, width of corridors, and waiting areas; otherwise, the facility should have a safe alternative.
For this reason, governmental authorities enforce laws and regulations to ensure protection against these exposures.
Special situations should be considered, such as:

- Non-stand-alone ambulatory centers, which are part of another building, where the leaders should ensure availability of maintenance with related documents, utility safety and effectiveness, emergency exits availability, and alternative ways that keep the physical environment safe in coordination with external authorities.
- When the organization has entities within the patient care facilities (such as an independently owned coffee shop or gift shop), it has an obligation to ensure that these independent entities comply with the laws, regulations, and facility management and safety programs.

If an external authority, such as civil defence & other local authorities, reported an observation during inspection, the ambulatory center leadership is responsible for providing a corrective action plan and follow up of any non-compliance within the required timeframe.

The ambulatory center should have a current permits, licenses and design drawings, in addition to budget availability for upgrading and/or replacement of instruments or systems to keep environmental safety and/or to expand services provided when required. environmental and facility safety plans are evaluated and updated with improvement when required.

Survey process guide:

- GAHAR surveyor may review documents demonstrating ambulatory center drawings, budget, and external authorities reports with action plans.

- During ambulatory centertours and tracers, GAHAR surveyor may observe compliance with laws and regulations and the matching of allocated spaces to departmental functions.

Evidence of compliance:

1. The ambulatory center complies with laws, regulations, and civil defence requirements as required.
2. The ambulatory center leadership responds to external inspection reports within the required timeframe.
3. The ambulatory center leadership works with the governing body to maintain the environment of care.
4. The non-standalone ambulatory centers has evidence of maintenance of shared utilities, systems, and different alternatives according to national laws and regulations.
5. The ambulatory center ensures that independent entities comply with all aspects of the facility management plans.
6. The ambulatory healthcare center budgets for maintaining and upgrading the center environmental safety.

Related standards:

EFS02 Environment and facility safety program monitoring, OGM.04 AMBULATORY CENTERleaders.

EFS.02 Ambulatory center environment and facility safety are overseen and monitored by a trained staff.

Safety

Keywords:
Environment and facility safety monitoring

Intent:

Maintaining an active environment and facility safety program requires special skills to measure performance, identify gaps and take corrective actions.

The ambulatory center ensures the availability of qualified staff according to the scope of the provided services, local laws, and regulations, such as training on safety requirements and civil defence.

The ambulatory center should have a committee overseeing environmental safety activities according laws and regulations through regular meetings; the committee could be held urgently if needed.

The committee's role should include a review of aggregated essential data, incident reports, drill reports, safety plan observations, and recommended actions,

The committee should report to the ambulatory center leadership quarterly, and feedback from ambulatory center leadership should be received.

the ambulatory center should create continuous monitoring mechanisms for environmental and facility safety.

Environment and Facility safety supervisors are responsible for inspecting buildings to identify maintenance and safety issues, such as clogged drains, leaky ceilings, and faulty electrical switches.

A multidisciplinary environment and facility surveillance team is formed from all stakeholders, e.g., (safety officer, utility responsible, quality, infection control,…)

The team shall perform surveillance rounds across all ambulatory center areas and services at least quarterly. Different tools could be used like inspection checklist that cover different components of the program. Risk assessment to identify high risk observations that require appropriate intervention is required.

environment and facility surveillance rounds reports should be submitted to the concerned stakeholders, environment and facility safety committee and ambulatory center leadership.

When independent entities or contracted vendors are located inside the ambulatory center, they should comply with related environmental safety requirements.

Survey process guide:

- GAHAR surveyor may review documents that demonstrate environment and facility surveillance rounds schedule, plan, agenda, notes or reports.

- the surveyor may review environment and facility safety committee meeting notes to verify if the round report observation were discussed or not.
- GAHAR surveyor may interview responsible staff members to ensure their awareness of environmental safety requirements.
- GAHAR surveyor may review responsible staff members' files to check their qualifications.

Evidence of compliance:

1. The ambulatory center ensures the availability of trained staff that matches the needs of the ambulatory center's scope of services, laws, and regulations.
2. The ambulatory center ensures that multidisciplinary environment and facility surveillance rounds are performed across all ambulatory center areas and services at least quarterly. And corrective actions are taken when indicated.
3. There is a quarterly report submitted to the ambulatory center leadership about the significant observations during the surveillance rounds and the corrective actions taken when needed.
4. The ambulatory center has an environment and facility safety committee with defined terms of reference.
5. The committee holds regular meetings and the minutes of meetings are recorded.

Related standards:

OGM.02 ambulatory center director, OGM.04 ambulatory center leaders, EFS.07 Safety Management Plan, DAS.04 Radiation safety program, DAS.09 Laboratory safety program.

Safe fire planning

EFS.03 GSR.14 Fire and smoke safety plan addresses prevention, alarm system response, and safe evacuation in case of fire and/or other internal emergencies.

Safety

Keywords:
Fire and smoke safety

Intent:

One of the critical considerations in the design for ambulatory center is the prevention of fire, particularly with respect to the combustibility of construction and furnishing materials and the spread of fire and smoke.

In the event of either accidental or malicious fires; early detection (alarm system) and suppression equipment needs to be readily accessible to combat these fires.

Staff members of the ambulatory center must be knowledgeable about equipment usage and communicate effectively based on previous arrangements and training.

Other internal emergencies may affect staff, patients, families, and vendors safety that may require evacuation when required and include but not limited to gas cylinder explosion, building collapse and swage leakage.

The ambulatory center should perform Ongoing risk assessment of the ambulatory center environment that include fire and smoke separation, areas under construction and other high-risk areas for example stores, laundry, oxygen supply storage areas, electrical control panels, medical records room, garbage room, etc. Risk mitigation measures are taken based on the fire risk assessment which should be updated annually.

The last resort, failing the ability to completely suppress the fire, is to evacuate the ambulatory center. Moving all patients, visitors, and staff out of dangerous and/or damaged facilities as safely as possible is always the goal of an evacuation. With respect to priorities of evacuation of independent cases, then dependent cases by use of simple and available tools like mattresses, bed sheets, trolleys, wheelchairs, or other tools.

It is important to recognize that people's attention to detail and processes will not be optimal in an evacuation scenario. To that end, understanding key principles will help staff members make good decisions during a chaotic event.

The ambulatory center develops a fire, smoke and non-fire safety plan based on environmental safety risk assessment that addresses at least the following:

a) Preventive measures that include at least the following:
   I. Assesses compliance with Civil Defence requirements and related laws and regulations.
   II. Safe storage and handling of highly flammable materials.
   III. Comply with no smoking policy according to laws &regulations.
   IV. Safe management of high-risk areas such as electric panels, and connections storage areas, fuel tanks and others.
b) fire alarm system, including the central control panel connected to all areas in ambulatory center according to its functionality, and ensure continuous monitoring 24/7.
c) Regular inspection testing of early detection system
d) Regular inspection testing and maintenance of fire suppression systems.
e) Safe evacuation through availability of safe, unobstructed fire exits, with clear signage to assembly areas and emergency light, in addition to other related signages like how to activate the fire alarm, using a fire extinguisher and hose reel.
f) The ambulatory center should perform proper training of all staff annually in a practical manner to make sure that everyone in the ambulatory center can demonstrate RACE and PASS and other activities that keep the safety of all during fire and non-fire emergencies with documentation of all results regularly.

Survey process guide:

- GAHAR surveyor may review the fire safety plan, facility fire safety inspections, and fire system maintenance.
- GAHAR surveyor may check that fire alarm; firefighting and smoke containment systems are working effectively and complying with civil defence requirements.
- GAHAR surveyor may review the plan of testing (drills) and staff training (all staff should be trained on fire safety).

Evidence of compliance:

1. The ambulatory center has an approved, updated fire and smoke safety plan that includes all elements from a) through e) in the intent.
2. All staff are trained on fire safety plans and can demonstrate their rules during fire or non-fire internal emergencies at least annually.
3. Fire risk assessment with risk mitigation measures are in place with corrective action when required.
4. The ambulatory center fire alarm system is available, functioning, inspected, tested and maintained on a regular basis.
5. The ambulatory center fire suppression system is available, functioning, inspected, tested and maintained on a regular basis.
6. Emergency exit doors and corridors are clearly signed and not obstructed.

Related standards:

EFS.01 ambulatory center environment and facility safety, EFS.04 Fire drills, EFS.05 Smoking-Free Environment, QPI.05 Risk management program, EFS.07 Safety Management Plan, WFM.06 Continuous education program.

EFS.04 GSR.15 Fire drills are performed in different ambulatory center areas.

Safety

Keywords

Fire drills

Intent:

Fire drills are regular training exercises and simulations, aiming that all staff will gain a thorough understanding of the fire safety plan, enabling them to respond swiftly, safely, and in an orderly, confident manner during an emergency, including safely evacuating patients through the designated emergency exits.

To ensure staff preparedness for fire and other internal emergencies, regular drills are conducted at least quarterly, one of them at least is unannounced.

The ambulatory center records fire drills details including, but are not limited to, the following:

a) Dates and timings consider Staff who participated in the drill.
b) Involved areas.
c) Shifts.
d) Corrective actions

Survey process guide:

- GAHAR surveyor may review the records of fire and evacuation drills with dates, timings, staff who participated, the involved areas in the AMBULATORY CENTERand corrective action plan based on the drill evaluation.

- GAHAR surveyor may Interview staff to check the awareness of fire safety plan and basic procedures in such cases like RACE and PASS (Rescue, Alarm, Confine, Extinguish/Evacuate and Pull, Aim, Squeeze, Sweep).

Evidence of compliance:

1. Fire drills are performed at least quarterly, including one unannounced drill.
2. All staff members participate in fire drills at least once annually.
3. Fire drill results are recorded from a) through d) in the intent.
4. Fire drill results evaluation is performed after each drill and corrective action plan when indicated.
5. The ambulatory center staff guarantee Safe evacuation of patients, staff and visitors.

Related standards:

EFS.01 ambulatory center environment and facility safety, EFS.03 Fire and smoke safety, WFM.06 Continuous education program.

EFS.05 The ambulatory center clinical and non-clinical areas are smoking-free.

Safety

Keywords:
Smoking-Free Environment

Intent:

According to the Centers for Disease Control (CDC), smoking causes about 90% (or 9 out of 10) of all lung cancer deaths. More women die from lung cancer each year than from breast cancer. Smoking causes about 80% (or 8 out of 10) of all deaths from chronic obstructive pulmonary disease (COPD). Cigarette smoking increases the risk of death from all causes in men and women. Literature shows that although ambulatory center restricts smoking inside, many people continue to smoke outside, creating problems with second-hand smoke, litter, fire hazards and negative role modelling. Smoke-free policies are an important component of an ecological and social-cognitive approach to reducing tobacco use and tobacco-related disease.

Regulations prohibit smoking inside healthcare facilities according to law and regulations.

Smoking-free policies were reported to have numerous positive effects on employee performance and retention, in addition to the prevention of fires inside different healthcare facilities.

The ambulatory center ensures a smoking-free environment for patients and environmental safety through the availability of smoking-free environment policy and procedure, and proper signage.

The policy should include any exceptions, penalties, and the designated smoking area outside the building.

All staff should be oriented about the smoking-free environment policy.

Survey process guide:

- GAHAR surveyor may review the smoking-free policy followed by interviewing staff and/or patients to check their awareness of ambulatory center policy, smoking areas' location and consequences of not complying to the policy.
- During the GAHAR survey, surveyors may be observed evidence of not complying to the policy such as cigarette remnants and cigarette packs specially in remote areas.

Evidence of compliance:

1. The ambulatory center has an approved policy for a smoking-free environment.
2. Staff, patients, and visitors are aware of the ambulatory center policy.
3. Occupants, according to laws and regulations, do not smoke in all areas inside the buildings.
4. The ambulatory center monitors compliance with the smoking-free policy.

Related standards:

EFS.03 Fire and smoke safety, EFS.02 Environment and facility safety program monitoring, WFM.06 Continuous education program.

Safe hazardous materials and waste management plan

EFS.06 GSR.16The ambulatory center plans safe handling, storage, usage and transportation of hazardous materials and waste management.

Safety

Keywords:
Hazardous materials safety

Intent:
Hazardous materials are substances, which, if released or misused, can pose a threat to the environment, life or health. Industry, agriculture, medicine, research, and consumer goods use these chemicals.
Hazardous materials come in the form of explosives, flammable and combustible substances, poisons. These substances are most often released because of transportation accidents or chemical accidents in ambulatory centers.
Because the effects of hazardous materials can be devastating and far-reaching, it is important that ambulatory centers plan their safe use and establish a safe working environment.
ambulatory center waste is any waste which is generated in the diagnosis, treatment, or immunization of human beings or in research in a
Healthcare waste includes infectious, chemical, expired pharmaceutical and radioactive items and sharps. These items can be pathogenic and environmentally adverse. Other waste items generated through healthcare but not hazardous include medication boxes, the packaging of medical items and food, remains of food, and waste from offices.
ambulatory center Waste Management means the management of waste produced by ambulatory centers using such techniques that will help to check the spread of diseases.
The ambulatory center should identify and control hazardous material and waste all over the ambulatory center to ensure that staff, patients, families, and vendors, and the environment are safe.

Waste materials are categorized into the following categories according to the WHO classification:

i. Infectious
ii. Pathological and anatomical
iii. Pharmaceutical
iv. Chemical
v. Heavy metals
vi. Pressurized containers
vii. Sharps

Hazardous materials and waste management plan includes, but is not limited to, the following:

a) A current and updated inventory of hazardous materials used in the ambulatory center according to the scope of services, the inventory should include the material name, hazard type, location, usage, consumption rate, and responsibility.
b) Safety data sheet (SDS) should be available and includes information such as physical data, hazardous material type (flammable, cytotoxic, corrosive, carcinogenic, etc.), safe storage, handling, spill management and exposures, first aid, and disposal.
c) Appropriate labelling of hazardous materials.
d) Procedure for safe usage, handling, and storage of hazardous materials.
e) Appropriate waste segregation, labelling, and storage,
f) Safe handling, transportation, and disposal of all categories of hazardous waste.
g) Availability of required protective equipment, spill kits, and eye washes.
h) Investigation and documentation of different incidents such as spill and exposure.
i) Compliance with laws and regulations, availability of required licenses, and/or permits
j) Staff training and orientation.
k) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review the hazardous material and waste management program to make sure that it covers all safety requirements of hazardous materials, safe storage, handling, spills, required protective equipment and waste disposal according to local laws and regulations.
- GAHAR surveyor may review the hazardous material and waste disposal plan, hazardous material, and waste inventories, as well as Safety Data Sheet (SDS).
- GAHAR surveyor may observe hazardous material labelling and storage in addition to waste collection, segregation, storage, and final disposal.

Evidence of compliance:

1. The ambulatory center has a hazardous material and waste management plan that addresses all elements from a) through k) in the intent.
2. Staff is trained on hazards material and waste management.
3. The ambulatory center ensures safe usage, handling, storage, availability of SDS and labelling of hazardous materials.

4. The ambulatory center ensures safe handling, storage, and labelling of waste according to laws and regulations.
5. The ambulatory center has a document for spill management, Investigation, and recording of different incidents related to hazardous materials.

Related standards:

EFS.01 ambulatory center environment and facility safety, EFS.02 Environment and facility safety program monitoring, DAS.09 Laboratory safety program, DAS.04 Radiation safety program, WFM.06 Continuous education program.

Safety and security planning

EFS.07 GSR.17 A safe work environment plan addresses high-risk areas, procedures, risk mitigation requirements, tools, and responsibilities.

Safety

Keywords:
Safety Management Plan

Intent:
Health services are committed to providing a safe environment for staff, patients, families, and vendors. ambulatory center safety arrangements keep patients, staff, and visitors safe from inappropriate risks such as electricity and from inappropriate behaviour such as violence and aggression.

The risk assessment shall be in place to identify potential risks because of system failure and/or staff behaviour, for example: wet floor; water leakage from the ceiling beside electrical compartments; unsecured electric panels, dealing with high voltage improper handling of sharps; non-compliance to personal protective equipment in a case dealing hazardous materials or exposure to spills or splash, availability of eye washer in high-risk area like the laboratory, and unsafe storage.

The ambulatory center must have a safety plan with safety mitigation measures based on the risk assessment that covers the building, property, medical equipment, and systems to ensure a safe physical environment for patients, families, staff, visitors, and vendors.

The safety plan based on an environmental safety risk assessment that addresses at least the following:

a) Safety measures based on risk assessment, for example, infectious agents' exposure, electric, radioactive hazards, vibration and noise exposure.
b) Effective planning to prevent accidents and injuries and minimize potential risks, to maintain safe conditions for all occupants to reduce and control risks.
c) Processes for pest and rodent control.

d) Regular inspection with documentation of results, performing corrective actions, and appropriate follow-up.
e) Responsibilities according to laws and regulations.
f) Safety training on a general safety plan.
g) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review safety plan/s to make sure that they include suitable risk assessment surveillance.
- GAHAR surveyor may review the surveillance rounds plan. Checklist, different observations, and proper corrective actions when applicable.
- GAHAR surveyor may observe the safety measures implementation in all areas and safety instructions posters in all high-risk areas.
- GAHAR surveyor may inspect workers in different areas like workshops and waste collection areas to check usage of suitable personal protective equipment (PPE).

Evidence of compliance:

1. The ambulatory center has an approved and updated plan to ensure a safe work environment that includes all elements from a) through g) in the intent.
2. Staff are trained on safety measures based on their jobs.
3. Risk mitigation is conducted based on risk assessment
4. Safety measures and PPEs are available and used whenever indicated.
5. Safety instructions are posted in all high-risk areas.

Related standards:

EFS.01 ambulatory center environment and facility safety, DAS.04 Laboratory safety program, DAS.09 Radiation safety program, OGM.13 Staff health, WFM.06 Continuous education program, QPI.05 Risk management program.

EFS.08 The ambulatory center performs a pre-construction risk assessment when planning for construction or renovation.

Safety

Keywords:

Pre-Construction risk assessment

Intent:

New construction or renovation in a ambulatory center has an impact on all occupants, who could suffer from changing air quality by dust or odours, noise, vibration, and wreckage.

Upon new construction or renovation in the ambulatory center, a pre-construction risk assessment (PCRA) should be performed and evaluated to develop a plan that will minimize associated risks. The ambulatory center ensures the involvement of all departments affected by construction or renovation, including project management, infection control, safety, security,

housekeeping, information technology, engineering, clinical departments, and external constructors. The pre-construction risk assessment includes, but is not limited to, the following:

i. Noise level.
ii. Vibration
iii. Infection control risk assessment (ICRA)
iv. Air quality
v. Fire risk
vi. Hazardous materials
vii. Waste and wreckage
viii. Any other hazards related to construction and renovation.

The ambulatory center ensures monitoring and documentation of all activities and all risks related to construction and renovation.

Survey process guide:

- GAHAR surveyor may review pre-construction risk assessment documents and check the implementation of risk assessment recommendations.
- GAHAR surveyor may interview staff, patients, or contractors in the construction area to check if they are aware of required precautions.

Evidence of compliance:

1. The ambulatory center performs a pre-construction risk assessment before any construction or renovation.
2. All affected services are involved in the risk assessment.
3. There is a mechanism, such as work permission, to perform preventive and corrective actions whenever risks are identified.
4. If a contractor is used, contractor's compliance is monitored and evaluated by the ambulatory center.

Related standards:

EFS.01ambulatory center environment and facility safety, EFS.02 Environment and facility safety program monitoring, QPI.05 Risk management program.

EFS.09 Security plan addresses the security of all occupants and properties.

Safety

Keywords:
Security Plan

Intent:
Security issues such as violence, aggression, thefts, harassment, suicide, bomb threats, terrorism, gunshots, and child abduction are common in ambulatory center.

Usually, ambulatory centers enforce a code of behaviour that does not tolerate physical or verbal aggression or abuse towards staff, patients, families, visitors, and vendors.

To keep all occupants safe, ambulatory centers may use a range of security measures, including the use of (closed-circuit television) CCTV cameras, and electronic access control systems for doorways. Some ambulatory centers also employ security staff. The ambulatory center ensures protection of all occupants from violence, aggression, thefts, harassment, suicide, medical records, Cybersecurity, and child abduction.

Security plan based on risk assessment. For identification of high-risk areas and measures for keeping staff, vendors, and patients secured all the time.

The security plan includes, but is not limited to, the following:

a) Security risk assessment.
b) Identification of staff, patients, families, visitors, and vendors with the restriction of their movement within the ambulatory center
c) Identification of restricted areas
d) Vulnerable patients such as the elderly, infants, those with mental disorders, and handicapped should be protected from abuse and the above-mentioned harms.
e) Drills for child abduction should be performed at least bi-annually to ensure child protection that includes but not limited to (scenarios, shifts, involved staff, corrective actions)
f) Monitoring of remote and isolated areas.
g) Workplace violence management (Any harm, such as violence, aggression, infant/child abduction)
h) Staff training as regards security requirements.
i) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review security plan/s to make sure that they include suitable risk assessment surveillance, security high-risk areas and security requirements, as well as access control areas.
- GAHAR surveyor may review the surveillance rounds plan. Checklist, different observations, and proper corrective actions when applicable.
- GAHAR surveyor may observe the implemented security measures, e.g., cameras, monitors, staff ID, and access-controlled areas

Evidence of compliance:

1. The ambulatory center has an approved updated security plan that includes items a) through I) in the intent.
2. All staff are trained on the security plan.
3. Risk mitigation is conducted based on risk assessment
4. Staff and vendors/ contractors' identification is implemented.
5. Occupants are protected from harm at all times.
6. Drill for child abduction at least bi-annually

Related standards:

EFS.01 ambulatory center environment and facility safety, QPI.05 Risk management program, WFM.05Orientation program, WFM.06 Continuous education program, PCC.08 Patient's belongings.

Safe medical equipment

EFS.10 GSR.18 Medical equipment plan ensures selection, inspection, testing, maintenance, and safe use of medical equipment.

Safety

Keywords:
Medical Equipment Plan

Intent:

Medical equipment is critical to the diagnosis and treatment of patients.
In most ambulatory centers, a trained biomedical staff manage the entire medical inventory and is responsible for dealing with medical equipment hazards. Not only does improper monitoring and management lead to inefficiency, but it can also seriously harm patient outcomes. As an example, poor maintenance increases the chances of downtime, and inadequate servicing and sterilization can be harmful to both doctors and patients. This is why it is crucial to establish some basic equipment safety and service procedures according to the manual or contracted agent of the equipment.
the ambulatory center develops a plan for medical equipment management that addresses at least the following:

a) Developing criteria for selecting new medical equipment.
b) Inspection and testing of new medical equipment upon procurement and on a predefined interval basis.
c) Training of staff on safe usage of medical equipment upon hiring upon installation of new equipment, and on a predefined regular basis by a qualified person.
d) Inventory of medical equipment, including availability and functionality.
e) Identification of critical medical equipment that should be readily available for the operator even such as life-support equipment, DC shock or AED.
f) Periodic preventive maintenance according to the manufacturer's recommendations which usually recommends using tagging systems by tagging dates and due dates of periodic preventive maintenance or labelling malfunctioned equipment.
g) Calibration of medical equipment according to the manufacturer's recommendations and/or its usage.
h) Malfunction and repair of medical equipment.
i) Dealing with equipment adverse incidents, including actions taken, backup system, and reporting.
j) Updating, retiring and/or replacing medical equipment in a planned and systematic way.
k) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review the ambulatory center medical equipment management plan and related documents, e.g. (inventory of medical equipment, preventive maintenance schedule, calibration schedule, and staff training records).

- During GAHAR survey, surveyor may check medical equipment functionality and trace some medical equipment records.

Evidence of compliance:

1. The ambulatory center has an approved updated medical equipment management plan that addresses all elements from a) through k) in the intent.
2. The ambulatory center has a qualified individual to oversee medical equipment management.
3. the ambulatory center ensures that only trained and competent staff handles the specialized equipment(s).
4. Records are maintained for medical equipment inventory, user training, equipment identification cards, company emergency contact, and testing on installation,
5. Records are maintained for medical equipment periodic preventive maintenance, calibration, and malfunction history.
6. Equipment adverse incidents are reported, and actions are taken.

Related standards:

EFS.01 AMBULATORY CENTERenvironment and facility safety, EFS.02 Environment and facility safety program monitoring, WFM.05 Orientation program, WFM.06 continuous education program, QPI.06 Incident reporting system.

Safe utility plan

EFS.11 GSR.19 Essential utilities plan addresses regular inspection, maintenance, testing and repair.

Safety

Keywords:
Utilities Management Plan

Intent:
ambulatory centers are expected to provide safe and reliable healthcare to their patients. Planning appropriate response and recovery activities for a failure of the ambulatory center utility systems is essential to satisfy this expectation.
These systems constitute the operational infrastructure that permits safe patient care to be performed.
Some of the most important utilities include mechanical (e.g., heating, ventilation and cooling); electrical (i.e., normal power and emergency power); domestic hot and cold water as well as other plumbing systems; sewage technology systems, including communications systems and data transfer systems; fire alarm, refrigerators, vertical transportation utilities; fuel systems; access control, and surveillance systems; medical gases, air and vacuum systems. The ambulatory center must have a utility management plan to ensure the efficiency and effectiveness of all utilities that includes at least the following:

a) Inventory of all utility key systems, for example, electricity, water supply, medical gases, heating, ventilation and air conditioning, communication systems, sewage, fuel sources, fire alarms, and elevators.
b) Layout of the utility system.
c) Staff training on utility plan.
d) Regular inspection, testing, and corrective maintenance of utilities.
e) Regular testing of alarms (refrigerators, nursing call alarms, medical gases, others).
f) Testing of the electric generator with and without a load on a regular basis.
g) Providing fuel required to operate the generator in case of an emergency.
h) Cleaning and disinfecting water tanks and testing water quality with regular sampling according to laws and regulations.
i) Preventive maintenance plan according to the manufacturer's recommendations.
j) The ambulatory center performs regular, accurate data aggregation, and analysis for example, frequency of failure, and preventive maintenance compliance for proper monitoring, updating, and improvement of the different systems.
k) The plan is evaluated and updated annually and/or when required.

Survey process guide:

- GAHAR surveyor may review utility management plan to confirm availability of all required systems, regular inspection, maintenance, and backup utilities.
- GAHAR surveyor may review inspection documents, preventive maintenance schedule, contracts, and equipment, as well as testing results of generators, tanks, and/or another key system to ensure of facility coverage 24/7.

Evidence of compliance:

1. ambulatory center has an approved updated plan for utility management that includes items a) through k) in the intent.
2. Staff are trained to oversee utility management.
3. Records are maintained for utility systems inventory, testing (drill) , periodic preventive maintenance, and malfunction history.
4. Critical utility systems are identified, and backup availability is ensured.
5. Regular drills are performed for electricity and water backup systems.

Related standards:

EFS.02 Environment and facility safety program monitoring, WFM.06 continuous education program, QPI.05 Risk management program.

EFS.12 Water services are safe and effective.

Safety

Keywords:

Water services

Intent:

Water delivery systems are essential components of the environment of care in ambulatory healthcare centers that must be continually maintained in a safe way.

Failure of safe water delivery will increase infection risk either directly through unsafe water consumption or use, or indirectly due to the inability of healthcare professionals to comply to basic infection control measures such as hand hygiene.

Water of appropriate quality used in the preparation of dialysis fluid is an essential component of hemodialysis and related therapies to protect hemodialysis patients from adverse effects arising from known chemical and microbiological contaminants found in water and improperly prepared dialysis fluid. Safe water services are dependent upon maintenance of water quality standards employed by the community public water supplier, typically a municipality in the region of the ambulatory healthcare centers. This responsibility for water quality then transitions to the facility once water enters the facility water distribution infrastructure, reflecting complementary roles for prevention of infections (refer to WHO wash

program).

The ambulatory healthcare center shall develop and implement a policy and procedures for the safe process of the management of water services that addresses at least the following:

a) Routine maintenance and monitoring of water distribution and treatment systems.
b) Continuing training and education of operators of water treatment systems.
c) Monitoring of water at all stages (feed, product and dialysis water).
d) Methods and frequency of measuring microbiological and chemical contaminants.

e) Maximum allowable concentrations of microbiological contaminants.

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center policy, followed by interviewing staff members to check their awareness of the policy.
- GAHAR surveyor may observe the accessibility of water on all premises.
- GAHAR surveyor may review chemical and bacteriological analysis reports for water services and dialysis water.
- GAHAR surveyor may assess corrective actions that were taken by the ambulatory healthcare center.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses all the elements mentioned in the intent from a) through e).
2. The ambulatory healthcare center has available continuous water supply.
3. Regular chemical and microbiological analyses for water services (domestic water services) and dialysis water are performed and recorded.
4. The ambulatory healthcare center conducts appropriate corrective actions when needed.

Related standards:

EFS.11 Utilities Management plan.

, IPC.02 IPC program, IPC.04 Infection risk assessment.

Safe emergency preparedness plan

EFS.13 Emergency preparedness plan addresses responding to disasters that have the potential of occurring within the geographical area of the ambulatory center.

Safety

Keywords:
Disaster Plan

Intent:

With climate changes, increased pollution and advancement of technologies, Earth is becoming vulnerable to natural disasters. Floods, droughts, cyclones, earthquakes, and landslides are common. The last few decades have witnessed an increased frequency of disasters causing tremendous human casualties, in terms of loss of life and disability, in addition to huge economic losses. Although these may not be totally preventable, their impact can be minimized by effective planning. Equally important are the peripheral emergencies like road, rail and air accidents, fire, drowning and stampedes in mass gatherings, industrial accidents, explosions

and terrorist attacks that have an inherent potential to convert into mass casualty incidents. The loss of life and disability is compounded by the lack of adequate medical preparedness both qualitatively and quantitatively across the country.

The ambulatory center must have a risk assessment tool to prioritize potential emergencies based on probability and impact.

The ambulatory center has an emergency preparedness plan that includes at least the following:

a) Communication strategies:
Internal communication may be in the form of Clear call tree that includes staff titles and contact numbers, and External communication channels may include civil defence, ambulance centre, police.

b) Clear duties and responsibilities for ambulatory center leaders and staff.
c) Identification of required resources such as utilities, medical equipment, medical, and nonmedical supplies, including alternative resources.
d) Business Continuity:
   i. Triaging.
   ii. Staff's main task is maintained in case of emergencies: management of clinical activities during disaster, such as basic daily activities.
   iii. Alternative care sites and backup utilities.
   iv. Safe patient transportation in case of emergency is arranged by the ambulatory center
e) Risk assessment of potential emergencies, internal and external disasters, such as heavy rains, earthquakes, floods, hot weather, wars, bomb threats, terrorist attacks, traffic accidents, power failure, fire, and gas leakage.
f) Drill schedule

The ambulatory center must have a drill schedule for emergencies at least biannually. Focused drills: each drill targets a specific area / function of the emergency response plan.

Through using varied Scenarios, different areas are covered over time, ensuring comprehensive practice. And ensure the attendance of staff.

Proper evaluation and recording of the drill include, but is not limited to:

   i. Scenario of the drill
   ii. Observations on code announcement, timing, staff attendance, response, communication, triaging, and clinical management.
   iii. Debriefing and Clear corrective actions if needed.
   iv. Feedback to the environmental safety committee.

g) The plan is evaluated and updated annually and/or when required.

The degree of preparedness shall be assessed according to the level of risk; different tools could be used, like hazards vulnerability analysis (HVA).

Survey process guide:

- GAHAR surveyor may review the emergency preparedness plan and its records to confirm that it covered all the identified risks.
- GAHAR surveyor may review preparations in terms of equipment, medication, supplies, action cards, and others during ambulatory center tours and tracers.
- GAHAR surveyor may review staff training through training documents and interviewing with the staff.

Evidence of compliance:

1. There is an approved ambulatory center emergency preparedness plan that includes items a) through g) in the intent.
2. Staff members are trained on the plan.
3. The ambulatory center performs at least one drill biannually that includes items from (i) through (v) in the intent.
4. The ambulatory center demonstrates preparedness for identified emergencies based on risk assessment.

Related standards:

WFM.06 Continuous education program, QPI.05 Risk management program, OGM.04 ambulatory center leaders, OGM.07 Stock management,

EFS.14: ambulatory center leadership supports green and sustainable activities.

Efficiency

Keywords:

Environmental Sustainability, Green Healthcare

Intent:

As energy deficiencies and environmental concerns escalate, adopting green practices in primary healthcare is no longer optional, it's essential. Sustainable solutions offer a win-win-win; triple win for health, earth planet, and budgets.

Primary healthcare facilities (ambulatory centers) strive to minimize their environmental impact while delivering quality care. ambulatory center leaders ensures to integrate environmental strategies into operations and governance, employee engagement and resource reduction.

For example, Energy consumption saving activities (lighting, heating/cooling), Water usage (clinical and non-clinical) and so on.

ambulatory center shall develop policy and procedures guiding environmental Sustainability activities, policy includes at least the following:

a) Leadership Commitment: Leaders demonstrate commitment to environmental sustainability by including it in ambulatory center policies, and ambulatory center leader ship ensures resource allocation.

b) Employee Engagement: including activities to raise awareness, train staff on climate change and environmental practices, and encourage participation in eco-friendly initiatives.
c) Proper resource allocation: develop and implement a plan to monitor and reduce the use of materials and environmental resources like energy and water and reduce unnecessary supplies use.
d) Waste Management: establish a comprehensive waste management hierarchy that prioritizes waste reduction and proper segregation.
e) Green Infrastructure: considers opportunities for green infrastructure solutions through prioritizing natural lighting, avoiding unnecessary outside lighting, using efficient LED bulbs, use lighting with motion sensors. Optimizes energy use through efficient use of air conditioning system on (24°C) and after-working hours' equipment shutdowns if applicable. Water-saving fixtures further enhance sustainability.
f) Monitoring through Regular rounds to check the commitment to environmental Sustainability activities and evaluating the effectiveness of implemented strategies and activities.

Survey Process Guide:

- GAHAR surveyor may review the ambulatory center policies to ensure they align with the above elements.
- GAHAR surveyor assesses the organization's commitment to environmental sustainability through interviews with leadership and staff.
- GAHAR surveyor may observe resource usage practices and waste management procedures.

Evidence of Compliance:

1. The ambulatory center has an approved Policy that addresses all elements from (a) through (f) in the intent.
2. Leadership Participate in environmental sustainability activities.
3. Staff are aware of environmental sustainability practices and participate in relevant activities.
4. The ambulatory center demonstrates participation in community awareness about environmental sustainability activities.

Related standards:

EFS.01 ambulatory center environment and facility safety, EFS.06 Hazardous materials safety, WFM.06 Continuous education program.

Infection Prevention and Control

Efficient structure of the infection prevention and control program

IPC.01 Dedicated and qualified healthcare professional(s) oversees the infection prevention and control activities according to applicable laws and regulations, national and international guidelines.

Effectiveness

Keywords:
IPC assigned team.

Intent:

The presence of a qualified and dedicated IPC professional(s) in the ambulatory healthcare center ensures increased effectiveness of the IPC program in all its phases including development, implementation, and monitoring.

The ambulatory healthcare center shall assign a team to assume full responsibility for all activities pertaining to the IPC program. This team shall provide oversight of the program, establish and implement a comprehensive action plan, and ensure that all staff members are appropriately educated and informed regarding their respective roles and responsibilities within the program. The team members' qualifications and numbers shall meet the ambulatory healthcare center needs. These needs are driven by the ambulatory healthcare center size, complexity of activities, and level of risks, as well as the program's scope.

Survey process guide:

- GAHAR surveyors may review the infection control structure in the organization chart.
- GAHAR surveyor may interview IPC team and inquire about their qualifications and check their awareness of their job description

Evidence of compliance:

1. The ambulatory healthcare center has an assigned dedicated IPC team.
2. The IPC team leader and each member has a defined job description.
3. The IPC Team leader is qualified by certification and education.
4. The IPC team member(s) communicate with the top management and all other relevant departments\disciplines.

Related standards:

IPC.02 IPC program, IPC.03 IPC committee, meetings, WFM.03 Job Description, WFM.04 Verifying credentials, OGM.02 Ambulatory healthcare center director.

IPC.02 A comprehensive infection prevention and control program is developed, implemented, and monitored.

Safety

Keywords:

IPC program.

Intent:

Healthcare-associated infections are common risks encountered in any ambulatory health care center, Therefore, constructing a comprehensive infection prevention and control (IPC) program is of utmost importance in order to effectively reduce these risks.

The program development requires a multidisciplinary approach that is carried on by qualified staff members and based on the annual Ambulatory risk assessment plan, national and international guidelines (CDC, WHO, APIC, IFIC, etc.), accepted practices, and applicable laws and regulations.

The program should include all areas of the Ambulatory and cover patients, staff, and visitors.

The Ambulatory shall establish and implement an infection prevention and control program that addresses at least the following:

a) Scope and objectives.
b) Infection control policies and procedures.
c) Risk assessment to identify departments and services with increased potential risk of infection and risk mitigation plan.
d) Monitoring system to monitor IPC program within the ambulatory,
e) Recording and investigation reported in addition to audit &/ or other KPIs of relevant polices.
f) Staff education and training on infection control principles and practices,
g) Outbreak investigation & management
h) Staff immunization,
i) Antibiotic stewardship program to promote the appropriate use of antimicrobial agents,
j) Continuously assess and improve infection control practices within the ambulatory.

Survey process guide:

GAHAR surveyor may review an infection control program to ensure that it is based on the risk assessment, covers all Ambulatory areas and includes all relevant individuals; review the training plan or an annual evaluation report and update of the IPC program.

GAHAR surveyor may review the documentation of monitoring of data on infection control program, performance measures, data analysis reports, recommendations for improvement and observe their implementation.

Evidence of compliance:

1. The Ambulatory has an infection control program that addresses all the elements mentioned in the intent from a) through i).

2. The healthcare professionals involved in infection control are aware of the contents of the program.
3. The program is based on an updated risk assessment, current scientific knowledge, accepted practice guidelines, and applicable laws and regulations.
4. The program is implemented in all Ambulatory center areas and covers patients, visitors, and staff.
5. The Ambulatory healthcare center monitors the reported data on the infection control program and takes actions to control or improve the processes as appropriate.

Related standards:

IPC.01 IPC assigned team, IPC.03 IPC committee, meetings, IPC.04 Infection risk assessment, OGM.02 Ambulatory healthcare center director, QPI.02 Performance measures, WFM.06 continuous education program, QPI.08 Performance improvement and patient safety plan.

IPC.03 The ambulatory healthcare center establishes a functioning multidisciplinary IPC committee that meets at least monthly.

Effectiveness

Keywords:
IPC committee, meetings.

Intent:

IPC challenges continuously arise in the different ambulatory healthcare center disciplines, which in turn provide input for the IPC team for their continuous evaluation of the situation.

There is a structured infection control committee; all relevant disciplines should be represented in the committee for example medical staff nursing services, housekeeping, laboratory, pharmacy, and sterilization services etc., and the committee should have the right to summon whoever it deems appropriate.

The IPC committee is responsible for at least the following:

a) Setting criteria to define ambulatory healthcare center associated infections.
b) Reported outbreaks..
c) Strategies to prevent infection and control risks.
d) Reporting infection prevention and control activities.
e) Annual reviewing and evaluation of the IPC program.

Survey process guide:

- GAHAR surveyor may review the committee matrix, terms of references and may review a sample of monthly minutes of meeting.
- GAHAR surveyor may review evidence of recommendations follow up and implementation.

Evidence of compliance:

1. There are clear terms of reference for the infection control committee that includes at least from (a) to (e) in the intent.
2. All relevant disciplines are represented in the committee.
3. The committee meets regularly.
4. The committee meetings are recorded. And decision mentioned.
5. Recommendations taken by the committee are implemented and followed up at the end of each meeting.

Related standards:

IPC.01 IPC assigned team.IPC.02 IPC program, IPC.04 Infection risk assessment, OGM.02 Ambulatory healthcare center director, IMT.01 Documentation management system.

Safe standard precautions

IPC.04 GSR.03 professional practice guidelines for hand hygiene are adopted and implemented throughout the ambulatory healthcare center to prevent healthcare-associated infections.

Safety

Keywords:

Hand Hygiene.

Hand hygiene is the cornerstone of reducing infection transmission in all healthcare settings. It is considered the most effective and efficient strategy for infection prevention and control and includes:

- Handwashing which is washing hands with plain or antimicrobial soap and water.
- Hygienic hand rub which is the treatment of hands with an antiseptic hand rub to reduce the transient flora without necessarily affecting the resident skin flora. These preparations are broad-spectrum and fast-acting.
- Surgical hand antisepsis/surgical hand preparation/ presurgical hand preparation which is antiseptic hand wash or antiseptic hand rub performed preoperatively by the surgical team to eliminate transient flora and reduce resident skin flora. Such antiseptics often have persistent antimicrobial activity.

Choosing the type of hand hygiene based on the type of procedure and risk assessment. Functional Hand hygiene stations (sinks, clean single-use towels, hand hygiene posters, general waste basket and appropriate detergent) must be present in appropriate numbers and places, according to national building codes. Alcohol-based hand rubs may replace hand wash in healthcare facilities unless hands are visibly soiled to overcome the shortage in sinks.

The Ambulatory healthcare center shall develop and implement a hand hygiene policy that includes at least the following:

a) Hand hygiene techniques.
b) Indications for hand Hygiene.
c) Personal protective equipment (PPE).
d) Accessibility of hand hygiene facilities.
e) Nail Care and Jewelry.
f) Hand hygiene education and training.
g) Monitoring the compliance.

Survey process guide:

- GAHAR surveyor may review the policy of hand hygiene and hand hygiene guidelines.
- GAHAR surveyor may interview Ambulatory
- staff to ask about hand hygiene techniques, and WHO's five moments of hand hygiene.

- GAHAR surveyor may review healthcare professionals' training records.
- GAHAR surveyor may observe hand washing facilities at each patient care area and check the availability of supplies (soap, tissue paper, alcohol hand rub, etc.) and hand hygiene posters.
- GAHAR surveyor may observe the compliance of healthcare professionals with hand hygiene technique and WHO five moments of hand hygiene with WHO observation audit tool

Evidence of compliance:

1. The Ambulatory healthcare center has approved Hand Hygiene policies and procedures based on current professional practice guidelines that address all the elements mentioned in the intent from a) to g).
2. Healthcare professionals are trained on these policies and procedures.
3. Hand hygiene is implemented according to the policy.
4. Hand hygiene posters are displayed in required areas.
5. Hand hygiene facilities are present in the required numbers and places.
6. The Ambulatory monitors the reported data on the hand hygiene process and takes actions to control or improve the process as appropriate.

Related standards:
IPC.02 IPC program, IPC.03 IPC committee IPC.04 Infection risk assessment, WFM.06 Continuous Education Program, QPI.02 Performance measures, QPI.08 Performance improvement and patient safety plan, WFM.07 Staff performance evaluation.

IPC.05 Standard precautions measures and the minimum infection prevention practices apply in any settings where healthcare is delivered.

Safety

Keywords:

Standard precautions measures.

Intent:
According to CDC, standard precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where health care is delivered. In addition to hand hygiene, standard precautions include:

i. Use of personal protective equipment (PPE) (e.g., gloves, masks, eyewear).
ii. Use of soap, washing detergents, antiseptics, and disinfectants.
iii. Respiratory hygiene / cough etiquette.
iv. Sharps safety (engineering and work practice controls).

v. Safe injection practices (i.e., an aseptic technique for parenteral medications).
vi. Sterile instruments and devices.
vii. Clean and disinfected environmental surfaces.

Proper selection of PPEs depends on risk assessments that are performed at the points of care, and according to the patient's suspected infection so staff education and training are therefore of utmost importance.

Survey process guide:

 During GAHAR Survey, the surveyor may check the availability and accessibility of PPE and may interview staff members to inquire about the constant availability, accessibility and proper use of PPE GAHAR surveyor may review PPE standardized products specifications.

Evidence of compliance:

1. The ambulatory healthcare center has PPE that is easily accessible and available.
2. Selection and use of PPE are based on the risk assessments that are performed at the points of care and according to the patient's suspected infection.
3. Responsible staff is aware of PPE proper use and disposal.

Related standards:

EFS.06 Safety Management Plan, IPC.02 IPC program, IPC.04 Infection risk assessment,

IPC.07 Respiratory hygiene protocol, cough etiquette, QPI.03 Risk Management Program, DAS.07 Radiation safety program.

IPC.06 Respiratory hygiene is implemented as an element of standard precautions.

Safety

Keywords:

Respiratory hygiene protocol, cough etiquette

Intent:

Respiratory hygiene and cough etiquette interventions are intended to limit the spread of infectious organisms from persons with potentially undiagnosed respiratory infections.

For respiratory hygiene interventions to be effective, early implementation of infection prevention and control measures needs to exist at the first point of entry to the ambulatory healthcare center and be maintained throughout the duration of the stay.

The effort of respiratory hygiene interventions shall be targeted at patients and accompanying significant others with respiratory symptoms and applies to any person entering an ambulatory healthcare center with signs of respiratory illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions.

Survey process guide:

- During GAHAR Survey, the surveyor may observe the availability of respiratory hygiene/cough etiquette posters in the appropriate places, accessibility and use of detergents, antiseptics, and disinfectants in the relevant areas and the availability, and accessibility of the relevant resources in proper places.
- During GAHAR Survey, the surveyor may observe assigned areas for patients with suspected respiratory infections and the implementation of respiratory patient placement.

Evidence of compliance:

1. Respiratory hygiene /cough etiquette posters are displayed at appropriate places.
2. Resources such as tissues and surgical masks are available in numbers matching patients' and staff members' needs.
3. Ambulatory healthcare centers designate space for patients with suspected respiratory infections to separate them from others.
4. Patients with suspected respiratory infections are identified and placed in designated areas.

Related standards:

IPC.02 IPC program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures

IPC.07 The ambulatory healthcare center ensures safe injection practices.

Safety

Keywords:

Safe injection practices.

Intent:

In the ambulatory healthcare centers, patients are continuously in need for injections whether for diagnostic or therapeutic purposes, unfortunately however it carries an associated risk of infection for the patients. In addition to needle stick, injuries among healthcare professionals are a common accident and, unsafe injection practices are associated with transmission of blood borne pathogens.

Accordingly, safe injection practices are crucial to ensure both patient and healthcare professionals' safety. Healthcare professionals must always use a sterile, single-use disposable syringe, needle for each injection given, and ensure that all injection equipment and medication vials remain free from contamination.

Survey process guide:

- During GAHAR Survey, the surveyor may observe the availability of Intravenous bottles and their proper use, and of single dose vials and the proper use of multi-dose vials.
- GAHAR surveyor may interview staff to check their awareness of safe injection practices

Evidence of compliance:

1. The intravenous bottles/bags are not used interchangeably between patients.
2. Use of multi-dose vials is done in accordance to the manufacturers' recommendations to ensure that vials are remain free from contamination.
3. The ambulatory healthcare center ensures that all staff has trained and aware of safe injection practices.
4. The ambulatory healthcare center ensures single use of the fluid's infusion.
5. The ambulatory healthcare center ensures sterility of any parenteral administration.

Related standards:

EFS.05 Hazardous materials safety, EFS.06 Safety Management Plan, IPC.02 IPC program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures QPI.03 Risk Management Program

IPC.08 Environmental cleaning and disinfection activities are aligned with current national/international guidelines.

Safety

Keywords:

Environmental cleaning activities.

Intent:

The healthcare environment is considered a reservoir for pathogens and may be a significant source of healthcare-associated infections so, cleaning and disinfection of environmental surfaces is an important tool to prevent the development of these infections.

Contact with contaminated surfaces in the ambulatory healthcare center can easily lead to cross-contamination of microorganisms between the environment and healthcare professionals

To provide quality of care, the ambulatory healthcare center shall develop a clear method and schedule for environmental cleaning and disinfection including walls, floors, ceilings, and furniture, this must be performed according to the classification of areas.

The environmental cleaning schedule must address the cleaning activities for each area as follows:

i. Activities to be done every day.

ii. Deep cleaning activities

The Ambulatory shall develop and implement an environmental cleaning and disinfection policy, and procedures based on national/international guidelines for the process of environmental/ all surfaces and equipment/device cleaning /disinfection that addresses at least the following:

a) Identification of risk areas.
b) High-touch environmental surfaces
c) Frequency of environmental cleaning and disinfection
d) Environmental detergents and disinfectants to be used.
e) Method of cleaning and disinfection

Survey process guide:

- During GAHAR Survey, the surveyor may review the list of all environmental services that require cleaning, cleaning schedules, and spill kits.
- During GAHAR Survey, the surveyor may interview healthcare professionals and environmental cleaning staff members to inquire about the availability, accessibility, use of disinfectant, and spill kits properly.

Evidence of compliance:

1. The Ambulatory has approved cleaning and disinfection policy and procedures, including items from a) to e) in the intent.
2. Staff members involved in environmental cleaning activities are trained on the policy.
3. The Ambulatory identifies high-risk areas with different schedules for each area and includes all elements mentioned in the intent from i) through ii).
4. The cleaning technique and disinfectant of choice match the requirements of each cleaned area according to the approved policy.

Related standards

EFS.05 Hazardous materials safety, IPC.02 IPC program, IPC.04 Infection risk

IPC.09 Current evidence-based aseptic techniques are followed during all medical procedures.

Safety

Keywords:

Sterile technique, Aseptic techniques.

Intent:

Aseptic technique refers to practices designed to render and maintain objects and areas maximally free from microorganisms. The term 'aseptic technique' includes several key elements: clean environment, conscientious practicing of hand hygiene, use of appropriate personal protective equipment, and use of standardized routine cleaning, disinfection, and sterilization practices.

All healthcare professionals shall be cognizant of their movement, barrier use, and practices to prevent inadvertent breaks in aseptic techniques, alerting others when the field or objects are potentially contaminated. Choice of the level of antisepsis shall be risk assessment based.

i. Surgical asepsis is the use of a sterile technique to prevent the transfer of any organisms from one person to another or from one body site to another. The goal of the sterile technique is to maintain the microbe count at an irreducible minimum.
ii. Surgical aseptic technique outside of the operating room refers to a practice in a setting outside the operating room that may not have the capacity to follow the same strict level of surgical asepsis applied in the operating room. However, the goal to avoid infection remains in all clinical settings.
iii. Medical asepsis, or clean technique refers to practice interventions that reduce the number of microorganisms to prevent and reduce transmission risk from one person (or place) to another.

The Ambulatory healthcare center shall develop and implement an aseptic techniques policy and procedures based on current professional practice guidelines and address at least the following:

a) Identification of risk procedures.
b) Types of aseptic techniques.
c) Patient preparation.

Survey process guide:

- GAHAR surveyor may review the policy for aseptic techniques.
- GAHAR surveyor may interview healthcare professional to check their awareness of the policy and to assess the implementation is done as relevant to their jobs.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy for aseptic techniques that include items from a) to c) in the intent.
2. Healthcare professionals are trained on how to implement the aseptic techniques, as relevant to their jobs
3. Various aseptic techniques are performed in the ambulatory healthcare center according to the aseptic techniques policy.

Related standards:

IPC.02 IPC program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, QPI.03 Risk Management Program, WFM.06 Continuous education program.

Safe transmission-based precautions and precautions for immunocompromised hosts

IPC.10 Patients with clinically suspected and/or confirmed communicable diseases follow ~~isolation~~ transmission-based precautions according to guidelines.

Safety

Keywords:

Isolation precautions.

Intent:

In addition to standard precautions, transmission-based precautions are used for patients known or suspected to be infected or colonized with certain infectious agent. Isolation precautions create barriers between people and microorganisms that help in preventing the spread of germs in the ambulatory healthcare center.

If the patient is determined to be at an increased risk for transmission of microorganisms, the patient should be transferred to a nearby fever hospitals and not to accept admission of any infective patient unless the ambulatory healthcare center's have standardized isolation room. The ambulatory healthcare center must have at least one standardized isolation room~~(s)~~

When the standardized isolation room(s) is not currently available, the patient should be separated into separate assigned areas/rooms.

Patients who present with clinical respiratory syndromes are instructed to practice respiratory hygiene and cough etiquette and given a surgical mask to wear until instructed to go to nearby hospital.

Survey process guide:

- GAHAR surveyor may review the policy for infection transmission-based precautions.
- GAHAR surveyor may interview staff to check their awareness of the policy.
- GAHAR surveyor may observe the isolation room(s)
- GAHAR surveyor may observe the adherence of healthcare professionals to the suitable PPE and hand hygiene practices according to the type of isolation.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide transmission-based precautions.
2. Healthcare professionals are trained and aware of the approved policies.
3. Standardized isolation room(s) and assigned areas for suspected infectious patient is designated according to the center capacity and the national and international guidelines.
4. Patients with suspected/ confirmed clinical communicable diseases are identified and separated in separate assigned areas/rooms

5. Healthcare professionals caring for patients with a suspected communicable disease are adherent to suitable PPE and hand hygiene practices according to the type of isolation.

Related standards:

IPC.02 IPC program, IPC.04 Infection risk assessment, IPC.06 Standard precautions measures, WFM.06 Continuous Education Program, QPI.03 Risk Management Program, IPC.07 Respiratory hygiene protocol, cough etiquette, EFS.01 Ambulatory healthcare center environment and facility safety structure.

Disinfection and sterilization

IPC.11 Patient care equipment is disinfected/sterilized based on evidence-based guidelines and manufacturer recommendations.

Safety

Keywords:

Sterilization/disinfection

Intent:

The processing of reusable patient care equipment is a critical process in any ambulatory,.

In clinical procedures that involve contact with medical/surgical equipment, it is crucial that healthcare professionals follow standard practices and guidelines to clean and disinfect or sterilize.

The cleaning process is a mandatory step in the processing of patient care equipment. Cleaning, disinfection, and sterilization can take place in a centralized sterile processing department. The assigned processing area shall have workflow direction.

The Ambulatory shall develop and implement a policy and procedures to guide the process of sterilization/disinfection that addresses at least the following:

a) Receiving and cleaning of used items.
b) Preparation and processing.
    i. The processing method is to be chosen according to the Spaulding classification. Disinfection of medical equipment and devices involves low, intermediate, and high-level techniques. High-level disinfection is used (if sterilization is not possible) for only semi-critical itemsthat come in contact with mucous membranes or non-intact skin, such as gastrointestinal endoscopes, respiratory and anesthesia equipment, bronchoscopes and laryngoscopesetc. Chemical disinfectants approved for high-level disinfection include glutaraldehyde,orthophtaldehyde and hydrogen peroxide.
    ii. Sterilization must be used for all critical and heat-stable semi-critical items.
    iii. Low-level disinfection (for only non-critical items) is used for items such as

stethoscopes and other equipment touching intact skin. In contrast to critical and somesemi-critical items, most non-critical reusable items may be decontaminated where theyare used and do not need to be transported to a central processing area.

c) labelling of sterile packs.
d) Storage of clean and sterile supplies: properly stored in designated storage areas that are clean, dry, and protected from dust, moisture, and temperature extremes. Ideally, sterile supplies are stored separately from clean supplies, and sterile storage areas must have limited access.
e) Logbooks are used to record the sterilization process.
f) Inventory levels.
g) Expiration dates for sterilized items.

Survey process guide:

- GAHAR surveyor may review Ambulatory policy guiding the process of sterilization/disinfection.
- GAHAR surveyor may observe to check the number of functioning pre-vacuum class B sterilizers, the presence of physically separated areas according to the standard with unidirectional airflow, and the presence of storage areas that meet the standard criteria.
- GAHAR surveyor may assess the ability of involved Healthcare professionals to perform the sterilization process properly.

Evidence of compliance:

1. The Ambulatory has an approved policy to guide the process of disinfection and sterilization that addresses all elements in the intent from a) through g).
2. Healthcare professionals involved in sterilization are competent.
3. The Ambulatory has at least one functioning pre-vacuum class B sterilizer.
4. The laws and regulations, Spaulding classification, and manufacturer's instructions (operating manual) guide sterilization or disinfection.
5. There are at least three physically separated areas for cleaning, packaging, and/or sterilization and storage.
6. Clean and sterile supplies are properly stored in designated storage areas that are clean, dry, and protected from dust, moisture, and temperature extremes.

IPC.12 A disinfection/sterilization quality control program is developed and implemented.

Safety

Keywords:

Disinfection/Sterilization quality control program

Intent:

Sterilization/ disinfection is a critical process in any ambulatory,; therefore, monitoring the sterilization/ disinfection process is crucial for ensuring a reliable and efficient sterilization

process. Management of the routine quality control (QC) of medical equipment disinfection/sterilization is a major responsibility of healthcare professionals.

Quality control measures are performed to monitor and ensure the reliability of disinfection/sterilization processes. Quality controls can identify performance problems not identified automatically and help to determine the safety of procedures. Management of routine quality control includes developing the QC protocols, implementation of the program, oversight of the program, and responsibility for determining the need for corrective action.

Quality control data shall be reviewed and recorded at regular intervals. Outliers or trends in performance that may indicate problems in the disinfection/sterilization process shall be analyzed and followed up, and preventive actions shall be taken and recorded before major problems arise.

The Ambulatory shall develop and implement a policy guiding disinfection/sterilization quality control, which includes at least the following:

a) Quality control elements, method and frequency include:
    i Cleaning monitor: Visual inspection with magnifying glasses (lighted magnifying glasses are preferred) should be done for each instrument after cleaning.
    ii Physical parameters (temperature, time and pressure) which are monitored every cycle.
    iii Chemical parameters (internal chemical indicator inside the sterilization pack - external chemical indicator on the outside of the sterilization pack), which are monitored for every pack.
    iv Biological indicator, which is done at least weekly.
    v The test for adequate steam penetration and rapid air removal shall be done every day before starting to use the autoclave, using Class 2 internal chemical indicators and process challenge devices, either porous or hollow.
    vi Porous challenge Pack: Bowie-Dick Sheets (class 2 indicator) inside a porous challenge pack (every load). Hollow load challenge (Helix test): a class 2 chemical indicator (strip) inside a helix (every load).
    vii Chemical test strips or liquid chemical monitors shall be used to determine whether an effective concentration of high-level disinfectants is present despite repeated use and dilution. The frequency of testing shall be based on how frequently these solutions are used.
b) Quality control performance expectations and acceptable results shall be defined and readily available to staff so that they will recognize unacceptable results in order to respond appropriately.
c) The quality control program is approved by the designee prior to implementation.
d) Responsible authorized staff member reviews Quality Control results at regular intervals.
e) Remedial actions were taken for deficiencies identified through quality control measures, and corrective actions were taken accordingly.

Survey process guide:

- GAHAR surveyor may review approved Ambulatory policy guiding the Disinfection/Sterilization quality control process and healthcare professionals' training records.
- GAHAR surveyor may interview involved staff members and other healthcare professionals to check their awareness of the Ambulatory policy.
- GAHAR surveyor may observe to check quality control procedures during visiting areas where disinfection/sterilization is performed.
- GAHAR surveyor may observe to ensure the quality of packaging material, the availability of mechanical monitoring, and chemical and biological indicators that meet the standardized product specifications.
- GAHAR surveyor may review logbooks for chemical and biological indicators documentation for each autoclave and logbook for chemical indicators.

Evidence of compliance:

1. The Ambulatory has an approved policy guiding Disinfection/Sterilization quality control process that addresses all elements in the intent from a) through e) and
2. The process of disinfection/sterilization quality control addressing all elements in the intent from i) through vii).
3. Healthcare professionals involved in sterilization/disinfection are competent in quality control performance.
4. Quality of packaging material, as well as chemical and biological indicators, are determined based on standardized product specifications and quality control tests for monitoring sterilization and high-level disinfectants are done regularly according to evidence-based guidelines.
5. Quality control processes are recorded, and corrective action is taken whenever results are not satisfactory.

Related standards:

IPC.02 IPC Program, IPC.13 Disinfection, sterilization QPI.03 Risk Management Program, WFM.07 Staff performance evaluation, OGM.07 Supply chain management.

Safe laundry and healthcare textile management

IPC.13 Laundry service and healthcare textile management are safe.

Safety

Keywords:

Laundry service, textile management.

Intent:

Contaminated healthcare textiles can be a major source of pathogenic microorganisms that can be acquired by improper handling of healthcare textile or by direct contact with the patient.

The provision of healthcare textiles is essential and rigorous standards must be followed during the reprocessing of the textiles to reduce the risk of infection and ensure the patient safety. Physically separated areas for sorting, washing, and drying, and/or storing of laundry is needed.

The ambulatory healthcare center shall develop and implement a policy and procedures to define laundry and healthcare textile services that address at least the following:

a) Processes of collection and storage of contaminated textiles.
b) Cleaning of contaminated textiles.
c) Number of washing machines needed according to center capacity.
d) Water temperature, detergents, and disinfectants usage.
e) Processes of storage and distribution of clean textile.
f) Quality control program (temperature, amount of detergents and disinfectants used, and maintenance) for each washing machine.

Survey process guide:

- GAHAR surveyor may review policy for safe laundry and healthcare textile services management.
- GAHAR surveyor may interview staff involved in laundry and health textile management to check their awareness of the process.
- GAHAR surveyor may observe laundry and health textile management' area to check for presence of physical barriers between sorting, washing, and drying, and/or storing of laundry.
- GAHAR surveyor may review records of water temperature, detergents and disinfectants amount and other quality control records.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to guide the safe laundry and healthcare textile services management that addresses all elements in the intent from a) through f).
2. Staff members involved in laundry and health textile management are aware of the approved policy.
3. Contaminated textile is collected, stored, and transported safely.
4. There are physically separated areas for sorting, washing, and drying, and/or storing of laundry.
5. A quality control program, including water temperatures, is implemented, and recorded.

Related standards:

EFS.01 Ambulatory healthcare center environment and facility safety structure, IPC.02 IPC program, IPC.04 Infection risk assessment, QPI.03 Risk Management Program

Organization Governance and Management

Effective governing body

OGM.01 The ambulatory healthcare center has a governing body structure, responsibilities, and accountabilities.

Effectiveness

Keywords:

Governing body Structure and clear responsibilities.

Intent:

The governing body is responsible for defining the ambulatory healthcare center's direction and ensuring the alignment of its activity with its purpose. It is also responsible for monitoring its performance and future development. Ambulatory healthcare center governing body can be a group of individuals (such as board of directors), one or more individual owners and in a centralized system several subsidiary centers are governed by one governing body, in order to ensure the proper governance and efficient management of any resources thus its structure has to be well defined. Therefore, defining the governing structure of an ambulatory healthcare center that shows lines of authority and accountability and ensures that it operates effectively and efficiently.

The mission statement is a description of any ambulatory healthcare center's core purpose.

Defining the main purpose of the ambulatory healthcare center in the form of a mission is one of the fundamental roles of the governing body, as the ambulatory healthcare center's mission must be aligned with the national healthcare mission, communicated to all relevant stakeholders, including staff, patients, and visitors.

Governing body responsibilities shall be defined and directed towards the ambulatory healthcare center principal stakeholders and shall include:

a) Defining the ambulatory healthcare center's mission, vision and values.
b) Ambulatory healthcare director selection and evaluation ensuring effective succession planning and leadership development.
c) Support, promotion, and monitoring of performance improvement, patient safety, risk management efforts, and safety culture.
d) Setting priorities for activities to be executed by the ambulatory healthcare center; The process of prioritization among selected activities follows this process of selection.
e) Prioritization criteria should be known to all to ensure a fair and transparent resource allocation process.
f) Reviewing the clinical governance activities and receives regular reports.
g) Approval of:
    I. The ambulatory healthcare center's strategic plan.
    II. The operational plan and budget, capital investments.
    III. The quality improvement, patient safety, and risk management programs.

The governing entity shall represented or displayed in an organizational chart or other similar document with clear determination of the flow of orders through the approved line of authority.

Ambulatory healthcare centers shall define the types of communication channels between the governing body, leaders and the ambulatory healthcare center staff. Communication channels may be in the form of social media, monthly meeting or annual conferences or other channels.

Survey process guide:

- GAHAR surveyor may review the policy that describe the structure, responsibilities and accountabilities of the governing body.
- GAHAR surveyor may observe governing body structure and flow of orders through the approved line of authority.
- GAHAR surveyor may interview staff to check their awareness of policy.

Evidence of compliance:

1. The governing body structure is represented in the Ambulatory healthcare centers chart.
2. The governing body meets at predefined intervals, and minutes of meetings are recorded.
3. The Ambulatory healthcare center has vision and mission statements approved by the governing body and are visible in public areas to staff, patients, and visitors.
4. The governing body has defined its responsibilities and accountabilities towards the Ambulatory healthcare center's principal stakeholders as mentioned in the intent from a) to g) and has a process for resource allocation that includes clear criteria for selection and prioritization.

5. The strategic plan, operational plans, budget, quality improvement, and risk management programs are approved, monitored, and updated by the governing body.
6. The governing body members and Ambulatory healthcare center leaders are aware of the process of communication and approve the communication channels.

Related standards:

OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders ,OGM.04 Scope of services. OGM.05 Strategic Plan OGM.06 Operational Plan.

Effective organization direction

OGM.02 A full-time qualified director is appointed by the governing body to manage the Ambulatory healthcare center according to applicable laws and regulations.

Effectiveness

Keywords:

Ambulatory healthcare center director.

Intent:

Executive director is the person who is responsible and accountable for implementing the governing body's decisions and acts as a link between the governing body and the ambulatory healthcare center leaders and staff. Such a position requires certain qualifications guided by relevant laws and regulations and/or as further defined by the governing body.

Ambulatory healthcare center shall appoint a qualified director and defining any leadership delegation authority for managing the center in the absence of the center's director. The director is responsible for the center's compliance with all applicable governmental laws and regulations.

The ambulatory healthcare center director must have appropriate training and/or experience in healthcare management, as defined in the job description.

The job description covers at least the following:

a) Providing oversight of day-to-day operations.
b) Ensuring clear and accurate posting of the ambulatory healthcare center's services and hours of operation to the community.
c) Ensuring that policies and procedures are developed, implemented by leaders, staff and approved by the governing body.
d) Providing oversight of human, non-human and financial resources.
e) Annual evaluation of the performance of the ambulatory healthcare center's committees.
f) Ensuring appropriate response to reports from any inspecting or regulatory agencies, including accreditation.

g) Ensuring that there is a functional, organization-wide program for performance improvement, patient safety, and risk management with appropriate resources.
h) Setting a framework to support coordination within and/or between departments or units, as well as a clear process of coordination with relevant external services.
i) Regular reports to the governing body on how legal requirements are being met.

Each committee must have terms of reference that include its membership, duties, accountability/reporting, frequency of meetings, quorum, and baseline agenda.

The committee meetings are to be held regularly, and the minutes of the meeting are documented.

The ambulatory healthcare center has at least the following committees:

a. Quality and patient safety committee
b. Mortality and morbidity committee

Survey process guide:

- GAHAR surveyor may review ambulatory healthcare center director' staff file to check compliance with all required documents of training, job description, role and responsibilities.
- GAHAR surveyor may review the policy for committee, types and formulation.
- GAHAR surveyor may review the delegation letters for tasks that the ambulatory healthcare center director delegated to any other staff member, when needed.

Evidence of compliance:

1. There is an appointment letter for the ambulatory healthcare center director according to applicable laws and regulations.
2. There is a job description for the ambulatory healthcare center director covering the standard requirements from a) through i) as in the intent.
3. The ambulatory healthcare center director has appropriate training and/or experience in healthcare management, as defined in the job description.
4. The ambulatory healthcare center ensures process of coordination and communication through established committees from a) through b) with defined terms of references, documented minutes, and annual reviews.
5. The governing body receives a periodic report from the ambulatory healthcare center leadership about quality, patient safety, and performance measures at least annually.
6. There is evidence of delegation of authority when needed.

Related standards:

OGM.01 Governing body Structure and clear responsibilities OGM.03 Ambulatory healthcare center leaders, OGM.05 Strategic Plan, IPC.03 IPC committee, meetings, EFS.01

Ambulatory healthcare center environment and facility safety structure, QPI.01 Quality management program.

OGM.03 The ambulatory healthcare center develops clinical governance program.

Effectiveness

Keywords:
Clinical governance program

Intent:
Clinical governance is a framework through which healthcare organizations are accountable for improving service quality and maintaining high care standards, focusing on following key pillars: clinical effectiveness, risk management, patient involvement, communication, clinical audit, staff continuous professional development.
Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria.

Clinical governance in ambulatory health care is a system that ensures everyone in the clinical service understands their role, shares responsibility, and is accountable for maintaining quality clinical care, clinical outcomes and safety for each patient.
The ambulatory health care centers shall establish a Clinical Governance program. This program aims to ensure the effective implementation and ongoing maintenance of clinical governance practices, address challenges, and promote continuous improvement across key areas according to specialities. The ambulatory healthcare center shall assign a qualified staff to supervise and ensure clinical governance implementation.

The clinical governance program shall cover at least the following:

a) Clinical services based on clinical programs and guidelines.
b) Clinical audit.
c) The incident reporting system.
d) Clinical risk management strategies.
e) Encouraging a patient-centered culture.
f) Staff training and ensuring their competence in clinical practices.

The ambulatory healthcare center shall submit a quarterly report to the governing body on how clinical governance requirements are being fulfilled.

Survey process guide:
▪ GAHAR surveyor may review the ambulatory healthcare center clinical governance program.
▪ GAHAR surveyor may interview the assigned staff member for supervising the clinical governance program and related staff to check their awareness of the program.
▪ GAHAR surveyor may observe that the provided clinical services are aligned with clinical guidelines.

Evidence of compliance:

1. The ambulatory healthcare center has a clinical governance program that covers all the elements mentioned in the intent from a) through f).
2. The ambulatory healthcare center has an assigned qualified staff member to supervise the clinical governance program.
3. Related staff members are aware of the ambulatory healthcare center's clinical governance program.
4. Clinical governance activities are reported to the governing body at least quarterly.
5. The clinical services are provided according to guidelines and protocols. 6. The clinical governance program is updated and evaluated annually

OGM.04 The responsibilities and accountabilities of the ambulatory healthcare center leaders are identified.

Effectiveness

Keywords:

Ambulatory healthcare center leaders.

Intent:

While, another standard addresses ambulatory healthcare center director's responsibilities, ambulatory healthcare centers usually have nursing director, medical director, information officer, financial director, and sometimes-operational director that is why the ambulatory healthcare center shall establish a collective of responsibilities in written documents for ambulatory healthcare center leader. The leader of the ambulatory healthcare center must be familiar with the concepts of quality improvement and patient safety programs, and thus can perform his roles and responsibilities. The ambulatory healthcare center leaders are responsible for:

a. Sustaining firm ambulatory healthcare center structure:
    i. Planning for upgrading or replacing systems, buildings, or components needed for continued, safe, and effective operation.
    ii. Collaboratively developing a plan for staffing the ambulatory healthcare center that identifies the numbers, types, and desired qualifications of staff.
    iii. Providing appropriate facilities and time for staff education and training.
    iv. Ensuring all required policies, procedures, and plans have been developed and implemented.
    v. Providing adequate space, equipment, and other resources based on strategic and operational plans and needed services.
    vi. Selecting equipment and supplies based on defined criteria that include quality and cost-effectiveness.
b. Running smooth directed operations:
    i. Creating "Just culture" for reporting errors, near misses, and complaints, and use the information to improve the safety of processes and systems.

ii. Designing and implementing processes that support continuity, coordination of care, and risk reduction.
iii. Ensuring that services are developed and delivered safely according to applicable laws and regulations and approved organization strategic plan with input from the users/staff.

c. Continuous monitoring and evaluation:
i. Ensuring that all quality management and patient safety activities is implemented, monitored, and action is taken when necessary.
ii. Ensuring the ambulatory healthcare center meets the conditions of facility inspection reports or citations.
iii. Annually assessing the operational plans of the services provided to determine the required facility and equipment needs for the next operational cycle.
iv. Annually reporting to the ambulatory healthcare center governing body or authority on system or process failures and near misses, and actions had taken to improve safety, both proactively and in response to actual occurrences.

d. Continuous Improvement.
Data from all over the ambulatory healthcare center shall collected, reviewed, analyzed, and reported to the upper management in order to determine the opportunities of improvement through an effective data driven decision-making.

Survey process guide:

- GAHAR surveyor may interview ambulatory healthcare center leaders to check their awareness of their roles and responsibilities.
- GAHAR surveyor may review ambulatory healthcare center leaders' job descriptions.

Evidence of compliance:

1. There is a job description for each ambulatory healthcare center leader to identify the required qualifications and responsibilities.
2. The responsibilities of the ambulatory healthcare center leaders include at least a) through d) in the intent.
3. Ambulatory healthcare center leaders are aware of and perform their responsibilities.
4. Leaders participate in staff education and training.

Related standards:

OGM.01 Governing body Structure and clear responsibilities, OGM.02 Ambulatory healthcare center director, OGM.05 Strategic Plan, WFM.03 Job Description, WFM.07 Staff Performance Evaluation

OGM.05 A strategic plan is developed under oversight and guidance of the governing body.

Effectiveness

Keywords:

Strategic Planning.

Intent:

Strategic planning is a process of establishing a long-term plan to achieve the ambulatory healthcare center's specified vision and mission through the attainment of high-level strategic goals.

A strategic plan looks out over an extended time horizon. The plan establishes where the ambulatory healthcare center is currently, where leadership wants to go, how they will get there, and how they will know when they have achieved the target.

It is essential that stakeholders are involved in developing the plan to ensure legitimacy, ownership, and commitment to the plan. A strategic plan shall be established on a higher level (governing body) with the involvement of ambulatory healthcare center leaders. The strategic plan shall be based on a comprehensive evaluation of the internal and external environmental factors (e.g., SWOT analysis, PEST analysis). The strategic plan spans shall be over a period of 3 - 5 years and shall be reviewed on a regular basis.

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center strategic plan.
- GAHAR surveyor may interview the ambulatory healthcare center's leaders to check their involvement and monitoring of strategic plan.

Evidence of compliance:

1. The ambulatory healthcare center has a strategic plan with defined achievable timeline for each desired goal/ outcome.
2. Participation of staff, ambulatory healthcare center leaders, and other identified stakeholders in the strategic plan.
3. The strategic plan is reviewed annually.

Related standards:

OGM.01 Governing body Structure and clear responsibilities, OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders, OGM.04 scope of services, QPI.02 Performance measures.

OGM.06 Operational plans are developed to achieve the strategic plan goals and objectives, with inputs from staff, service providers, and other stakeholders.

Efficiency

Keywords:

Operational Plan.

Intent:

Operational plans are the means through which organization fulfill their mission. They are detailed, containing specific information regarding targets and related activities and needed resources within a timed framework.

Leaders establish operational plans that include at least the following:

a) Clear goals and objectives (SMART objectives).
b) Specific activities and tasks for implementation.
c) Timetable for implementation.
d) Assigned responsibilities.
e) Sources of the required budget and resources.

Leaders regularly evaluate the annual operational plans of the services provided to determine the required resources needs for the next operational cycle. Any operating cycle ends with an analysis or an assessment phase through which planners understand what went well and what went wrong with the plan. This analysis or better-called lessons learned should feed into the new cycle of planning to improve the ambulatory healthcare center performance.

Survey process guide:

- GAHAR surveyor may interview staff and leaders to check their awareness of the operational plan they follow and give them an opportunity to talk about their inputs and how they are communicated.
- GAHAR surveyor may review the evidence of monitoring operational plan progress, identification of opportunities of improvement and actions taken to improve performance.

Evidence of compliance:

1. The ambulatory healthcare center has operational plans that include a) to e) in the intent.
2. Staff is aware and actively participate in designing for the operational plans.
3. Operational plans progress reports are done quarterly.
4. Leaders evaluate the operational plans annually, with inputs considered for a new cycle of planning.

Related standards:

OGM.01 Governing body Structure and clear responsibilities, OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders, QPI.02 Performance measures

Efficient supply chain management

OGM.07 The ambulatory healthcare center has effective supply chain management.

Efficiency

Keywords:

Supply Chain and stock Management.

Intent:

The supply chain generally refers to the resources needed to deliver goods or services to a consumer. A supply chain shall include all activities related to manufacturing, the extraction of raw materials, processing, storing and warehousing, and transportation. In healthcare, managing the supply chain is typically a very complex and fragmented process.

Healthcare' supply chain management shall involve obtaining resources, managing supplies, and delivering goods and services to providers and patients. To complete the process, physical goods and information about medical products and services usually go through a number of independent stakeholders, including manufacturers, insurance companies, ambulatory healthcare centers, providers, group purchasing organizations, and several regulatory agencies.

For critical supplies, i.e. supplies vital to the support of operations, the ambulatory care center shall identify the steps in the supply chains to decide where the significant risks reside.

Resources include financial, human resources, technology, information systems. The governing bodies shall develop plans for resource allocation to increase efficiency and transparency so; the ambulatory healthcare center shall develop a policy and procedures for

supply chain management. The policy shall describe the process of resource procurement prioritization and selection criteria. Prioritization criteria shall be known to all leaders to ensure a fair and transparent resource allocation process.

The policy of the supply chain management addresses at least the following:

a) Supplier's identification and selection process.
b) Methods for suppliers and/or distributors' monitoring and evaluation, to ensure that the purchased supplies are provided from reliable sources that refrain from dealing with counterfeit, smuggled, or damaged supplies.
c) Setting pre-defined acceptance criteria for suppliers that may include evaluation based on the suppliers' response upon request, quality of received supplies, lot number, and expiry date.
d) Supplies monitoring and evaluation, to ensure that no recalled medications, samples, devices, medical supplies, or equipment are provided.
e) Monitoring transportation of supplies, to ensure that it occurs according to applicable laws and regulations, and manufacturer's recommendations.
f) The ambulatory healthcare center shall highlight in the policy the procedures for managing stock\ inventory addressing at least the following:
    I. Compliance of storage to the applicable laws, regulations, and organization policies
    II. Stock management and tracking the use of critical resources and supplies.
    III. Management of stocks safely, efficiently and recording stock items that should at least have the following (unless stated otherwise by laws and regulations):
        i. Date received
        ii. LOT number and expiration date
        iii. Whether acceptance criteria were met or not and if any follow-up required
        iv. Date placed in service or disposition, if not used.

Survey process guide:

- GAHAR surveyor may review supply chain management policy and records.
- GAHAR surveyor may interview responsible staff to check their awareness of the policy. GAHAR surveyor may observe the proper implementation of the safe storage strategies.

Evidence of compliance:

1. The ambulatory health care center has an approved policy of supply chain management that addresses all elements from a) through f).
2. Supplies are monitored and evaluated to ensure matching with the pre-defined acceptance criteria that determined in center's policy.
3. Basic information is recorded for stock items as mentioned from i) through iv) of item III) in the intent.
4. Critical supplies are identified and clear processes are followed in case of shortage.
5. Suppliers are monitored and evaluated at least annually.

OGM.08 The ambulatory healthcare center manages the patient billing system.

Efficiency

Keywords:

Billing System

Intent:

The ambulatory healthcare center shall provide patients and their families by a receipt for services rendered, including insurance patients. It is one of the patient and family rights to receive an initial estimated cost for their treatment if requested. For third-party payer systems, the process for billing is based on the requirements of insurance companies/agencies, which generally have reimbursement rules with a predetermined time frame.

The ambulatory healthcare center shall develop a policy and procedures for the billing process that addresses at least the following:

a) Availability of an approved price list for services provided to patients and their sponsors.
b) Patients and families are informed of an initial estimated cost of required services and any potential cost pertinent to the planned care.
c) Process to ensure that patients and families are obtained an accurate invoice for services rendered.
d) Use of the approved codes for diagnoses, interventions, and diagnostics, if applicable.

Survey process guide:

- GAHAR surveyor may review the billing policy and center's price lists.
- GAHAR surveyor may interview responsible staff and some patients to check compliance with the approved policy.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy for billing patients that include items from a) to d) in the intent.
2. There is an approved price list.
3. In the case of a third-party payer (or health insurance), the timeliness of approval processes is monitored.
4. Responsible staff is fully aware of the various health insurance processes and different payment methods.

Related standards:

PCC.02 Patient and family rights, PCC.03 Patient and family responsibilities, OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders, IMT.02 Standardized symbols and Abbreviations.

OGM.09 The ambulatory healthcare center implements a process for selection, evaluation, and continuously monitoring contracted services.

Effectiveness

Keywords:

Contracted services management.

Intent:

Ambulatory healthcare center leadership defines the nature and scope of services provided by contracted services, including clinical and non-clinical services. Ambulatory healthcare center leaders shall describe, in writing, the contractual agreements that outline the nature and type of the services to be provided through the contract. For example, outsources laboratory and radiology services or laundry services.

Leaders shall participate in the selection, evaluation, and continuously monitoring contracted services to ensure that the service providers fully comply with the environmental safety, patient safety, and quality requirements and all relevant accreditation standards requirements.

The quality of services provided by the independent practitioners is monitored as a component of the ambulatory care center's quality and patient safety program.

The contracted services shall monitored through performance measures and evaluated at least annually to determine if a contract should be renewed or terminated. Findings and results of contract monitoring shall be reported to center leaders to be acted upon. The ambulatory healthcare center leaders shall determine the reporting frequency and mechanism, and develop a process for how the ambulatory healthcare center shall respond when the quality requirements are not met.

Survey process guide:

- GAHAR surveyor may review the approved documents of the contracted services.
- GAHAR surveyor may interview center's leaders and responsible staff to determine contractors' monitoring, evaluation, and renewal processes.

Evidence of compliance:

1. There is a list of all contracted services, including clinical and non-clinical services.
2. Head of departments/services participates in the selection, evaluation, and monitoring of contracted services.
3. The performance measures for monitoring contracted services are integrated into the center performance improvement and patient safety plan.
4. Each contract is evaluated at least annually to determine if it should be renewed or terminated.
5. If contracts are terminated, the ambulatory healthcare center has a clear process to maintain the continuity of patient care.

Related standards:

OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders DAS.10 Referral Laboratory services., DAS.22 Contracted blood banks

Leadership role in quality and patient safety

OGM.10 The ambulatory healthcare center leaders create and support a culture of safety and quality within the ambulatory healthcare center.

Effectiveness

Keywords:

Safety Culture.

Intent:

Healthcare is complex, and sometimes, due to unintentional errors, it can harm patients and even staff. To minimize such risk, causes of errors and near misses should be explored and efforts made to prevent their occurrence in the future. Leaders shall create a just culture to encourage reporting errors and near misses. For this to happen, a safety culture within the facility is essential where staff is engaged and feel confident when reporting on a safety incident that they will be treated fairly, in a confidential manner, and that the information they provide will be used to improve the care process and environment. Leaders shall demonstrate their commitment to a culture of safety and set rules for those who work in the center with behaviors that are not consistent with a safe culture.

. The ambulatory healthcare center can adopt some of the following measures:

a) Lead by example: demonstrating a commitment to safety and quality in their actions and decisions sends a powerful message throughout the organization.
b) Open communication**:** encourage open and transparent communication at all levels. Employees should feel comfortable reporting safety concerns, near misses, and incidents without fear of reprisal.
c) Provide resources**:** to support high-quality care delivery.
d) Training and education**:** Invest in ongoing training and education programs for all staff members.
e) Feedback and learning from errors: establish a blame-free environment where errors and near misses are treated as learning opportunities.
f) Recognize and reward: recognize and reward individuals and teams for their contributions to safety and quality.
g) Leadership safety rounds**:** to promote a no-blame and justice culture by encouraging open communication, addressing safety concerns, and fostering a collaborative and supportive environment focused on continuous improvement.
h) Data-driven approach**:** use data to drive decisions and identify trends.
i) Sustain focus: consistently reinforce the importance of safety and quality make it an ongoing agenda item in meetings, share success stories, and celebrate milestones.

Survey process guide:

- GAHAR surveyor may review records of leaders' safety rounds.
- GAHAR surveyor may interview staff to check support for quality initiatives safety culture.

Evidence of compliance:

1. The leaders are aware of the measures to promote patient safety and quality culture
2. Leaders participate in safety rounds to support staff in reporting errors.
3. Leaders create a no-blame/just culture to encourage reporting errors and near misses.
4. Lessons learned from incident reporting system are communicated

Related standards:

OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders

QPI.01 Quality management program, QPI.04 Incident reporting system, QPI.08 Performance improvement and patient safety plan, QPI.09 Sustaining Improvement

Safe, ethical, and positive organization culture

OGM.11 The ambulatory healthcare center ensures positive workplace culture.

Effectiveness

Keywords:

Positive Workplace Culture.

Intent:

Studies highlighted the importance to provide healthcare workers especially the healthcare professionals with a safe and comfortable work environment.

The ambulatory healthcare center shall develop an approved policy and procedures of positive workplace culture. The policy addresses at least the following:

a) Workplace cleanliness, safety and security measures
b) Management of workplace violence, discrimination, and harassment
c) Communication channels between staff and ambulatory healthcare center leaders d) Staff feedback measurement
e) Planning for staff development
f) Planning to maintain the staff healthy lifestyle.

The ambulatory healthcare center shall plan to maintain their staff healthy lifestyle for example; promoting physical and mental health camp/activities in order to reduce stress, provide a weight management program, introduce stress consultation and counselling services for staff.

Survey process guide:

- GAHAR surveyor may review approved policy for positive workplace culture
- GAHAR surveyor may observe workplaces and may interview staff to inquire about workplace incidents.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy for positive workplace culture, addresses at least item a) to f) in the intent.
2. The workplace is clean, safe, and security measures are implemented.
3. Measures of workplace violence, discrimination, and harassment are implemented.
4. Staff feedback and satisfaction are measured and periodically analyzed.

Related standards:

EFS.08 Security Plan OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders OGM.12 Ethical Management, OGM.13 Staff Health program, WFM.01 Workforce Laws and regulations QPI.02 Performance Measures,

OGM.12 The ambulatory healthcare center establishes appropriate ethical management.

Effectiveness

Keywords:

Ethical Management

Intent:

Medical ethics involves examining a specific problem, usually a clinical case, and using values, facts, and logic to decide what the best course of action should be. Healthcare professionals may deal with a variety of ethical problems, for example, conflict of interest and inequity of patient care.

The policy of ethical management addresses at least the following:

a) Developing and implementing the code of ethics
b) Developing and implementing of ambulatory healthcare center values
c) Handling medical errors and medico-legal cases
d) Managing clinical research
e) Identifying conflict of interest
f) Management of ethical dilemma that may arise, including reporting methods, resolving timeframe and communicating the results to impacted stakeholders.
g) Management of discrimination, and harassment.
h) Ensuring Impartiality and gender equality

Survey process guide:

- GAHAR surveyor may review ambulatory healthcare center ethical management policy.
- GAHAR surveyor may interview staff to check their awareness of center's code of ethics.
- GAHAR surveyor may observe mechanisms put in place to ensure gender equality as per the Egyptian law requirements.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy for ethical management that addresses at least a) to h) in the intent.
2. All Staff is aware of the ethical management policy.
3. Ethical issues are discussed and managed according to the approved code of ethics within defined timeframes.
4. Addressed ethical issues are used for education and staff professional development.

Related standards:

APC.05 Professional standards during surveys, PCC.01 Ambulatory healthcare center advertisement, OGM.11 Positive Workplace Culture, PCC.02 patient and family rights.

Effective staff engagement, safety, and health

OGM.13 The ambulatory healthcare center has an effective staff health program in accordance with the applicable laws and regulations.

Safety

Keywords:

Staff Health program.

Intent:

The ambulatory healthcare center shall implement a staff health program to ensure the safety of the staff according to workplace exposures.

A cornerstone of the staff occupational health program is the hazard/risk assessment, which identifies the hazards and risks related to each occupation.

This is done in order to take the necessary steps to control these hazards to minimize possible harm arising and, if not possible, to lessen its negative sequel.

This is achieved through an ambulatory healthcare center-wide risk assessment program that identifies high risks areas and processes.

The program scope covers all staff, the program address at least the following:

a) Pre-employment medical evaluation of new staff
b) Periodic medical evaluation of staff members
c) Screening for exposure and/or immunity to infectious diseases.
d) Exposure control and management to work-related hazards
    I. Ergonomic hazards that arise from the lifting and transfer of patients or equipment, strain, repetitive movements, and poor posture
    II. Physical hazards such as lighting, noise, ventilation, electrical and others
    III. Biological hazards from blood borne and airborne pathogens and others
e) Staff education on the risks within the ambulatory healthcare center environment as well as on their specific job-related hazards.
f) Positive health promotion strategies, such as smoking cessation or encouraging physical activity.
g) Staff preventive immunizations.
h) Recording and management of staff incidents (e.g., injuries or illnesses, taking corrective actions, and setting measures in place to prevent recurrences).
i) Infection control staff shall be involved in the development and implementation of the staff health program as the transmission of infection is a common and serious risk for both staff and patients in healthcare facilities.

j) All staff occupational health program-related results (medical evaluation, immunization, work injuries) shall be documented and kept according to laws and regulation

Survey process guide:

- GAHAR surveyor may interview staff members who are involved in developing and executing staff health program to check program structure, risks, education and orientation records
- GAHAR surveyor may review a sample of staff health records to check the evidence of immunizations, post-exposure prophylaxis and interventions and others staff occupational health program-related results.

Evidence of compliance:

1. There is an approved ambulatory healthcare center's staff health program that cover a) through j) in the intent.
2. There is an occupational health risk assessment that defines occupational risks within the ambulatory healthcare center.
3. Staff members are aware of the risks within the ambulatory healthcare center environment, their specific job-related hazards, and periodic medical examination.
4. All staff members are subjected to the immunization program and to work restrictions according to laws and regulations and the approved ambulatory healthcare center guidelines.
5. All test results, immunizations, post-exposure prophylaxis and interventions are recorded in the staff's health record.
6. There is evidence of taking action and informing employees in case of positive results.

Related standards:

EFS.06 Safety Management Plan, IPC.04 Infection risk assessment, OGM.11 Positive Workplace Culture, WFM.01 Workforce Laws and regulations, QPI.03 Risk Management Program

OGM.14 Ambulatory health care services are planned in line with international, national, regional, or local community initiatives.

Effectiveness

Keywords:

Community Initiatives.

Intent:

Community is a group of individuals, families, groups, facilities, or organizations that interact with one another, cooperate in common activities, solve mutual concerns, usually within the geographic area served by ambulatory healthcare center.

The ambulatory healthcare center shall develop and implement a plan for community involvement that may include initiatives as implementation of international women health, oncology health and diabetes health initiatives or the national initiatives of Universal Health Insurance, 100 Million Healthy Lives or others.

The ambulatory healthcare center service planning shall be aligned with community health needs and may include evaluating prevalent health conditions, identifying gaps in diagnostic services, and adapting capabilities to support public health priorities.
The ambulatory healthcare center utilizes information gathered from primary and/or secondary sources to assess the health needs of targeted populations and decide which services to provide or update existing service packages accordingly. Primary data is data directly collected through surveys of citizens and providers, interviews, focus groups, etc. Secondary data is data obtained from other entities such as vital statistics, registries, censuses, etc.

Survey process guide:

- GAHAR surveyor may review community involvement plan to check that is it aligned with other national initiatives and with laws and regulations
- GAHAR surveyor may interview staff to check their awareness of community initiatives.

Evidence of compliance:

1. The ambulatory healthcare center services reflect alignment with international, regional, and/or national community initiatives.
2. All staff is aware of the community involvement plan and initiatives.
3. The ambulatory healthcare center aligns the provided services with the assessed community health needs.
4. Community involvement plan is updated periodically to meet the needs of the community.

Related standards:

OGM.02 Ambulatory healthcare center director, OGM.03 Ambulatory healthcare center leaders, ACT.03 Physical access and comfort, OGM.04 scope of service.

Workforce management

Efficient workforce planning

WFM.01 Workforce recruitment, education, training, and appraisal processes comply with laws and regulations.

Efficiency

Keywords:

Workforce Laws and regulations

Intent:

Laws and regulations mediate the relationship between workers, ambulatory healthcare center, syndicates and the government.

Laws and regulations, which provide for the rights of employees to work, is enforced through the employment contract. The ambulatory healthcare center should outline the essential aspects of workforce recruitment, education, training, and appraisal processes within the organization and ensure that these processes are aligned with relevant laws and regulations. Ensuring compliance not only safeguards the organization from legal risks but also promotes fairness, equity, and professionalism in our workforce practices. The ambulatory healthcare center identifies all applicable laws, regulations, and norms, including syndicates' codes and requirements, and defines the legal framework for its workforce management.

Survey process guide:

- GAHAR surveyor may review the legal framework documents, observe workforce management practices, or review staff files, including independent practitioners, to check compliance with laws and regulations. .

Evidence of compliance:

1. There are qualified staff to manage and develop the workforce processes.
2. The ambulatory healthcare center identifies all applicable laws, regulations, and norms that guide workforce management.
3. Responsible staff members are aware of laws, regulations, and norms that guide workforce management.
4. The workforce is managed and developed according to applicable laws, regulations, and norms that guide workforce management.

Related standards:

WFM.02 Staffing Plan, WFM.03 Job Description, IMT .01 Documentation management system, WFM.04 Verifying credentials.

WFM.02 Ambulatory healthcare center develops a staffing plan to ensure that provided services meet the needs of safe patient care.

Efficiency

Keywords:

Staffing Plan

Intent:

Staff planning is the process of making sure that the ambulatory healthcare center has the right people to carry out the work needed for business successfully through matching up detailed staff data including skills, potential, aspirations, and location with business plans.

The shortage of competent, skilled healthcare professionals in multiple areas is an alarming sign, especially in critical care disciplines such as intensive care units and anesthesia

The ambulatory healthcare center must comply with laws, recommendations of professional practices that define desired education levels, skills, or other requirements of individual staff members including independent practitioner or that defines staffing numbers or mix of staff for the ambulatory healthcare center.

The staffing plan is reviewed on a regular basis and updated as necessary by the leaders of each clinical or managerial area who defines the individual requirements of each staff position.

Leaders consider the following factors to project staffing needs:

a) The ambulatory healthcare center mission, strategic and operational plans
b) Complexity and severity mix of patients served by the ambulatory healthcare center
c) Services provided by the ambulatory healthcare center
d) Workload during working hours and different shifts.
e) Technology and equipment used in patient care

Survey process guide:

- GAHAR surveyor may review the ambulatory healthcare center staffing plan.
- GAHAR surveyor may review staff files to check compliance of staffing plan to professional practices recommendations.

Evidence of compliance:

1. Staffing plan matches the mission, strategic and operational plans
2. Staffing plan complies with laws, regulations, and recommendations of professional practices

3. Staffing plan identifies the estimated needed staff numbers including independent practitioners and skills with staff assignments to meet the ambulatory healthcare center needs.
4. The staffing plan is monitored, reviewed and updated at least annually.

Related standards:

WFM.01 Workforce Laws and regulations OGM.02 Ambulatory healthcare center director OGM.03 Ambulatory healthcare center leaders.

WFM.03 The ambulatory healthcare center implements a uniform recruitment process.

Equity

Keywords:

Recruitment process

Intent:

Recruitment and selection is the process of advertising a vacant position and choosing the most appropriate person for the job.

The ambulatory healthcare center provides an efficient and centralized process for recruiting and hiring staff members, including independent practitioners, for available positions.

If the process is not centralized, similar criteria and processes must result in a uniform process across the ambulatory healthcare center for similar types of staff.

The ambulatory healthcare center shall develop and implement a policy guiding the recruitment process that addresses at least the following:

a) Collaboration with service/department leaders to identify the need for a job,
b) Communicating available vacancies to potential candidates,
c) Announcing criteria of selection,
d) Application process,
e) Recruitment procedures.

Survey process guide:

GAHAR surveyor may review a policy describing the recruitment process
GAHAR surveyor may check a sample of staff files, including independent practitioners' files, to assess compliance with the ambulatory healthcare center policy.
GAHAR surveyor may interview staff members involved in the recruitment process to assess the process.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to recruit staff members, including independent practitioners, that addresses all the elements from a) through e) in the intent.
2. Staff involved in the recruitment process are aware of the ambulatory healthcare center policy.
3. The recruitment process is uniform across the ambulatory healthcare center for similar types of jobs.
4. The ambulatory healthcare center leaders participate in the recruitment process.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.02 Staffing Plan, OGM.08 Ambulatory healthcare center leaders

WFM.04 Ambulatory healthcare center develops job descriptions to address each position requirements and responsibilities.

Effectiveness

Keywords:

Job Description.

Intent:

The job description is a general written statement of a specific job, based on the findings of a job analysis. It generally includes duties, purpose, responsibilities, scope, and working conditions a job.

In the ambulatory healthcare center, a job description is required to make sure that staff responsibilities are current and aligned with the ambulatory healthcare center policy.

The ambulatory healthcare center shall ensure that the job description is based on education, training, and experience level of each staff. Job description is a process to identify and to authorize the individual to practice independently in the ambulatory healthcare center. In addition, job description is a process to evaluate the extent to which the staff fulfill their job responsibilities.

Job descriptions are required for all types of staff, clinical, non-clinical, full- time, and part-time, temporary staff, and those who are under training or supervision.

Each ambulatory healthcare center leader or head of department is responsible to develop staff job description that fulfill all the necessary requirements approved by the ambulatory healthcare center. It includes at least; job title, main duties and responsibilities, reporting relationships, qualifications, education, experience, training, and technical skills necessary for entry into this job and Special demands may needed.

Survey process guide:

- GAHAR surveyor may review a sample of staff files to check of staff job description' availability.
- GAHAR surveyor may interview staff to check their awareness about their job description and compliance with its items.

Evidence of compliance:

1. There is current job description for every position.
2. Job descriptions address each position's responsibilities, required qualifications, and reporting structure.
3. On assignment, the job description is discussed with staff members, including independent practitioners.
4. The job description is signed by the staff and kept in the staff's file

Related standards:

WFM.08 Medical Staff Structure, WFM.12 Nursing Structure, WFM.07 Medical Staff Performance

Evaluation, OGM.03 Ambulatory healthcare center leaders, IMT.01 Documentation management system,

WFM.10 clinical privileges

WFM.05 The ambulatory healthcare center implements an effective process to verify credentials of all staff members.

Effectiveness

Keywords:

Verifying credentials.

Intent:

Credentials are documents that are issued by a recognized entity to indicate completion of requirements or the meeting of eligibility requirements, such as a diploma from a medical school, specialty training (residency) completion letter or certificate, completion of the requirements of the related syndicates, authorities and/or others, a license to practice.

These documents, some of which are required by law and regulation, and need to be verified from the original source that issued the document. The ambulatory healthcare center shall develop a process of verifying credentials for all staff members (including independent practitioners) and match the requirements of the position with the qualifications of the prospective staff member must be done.

Survey process guide:

- GAHAR surveyor may review the documents of the credential verification process.
- GAHAR surveyor may check a sample of staff member (including independent practitioner's) files to check the availability of required credentials for each position.
- GAHAR surveyor may interview staff members who are involved in credentialing process to check their awareness of the process.

Evidence of compliance:

1. There is a process for verifying credentials of all staff in the ambulatory healthcare center.
2. Required credentials for each position are identified and available in each staff file (including independent practitioners' files).
3. Primary source verification is uniformly applied for all required credentials.
4. Actions are taken and documented when credentials cannot be verified.

Related standards:

APC.02 Registration of staff, WFM.08 Medical Staff Structure, WFM.12 Nursing Structure, WFM.01 Workforce laws and regulations

Efficient staff filing process.

WFM.06 A staff file is developed for each workforce member.

Efficiency

Keywords:

Staff Files

Intent:

It is essential for the ambulatory healthcare center to maintain a staff file for each staff member, including independent practitioners.

An accurate staff file provides a recording of the staff's knowledge, skill, competency, and training required for carrying out job responsibilities.

In addition, the record shows evidence of staff performance and whether they are meeting job expectations.

Each ambulatory healthcare center staff member, including independent practitioners, has a record(s) with information about their qualifications; required health information, such as immunizations and evidence of immunity; proof of participation in orientation as well as ongoing in-service and continuing education; evaluation results, including staff member performance of job responsibilities and competencies; and work history.

Records are standardized and are kept currently according to ambulatory healthcare center policy.

Staff files, including independent practitioners, may contain sensitive information that must be kept confidential.

The ambulatory healthcare center shall develop and implement a policy and procedures that guide the management of staff files, including independent practitioners, that address at least the following:

a) Staff file initiation.
b) Standardized Contents such as:
    i Qualifications, including education, training, licensure, and registration, as applicable.
    ii Work history.
    iii Documentation of credentials evaluation and primary source verification.
    iv Current job description.
    v Recorded evidence of newly hired general, departmental, and job-specific orientation.
    vi Ongoing ambulatory healthcare center and professional education received.
    vii Copies of provisional and annual performance evaluations.
c) Update of file contents.
d) Storage.
e) Retention time according to laws and regulations.
f) Disposal.

Survey process guide:

GAHAR surveyor may review the ambulatory healthcare center policy guiding staff file management.
GAHAR surveyor may interview staff involved in creating, using, and storing staff files to assess their awareness.
GAHAR surveyor may check a sample of staff files to assess the standardized contents.
GAHAR surveyor may visit the area where staff files are kept, assessing storage conditions, retention, confidentiality, and disposal mechanism.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy to develop and maintain staff files that address at least elements from a) through f) in the intent.
2. Staff members involved in creating, storing, and using staff files are aware of the policy requirements.
3. Staff files are confidential and protected.
4. Staff files include all the required records from i) through vii), as mentioned in the intent.
5. Former staff files are retained for a specific time as per ambulatory healthcare center policy, and the ambulatory healthcare center maintains confidentiality during the disposal of files.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.04 Job Description, WFM.05Verifying credentials, WFM.07 Orientation Program, WFM.08 Continuous Education Program, WFM.09 Staff Performance Evaluation, IMT.05 Confidentiality and Security of data and information, IMT.07 Retention of Data and Information

Effective orientation program

WFM.07 Newly appointed, contracted, and outsourced staff undergo a formal orientation program.

Effectiveness

Keywords:

Orientation Program

Intent:

The decision to appoint an individual to an ambulatory healthcare center sets several processes in motion. To perform well, a new staff member, no matter what his or her employment experience, needs to understand the entire ambulatory healthcare center structure and how his/ her specific clinical or nonclinical responsibilities contribute to the ambulatory healthcare center mission.

This is accomplished through a general orientation to the ambulatory healthcare center and his/ her role and a specific orientation to the job responsibilities of his/ her position.

Staff orientation, especially when first employed, with the ambulatory healthcare center policies, ensures alignment between ambulatory healthcare center mission and staff activities.

It also helps to create a healthy ambulatory healthcare center culture where all staff works with a shared mental model and towards agreed-upon objectives.

Staff orientation also facilitates the integration of new staff with the already available to rapidly form effective teams that offer safe and quality care.

The ambulatory healthcare center builds a comprehensive orientation program that is provided to all staff members regardless of their terms of employment

Staff orientation occurs on three levels: General orientation, department orientation and job-specific orientation

General orientation program addresses at least

a) The ambulatory healthcare center mission, vision, and values
b) Ambulatory healthcare center structure
c) Ambulatory healthcare center policies for the environment of care, infection control, performance improvement, patient safety and risk management.
d) Ethical framework and code of conduct.
e) Patient and family rights.

Department orientation program addresses at least:

f) Review of relevant policies and procedures
g) Operational processes,
h) Work relations.

Job Specific orientation

i) Job-specific duties and responsibilities as per the job description.
j) High risk processes
k) Technology and equipment use
l) Staff safety and health requirements and measures

The ambulatory healthcare center shall develop a staff manual that describe processes of staff appointment and reappointment, staff appraisal, staff complaints management, staff satisfaction measurement, code of ethics, disciplinary actions, and termination

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the process of orientation
- GAHAR surveyor may check a sample of staff files to check evidence of attendance of general, departmental and job specific orientation

Evidence of compliance:

1. General orientation program is performed and it includes at least the elements from a) through e).
2. Department orientation program is performed and it includes at least the elements from f) through h).
3. Job specific orientation program is performed and it includes at least the elements from i) through l).
4. All new staff member attends orientation program regardless of employment terms.
5. Orientation completion is recorded in the staff file.

Related standards:

WFM.03 Job Description, WFM.06 Continuous Education Program, EFS.13 Disaster Plan , IPC.05 Hand Hygiene,IPC.08 Safe injection practices, EFS.02 Fire and smoke safety, EFS.05 Hazardous materials safety

Effective training and education

WFM.08 A continuing education and training program is developed and implemented.

Effectiveness

Keywords:

Continuous Education Program

Intent:

For any ambulatory healthcare center to fulfill its mission, it has to ensure that its human resources have the capacity to deliver its services over time.

Continuous education and training programs help guarantee that the training plan, especially if designed to satisfy staff needs necessary to deliver the ambulatory healthcare center mission.

The program is designed in a flexible manner that satisfies all staff categories based on a process of need assessment, tailored training plan, delivery, and reflection.

The program is designed based on services provided, new information, and evaluation of the staff needs. Evidence-based medical and nursing practices and guidelines and other resources are accessible 24 hours to all staff.
The ambulatory healthcare center ensures that education and training are provided and recorded according to the staff member's relevant job responsibilities needs that may include the following:

a) Patient assessment
b) Infection control policy and procedures, needle stick injuries and exposures
c) Environment safety plans
d) Occupational health hazards and safety procedures, including the use of personal protective equipment
e) Information management, including patient's medical record requirements as appropriate to responsibilities or job description
f) Pain assessment and treatment
g) Clinical guidelines used in the ambulatory healthcare center
h) Valid Basic cardiopulmonary resuscitation training for all staff that provides direct patient care
i) Quality concept, performance improvement, patient safety, and risk management.
j) Patient rights, Patient satisfaction, and the complaint/ suggestion process.
k) Provision of integrated care, shared decision making, informed consent, interpersonal communication between patients and other staff cultural beliefs, needs and activities of different groups served
l) Defined abuse and neglect criteria
m) Medical equipment and utility systems operations and maintenance

Survey process guide:

- GAHAR surveyor may interview some staff members and inquire about the process of continuous education and training
- GAHAR surveyor may check a sample of staff files to check evidence of attendance of education and training program

Evidence of compliance:

1. There is a continuing education and training program for all staff categories that may include elements in the intent from a) through m).
2. Resources needed to deliver the program are identified and available to deliver the program.
3. The educational program is based on the training needs assessment of the staff.
4. Department heads approve the departmental education activities necessary to maintain departmental care delivery.

Related standards:

WFM.05 Orientation Program, QPI.02 Performance measures, OGM.02 Ambulatory healthcare center director, WFM.07 Staff performance evaluation.

Equitable staff performance evaluation

WFM.09 Staff performance and competency are regularly evaluated.

Equity

Keywords:

Staff Performance Evaluation

Intent:

Staff performance evaluation is an ongoing process that is also called performance appraisal or performance review, which is a formal assessment for managers to evaluate an employee's work performance, identify strengths and weaknesses, offer feedback, and set goals for future performance Performance evaluation effectively contributes to individual, team, ambulatory healthcare center improvement when based on a defined transparent process with clear declared criteria relevant to the job functions.

The ambulatory healthcare center shall provide written probationary evaluation after the probationary period in accordance with national laws and regulations, and then regular reevaluation is performed at least annually

It is the department head's responsibility to ensure all staff is evaluated within the prescribed cycles and that performance ratings issued by the immediate supervisor reflect staff actual performance.

Recorded process of employees' performance evaluation including performance review methods, tools, evaluation dimensions, criteria, time interval, appeal process, and responsible person for each staff category.

Performance evaluation criteria for medical staff members include those related to patient's medical record recording and medication use. Such as:

a. Patient's medical record review for completeness and timeliness.
b. Utilization practice and medication use.
c. Compliance with approved clinical guideline
d. Complications, outcomes of care, mortality, and morbidity
e. Professional development

Competency is the process to determine the ability of staff to fulfill the primary responsibilities of the position for which a person was hired. Observing and measuring competency for every position in the center is one of the most important duty of the department leaders and to ensure that each staff member shall understand the expectations, responsibilities, activities and competencies required for his or her position.

Competency shall be done after the probationary period (initial competency assessment), then on an ongoing basis at least annually for at least the following (the nursing staff, staff who provide medical imaging services, laboratory services, procedural sedation services and POCT service and staff who are handling critical medical equipment).

Survey process guide:

- GAHAR surveyor may interview department/service or ambulatory healthcare center leaders and inquire about used tools for staff performance evaluation and competency evaluation.
- GAHAR surveyor may check a sample of staff files to assess completion of performance and competency evaluations.

Evidence of compliance:

1. Performance and competency evaluation are performed at least annually for each staff member and linked to the education and training provided.
2. Performance evaluation records for medical staff members include at least all elements from a) through e) in the intent
3. Performance evaluation is performed based on the current job description.
4. Actions are taken based on a performance review.
5. There is evidence of employee feedback on performance and competency evaluation
6. Performance and competency evaluation is recorded in staff members' files.

Related standards:

WFM.03 Job Description, WFM.06 Continuous Education Program, WFM.10 Clinical privileges, WFM.01 Workforce laws and regulations

Efficient medical staff structure

WFM.10 An organized medical staff structure is developed to provide oversight on quality of care, treatment, and services.

Effectiveness

Keywords:

Medical Staff Structure

Intent:

Medical staff are all physicians, dentists, and other professionals who are licensed to practice independently (without supervision) and who provide preventive, curative, restorative, surgical, rehabilitative, or other medical or dental services to patients; or who provide interpretative services for patients, such as radiology, or laboratory services.

The term medical staff is thus inclusive of all physicians, and other professionals permitted to treat patients with partial or full independence, regardless of their relationship to the ambulatory healthcare center The ambulatory healthcare center defines those other practitioners, such as house officers, and junior doctors, that are no longer in training, but may or may not be permitted by the ambulatory healthcare center to practice independently.

Those medical staff have a diagram describing the line of authority within the ambulatory healthcare center.

Survey process guide:

- GAHAR surveyor may review a document describing medical staff structure and medical staff bylaws.
- GAHAR surveyor may interview staff members to check their awareness about the medical staff structure.

Evidence of compliance:

1. The ambulatory healthcare center has a medical staff structure that is developed according to the ambulatory healthcare center's mission, scope of services and recommendations of professional practices to meet patient needs.
2. Medical staff structure is approved by the governing body.
3. Medical staff structure clearly defines lines of authorities during working hours and after hours.
4. Medical staff bylaws are developed and approved by the governing body.

Related standards:

OGM.01 Governing body Structure and clear responsibilities, OGM.02 Ambulatory healthcare center director, WFM.01 Workforce Laws and regulations

Efficient medical workforce structure

WFM.11 Appointment of medical staff members is performed according to applicable laws and regulations and approved medical staff bylaws.

Effectiveness

Keywords:

Medical Staff Appointment

Intent:

The appointment is the process of reviewing an initial applicant's credentials to decide if the individual is qualified to provide patient care services that the ambulatory healthcare center patients need, and the ambulatory healthcare center can support with qualified staff and technical capabilities.

For initial applicants, the information reviewed is primarily from outside sources.

The ambulatory healthcare center policy identifies the individuals or mechanisms accountable for this review, any criteria used to make decisions, and how decisions will be documented.

The policy identifies the process of appointment of independent practitioners for emergency needs or a temporary period

Survey process guide:

- GAHAR surveyor may check a sample of staff files to check evidence for uniform process for the appointment of medical staff.
- GAHAR surveyor may interview staff members who are involved in appointment process to check their awareness of the process.

Evidence of compliance:

1. There is a uniform process for the initial appointment of medical staff members.
2. Medical staff appointments are made according to the ambulatory healthcare center medical staff bylaws.
3. Medical staff appointments are consistent with the ambulatory healthcare center's mission, patient population, and services provided to meet patient needs.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.02 Staffing Plan, WFM.03 Job Description WFM.10 Clinical Privileges.

WFM.12 Medical staff members have current and specific delineated clinical privileges

Safety

Keywords:

Clinical Privileges

Intent:

The ambulatory healthcare centers shall define and require clinical privileges to apply for all medical staff members based on evaluation of the individual's credentials and performance. The determination of a medical staff member's current clinical competence and making a decision about what clinical services the medical staff member will be permitted to perform often called privileging is the most critical determination that the ambulatory healthcare center will make to protect the safety of patients and to advance the quality of its clinical services.

Decisions regarding a practitioner's clinical competence, and thus what clinical privileges he/she is to be granted, are based primarily on information and documentation received from outside the ambulatory healthcare center. Independent practitioners who provide patient care services on the premises of the ambulatory healthcare center but are not employees or permanent staff are privileged, and evaluated. Specialty training programs may identify and list the general competencies of that specialty in areas of diagnosis and treatment with the ambulatory healthcare center assigning privileges to diagnose and treat patients in those specialty competency areas.

The ambulatory healthcare center shall develop a policy of clinical privileges delineation the policy shall address at least the following:

a) Medical staff members and independent practitioners with clinical privileges are subject to medical staff bylaws
b) Privileges indicate if the medical staff can admit, consult, and treat patients.
c) Privileges define the scope of patient care services and types of procedures they may provide in the ambulatory healthcare center.
d) Privileges are determined based on documented evidence of competency (experience-qualifications – certifications-skills) that are reviewed and renewed at least every three years
e) Privileges are available in areas where medical staff provides services pertinent to granted privileges
f) Medical staff members with privileges do not practice outside the scope of their privileges.
g) When medical staff are granted a privilege under supervision, clinical privileges address the accountable supervisors, mode, and frequency of supervision.

Survey process guide:

- During the GAHAR survey, the surveyor may review the policy of clinical privileges delineation.
- GAHAR surveyor may interview medical staff members and inquire about delineated privileges.

- GAHAR surveyor may check a sample of medical staff files to check for presence of clinical privileges.

Evidence of compliance:

1. The ambulatory healthcare center has an approved policy that addresses at least all elements from (a) through(g) in the intent
2. Medical staff members are aware of the process of clinical privileges delineation and what to do when they need to work outside their approved clinical privileges
3. Clinical privileges are delineated to medical staff members based on defined criteria
4. Clinical privileges are accessible to and used by staff involved in booking of surgery and invasive procedures
5. Physicians and dentists' files contain personalized recorded clinical privileges, including renewal when applicable.
6. Physicians and dentists comply with their clinical privileges.

Related standards:

DAS.02 Medical imaging services healthcare professionals.

DAS.09 Laboratory Staff, SAS.02 Qualified Anesthesiologist. SAS.07 Sedation administration and monitoring_ Sedation complications., SAS.10 Provision of surgeries and invasive procedures.

, WFM.03 Job Description, WFM.09 Medical Staff Appointment, WFM.01 Workforce laws and regulations

WFM.13 The ambulatory healthcare center ensures safe and efficient working hours

Safety

Keywords:

Staff burnout and turnover.

Intent:

Attention to health and well-being of healthcare providers and workers become more important when we consider the fact that employees are the greatest asset in an organization. Burnout is a combination of exhaustion, cynicism, and perceived inefficacy resulting from long-term job stress. The consequences of burnout are not limited to the personal well-being of healthcare providers and workers; many studies have demonstrated that provider burnout is detrimental to patient care. The ambulatory healthcare center shall ensure management of staff working hours and application of the national laws and regulations efficiently to avoid burnout.

The policy of efficient working hours shall address at least the following:

a) Measures to avoid staff burnout like fair distribution of tasks, workload monitoring, and provide adequate staffing.
b) Planned rest times and minimize excessive overtime.
c) Maternity protection and arrangements for breast-feeding.
d) Proper shift scheduling and Setting staff working hours according to the national laws and regulations

Survey process guide:

- GAHAR surveyors may review the ambulatory healthcare center policy for working hours and compliance with national laws and regulations.
- GAHAR surveyor may interview staff to inquire about the measures taken to ensure appropriate working hours

Evidence of Compliance:

1. The ambulatory healthcare center has an approved policy and procedures that clearly describe the process to ensure safe and efficient working hours, the policies address a) to d) in the intent.
2. Staff is aware of the ambulatory healthcare center policy.
3. The staff schedules ensure suitable working hours, planned rest times, maternity protection, and arrangements for breastfeeding according to laws and regulations.
4. When working hours exceed the approved limits, measures are taken to ensure staff safety and satisfaction

Related standards

WFM.01 Workforce Laws and regulations, WFM.08 Medical Staff Structure, OGM.11 Positive Workplace Culture

WFM.14 The ambulatory healthcare center has a defined nursing structure that is led by a qualified nurse director.

Effectiveness

Keywords:

Nursing Structure

Intent:

The nursing director has an influential role in the creation of a safe, healthy, productive working environment for nursing staff that promotes collaboration, productivity, and professional growth. Successful nursing directors have qualifications and expertise in management and leadership.

Standards of nursing practice provide and outline the expectations of the professional role for nurses, including scope and standards of practice and related competencies. They reflect a desired and achievable level of performance against which a nurse's actual performance can be compared. The main role of the nursing director is to direct and maintain the safe and effective nursing practice.

Nursing staff newly hired and freshly graduate practice must be under supervision after receiving all educational and training needs for the job.

The ambulatory healthcare center clearly defines the nursing structure The nurse director responsibilities are to include at least the following:

a) Responsible for developing and implementing written nursing standards of practice and recording for nursing assessment, nursing care plan, nursing reassessment, and treatments
b) Responsible for evaluating the effectiveness of nursing treatments
c) Member of the senior leadership team of the ambulatory healthcare center and attending the senior leadership staff meetings
d) Ensuring that schedules and assigned tasks to the staff are completed

The ambulatory healthcare center defines the trainee nurses and their role in the ambulatory healthcare center during the training period. In addition, supervisors of the trainee nurse's monitors and evaluate their performance during the training period

The ambulatory healthcare center sets guidelines for nursing practices

Survey process guide:

- GAHAR surveyor may review a document describing nursing staff structure.
- GAHAR surveyor may review staff file of nursing director
- During the GAHAR survey, the surveyor may interview nurse trainees/nurses and inquire about their performance and available scientific resources

Evidence of compliance:

1. There is a current, approved job description for the nursing director describing responsibilities as addressed in the intent from item a) to d).
2. The nursing director file fulfills the licensure, qualification, and expertise as required by the job description
3. The ambulatory healthcare center defines trainee nurses and the duration of working under training
4. Trainee nurses' practice under supervision through their job description and their performance is monitored and evaluated.
5. Nursing standards of practice are adopted, educated and implemented.

Related standards:

WFM.01 Workforce Laws and regulations, WFM.03 Job Description, WFM.04 Verifying credentials WFM.07 Staff Performance Evaluation

Information Management and Technology

Effective information management processes

IMT.01 Information management processes are planned and implemented according to the AHC needs, applicable laws, and regulations.

Effectiveness

Keywords:
Information management plan

Intent:

National laws and regulations address the core principles and practices essential for the effective management of an organization's information assets, including confidentiality, release of patient information, the retention period for documents, and reporting of specific information to inspecting and regulatory agencies.
An information management plan includes the identification of the information needs of different units and the implementation of a process to meet those needs.
The information management plan aims at providing accurate, meaningful, comprehensive, and timely information to assist in an information-based decision-making process.
The AHC shall make the necessary efforts and take steps to comply with relevant laws and regulations in the field of information management.
The AHC shall develop an information management plan in response to identified needs. The development of an effective information plan shall address the following:

a) The identified information needs of clinical and managerial AHC leaders.
b) The information needs and requirements of external authorities and agencies.
c) Telehealth and AI application (if applicable)
d) The size and type of services provided by the AHC.
e) Critical processes where recording is mandated.
f) Clinical coding (diagnosis and procedure codes) matching those provided by health authorities and/or third-party payers.
g) Staff training according to their responsibilities, job descriptions, and data and information needs.

Survey process guide:

- GAHAR surveyor may review the information management plan.
- GAHAR Surveyor may interview staff to assess plan implementation and may ask to demonstrate the process of information needs assessment and actions taken to meet identified needs.
- GAHAR surveyor may review response reports from inspecting and regulatory agencies and demonstrate the process of information needs assessment and action taken to meet identified needs.

Evidence of compliance:

1. The AHC leaders perform information needs assessment.
2. The AHC has an approved information management plan that includes items from a) through g) in the intent.
3. The AHC stores all its records and information according to laws and regulations.

4. The AHC responds within defined timeframes to any required reports from inspecting and regulatory agencies.
5. Recording of processes is required based on their criticality, and compliance with laws and regulations.
6. When gaps are identified, actions are taken to comply with laws and regulations.

Related standards:

APC.01 Accurate and complete information, IMT.02 Document control system, IMT.10 Health information technology evaluation, OGM.04 AHC leaders, OGM.08 Billing System, WFM.06 Continuous Education Program, WFM.04 Staff Files, IMT.06 Retention of Data and Information, IMT.04 Confidentiality and Security of data, IMT.12 Data back-up.

Effective document management and recording

IMT.02 Documentation management system is developed for all the ambulatory healthcare documents.

Effectiveness

Keywords:

Documentation management system,

Intent:

Establishment of a uniform and consistent method for developing, approving, tracking, and revising documents (such as policies, plans, programs, procedures, and others) prevent duplication, discrepancies, omissions, misunderstandings, and misinterpretations. The tracking system of issuing and changes allows staff to easily identify relevant policies and procedures, and ensures that staff are informed about changed policies.
The AHC shall develop a policy and implement procedures for the document control system.
The policy shall address at least the following:

a) Standardized formatting.
b) Document control system for tracking of issues and tracking of changes.
c) The system allows each document to be identified by title, date of issue, edition and/or current revision date, the number of pages, who authorized issue and/or reviewed the document and identification of changes of version.
d) Required policies, procedures, plans, programs, and guidelines are available and disseminated to relevant staff.
e) Staff understand how to access those documents relevant to their responsibilities.
f) Retirement of documents.
g) Policies revisions and updates

Survey process guide:

- GAHAR surveyor may review the policy, the related documents, which include the AHC policies and procedures; to ensure that they have a standardized format, tracking system, identified approver, issuing, and revision date.
- GAHAR surveyor may interview involved staff to check their awareness of the development process, as well as approving, tracking, and revising of documents.
- GAHAR surveyor may interview staff to check their awareness about access to relevant documents, tracking changes in the documents, and process for management of retirement of documents.

Evidence of compliance:

1. The AHC has a policy that addresses items from a) through g) in the intent.
2. The AHC leadership, heads of services, and the relevant process owners are aware of this policy.
3. Staff can access those documents relevant to their responsibilities.
4. All documents are developed in a standardized format and can be tracked according to the policy.
5. Policies are revised at least every three years.

Related standards:

IMT.01 Information management plan, QPI.01 Quality improvement Plan, IMT.06 Retention of Data and Information, IMT.10 Health information technology evaluation.

IMT.03 GSR.29 The AHC defines standardized symbols and abbreviations.

Efficiency

Keywords:
Abbreviations

Intent:
Usually, codes, symbols, and abbreviations are used to squeeze a lot of writing into a small space. This may cause miscommunication between healthcare professionals and potential errors in patient care.

The AHC shall develop a policy and procedures for approved and non-approved symbols and abbreviations according to the AHC scope of service and approved official language of communication inside the center that addresses at least the following:

a) Approved symbols/abbreviations list.
b) The list of not-to-use symbols/abbreviations is guided by reliable references, such as the Institute for Safe Medication Practices (ISMP) list.
c) Non-English abbreviations and illegible handwriting.
d) Situations where symbols and abbreviations (even the approved list) must not be used, such as informed consent and any record that patients and families receive from the AHC about the patient's care.

Survey process guide:

- GAHAR surveyor may review AHC policy for abbreviations.
- GAHAR surveyor may review a sample of medical records to check for the used symbols/abbreviations with medication orders and inpatient medical records.
- GAHAR surveyor may interview medical staff to check their awareness about symbols/abbreviations requirements.

Evidence of compliance:

1. The AHC has an approved policy that includes all the elements in the intent from a) through d).
2. All staff who record in the patient's medical record are aware of the policy requirements.
3. Symbols and abbreviations, including the approved list, are used according to the policy.
4. Violation of the list of not-to-use symbols/abbreviations is monitored, and corrective actions are taken.

Related standards:
IMT.08 Patient's Medical record Management, OGM.12 Billing System, IMT.09 Medical Record Review, PCC.08 Informed consent, MMS.11 Ordering, prescribing, transcribing

Ensuring confidentiality and security of information

IMT.04 **The AHC** ensures data and information confidentiality, security, and integrity.

Patient-*centeredness*

Keywords:
Confidentiality, Security and Integrity of information.

Intent:
Confidentiality means that health information is not made available or disclosed to unauthorized patients or processes.

Information security is the protection of information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction. Information security is achieved by ensuring the confidentiality, integrity, and availability of information.

Integrity means the property that health information has not been altered or destroyed in an unauthorized manner. Data integrity ensures that data remains unchanged and uncorrupted from the moment it is created, or entered into a system, until the time it is no longer needed or is archived. Patient's medical record and information are protected at all times and in all places. Including protecting it from water, fire, or other damage, and unauthorized access.

Availability denotes that health information is accessible and useable upon demand by an authorized person. **The AHC** shall define who is authorized to view and administer health information or clarify and improve how and when health information is provided to patients or other healthcare entities.

To ensure information confidentiality and security, it is necessary for all staff members to sign an agreement stating their commitment. This agreement confirms their understanding of the confidentiality policy and procedures, as well as their familiarity with their respective roles.

Egyptian laws and regulations address topics related to confidentiality, the release of patient information, and reporting of specific information to inspecting and regulatory agencies. The facility shall make the needed efforts and take steps to comply with relevant laws and regulations in the field of information management.

The AHC shall develop and implement policy and procedures to ensure data confidentiality, security, and integrity that addresses at least the following:

a) Determination of who can access (list of authorized individuals).
b) The circumstances under which access is granted.
c) Confidentiality agreements with all those who have access to patient data.
d) Procedures to ensure privacy and cybersecurity of patient information.
e) Procedures to follow if confidentiality or security of information has been breached.
f) Procedures to secure medical report release, in accordance with law and regulations.
g) Procedures to secure the confidentiality of patient information that is communicated through e-mail or mobile applications.
h) Protective measures to ensure medical information integrity in the medical records department and server storage area.

i) Action(s) to be taken when an integrity issue is identified.

Survey process guide:

- GAHAR surveyor may review the facility policy for data confidentiality, security, and integrity.
- GAHAR surveyor may interview responsible staff members to check their awareness of **The AHC** policy.
- GAHAR surveyor may observe the implemented measures for medical records and information protection.
- GAHAR surveyor may review staff files to check for the signed confidentiality agreement.

Evidence of compliance:

1. **The AHC** has an approved policy that includes all the points in the intent from a) through i).
2. All responsible staff members are aware of the policy requirements.
3. Only authorized individuals have access to patient's medical records (information) according to the level of accessibility.
4. There is a signed confidentiality agreement in each involved staff member's file.
5. Procedures are followed if confidentiality, security, or integrity of information has been violated.
6. The medical records department and server storage area have measures to ensure medical records and information protection.

Related Standards:
IMT.05 Retention of medical records, data, and information, IMT.06 Patient's Medical record Management, IMT.08 Health information technology, PCC.02 Patient and family rights, IMT.07 Medical Record Review, IMT.01 Information management plan.

IMT.05 Retention time of records, data, and information is performed according to applicable national laws and regulations.

Timeliness

Keywords:
Retention of data and information

Intent:

As medical records, data, and information have an important role in patient care, legal documentation, continuity of care, and education. The AHC has to retain them for a sufficient period of time. The different data retention policies weigh legal and privacy concerns against economics and need-to-know concerns to determine the retention time, archival rules, data formats, and the permissible means of storage, access, and encryption. The AHC shall develop and implement a policy and procedures on data and information retention. The policy shall address at least the following:

a) Retention time for each type of document.
b) Information confidentiality shall be maintained during the retention time.
c) Mechanism to identify records that shall be archived.
d) Retention conditions, archival rules, data formats, and permissible means of storage, access, and encryption.

e) Data destruction procedures according laws and regulations.

Survey process guide:

- GAHAR surveyor may review the data retention time policy.
- GAHAR surveyor may review the list of retention times for different types of information.
- GAHAR surveyor may interview staff asking to demonstrate the process of records retention and destruction and/or removal of records, data, and information.
- GAHAR surveyor may observe the record/logbook of documents destruction and/or removal.

Evidence of compliance:

1. The AHC has an approved policy that includes all the items in the intent from a) through e).
2. All staff is aware of the policy requirements.
3. The information confidentiality is maintained during the retention time.
4. Data are archived within the approved timeframe.
5. Destruction and/or removal of records, data, and information are done as per laws, regulations, AHC's policy, and procedure.

Related standards:

IMT.04 Confidentiality and Security of data, IMT.01 Information Management plan, IMT.07 Medical record Management, IMT.02 Document control system.

Availability of patient-specific information

IMT.06 The Patient's medical record is managed to ensure effectiveness.

Effectiveness

Keywords:
Patient's Medical record Management and usage.

Intent:
Patient medical records are available to assist the healthcare professional in having quick access to patient information and to promote continuity of care and patient satisfaction.

Every patient evaluated or treated in the AHC has a medical record. The file is assigned a number unique to the patient and is used to link the patient with their health record. A single file with a unique number enables the AHC to easily locate a patient's medical record and document the patient's care over time.

The patient's medical record must have uniform contents and order. The main goal of developing a uniform structure of the patient's medical record is to facilitate the accessibility of data and information to provide more effective and efficient patient care.

The AHC shall develop and implement a comprehensive policy and procedures for medical record management. This policy shall cover, at least, the following elements:

a) Medical record flow management, including the initiation of a patient's medical record, generation of unique identifiers, tracking, secure storage, and ensuring availability when needed to healthcare professionals.
b) Uniformity in the content and order of medical records, and standardized use across the organization.
c) Patient's medical record release.
d) Management of voluminous patient's medical records.
e) Provisions to guide the appropriate use and completeness of the patient's medical record, including defining individuals authorized to make entries.
f) Process to ensure that only authorized personnel can make entries, with each entry clearly identifying the author, along with the date and time of documentation.
g) A defined process for correcting or overwriting entries in the patient's medical record, ensuring integrity and accountability of the documentation

Survey process guide:

- GAHAR surveyor may review the AHC policy for medical record management.
- GAHAR surveyor may check that each patient's medical record has a unique identifier for each patient, medical record contents, format and location of entries, and medical records movement logbook.

- GAHAR surveyor may observe patient's medical record availability when needed by healthcare professionals and contain up-to-date information within an appropriate timeframe.
- GAHAR surveyor may interview staff to assess awareness about managing patients' medical records in the AHC.

Evidence of compliance:

1. The AHC has an approved policy for medical record management that includes all the items in the intent from a) through g).
2. Responsible staff using patients' medical records are aware of the policy requirements.
3. A patient's medical record is initiated with a unique identifier for every patient evaluated or treated, and only authorized individuals make entries in the patient's medical record
4. The patient's medical record contents, format, and location of entries are standardized.
5. The patient's medical record is available when needed by a healthcare professional.
6. All entries in the medical record are legible, the author, date, and time of all entries in the patients' medical records can be identified, and entries in the patient's medical record are corrected or overwritten (if needed) in compliance with law, regulations, and policies.

Related standards:

IMT.03 Document control, IMT.04 Abbreviations, IMT.05 Confidentiality and Security of data and information, IMT.07 Retention of Data and Information, IMT.09 Medical Record Review

Effective patient's medical record management

IMT.07 The AHC establishes the patient's medical record review process.

Effectiveness

Keywords:

Medical record review process

Intent:

Review of medical records is usually performed to ensure that they are accurate, clinically pertinent, complete, current and readily available for continuing patient care and to recommend action when problems arise in relation to medical records and the medical filing service.

The AHC shall develop a policy and procedures to assess the content and the completeness of patient's medical record.

The policy shall address at least the following:

a) Review of a representative sample of all services.
b) Review of a representative sample of all disciplines/staff.
c) Involvement of representatives of all disciplines who make entries.
d) Review of the completeness and legibility of entries.
e) Review occurs at least quarterly.
f) Random sampling and selecting approximately 5% of patients' medical records.

Survey process guide:

- GAHAR surveyor may review the policy of patient's medical record review.
- GAHAR surveyor may interview staff to assess their awareness about the process of reviewing patient's medical record.
- GAHAR surveyor may check the results of the review process and actions taken to improve performance.

Evidence of compliance:

1. The AHC has an approved policy that includes all the points in the intent from a) through f).
2. An authorized responsible staff performs the medical record review focusing on timeliness, accuracy, completeness, and legibility of the medical record.
3. Medical record-Review results are reported to the AHC leaders.
4. Corrective actions are taken when needed

Related standards:

IMT.02 Document control system, IMT.03 Use of symbols and abbreviations, IMT.04 Confidentiality and Security of data, IMT.07 Patient's Medical record Management, IMT.08 Patient's medical record usage, QPI.02 Performance Measures

Effective information technology in healthcare

IMT.08 The use of health information technology systems is safe and efficient.

Effectiveness

Keywords:
Health information technology.

Intent:
Implementation of health information technology' systems can facilitate workflow; improve the quality of patient care, and patient safety. The selection and implementation of health information technology' systems require coordination between all involved stockholders to ensure proper selection and integration with all interacting processes. Following implementation, evaluation of the usability and effectiveness of the system shall be done.
Downtime event is any event where a health information technology' system (computer system) is unavailable or fails to perform as designed. It significantly threatens the safety of the care delivery and interruption of the care provision in addition to the risk of data loss.
The ambulatory healthcare center shall develop a policy to ensure the continuity of safe patient care processes during planned and unplanned downtime including the measures / alternatives that had been undertaken. The policy shall address the downtime recovery process to ensure data integrity.
Data backup is a copy of data that is stored in a separate location from the original, which may be used to restore the original after a data loss event, having a backup is essential for data protection. Backups shall occur regularly in order to prevent data loss. The ambulatory healthcare center shall ensure the backup information is secure and accessible only by those authorized to use it to restore lost data.

Survey process guide:

- The GAHAR surveyor may perform an interactive staff interview asking to demonstrate the process of selection, implementation, and evaluation of information technology, followed by checking the implementation of the process by review of the related documents, which include result of system evaluation.
- The GAHAR surveyor may review the document of the planned and unplanned downtime response, followed by checking the implementation of the process by review of the related documents, which includes work instructions for planned and unplanned downtime, stock of needed forms to be used during downtime and result of annual program testing.
- The GAHAR surveyor may interview staff to assess awareness of the response to planned and unplanned downtime.
- The GAHAR surveyor may check implementation of data backup process.

Evidence of compliance:

1. The ambulatory healthcare center health information technology' systems are selected, implemented in collaboration to center's leaders and stakeholders.
2. The ambulatory healthcare center has an approved policy for downtime including the recovery process.
3. The staff is aware of the health information technology' system.
4. Data backup process and frequency of backup is identified according to center policy.

Related standards:
IMT.01 Information management system, IMT .03 Confidentiality and Security of data and information, IMT.04 Retention of data and information

Quality and Performance Improvement

Effective leadership support

QPI.01 The Ambulatory HC leaders plan, document, implement, and monitor an organizational-wide quality improvement and patient safety plan.

Effectiveness

Keywords:
Quality improvement plan

Intent:

It is essential for organizations to have a framework for their quality management system to support continuous improvement. This requires leadership support, well-established processes, as well as active participation from all ambulatory HCs units'/ services' heads and staff. Leaders shall develop a quality improvement, patient safety, and risk management plan(s) that should be comprehensive and adequate to the size, complexity, and scope of services provided. The plan(s) shall address at least the following:

a) The goal(s) of the plan that fulfils the AHC's mission.
b) Defined responsibilities of improvement activities.
c) Data collection, data analysis tools, and validation process.
d) Defined criteria for prioritization and selection of performance improvement projects.
e) Quality improvement model(s) used.
f) Information flow and reporting frequency.
g) Training on quality improvement and risk management approaches.
h) Regular evaluation of the plan (at least annually).

The Ambulatory HC leaders shall assign a qualified individual(s) to oversight, communicate the quality activities, and provide management, leaders, and responsible staff with all needed information and should have the proper support from them. The Ambulatory HC shall establish a multidisciplinary committee for performance improvement, patient safety, and risk management, with a membership of top leaders as committee chairpersons. The committee shall provide oversight and make recommendations to the governing body concerning the effectiveness, efficiency, and appropriateness of quality, safety and risk management of health services provided across the facility. The committee shapes the quality culture of the facility through terms of reference that include at least the following:

i. Ensuring that all designated care areas participate in quality improvement activities.
ii. Ensuring that all required measurements are monitored, including the frequency of data collection.
iii. Reviewing adverse events, near-misses, and root cause analyses to prevent recurrences.
iv. Developing and implementing strategies to enhance patient safety and minimize risks.
v. Monitoring compliance with regulatory and accreditation standards related to quality and safety.
vi. Reviewing indicators and identifying opportunities for improvement
vii. Reporting information to Ambulatory HC leaders, appropriate staff members and the governing body about the performance data and quality improvement activities within a defined timeframe.

Survey process guide:

- GAHAR surveyor may review the quality improvement plan, related documents, and tools.
- GAHAR surveyor may interview Ambulatory HC leaders and quality coordinators to check their awareness of the plan contents, staff training related to quality concepts, data management, and plan(s) implementation in different leadership AHC areas.

Evidence of compliance:

1. The Ambulatory HC has an approved quality improvement plan addressing the items from a) through h) in intent.
2. A qualified individual(s) is assigned to oversight the quality improvement activities.
3. The plan is communicated to all relevant stakeholders.
4. There is a multidisciplinary performance improvement, patient safety, and risk management committee(s) with terms of references, including items from (i) through (vii) in the intent.
5. The committee(s) meets at predefined intervals and documents the minutes of the meeting.
6. The quality improvement plan is evaluated and updated at least annually.

Related standard:

OGM.01 Governing body Structure and responsibilities, OGM.02 Ambulatory HC Director, OGM.04 Ambulatory HC leaders, QPI.02 Performance Measures.

QPI.02 Performance measures are identified, defined, and monitored for all significant processes.

Effectiveness

Keywords:
Performance measures

Intent:

Performance measures are values which demonstrate AHC's performance, strengths, and opportunities for improvement. Effective design and clarity of scope are fundamentals in establishing and maintaining value-added business indicators. Performance measure must be Specific, Measurable, Achievable, Relevant, and Time-bounded (SMART). To define a measure properly, a description of at least the following is needed:

i. Definition
ii. Defined data source
iii. Specified frequency
iv. Sampling techniques
v. Formula
vi. Methodology of data collection and analysis

The AHC shall select a mixture of performance measures that focuses on activities that might be risky in nature to patients or staff, occurring in high volume, associated with problems or high cost. This includes at least one indicator for each of the following:

a) Average waiting times in the relevant service areas.
b) Patient's medical record completeness.
c) Medication errors, near-misses, and adverse outcomes.
d) Patient and family satisfaction rates.
e) Patient complaints.
f) Staff satisfaction.
g) Staff complaints.
h) Procurement of routinely required supplies and medications.
i) GAHAR safety requirements
j) Facility management (EFS plans)

Once data has been collected for a meaningful amount of time, process improvements can begin to be evaluated. The amount of data that should be evaluated for a performance measure will obviously vary based on how often the data is reported and the frequency with which the subject of the measure occurs. The AHC uses different charts to track the improvement progress and decides the next step in the improvement plan. The AHC shall make its performance measures results publicly available at least annually.

Survey process guide:

- GAHAR surveyor may interview some staff members and ask them about performance measurement in their units/services and evaluate staff awareness about the relevant improvement.
- GAHAR surveyor may review the document for the selected measures, and assess the criteria of selection, prioritization, followed by an interactive session to assess the implementation of the measures.

Evidence of compliance:

1. AHC selects appropriate performance measures according to its scope of services.
2. There is an approved identification card for each selected performance measure, that include all elements mentioned in the intent from i) through vi)
3. The relevant performance measures are monitored frequently.
4. AHC leaders make appropriate decisions based on reported performance measures.
5. Performance measures are reported to external authorities as required.

Related standards:

QPI.01 Quality improvement Plan, QPI.03 Data collection, review, aggregation, and analysis, QPI.08 Sustained Improvement activities, OGM.01 Governing body Structure and responsibilities, OGM.02 AHC director, APC.03 Sustaining compliance with accreditation standard. (GSR.01 to GSR.10)

QPI.03 The Ambulatory Healthcare Center has a process in place for data aggregation, analysis, and validation.

Effectiveness

Keywords:

Data aggregation, analysis, and validation

Intent:

To reach conclusions and make decisions, data must be aggregated, analysed, and transformed into useful Information.

Data is reviewed, aggregated, analysed, trended, properly displayed and transformed into useful information in order to reach conclusions and to make decisions by **The Ambulatory** head of departments. So, a qualified staff having the appropriate experiences and skills is assigned to do these tasks as data analysis provides continuous feedback of quality management information to help those individuals make decisions and continuously improve technical and managerial processes

The Ambulatory head of departments determine how often data are aggregated and analysed.

The frequency depends on the activity or area being measured, the frequency of measurement, and the **The Ambulatory**'s priorities.

The analysis process includes comparisons internally, with other **The Ambulatory** Healthcare centers when available, and with published scientific standards and desirable practices. Data are analysed when undesirable trends and variation are evident from the data.

Data validation is vital to ensure the data is clean, correct, and useful. **The Ambulatory** shall use these elements to ensure the quality of data:

a) Validity: data measure what it is supposed to measure.
b) Reliability: everyone defines, measures, and collects data uniformly.
c) Completeness: data include all the values needed to calculate performance measure
d) Precision: data have sufficient detail.
e) Timeliness: data are up to date. Information is available on time.
f) Integrity: data are true.

Conditions at which data should be validated include at least the following:

I) Starting a new measure in general and a clinical measure in specific
II) Publishing the data to the community
III) Any change in the data collection methodology

IV) Unexplained results without justification

V) Change in the source of data

VI) Change in the scope of data collected

VII) Sent to external bodies

Survey process guide:

- GAHAR surveyor may review **The Ambulatory** data review and validation process and assess the implemented data review techniques.
- GAHAR surveyor may interview the responsible staff for data analysis to check their awareness.

Evidence of Compliance:

1. There is a written process for data review and validation as mentioned in the intent from I) through VII).
2. Responsible staff members for data aggregation, analysis, and validation are aware and trained about their roles.
3. Data is aggregated and analyzed on regular basis.
4. Data review techniques are implemented to ensure all the elements from a) to f) in the intent are considered.

Related standards:

QPI.01 Quality improvement plan, QPI.02 Performance measures, QPI.07 Sustained improvement activities, OGM.04 **The Ambulatory** head of departments.

Efficient risk management program

QPI.04 A risk management plan/program is developed.

Safety

Keywords:

Risk management program

Intent:

Risk management is designed to identify potential events that may affect the AHC and to protect and minimize risks to the AHC property, services, and employees. Effective risk management shall ensure the continuity of AHC operations. An important step of risk management is risk analysis at which you can assess the high-risk processes. The AHC needs to adopt a proactive approach to risk management that includes developing risk mitigation strategies. AHC should take reactive and proactive measures to address identified risks. The AHC shall develop and implement a risk management plan/program with essential components that include at least the following:

a) Scope, objective, and criteria for assessing risks.
b) Risk management responsibilities and functions.
c) Policies and procedures support AHC risk management framework.
d) Staff training on risk management concepts and tools.
e) Risk identification including, risk register.
f) Risk prioritization and categorization (i.e., strategic, operational, reputational, financial, other).
g) Risk Reduction plans and tools with priority given to high risks.
h) Risk reporting and communication with stakeholders and governing body.
i) The risk management program/plan is updated annually.

The AHC has a proactive risk reduction tool (e.g., Failure Mode Effect Analysis (FMEA)) that can be used in the AHC.

Survey process guide:

- GAHAR surveyor may review the AHC risk management program/plan, the risk register, and the risk assessment process.
- GAHAR surveyor may review the reported risk management activities and assess the risk mitigation processes.

Evidence of compliance:

1. The AHC has a risk management plan/ program that includes the elements from a) to i) in the intent.
2. Actions are taken according to the results of risk assessment.
3. Results of risk management activities are communicated to the governing body at least quarterly.
4. The risk management plan and the risk register are evaluated and updated at least annually or when indicated.
5. The AHC has a proactive risk reduction tool for at least one high-risk process annually.

Related standards:

EFS.03 Fire and smoke safety, EFS.07 Safety Management Plan, EFS.08 Pre-Construction risk assessment, EFS.09 Security plan, EFS.12 Disaster Plan, IPC.02 IPC program, risk

assessment guideline, ACT.04 Patient's flow risks, QPI.06 Incident Reporting System, QPI.07 Sentinel events, OGM.01 Governing body Structure and responsibilities, OGM.02 AHC Director.

QPI.05 An incident-reporting system is developed.

Safety

Keywords:
Incident reporting system

Intent:
Strong risk management is supported by efficient incident reporting systems that, as defined by the system, can identify an incident that could be any event that affects patient or employee safety. Reporting incidents has an important influence on improving patient safety. They can provide valuable insights into how and why patients can be harmed at the AHC level. In most AHCs, injuries, patient complaints, medication errors, equipment failure, adverse reactions to drugs or treatments, or errors in patient care shall be included and reported. Incident reports policy helps to detect, monitor, assess, mitigate, and prevent risks that includes at least the following:

a) List of reportable incidents, near misses, adverse events and sentinel events.
b) Incident management process includes how, when, and by whom incidents are reported and investigated.
c) Incidents requiring immediate notification to the management.
d) Incident classification, analysis, and results reporting.
e) Indication for performing intensive analysis and its process.

Adverse events can have significant negative consequences for both patients and staff. The AHC should understand the emotional and psychological impact of such incidents and should be dedicated to offering comprehensive support to the affected patients and staff, including both immediate and ongoing assistance. Transparent communication and thorough follow-up are ensured to address any concerns, fostering a culture of safety and trust.

Survey process guide:

- GAHAR surveyor may review the incident reporting policy, incident reporting list, a sample of reported incidents, and assess the corrective actions taken.
- GAHAR surveyor may interview staff to check their awareness of the incident-reporting system including identification, analysis, and correction of gaps to prevent future re-occurrence.

Evidence of compliance:

1. The AHC has an approved incident-reporting policy that includes items from a) through e) in the intent.
2. All staff are aware of the incident-reporting system, including contracted and outsourced services.
3. Reported incidents are investigated, and corrective actions are taken within the defined timeframe.
4. The AHC communicates with patient's/services users on any related adverse events they are affected by and provides both immediate and ongoing assistance.
5. The AHC provides emotional, psychological, and professional support to staff affected by adverse events.

Related standards:

QPI.05 Risk Management Program, QPI.07 Sentinel events, QPI.08 Sustained Improvement activities, MMS.13 Medication errors, near miss, medication therapy problems, adverse drug effects/events.

QPI.06 The AHC defines, investigates, analyzes and reports sentinel events and takes corrective actions to prevent harm and recurrence.

Safety

Keywords:
Sentinel events

Intent:
A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury. Serious injury specifically includes loss of limb or function. A sentinel event signals an immediate investigation and response. Root cause analysis is also indicated in potential adverse event (near-miss).Near-miss or close call is a serious error that has the potential to cause an adverse event but fails to do so, because of chance or because it is intercepted. Also called a potential adverse event.

The AHC is required to develop a policy for sentinel event management that includes at least the following:

a) Definition of sentinel events such as:
   i. Unexpected mortality or major permanent loss of function not related to the natural course of the patient' illness or underlying condition
   ii. Wrong patient, wrong site, wrong procedure events
   iii. Patient suicide, attempted suicide or violence leading to death or permanent loss of function
   iv. Unintended retention of a foreign object events in a patient after surgery or invasive procedure
   v. transmission of a chronic or fatal disease or illness as a result of infusing blood or blood products or
   vi. Wrong delivery of radiotherapy
   vii. Infant abduction or an infant sent home with the wrong parents;
   viii. Any peri-partum maternal death
   ix. Rape, workplace violence such as assault (leading to death or permanent loss of function), or homicide (willful killing) of a patient, staff member, practitioner, medical student, trainee, visitor, or vendor
   x. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams
   xi. Fire
b) Internal reporting of sentinel events.
c) External reporting of sentinel events.
d) Team member's involvement.
e) Root cause analysis.
f) Corrective action plan taken.

All sentinel events are communicated to GAHAR within 48 hours of the event or becoming aware of the event. All events that meet the definition shall have a root cause analysis in order to have a clear understanding of contributing factors behind the system gaps. The analysis and action shall be completed within 45 days of the event or becoming aware of the event.

Survey process guide:

- GAHAR surveyor may review the AHC policy for the management of sentinel events.
- GAHAR surveyor may review a sample of reported sentinel events and assess the investigation, root cause analysis, and corrective actions that were taken.
- GAHAR surveyor may interview AHC leaders to check their awareness.

Evidence of compliance:

1. The AHC has a sentinel events management policy covering the intent from a) through f), and leaders are aware of the policy requirements.
2. All sentinel events are analyzed and communicated by a root cause analysis in a time period specified by leadership that does not exceed 45 days from the date of the event or when made aware of the event.
3. All sentinel events are communicated to GAHAR within 48 hours of the event or becoming aware of the event.
4. The root cause analysis identifies the main reason(s) behind the event and the leaders take corrective action plans to prevent recurrence in the future.

Related standards:

OGM.01 Governing body Structure and responsibilities, OGM.02 PHC Director, OGM.04 PHC leaders, QPI.05 Risk Management Program, QPI.06 Incident Reporting System, APC.01 Accurate and complete information.

Sustaining improvement

QPI.07 Sustained improvement activities are performed within an approved time frame.

Efficiency

Keywords:
Sustained improvement activities

Intent:

Sustaining improvement requires empowering the AHC staff members for improvement. Although employees play a vital part in the continuous improvement process, it is management's role to train, empower, and encourage them to participate with ideas. An effective continuous improvement program needs continuous measurement and feedback. Before starting, AHC baseline performance needs to be measured. New ideas for improving performance can then follow. Plan-Do-Check-Check (PDCA) cycle, Focus PDCA or other improvement tools allow for scientific testing improvement progress. The cycle ensures continuous improvement by measuring the performance difference between the baseline and target conditions. This information gives immediate feedback on the effectiveness of the change that can help in measuring the impacts of a continuous improvement program and that is the most effective way of sustaining it.

Survey process guide:

- GAHAR surveyor may review an improvement project, to learn how the AHC utilize data to identify potential improvements and to evaluate actions' impact.
- GAHAR surveyor may review the AHC monitoring and control mechanisms to sustain the achieved improvements.

Evidence of compliance:

1. There is a written process or methodology for improvement.
2. Actions to correct problems are taken within the approved timeframe.
3. Improvement activities are tested, and the results are recorded and implemented.
4. There is evidence that patient safety processes are improved and controlled
5. Quality improvement activities are monitored and results are reported to the governing body.

Related standards:

QPI.01 Quality improvement Plan, QPI.02 Performance Measures, OGM.02 AHC director, OGM.04 AHC leaders, APC.03 Sustaining compliance with accreditation standard.